Priority 5: Maintaining Independence				Age Well
We will support more older residents to remain independent and healthy for longer. We will ensure they are always treated with dignity and are fully valued				
Shared outcomes	**Updates on activities delivering on priority**	**Challenges to progress**	**Plan for the year ahead**	**RAG Rating**
5.1 More older residents to remain well, safe and independent in their home for longer	• **Physical activity programme** • Active Oxfordshire -Participants recorded 36% fewer GP appointments in the 4 weeks prior to their 3-month review following being part of Move Together, compared to the 4 weeks before their initial assessment. This can be translated into a saving of 4 GP appointments per participant per annum. -There was a 28% reduction in 111/out-of-hours demand in the 4 weeks prior to the 3-month review compared to IA, and participants reported 12% fewer falls -60% of those having a 3-month review had increased the amount of activity they were doing between the initial assessment and 3-month review. Of those who achieved an increase in activity, the average weekly increase was 316 minutes per week or 45 extra minutes a day. This is the equivalent of an extra 4,500 steps per day at a moderate pace. • Age UK Oxfordshire -944 people have taken part in a community class in the last year. -% of participants who have tripped or fallen has decreased from 41% prior to 34% during the 12 week stay strong and steady classes. -% of people that had to attend A&E after a fall decreased from 11% prior to 1% during the 12 week stay strong and steady classes	Both these contracts have now been formalised but are due to end March 25. Both these contracts included short term investments that have not been confirmed going forward (from April 25). Full procurement exercise will need to be undertaken as there is no option to extend beyond March 25.	Oxfordshire falls pathway is currently being reviewed with key stakeholders from the system being involved. One of the main aims of these contracts, when initially set up, was to be aligned and fully supporting the health and social care service provision in the prevention and management of falls in Oxfordshire. This alignment was made possible with the improvements implemented as part of the new contract as of 1.4.23. More work is being done now to map out all of the services involved in the falls pathway to further identify gaps and improvement opportunities. More focus is being added on prevention as well. This contract is within the scope of this review and any recommendations can then be taken forward in time and within procurement requirements.	Green

	Review of Falls pathway and reduction in >65 admissions in Q1 2425
	
	• Oxfordshire falls pathway is currently being reviewed with key stakeholders from the system being involved. One of the main areas we are focusing on is the interface between services. Mapping exercise has shown that in theory we have all the services we need in the system, and it is the interface between them that needs to be further improved.
		Sustainability is the main challenge we are focusing on at present. The number of falls related admissions has been going down and the main focus of the group is to maintain and sustain that performance. The actions in the plan for the year ahead have been identified to support this challenge.	• Deep dive into 20 acute admissions and analysis of the opportunity to have prevented admission
			• Deep dive into GP practices with significant falls admissions increases
			• Explore why 14% of falls admissions from November 23 deep dive don't relate to falls: data recording or referral issues?
			• Identify the opportunity to avoid high % of admission rate (64) for frailty score of less than 6
			• MIL (Medication Information Leaflet) implementation
			• Development of out of hours support options across UCR/SCAS
			• Expansion of Call before convey 24/7: for October 24
			• Information and preventative support
			  ○ AUKO leaflet
			  ○ AUKO/Falls service interface and joint working
			
			Isle of Wight model to be further explored
				Green

	Our Better Care Fund (BCF) Plan for 2024-25 includes plans for schemes specifically to reduce non-elective admissions for long-term conditions – see 'Plans for Year ahead column At the time of writing, actual admissions have reduced by 1% year on year since 2021-22 and admissions to Same Day Emergency Care (SDEC) settings have increased by 5%. Note that the increase in SDEC admissions includes a planned increase in people who are seen in same day emergency care and then returned home without admission to a bed.	Some specific avoidable admission projects for BCF have not yet commenced i.e. Heart failure readmissions	Our Better Care Fund plan for 24/25 forecasts a net reduction of 0.9% for avoidable admissions. Our plan contains several schemes that support this, including: • Expansion of Integrated Neighbourhood Teams and Virtual Wards. Working with UCR and BCF funded community SDEC this capacity increases Oxfordshire's ability to support more complex people in the community • Targeted schemes around Heart Failure readmissions and admission avoidance from ED • Step up capacity to avoid admission from ED and SDEC for high intensity users, including people with mental health and alcohol-related conditions.	Amber

	Hip fractures: 23/24 has seen a reduction in hip fractures after the post covid increase we saw in 21/22 and 22/23. Numbers in 23/24 are lower than pre covid period of 2019/20 as well	Still working on reducing numbers. reduce the number of emergency hospital admissions due to falls in people aged 65 and over as measured by BCF metrics. Plan trajectory needs to be <7 per day. We need to reduce falls by one per day for target.	Data is still being reviewed at present to understand these numbers i.e. GP practice performance, care homes vs homes, male vs females. Falls information leaflet and resource is being developed that will provide advice and information to people at risk of falls and their families around: importance of environment (clutter etc), vit D supplements, exercises they can do on their own and other risk factors and things they can do to mitigate them.	Amber
5.2 Enable older people who have lost a degree of independence to regain independence or support their health and wellbeing in their chosen setting	**Expansion of discharge to assess (D2A)** The D2A model was rolled out across Oxfordshire from January 2024 and has seen an average of 425 referrals per month since. The model has significantly improved flow through reducing the number of pathway 2 beds.	There have been issues with payments processes and internal infrastructure in the Council. A new payments process is being developed to address this. Sometimes D2A packages are not picked up during the morning huddles with providers. As a workaround, they are being sourced via e-Brokerage under D2A mitigation and picked up by Zonal Providers The shift to home assessments can be difficult for patients and their families. The Social Connections public engagement programme with BOB ICB has helped us address the public's concerns. Additionally, Healthwatch are conducting a review on people's experience of being discharged from hospital. The final report will be published in the Autumn and will be used to improve the framework.	We are developing our internal infrastructure, including payments and data collection to better support the D2A model. The 2 year extension of our Live Well at Home Framework for all reablement and home care providers will support this. We launched a Trusted Assessor pilot in June which has shown promising impact on the flow of cases through D2A. The pilot intends to promote safe and timely discharges from hospital to Adult Social Care by using assessments carried out in hospital. This avoids the need for an assessment at 72 hours by OCC staff and supports the provider in deployment of staff.	Green
	Q1 2425 performance on discharge home • At month 3 we are at 92.4% of discharges to usual place of residence. This is slightly ahead of our 92% for this point in the year. This progress has been supported by the reclassification of returns to care homes as P0s (from P3) and will continue to rise as our data quality improves.	There have been challenges around implementing our Live Well at Home Framework to support fast discharge. Where providers cannot pick up care quickly, the care is distributed via our e-brokerage systems which lengthens the process for discharge. We are addressing this as part of the extension for the contract.	Our BCF plan for 24/25 projects that we will reach 95% discharges to usual place of residence. Our plan to achieve this is as follows: - Continue with the implementation of D2A and Trusted Assessor approach - The Transfer of Care hub is moving into oversight of all hospital discharge	Amber

	• We have reduced the Length of Stay for those who are Medically Optimised for Discharge in all pathways during 23/24 and plan to further that in 24/25 through the embedding of D2A and the implementation of more trusted assessor approaches across our pathways.		pathways (including Mental Health) and we have opportunities to reduce the Length of Stay across these. - Our BCF plan supports more complex people who interact with acute and mental health pathways. It supports admission avoidance and complex discharges, particularly for people with presentations relating to mental health and homelessness, including alcohol issues. - The BCF plan also supports the development of out of hospital and targeted support for people living with learning disability and or autism; both in improving discharge planning from acute and specialist settings, and in providing alternatives to admission and increased housing options - In July we launched a new care homes framework for social care that specifies care needs and inputs required to reduce the level of debate and delay for patients on P3 pathways.	
	Reablement performance on back to independence • The Live Well at Home Framework is delivering on its aim to support Oxfordshire residents to live independently at home. Aligned with the intentions of the Framework, the majority of reablement cases achieve independence or a reduction in care needs. At the time of writing, across all 5 zones, an average of 76.3% of reablement cases are discharged independent, exceeding the 65% KPI target. For independence and reduced care needs combined across all 5 zones, the average is 88.76%, exceeding the 75% KPI target. • The majority of people who are identified as requiring long-term care after a Reablement episode have a reduction in their care needs. Since September 2022, there has been an average of a 60% reduction in the average number of care hours following reablement across all 5 zones.	**Length of Stay in Reablement** • LoS has reduced over time but there is opportunity for further reduction. The average LOS for reablement across all 5 zones is 31.5 days. This exceeds the KPI for 21 days	We are aiming to further reduce the Length of Stay in reablement through further developing the efficiency of the LWAH framework. Our developing Technology Enabled Care Strategy also has the potential to support independence outcomes.	Green

	Community reablement • We have seen a steady increase in community reablement starts since January 2024. This aligns with our aim of working proactively to support people in their own homes and prevent admission to hospital. **Short Stay Hub Beds (SSHB)** The SSHB service enables quicker discharges from the acute hospitals for individuals that require a bed service for rehabilitation or if they require a period of care/assessment and cannot return home and do not require a hospital bed. These beds have direct therapy input which enables more individuals to go home.	As expected, referrals into D2A from community reablement remain significantly lower than referrals from hospitals. There is opportunity to further increase these. We have reduced SSHB upon introduction of the D2A programme. The SSHB now seem to have more referrals for complex needs.	An increased focus on community-based services as outlined in the rest of this document should result in an increase in proactive reablement referrals. The SSHB contract will end in March 2024. Along with system partners we are drawing up a new model of care for these beds that is in line with the current level of needs. We expect to go out to procurement early next year to secure this service and for continuation of this vital provision. These beds help to reduce the LOF in hospital and are well used with low voids.	Amber
	Dementia diagnosis rate Previous OH memory clinics demand and capacity analysis completed showing a shortfall of 310 diagnostic episodes to achieve 66.7% by March 25. With current activity DDR is expected to be 64.3% by March 25. CMHT and OUH data not yet received, but activity is expected to be lower. Approximately 600 people on the waiting list.	Capacity in memory assessment services (MAS) is the main challenge because: • Dementia prevalence rates increase every year and therefore more diagnostic activity is required just to maintain the DDR • Higher mortality rates increase the number of dementia diagnoses needed each month to replace those going off the dementia register which further exacerbates the commissioning gap.	Some of the other mitigating actions include diagnosing people in care homes via DiADem tool and data cleansing exercise in primary care.	Red

		There are also a number of contributing factors which are impacting on the capacity and efficiency of memory assessment services: • Post-Covid backlogs put high demand on services (ie. resources required to triage and manage a waiting list). Unless we address the capacity issue in memory clinics, we are not going to see much improvement to the DDR. With the current capacity and mitigating actions, we are only able to maintain current performance.		
	Care homes admissions: use of Care bands Where an individual requires a care home bed, this is sought in a timely manner	In July 2024 a new integrated Care Home Framework (CHF) was introduced to purchase care home beds for those with eligible needs under the Care Act 2014 and those meeting the eligibility criteria for 100% CHC (NHS Continuing Health care) funding. A care bands model has been applied to the CHF which is understood by operational staff and by providers. This model defines the care needs of the individual and care delivery inputs. There was extensive engagement during 2023 with the Council and Health staff, care home providers and residents of care homes and their families. The CHF aims to standardise the quality of care within the care homes. This is in the early stages and in time will be able to show our spend under the different care bands. Automated E-Brokerage is being used to send and allocate referrals thereby saving valuable time for the providers and the Council staff and enabling quicker admissions to care homes.	We have a good level of care home providers on the CHF; however, we noted more providers showed interest hence the Council has decided to re-open the CHF in Sept 2024. By December this should increase the number of care homes available on the CHF and thereby increasing the choice available to meet the needs of individuals requiring a care home placement. By Nove/Dec we will be able to view reports showing our placing behaviour and spend across the different care bands; helping us budget for future placements. It should also highlight any gaps in our services. We aim to seek any future block bed arrangements through the CHF which guarantees a set of terms and conditions including quality criterion.	

	Care homes admissions: use of ECH • All requests for residential care home placements are now scrutinised by senior ops managers at the ASC managers forum, all requests need to demonstrate they have considered ECH before being approved • We have asked ops managers to ask the question *how could this person be supported in ECH instead of a residential care home?* Commissioners could consider options for additional service requirements to support while ensuring ECH doesn't become a quasi-residential care home. • Ongoing marketing and education, raising awareness of ECH amongst social care & stakeholders especially around routes to appeal.	We believe it's possible to achieve a diversion of approx. 15% of care home placements into ECH measured by our soon to be published specialist housing needs analysis, but this is reliant on: 1. Allocations panels for each extra care housing schemes that meet regularly and have up to date data about vacancies in and applicants for extra care housing (for each scheme). 2. Allocations panels that are chaired by a representative from the local authority Adult Social care team. 3. An extra care housing allocations policy with eligibility criteria that prioritises applicants with local authority social care eligible care needs (over applicants with no care needs). 4. A local authority front line social care staff team that is focussed exclusively on assessing applicants for extra care housing schemes and being fully aware of the balance of care needs in existing extra care schemes, to ensure vacancies are filled by people with the most appropriate eligible care needs from the local authority's perspective (and to reflect the mix of care needs agreed for a scheme). Elements 1 – 3 are in progress and require part adjustment. Full realisation of the ambition is reliant on dedicated operational resourcing in 4 above.	• Refine the allocations panel process • Produce an Extra Care Housing strategy/market position statement supplement that factors in the outcome of the needs analysis. • Continue to seek additional commissioning and dedicated ECH operational resource.	Amber
	Oxfordshire Way and supporting people at home <u>Community Links & Social Prescribing</u> As at July 2024, 73% of referrals made by Adult Social Care to the Community Links Service by Age UK Oxfordshire no longer require intervention from Adult	The service is fully staffed but working over capacity due to demand.	Outcomes impact analysis, and analysing feedback from one to one community connecting support.	Green

	Social Care after connecting support from Community Links. <u>Urgent Community Links & Oxford Health Age Well team work</u> Works with people within the acute and community hospitals who are medically fit to return home, assisting with support arrangements necessary to enable the person's discharge and to avoid readmission. Successfully supported 2244 in hospital in 2023-24. Also supported 354 people jointly with the Ageing Well health teams with a focus on the early, multifaceted support to the most frail people who are most at risk of an episode leading to institutional care, so that they can stay happily and actively in their community for as long as possible.	Challenge is managing the significant increase in referrals.	Continue to support timely and safe discharges from hospital and avoiding admissions or readmissions.	
5.3 More older people empowered to take part in decision making about their own health and wellbeing	**Live Well Oxfordshire** Live Well Oxfordshire care and support guide 2024-25 published in July 2024 brochure for people that are digitally excluded. Live Well Oxfordshire online directory is promoted via Champions and at various groups on a rolling programme. In 2022 there were 68,524 visits to the Live Well Oxfordshire online directory. This increased to 141,497 in 2023. Included in this were 182,219 page views in 2022 which rose to 347,447 in 2023.	It has been a challenge working with the developer to ensure enhancements are able to be completed on our timeline.	Funding has been received to develop Live Well Oxfordshire to include guided searches and Care finder which will assist people in finding care solutions. Plans for a marketing campaign for Live Well Oxfordshire aligned with the Oxfordshire Way	Amber

	Specialist advice service There are many Oxfordshire residents experiencing financial difficulties relating to benefits and not everyone is claiming what they are entitled to. The recently commissioned **advice service** will have a particular focus on ensuring it is promoted to and accessible to people living in the Lower Super Output Areas (LSOAs) in the county which are classified within the 20% most deprived nationally and most likely to experience inequalities, and to people with protected characteristics. The service will include preventative training for people in communities before they reach a crisis point. This may include training on money management, budgeting and awareness raising for sources of support. This will be an empowering service supporting people to take responsibility for themselves and to develop skills.	A challenge is ensuring that people are claiming benefits they are entitled to which can impact on health, housing etc. Working stigma. Health inequalities.	New contract starts 1 October 2024. Combined with health inequalities work. Prevention offer – community based education. Citizens Advice services have joined up, and therefore should be easier for people to find the right door.	Green
	Co-production Advisory Board The Board is made up of experts by experience. The members look at the work of the Council and collectively offer advice on how co-production may be applied to projects. We have recruited members from existing informal networks of citizens who have drawn on our services in Oxfordshire. We are currently co-producing a recruitment campaign that will attract other citizens who have been persistently under-represented or excluded from most forms of participatory work with local authorities. Our current membership includes those who have experienced service provision of domestic abuse, homelessness, Mental Health and unpaid carer support.	Ensuring awareness of co-production processes and opportunities are well known and developed. Ensuring the voice of people who draw on care and support is in all commissioning/operational activity. Cultural change is a challenge.	Creating a consultation group of older people to help us to co-produce future commissioning requirements with the support of Age UK Oxfordshire. Foster active community participation through events, regular forums for open dialogue, and collaborative decision-making processes on initiatives that promote unity.	Amber
	Dementia Oxfordshire Service designed to reach all people living with dementia in the community. Co-designing training and leaflets to support the dementia community with people who draw on care and support. co-produced support and education sessions that have been created with the help of people who are	Contingency planning requires support and promotion for the person living with dementia and their carers/families.	Mild Cognitive Impairment included in the contract with Age UK Oxfordshire will be developed further. Dementia Plan ongoing. Support the promotion of the training for carers and people living with dementia, and professionals.	Green

	living with the condition themselves, for people living with dementia and their unpaid carers. These include post diagnosis sessions and Understanding dementia for informal care givers.			
	Health inequalities Tackling health inequalities is a priority in the operational plans of our partners and stakeholders. For example, supporting Age UK Oxfordshire as it works with LGBTQI+ older adults in including their voice in services.	Challenge is reaching people to enable their voices to be heard, and to ensure all commissioning activity reflects all aspects of the community.	Strengthen the recruitment of staff from all communities. Support the community groups across Oxfordshire that can offer a range of support, and which address the increased barriers that exclude groups experience, to help increase resilience	Amber

Priority 6: Strong social relationships — Age Well

Everyone in Oxfordshire should be able to flourish by building, maintaining, and re-establishing strong social relationships. We want to reduce levels of loneliness and social isolation, especially among rural areas.

Shared outcomes	Updates on activities delivering on priority	Challenges to progress	Plan for the year ahead	RAG Rating
6.1 More connected communities and closer links between health, social care, and community-centred interventions, ensuring no age exclusions	**Oxfordshire Way Prevention strategy** Draft strategy to be completed by September 2024. Delivery plan to be drafted by December 2024.	Ensuring the plans as they develop best describe the activities that are taken forward. Ensuing communities with least assets are prioritised in delivery plans. Identifying activities that make a measurable difference to supporting older people's inclusion and have continued social care investment.	Identify measurable outcomes that demonstrate impact. Engagement process to be agreed over autumn. Review progress quarterly at PHIF forum.	Green

	Oxfordshire way • <u>Mapping</u> Mapping community link workers and social prescribers • <u>Increasing access to arts and nature through social prescribing.</u> Testing the use of micropayments to providers for supporting equitable access to community arts and nature based social prescribing opportunities. Referrals will be made through the Live Well Oxfordshire directory of groups, services and information.	IT system integration may require more time to develop.	We plan to integrate EMIS with Live Well Oxfordshire so that social prescribing referrals to organisations can be more efficient.	Amber
	Consortiums We are supporting the VCS to consider working in partnership with each other to ensure the sector is in a position to collaborate for improved joint delivery of future provision.	Cultural change is a challenge when there is competition as this requires greater levels of trust and transparency. Making some of the changes to the restrictions due to procurement requirements to enable partners of choice to work together.	Creating further opportunities to explore collaborative working, making use of sub-contracting, alliances and joint commissioning.	Amber
	Well Together A grant programme providing substantial prevention funding directly to existing and new social infrastructure organisations and groups in the 10 priority areas in Oxfordshire to address health inequalities and support prevention. Funding from ICB.	Uncertainty of funding after 2025.	Review impact of grants and prioritising health inequalities funding.	Green

	Community capacity grants *(applies also to shared outcome 6.2)* The purpose of the grants is to build up and strengthen grass roots organisations in their own local areas, especially where we know there are gaps or insufficient development of local resources. The aim is to ensure residents have access to community services to support being independent and reduce reliance on formal statutory services. Funded by the council and administered by Oxfordshire Community & Voluntary Action.	Ensuring interventions are both targeted and impactful.	Bring all impact assessments from VCS together to form local picture and establish mechanisms to measure and communicate the impact and value of community grants and initiatives, demonstrating the value of the sector and attracting continued support.	Green
	Communities of practice Brings together practitioners, charities and volunteers involved in Adult Social Care to share experiences and solve problems in order to provide better visibility of/and access to available support, and a more joined-up experience for adults with social care needs within the community.	Multiple stakeholders working on a wide variety of issues and concerns requires continued support.	Explore the potential of hub models in supporting VCS organisations, for instance with central based training.	Green
	Carers *(applies also to shared outcome 5.3)* <u>Carer groups:</u> Held across the county for unpaid carers to come together and talk to other carers who understand their situation. They can also bring their cared for person. Some carer support groups are for unpaid carers in general while others are aimed at carers of people with specific conditions such as dementia, autism, mental health illness or addictions. There are also groups for specific communities for example Veterans. <u>Short breaks for carers:</u> Action for Carers Oxfordshire working with local businesses to provide services which give unpaid carers a short break and help them to continue in their caring	Identifying more unpaid carers to combat social isolation. Joining up the carer system so carers only need to tell their story once. Respite/short breaks oversubscribed.	Improve the provision of respite care to support unpaid carers to meet the needs of those with more complex conditions. With Carers Oxfordshire we are generating opportunities to support carers back to work and employment if they choose through short breaks and support this will be evaluated to see the impact it has. Support community-led projects that bring together residents, local businesses and organisations to work towards common goals such as more short breaks offers.	Green

	role. Examples are Laundry service and Feet up Friday (a hot, nutritious meal delivered to the door on a Friday).		Delivery of All age carer strategy action plan ensuring improved carer identification, respite offers and support outside of caring.	
	Place shaping Completed mapping of community connectors and social prescribers across Oxfordshire and held a network meeting to support connection.	Current demand for primary care services has limited the capacity of GP practices to engage with place based work focused on prevention. We need to ensure that various place based initiatives to promote better connection between communities and health and social care do not duplicate each other and that community connectors work with each other to add greatest value to their communities.	Refine mapping of community connectors and social prescribers and publish on the Live Well website. Work with the Integrated Neighbourhood Teams to ensure that this work links to community activities and draws on community assets.	Green
	Good Neighbour Schemes Volunteers who help older people, or people with disabilities with shopping, dog-walking, lawn-mowing, form-filling, collecting prescriptions, befriending. There are 49 GNS working across the county and many smaller voluntary groups offering local transport etc. Start-up funding is available to support the setup of new Good Neighbour Schemes and other community assets.	Finding and supporting volunteers can be a challenge.	Measure the level and impact of community involvement through volunteer activities, participation in civic events, and engagement in local initiatives.	Green
	Shared Lives Scheme Operates across Oxfordshire and offers short breaks, long term accommodation or daytime support to adults who have support needs and want to have an ordinary living experience by staying with a household approved with the Scheme. The Scheme is registered and inspected by the CQC and Shared Lives Carers are fully trained and supported by the Scheme and share their home and community life with people who stay with them.	Having sufficient shared lives carers. Dementia strand: condition can be progressed so that shared lives can't meet their needs. Referral systems are currently at a later stage than required.	Funding received to develop the service for people leaving care, and a strand for people with dementia.	Amber

	Homeshare service – Age UK Oxfordshire Safely matches an older person, or couple, who would benefit from practical help or companionship at home, with another person who can lend a hand and who needs affordable accommodation. In return for the accommodation in a welcoming home, the Sharer offers the Householder 10 hours of their time each week as a combination of companionship and practical help.	A challenge can be finding appropriate matches. Recruitment of staff to work on the homeshare project took longer than expected.	Receiving funding via Accelerated Reform Fund. Age UK Oxfordshire has successfully recruited and has a marketing plan to help expand the existing service.	Green
	Community Micro Enterprises Helping people and communities across the country to use their talents to start and run small enterprises and community businesses that support and care for other local people. They create good local jobs and keep local money local. There are currently 94 CMEs in Oxfordshire helping people remain independent, connected with and contributing to their community. These people are taken through the 'doing it right' standards with Community Catalysts to ensure micro-enterprises are viable, sustainable and provide safe, high-quality, person-centred services.	Challenge is attracting new providers and promoting their availability.	Using Care Finder and Guided Searches on Live Well Oxfordshire to assist people in finding care solutions through CMEs. Focus on encouraging activities particularly for people with learning disabilities.	Green
6. 2 Better understanding of the unique strengths and challenges of living in Oxfordshire's rural areas	**Local Area Coordination (LAC)** Oxfordshire has introduced Local Area Coordinators to provide a means by which people can be introduced or introduce themselves with no thresholds or time limits	Developing a new model in restricted financial circumstances means the provision can only be made available in four communities (to date). Developing robust outcome measures is a challenge.	LACS are currently in two areas of the county and work is ongoing for a further two areas in Didcot and Kidlington.	Green

	and on their own terms. They can then build a relationship at their own pace and work through what matters to them and what they need to live the life they wish to. The LAC helps people connect with their community and gather support from there. The LACs have a dynamic role which includes cultivating strong partnerships with community members, groups, agencies and services to support local community capacity building and closer collaboration.			
	Place shaping Healthwatch and OCF have completed a study looking at the needs of Ambroseden and surrounding villages. These findings have been shared with District colleagues so that it can inform planning policy and community development	Dispersed population with smaller pockets of often hidden health inequalities means that improving health and wellbeing in rural areas is costly. It has not been a primary priority compared with reducing health inequalities in urban areas where there is a larger population experiencing inequality	Work with partners to gather data to better understand the health and wellbeing issues facing rural communities and the assets they have available to support health improvement. Ensure that rural communities are included as part of the Marmot work to address health inequalities in Oxfordshire.	Green
6.3 Digital support for virtual connection & improved digital skills	**Digital inclusion strategy** Digital inclusion strategy underpinned by annual action plan: Action: Research, identify and promote support around digital literacy for carers, including young carers: Response: Accelerated Reform Fund secured to improve online digital access to the carer's assessment Age UK Oxfordshire has a digital inclusion workstream. This includes managing a team of volunteers that provide digital support in the community to help older people get online and learn more about the digital world. There is also a small tablet loan scheme and access to a limited number of free data SIMS.	Tackling the digital divide It remains a challenge for carers without digital access. Securing funding for this area of work has been challenging for Age UK Oxfordshire. This is not funded by OCC or ICB.	Continue to ensure we maintain a telephone and outreach service for carers to access. We will continue with paper-based information. Digital Inclusion campaign October 2024. Continue to support the action plan for the Digital Inclusion Strategy.	