NHS
Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE
COUNTY COUNCIL

PLANNING TO MEET THE HEALTH & SOCIAL CARE NEEDS OF OLDER PEOPLE IN OXFORDSHIRE

OXFORDSHIRE
OLDER PEOPLE'S JOINT COMMISSIONING STRATEGY
2013 – 2016

Foreword by the Chairman and Vice Chairman of the Adult Health and Social Care Partnership Board

We are very pleased to launch the Oxfordshire Joint Older People's Commissioning Strategy 2013 – 2016.

We celebrate the fact that people are living longer. As the number of older people in the population increases, they are the main consumers of Health and Social Care Services. It is important that we work together to make sure the services we commission are right for people in Oxfordshire.

This joint strategy has been put together by a team of older people, people from the voluntary sector, our two local NHS trusts, the district and city councils, GPs and the County Council. We have consulted widely on the draft joint strategy.

Thank you for telling us what you think is important, what works well now, and what you would like us to do better. We hope this final document reflects what you have said and we will ensure that there are opportunities for you to continue to be involved in shaping services.

We look forward to working with you.

Chairman of the Adult Health and Social Care Board

Dr Joe McManners - Vice Chairman of Adult Health and Social Care Board

Introduction

1.1 This joint strategy sets out the areas where Oxfordshire Clinical Commissioning Group (OCCG) Oxfordshire County Council (OCC) will work together to support the delivery of: 'Ageing Successfully: Forward from 50'.

1.2 The joint strategy has been developed with a steering group of older people, carers, commissioners, providers and partners. Together we believe that a joint approach will work better for people in Oxfordshire.

1.3 Oxfordshire County Council is responsible for the social care and support of older people. Oxfordshire Clinical Commissioning Group is the body that commissions most health services. The Oxfordshire Older People's Joint Commissioning Strategy is designed to meet the needs of:

- Ageing adults
- Older People
- People with dementia
- Carers

1.4 'Ageing Successfully', published in March 2009, by the Oxfordshire Health and Wellbeing Partnership Board, sets out the vision and strategic direction for improving outcomes for Older People in Oxfordshire.

"We celebrate the fact of our ageing population. We want all people as they age to lead lives that are healthy and personally and socially fulfilling. Our mission will be to achieve significant and measured improvement in how we plan and deliver services so that our community will be supported to age successfully."

1.5 The total funding available in 2012/2013 to support this joint strategy is just over £360 million.

1.6 The joint strategy starts with a summary of some of our achievements so far. It sets out our vision for supporting older people, what success will look like as described by older people and our main priority areas. The big changes that are needed and how we are going to make them happen are set out in a detailed action plan. Other information and evidence is set out in the Appendices.

2. Consultation on the draft joint strategy

2.1 OCC and OCCG carried out a period of consultation on the draft joint strategy from 30 November 2012 to 4 February 2013. A wide variety of engagement methods were used to support the consultation, including a survey, two public workshops and presentations on the draft strategy to particular groups. Overall, a good range of responses were received, with 98 people taking part in the online survey.

2.2 Overall the survey responses were positive about the vision, what will success look like and the Six Main Priorities. Key themes from the survey comments and stakeholder groups were:

- Was the vision achievable in the current economic situation?
- More accessible information was wanted about where and who to go to for support
- The need for reassurance that the move to providing more services in the community would mean that care would improve and be right for older

people's needs

- Difficulty in accessing services, in particular for frail older people and older people living in rural issues
- Loneliness and isolation was raised again and again as an issue that had not been addressed
- Dignity and respect should run right through the strategy
- More focus needed on support and recognition for carers
- The emphasis on staying well and taking individual responsibility was welcome and should be strengthened
- Quality of services, delivered by skilled and trained staff, was a key area to improve
- Services joining up and working well together was seen as vital to putting the priorities into action
- People appreciated the opportunity to contribute to the joint strategy and wanted to be kept informed of progress with delivering the priorities

3. What we have achieved so far

- In February 2012 we undertook a survey of our Adult Social Care clients. The responses overall, and from older people in particular, showed a similar pattern with most people satisfied with the services they received (88% of older people) and feeling they had a high quality of life (88% of older people).
- People who use services, their carers, local communities, statutory agencies and their partners have a long history of working successfully together.
- We have a good record of supporting people to have choice and control over the services and support they receive. We have high numbers of older people who have a personal budget and high numbers of people who have decided to take their personal budget as a direct payment. We have also made good progress with introducing personal health budgets for people with continuing health care needs.
- We have developed a Crisis Response Service to ensure people get the support they need at home and avoid going into hospital unnecessarily.
- We are supporting more carers than we have done before.
- We have developed a new payment by results reablement service that started on 1 October 2012.
- We opened three Extra Care Housing Services during 2012, which means we have 407 extra care housing flats in Oxfordshire.
- We have built on the success of the stroke service in hospitals and we have met the high national standards in most areas of the service.
- We have significantly increased the number of people who have a specialist bladder and bowel assessment in the community, which means they do not have to go into hospital.
- We have reduced the number of people who go straight to hospital after having a fall (without sustaining a fracture) through them receiving an assessment and treatment at home within 3 to 7 days.

- We have put in place a new service for (mainly) older people who have had a fracture which will reduce the chance of them having a further fracture.
- To increase participation by older people in more healthy activities we have set up 'Generation Games', a new service that provides information and tells people where to go to join exercise classes.
- The number of older people and people with long term conditions with depression and anxiety who receive talking therapies has increased.
- The prescriptions for antipsychotic drugs in people newly diagnosed with dementia within Oxfordshire has decreased from 6.07 per cent in 2006 to 3.1 per cent in 2011.
- We now have a care home support service which provides valuable support to some of the frailest members of society through a team of nurses and therapists led by a consultant gerontologist. The service supports the professional development of care home staff and enhances the experience and outcomes for residents.

4. Vision - what are we trying to achieve?

4.1 We celebrate our ageing population in Oxfordshire; however we acknowledge that the natural effect of ageing means that the likelihood of ill health increases with age. We want all people as they age to lead lives that are healthy and personally and socially fulfilling. Our goal for older people in Oxfordshire is:

To enable people to live independent and successful lives

4.2 To achieve this, we will promote healthy approaches to ageing including encouraging healthy lifestyles along with a focus on reducing ill health through early identification of problems and intervention. We will also invest in community services to achieve better outcomes for people and reduce the need for hospital and inappropriate residential care, including ensuring quality of care in services.

5. What will success look like?

5.1 Older people, their families and carers, regardless of who they are, where they live and what their needs are, will be able to say:

a) I am generally healthy and I am aware of and supported to take actions to help me remain as healthy as possible as I become older.
b) I am aware of and able to access services and advice to keep me healthy and/or if I need help.
c) I take advantage of the free screening programmes available to me including the NHS health checks programme.
d) I am treated with dignity and respect.
e) I am given control of my care and support and supported to make choices in my daily life.

f) I do not have to describe what my needs are again and again to lots of different professionals and the services that support me are of the right level to cater for my individual needs.

g) I am protected from avoidable harm and supported to live safely in my home environment, yet I have my own freedom to make independent and informed choices.

h) I understand how my care and support works, my care is regularly reviewed in my best interests, and I know what the options are for what happens next.

i) I see public money being spent well by joined up services, without duplication and waste and in a fair and consistent way.

j) I am helped and supported to keep in touch with my family and friends.

k) I get the right treatment and medication for my needs and I get the support I need in the right setting.

l) I am happy with the quality of my care and support.

m) I find that all local organisations have policies that support me to maintain my independence and good quality of life.

5.2 The health and social care system will ensure that:

a) Services and advice are available and accessible to help people remain healthy for as long as possible.

b) The person and their carer/s are at the centre; services are designed around them and matched to the individual's needs.

c) Services will be planned and available on a seven day a week basis.

d) Support is provided in the most appropriate and timely way and at the closest point to the person's home/usual place of residence.

e) Where hospital care is needed, planning to move back home starts from day one of admission – with the aim of people living in the community, supported by local services.

f) Support for a person's physical, mental, cultural and social needs is co-ordinated and delivered in a joined up way.

g) Support is focused on improving the quality of care and quality of life and promotes dignity, human rights, choice and independence.

h) Needs determine the services people receive, not the location or who pays the bill and support provided is good value for money.

6. Six Main Priorities

6.1 Through the process of developing this joint strategy we have decided upon 6 main priorities. The first three cover the journey a person may make as they grow older and in need of support. Priorities 4, 5 and 6 are relevant to all the first three priorities. The priorities are not ranked in any order and each is as important as the other.

Priority 1: I can take part in a range of activities and services that help me stay well and be part of a supportive community.

Priority 2: I get the care and support I need in the most appropriate way and at the right time.

Priority 3: When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.

Priority 4: As a carer, I am supported in my caring role.

Priority 5: Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well.

Priority 6: I see health and social care services working well together.

6.2 We have also identified some cross cutting themes that are common to all the priorities:

- Promoting equality
- Loneliness and isolation
- Issues for older people living in rural areas
- Housing Options
- Information and Advice
- Dignity and respect

Priority 1: I can take part in a range of activities and services that help me stay well and be part of a supportive community
Where are we now? • The County has a growing older population, the number of residents aged over 85 is predicted to more than double by 2033 • We know that investing in preventative approaches keeps people well for longer but there is sometimes a lack of evidence about which service or approach is working well • People tell us they want information and advice about what is available - not everyone knows what is available to support them • Not all local policies and services encourage people to be independent, support each other and prevent people becoming isolated • We know that there are good things happening across Oxfordshire that support and involve older people in their communities, like Good Neighbour Schemes, but these are patchy and not consistent • The District and City Council have strategies to support older people in their communities, but these are not always in line with the priorities of the County Council or the Clinical Commissioning Group • The County Council has recently launched Support Finder - one place where you can find out about care and support services in Oxfordshire

Priority 2: I get the care and support I need in the most appropriate way and at the right time

Where are we now?

- Older people in Oxfordshire expect a flexible range of services built around their individual needs so that they can maintain independence and stay as close to home for as long as possible
- The proportion of money Oxfordshire spends in the community is lower than elsewhere and money needs to be re-invested in community services
- Spending on older peoples' services in Oxfordshire is higher than might be expected compared to other areas but satisfaction is lower than might be expected
- There are many services that support people in the community but people are not aware of them.
- Joined up care is the exception rather than the rule
- Current models of care appear to be outdated at a time when society and technology is developing rapidly and changing the way older people communicate with providers of services
- Care still relies too heavily on individual and expensive professional input although older people want to play a much more active role in their care, support and treatment
- It still appears to be easier for someone to be admitted to hospital than be supported with appropriate services at home
- Services that support people at the end of life are good but not consistent
- There are different methods across Oxfordshire in the way that GP's and primary care decide on the services and next steps for people
- Because Oxfordshire is a rural county we need to make sure that people are able to get to the right support and services

Priority 3: When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready

Where are we now?

- More work is needed to avoid hospital admission in the first place
- There is general consensus that older people are admitted to care homes too early particularly from hospital and for people who pay for their own care
- It takes too long for people to be supported back home after a period of time in hospital
- Services do not always see older people as part of the care team
- The current quality of care in hospitals is variable. For example, last year it was reported that there was poor nutrition for some patients and although this has improved, it needs to improve further[1]
- Outpatient appointments are not always sent out in time for people to attend and there are too many cancelled appointments
- Health and social care teams need to work better together
- We need to ensure we use new medical technologies effectively
- We need to make better use of research and information

[1] CQC Dignity and Nutrition Inspection programme October 2011

Priority 4: As a carer, I am supported in my caring role

Where are we now?

- An increasing number of people are engaged in caring for elderly friends and relatives and many more volunteer to help. Many of these people are elderly themselves
- We are supporting more carers than before but we need to focus on identifying more carers so we can offer advice and support
- Increasing numbers of carers have used a direct payment to support them continue their caring role

Priority 5: Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well

Where are we now?

- There is a growing number of people with dementia in the County
- Early diagnosis is getting better but needs to improve further
- People with dementia and their carers face stigma and isolation and are fearful of making themselves known
- Staff working with people with dementia need more support and training to help them deliver high quality care
- Services focus on physical health rather than providing a joined up service that takes account of a person's mental and social care needs

Priority 6: I see health and social care services working well together

Where are we now?

- People in Oxfordshire have told us that they want health and social care services to work more closely together
- There is strong commitment of services to working in partnership in Oxfordshire
- There is a joint health and social care budget for older people but it does not include all the funding available to support older people or the ability to use funds flexibly
- Service providers have told us that the Council and Clinical Commissioning Group sometimes put incentives in their separate contracts with providers that may work against each other
- We need to work differently to make the best use of the money available

Action Plans

Priority 1: "I can take part in a range of activities and services that help me stay well and be part of a supportive community"				
No	**What we are going to do and expected benefits**	**Actions**	**Timescale**	**Commissioning Lead**
1	Encourage adults to be more physically active *More older people to be involved in physical activity leading to improved health and well being*	1. Commissioned 'Generation Games' an active aging project. Contract with Age UK, to end February 2015.	Start Summer 12 and end Feb 2015	OCCG
2	Working with all agencies we will support communities to develop initiatives to maintain good health and wellbeing and reduce loneliness and isolation. For example, develop dementia friendly communities, time banks to exchange skills and voluntary transport schemes *Addresses loneliness and isolation and enhances well-being. Evidence is that this improves quality of life and enables people to remain independent for longer*	1. Work with the city, district and town and parish councils to ensure all our policies support this strategy	April 13-March 14	OCC
		2. Review of outreach service with aim to re-procure by Oct 13	April- Oct 13	OCC
		3. Tier 2 day service reviews	Oct -13	OCC
		4. Ensure that it is clear when a service is free for people or where there may be a charge	July -13	OCC
3	Ensure eligible adults between the ages of 40 and 74 are offered an NHS health check once every 5 years. *Enables people to stay healthy and living independently at home*	1. Ensure that the NHS Health checks programme is extended to include alcohol brief advice and dementia awareness	April -13	OCC Public Health
		2. Work with GPs to make health checks available from every GP practice in Oxfordshire	July -13	
		3. Raise public awareness to ensure that uptake of the programme achieves at least 50%	Nov-13	
4	Offer winter flu vaccinations to people aged 65 and over And that people under the age of 65 who are at risk because of other health conditions are offered flu vaccination. *Enables people to stay healthy and living independently at home*	1. There will be an effective flu campaign that will ensure people who are at risk from flu or over the age of 65 will be offered a flu vaccination within their local community	Commences Oct 13	Public Health England with OCC Public Health
		2. Regular data will be provided to GP practices to ensure that they have information to enable them to achieve 75% of over 65'S vaccinated	Nov 13 -Feb 14	
		3. Work with OCCG to develop plans and targets for improved uptake of vaccination for people in at risk categories under the age of 65	Sept- 13	
5	Increase the number of people who have quit smoking *Enables people to stay healthy and living independently at home*	We will procure additional services which will offer smoking cessation to people outside of traditional settings	July -13	OCC Public
6	Ensure high levels of uptake for cancer screening programmes *Enables people to stay healthy and living independently at home*	1. We will work OCCG localities to identify low uptake groups and to develop local plans to improve uptake	March- 14	Public Health England with OCC Public Health
		2. Regular data will be provided to GP practices to ensure that they have information to enable them to monitor uptake	Nov 2013	
7	Develop a range of options to help people with practical support in their own homes (such as handyman services, shopping, gardening and cleaning) *Enables people to stay healthy and living independently at home*	1. Review range of current services	July -13	OCC
		2. Work with providers to improve offer	July -13	OCC
		3. Stimulate the market to provide these services or re-commission, decommission or commission new services	March- 14	OCC
8	Develop an information and advice service that supports people who have their own funds to buy their own care and support services *Enables people to stay healthy and independent, increases choice and control. Less people choosing care homes too early*	1. Carry out a needs analysis	April- 13	OCC
		2. Develop a range of options	April -13	OCC
		3. Agree specification	June -13	OCC
		4. Commission new service	Nov- 13	OCC
9	Ensure that advice is given to support people to help themselves as part of preventing illness or a recurrence of an accident/illness and encourage and support people to start thinking	1. Information specifications to include advice on preventing illness.	To be confirmed (TBC)	OCC)
		2.Communications and media plan	TBC	TBC

	of and planning early to meet their needs as they get older and also take more responsibility for meeting their own needs *Prevention and enables people to stay healthy and independent*			
10	Ensure that people get the right equipment and/or assistive technology *More people living independently at home. Reduced need for expensive care services*	1. Review and develop equipment strategy and that includes improved used of assistive technology	March -13	OCC
		2. Deliver action plan	May 13-Dec 14	OCC

Priority 2: "I get the care and support I need in the most appropriate way and at the right time"				
No	**What we are going to do and expected benefits**	**Actions**	**Timescale**	**Commissioning Lead**
1	Review and redesign the range of community services that support people: • To live independently at home and receive good quality local support of their choice, when needed • To avoid getting into a crisis situation • If a crisis occurs *Admission avoidance supports people at home for longer so reduces length of stay in acute hospitals and care homes, and Continuing Health Care. People have their needs met quickly and therefore reduce the need for long term care and support*	1. Describe how services should look to: - Avoid admissions to hospital - Ensure early and appropriate discharge from hospital - Ensure people are supported well at home	By May- 13	OCC and OCCG
		2. Review existing services against these models and make recommendations for change Services to look at are: reablement, supported hospital discharge service, hospital at home service, community nursing service, community bladder and bowel services, end of life services, alert service, Health and Well Being Centres, community hospitals, intermediate care services, crisis response service, therapy and rehab services, domiciliary care services, care home support service	By July- 13	
		3. Implement Single Point of Access	April- 13	
		4. Review the rehabilitation and reablement service and decide on the future shape of that service in preparation for re-procurement in 2014/15 as a result of 2 above	March- 14	
		5.Implement integrated health and social care locality teams	TBC	
		6. Agree an overall model to include integrated services, diagnostics, bed based services and integrated GP/Gerontology/Psychological support for the community		
		7. Review communications services for people with strokes		
		8. Improve secondary prevention services for people who have had fragility fractures		
		9. Increase the use of equipment and assistive technology	March- 14	
		10. Implement discharge to assess across OCC, Oxford University Hospitals and Oxford Health		
		11. Improve the support and services that people receive when they are in a care home - for short or long term		
		12. Reduce waiting lists - with use of winter pressures funding	13. June- 13	13. OCC
		13. Review of Shared Care Protocols		
2	Ensure that we have the right number of Extra Care Housing (ECH) places (housing with personal care provided on site) available.	1. Implement ECH plan	April 13 - March-15	OCC

	Increased number of older people living at home. People with dementia having needs met in appropriate way	2. Review options for extending the ECH plan	June-13	OCC
		3. Develop range of dementia appropriate services for ECH	March-13	
3	Work with the City and District Councils to develop good housing options *More people living independently at home/ in new home and more people having needs met appropriately and better use of resources and reduced costs*	1. Joint seminar to identify alternative housing options	Jan-13	OCC
		2. Develop housing strategy and implementation plan	July-13	OCC
4	Ensure that the transport needs of people getting to services and supports are taken into account *People are able to attend the range of supports/services and leads to more people living independently and reduced loneliness and isolation*	1. Review current position and develop plan	TBC	OCC
5	Promote personalised ways of working and improve choice and control through the extension of personal budgets and personal health budgets *Improved choice and control, more people having needs met appropriately, better use of resources and reduced costs*	Ensure roll out of Personal Health Budgets and personal social care budgets.	2014/15	OCC and OCCG

Priority 3: "When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready"				
No	**What we are going to do and expected benefits**	**Actions**	**Timescale**	**Commissioning Lead**
1	Improve the experience and services that people receive when they are in hospital *Improves quality, efficiency and effectiveness ensuring people are treated well and discharged in a timely way that promotes independence and well being*	Dignity and respect Improve the care of people needing end of life services		OCCG
2	Work with Care Homes to ensure the care home market delivers good quality and safe provision at a market price that is financially sustainable, for people who are self-funders and council/NHS funded *Development of the right range and number of care homes for Oxfordshire. People supported well in care homes with good quality care. Reduced and appropriate admissions to hospital*	1. Agree commissioning intentions that will inform market position statement	Apr-13	OCC
		2. Implement Order of St John delivery plan	April 13 - March 14	OCC
3	Ensure that services are safe and secure by regular contract reviews and information gathering on providers and target work with poor performing providers and working with the Oxfordshire Safeguarding Adults Board *Improved quality and reduced risk to clients/carers. Improved carer and client satisfaction*	1. Agree quality standards	TBC	OCC and OCCG
		2. Agree monitoring process	TBC	
		3. Reviews based in risk analysis		
4	Actively work with people who use services and carers, local communities and partners in the design, development, purchase, delivery and review of local support services *People engaged and able to contribute to success of strategy.*	1. Complete consultation on the strategy	March 13	OCC and OCCG
		2. On-going involvement of steering group	March 13- Sept 13	OCC and OCCG
		3. Develop Older People's Partnership Board	Sept- 13	OCC and OCCG
5	Commission services in a way that ensures good outcomes/making a difference for older people and their carers and ensure that	1. Outcomes in all specifications and contracts	March-13 and ongoing	OCC and OCCG

	contracts with service providers are set up so that they work together to deliver this strategy and are rewarded to do so *Focus on outcomes that matter for people Improved joint working, less handovers, more flexible support services*	2. Agree NHS/OCC approach to outcomes based commissioning and provider collaboration		

Priority 4: "As a carer, I am supported in my caring role"

No	What we are going to do and expected benefits	Actions	Timescale	Commissioning lead
1	Increase the identification of all carers across Oxfordshire to: *More carers supported early and report improved involvement in decision making and support planning with/about the person they care for.*	Agree targets with each partner agency, using the Carers Strategy, for improved identification rates. Carers Board to receive and monitor reported data. Improve data collection and management. Improve identification of and service planning for Black and Minority Ethnic groups and "hard to reach" carers.	March-14	OCC
2	Improve access to emergency support for all s *Reduces carer stress, reduces admissions to acute hospital, improves quality of life, reduces admissions to care homes and call on 'Funded Nursing Care' and CHC funding*	Increase marketing of current emergency support services. Seek opportunities to integrate emergency response activities.	March -14	OCC
3	Provide more direct payments to support carers to have a break. Provide better support for carers to remain in employment *Reduces carer strain, reduces admissions to acute hospital, improves quality of life, reduces admissions to care homes and call on 'Funded Nursing Care' and CHC funding*	Audit of current uptake of carer breaks to improve targeting. Review and develop improvement plan for respite provision. Agree future resourcing for carer breaks and support for 2015/16.	March -14	OCC
4	Continue to provide carers with support and training to help them support people in a safe way, such as moving and handling training *Reduces carer strain, reduces admissions to acute hospital, improves quality of life, reduces admissions to care homes and call on 'Funded Nursing Care' and CHC funding*	Identify carer training needs at point of first contact. Improve marketing carer training opportunities, to improve and target early uptake.	March -14	OCC

Priority 5: "Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well"

No	What we are going to do and expected benefits	Actions	Timescale	Commissioning Lead
1	Develop a dementia awareness campaign and dementia friendly communities *More people with dementia supported to continue living in their own home. Increased independence*	1. Use the Dementia Challenge fund to create 60 learning groups across the county.	Mar-14	OCC and OCCG
		2. Endorse and support awareness campaign by voluntary organisations.	April 13- March 15	
2	Improve information and advice and guidance services *Combining early diagnosis and support with ensuring dementia friendly communities reduces the probability of people going in to care homes by 2 years, therefore reduces call on FNC and CHC funding. Early support to carers*	1. Commission Dementia Web Oxfordshire.	Oct-13	OCC and OCCG
		2. Dementia Advisers and support workers will be able to download paper copies of information required.	Oct 13	
		3. Provide information covering the dementia pathway on the regional website www.ourhealth.southwest.nhs.uk	June-13	OCC and OCCG
3	Implement the learning site proposal for a collaborative model between primary care and Oxford Health in South West Locality. Improve memory clinic services *Early and more diagnosis of people with dementia will lead to more people being supported to live independently at home and reduce hospital admissions. Early support to carers*	1. Continue to monitor and review the operations of the memory services.	Mar-14	OCCG
		2. Facilitate collaboration between primary and secondary care to ensure timely diagnosis and effective support closer to people's homes.	Mar-14	OCCG

4	Put in place a service that trains staff in hospitals and in the community to be more aware of the needs of people with dementia *Early and more diagnosis of people with dementia will lead to more people being supported to live independently at home and reduce hospital admissions. Early support to carers*	Use the Dementia Challenge Fund to train the workforce in both hospital and community. Dementia CQUIN and OUH Inpatient Integrated Psychological Medicine Service, which requires some awareness training, is being implemented.	Mar-14	OCC and OCCG
5	Ensure that all health and social care services understand the needs of people with dementia and provide a quality service to them *Early and more diagnosis of people with dementia will lead to more people being supported to live independently at home and reduce hospital admissions. Early support to carers*	To be achieved through CQUIN, Sustainable Workforce project funded with Dementia Challenge monies. Embed this is in service provider contracts.	Mar-14	OCC and OCCG
6	Provide continued support for carers of older people with dementia through day opportunities and training support *Early and more diagnosis of people with dementia will lead to more people being supported to live independently at home and reduce hospital admissions. Early support to carers*	Training for carers (including CBT) is being provided. Take up of carer's respite fund through GPs is being monitored.	Mar-14	OCC

Priority 6: "I see health and social care services working well together"				
No	**What we are going to do and expected benefits**	**Actions**	**Timescale**	**Commissioning Lead**
1	Develop a set of clear commissioning intentions to support the health and social care market to deliver services – this will include a market position statement from June 2013 *Clear set of outcomes and actions communicated to the market to ensure people's needs are met in a timely way*	1. Strategy published after c consultation	March-13	OCC and OCCG
		2 Delivery plan agreed	Delivery plan from April -13	OCC and OCCG
		3. Market position statement	Market position statement June -13?	OCC
2	Review the pooled budget arrangement and extend the services and budgets to be included in pool *Supports the delivery of the commissioning strategy. Facilitates integrated services*	1. New S75 in place for June 13. With Agreed services and funding to be brought into a larger pool. Agreed risk sharing. Agreed governance, membership and terms of reference	June-13 April-13	OCC and OCCG
3	Ensure that there is a trained and skilled workforce available to meet the range of needs of older people *Skilled and trained workforce to meet increasing demands*	1. Develop workforce strategy		OCC and OCCG
		2. Implement and communicate strategy		
		3. Annual review		