Divisions Affected – All

HEALTH AND WELLBEING BOARD
12 March 2026

HEALTH AND WELLBEING STRATEGY UPDATE – Priorities 5 and 6
AGE WELL

Report by Karen Fuller

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to note the progress on the delivery of priorities 5 & 6 for Age Well within the Health and Wellbeing Strategy.**

2. **The Board is recommended to note and agree the proposed amendments to the Health and Wellbeing Board Shared Outcome metrics.**

Background

3. [The Health and Wellbeing Strategy](#) sets out our vision to improve the health and wellbeing of people of Oxfordshire between 2024-2030.

4. The Strategy has been built around a 'life course approach to wellbeing' and includes priorities for Start Well, Live Well, and Age Well. The strategy also includes cross cutting priorities around the 'Building Blocks of Health', which cover factors that impact everyone's health, such as housing and education.

5. Oversight of progress against the Outcomes Framework was agreed by the Board in [March 2024](#) to be through a rotating update on four thematic areas of the strategy. Delivery against the agreed priorities is the responsibility of all organisations across health and social care, and progress is reported regularly to the Health and Wellbeing Board.

6. This report is the second annual report of the progress against the priorities identified for Age Well:

    - **Priority 5: Maintain Independence**
      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.

- **Priority 6: Strong social relationships**
  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.

7. The paper gives an overview of performance against the Shared Outcome metrics, highlighting areas of success and areas for improvement. A summary of performance against the metrics is detailed in the Annex 1 – Age Well Performance Report.

8. The paper also proposes some amendments to some of these metrics due to:

- Some metrics being based on data that is no longer gathered nationally or locally
- Annual changes to nationally determined metrics, such as the Better Care Fund (BCF)
- Contextual changes since the metrics were developed in 2024, such as the development of the Marmot Programme, NHS planning – including Medium Term & Neighbourhood plans, and changes resulting from Local Government Reorganisation.

9. We will work with HWBB partners to update the measures to ensure we can monitor progress against the HWBB outcomes. We will identify metrics which are meaningful and reflective of our system ambitions for supporting older people in Oxfordshire. This will align with a broader review of the shared outcomes led by Public Health.

Older People in Oxfordshire

10. The 2021 Census data indicated that there are 137,067 people aged 65 and over in Oxfordshire (18.3% of the population broadly in line with England). Better Care Fund (BCF) growth projections for 25/6 suggest that this number could now be 139,999.

11. Between the 2001 and 2021 Censuses, Oxfordshire saw its population aged 65 and above increase by over 50%. Vale of White Horse experienced the highest growth, followed by West Oxfordshire, while Oxford City had the smallest increase.

	2001 Census	2021 Census	% change
Cherwell	17,726	28,026	58%
Oxford City	16,149	18,973	17%
South Oxfordshire	19,578	30,549	56%
Vale of White Horse	16,333	27,463	68%
West Oxfordshire	15,308	24,759	62%
Total	85,094	129,770	52%

12. Oxfordshire is the most rural county in the South East region. Rural districts have a much higher proportion of older people: 20% of the population of South

Oxfordshire, 20% of Vale of White Horse and West Oxfordshire, 17% of Cherwell, and 12% of the population of Oxford City are people aged 65 and over.

13. Public Health England data shows that healthy life expectancy at 65 is 14 years for women and 12.6 years for men in Oxfordshire. This is higher than South East and England averages. However, health inequalities remain a challenge in Oxfordshire. We have partnered with the UCL Institute of Health Equity to become a [Marmot Place](), meaning we have committed to tackling health inequalities and improving health fairness in Oxfordshire by working with local partners across the system. These partners include local authorities, communities, public services, businesses, and voluntary sector organisations.

Update on Age Well Priority 5: Maintaining Independence

Priority 5.1. More older residents to remain well, safe and independent in their home for longer

14. The shared (system) outcomes underpinning this priority are as follows:

Shared outcome 5.1 – Ensuring more older residents remain well, safe and independent in their home for longer.

15. This involves supporting people in their own homes and within their communities and thus reducing the need for care in more acute or more restrictive settings. This aligns closely with the Council's 'Oxfordshire Way' vision, and the NHS Long Term planed shift to Neighbourhood health and care.

16. In 2025/26,

- The number of people 65+ who are supported by social care at home has increased by 3.97% - c. 100 people - over the last 12 months
- We also offer additional ways for people to retain independence in their communities but with onsite wraparound support through our 21 Extra Care Housing schemes. Care hours delivered in these schemes increased by 6.9% in 25/6, linked in part to the opening of a new scheme – Fern Meadows - in Faringdon.
- The 24/5 ASCOF data shows that the rate of permanent admissions to care homes was below the England average. Our performance against the BCF metrics also remains on target.
- We have remained on target for admissions due to long term conditions and achieved our planned zero growth target for non-elective admissions for people aged over 65.
- Falls-related admissions are above the target we set in the BCF plan but reduced by 11% in Q3.

17. Key factors underpinning this performance include preventative services to increase strength and prevent falls, and through ensuring our urgent care

pathways and services are tailored towards supporting the person's needs in the community rather than through an emergency ambulance conveyance and/or admission to hospital.

18. **Physical activity**

There is an important connection between physical activity, specific resilience that enables older people to remain safe and independent in their own home and overall wellbeing. Data on physical activity among older people (collected by Sport England until 2023/24) showed that the proportion of inactive older people had decreased by 6% points in the year to 28% and remained just below the England average at the final data return

19. Our main partnership to support older people to remain physically active is with **Active Oxfordshire** that delivers the [Move Together initiative](), a county-wide programme designed to help people, especially those with long-term health conditions, disabilities, or who are inactive, become more physically active and improve their wellbeing. In 2024/25, 45% of people referred to Move Together were aged 65 or over. 64% of participants increased the amount if activity they were doing, 91% built physical activity into their daily routine and nearly 70% of participants who were completely inactive at initial assessment increased their physical activity levels and sustained it for at least 9 months.[1]

20. In addition to this, **Community Capacity Grants** fund a wide range of grassroots organisations providing physical and social activity initiatives for older people, such as community exercise classes, mental health and activity programmes, and local walking groups. The [Connected Communities Fund End of Year Report 2024-2025]() shows that in its third year, the Fund continues to help older people and adults with additional needs feel connected and supported in their communities. In 2024-25, 73 funded groups delivered over 2,000 sessions, supporting more than 1,500 individuals and recording 45,000 attendances across the year. Examples of activities delivered include coffee mornings, creative workshops and culturally inclusive exercise sessions, all of which enable Oxfordshire residents to connect with local opportunities close to their homes.

21. **Emergency hospital admissions due to falls for people 65+**

22. Falls are one of the leading causes of injury for older adults and falls-related admissions were a key metric for the BCF in 25/6. This is monitored monthly, whereas the national hip fractures metric in 5.13 is only available annually.

23. Some falls can be prevented through simple steps such as strength and balance exercises, home safety checks, and regular health reviews. The Oxfordshire Falls working group, attended by partners across the health and social care system, has developed a falls action plan to reduce the risk of admissions due to falls. Feedback from colleagues was that there was a lack of knowledge and understanding about what is on offer in Oxfordshire to

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[1] Please see [Move Together 2024-25 Report]() for more details and evidence of impact

prevent falls. From this, a **Falls Awareness Campaign** launched in December 2025, with the aim of raising public and health and care professionals' awareness on local support services, including

- Age UK Oxfordshire's exercise and information programme, [Stay Strong and Steady]
- Oxford Health NHS Foundation Trust's [Falls Prevention Service] - offers a one-off multifactorial assessment to create a personalised risk management plan for reducing falls
- Support with adaptations to homes provided by City and District Home Improvement Agencies to help older, disabled, and vulnerable residents live safely and independently in their own homes.
- Dedicated helpline has been set up with Single Point of Access (SPA) to support care homes in assisting with falls and avoiding a hospital admission where appropriate.

24. **The Stay Strong and Steady Programme** and the **Community Exercise Programme** as part of Age UK Oxfordshire's physical activity and falls prevention contract funded by Public Health and ICB and jointly managed by the Age Well team. **Stay Strong and Steady Programme** offers exercise and education in the community for older people who have either experienced a fall or are considered at risk, aiming to lower the likelihood of future falls. Between April and September 2025, 213 people were referred, and 151 attended a total of 154 sessions held throughout the county. Participants have noted improvements in strength, mobility, and confidence in their balance. The **Community Exercise Programme** provides 52 weekly classes across Oxfordshire, as well as sessions via Zoom. 10,076 people attended the classes, 80% of them were over the age of 75, and 24% were over 85.

25. **Satisfaction of people who use services with the care and support they receive**

The data on overall satisfaction of people who use services with their care and support is collected annually as part of Adult Social Care Outcomes Framework (ASCOF). We have yet to receive the 25/6 data but, in 2024-25, our performance fell slightly short of the national average of 62.7%, which 59% of older people were very or extremely satisfied with their care. We are working closely with our care market to gain local feedback and seek opportunities to improve.

26. **Proposed metric changes for Shared Outcome 5.1**

Metric	Proposal	Rationale
5.10 – Proportion of older people who are inactive	To be reviewed with Public Health	National data no longer collected – opportunities to report locally
5.11 – Emergency hospital admissions due to falls in people 65+	Keep – but note no longer measured in BCF 26/7 (monitored	BCF 25/6 metric

	locally as part of Urgent and Emergency Care Dataset)	
5.12 – Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions)	Keep – but note no longer measured in BCF 26/7 (as above)	BCF 25/6 metric
New – Emergency admissions to hospital for people 65+	Add	BCF metric 25/6 & 26/7

Shared outcome 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.

27.   In instances where a loss of independence in the community or after hospital admission, Oxfordshire continues to adopt a 'home first' approach. In this model we support people to regain their independence in their own home or leave hospital as soon as they medically ready for discharge by providing them with the necessary support in their own homes.

28.   Home First is focussed on reablement which helps people retain or regain independence in their own home and/or on discharge from hospital. In 2025/26 there has been an increase in community reablement, meaning we can proactively identify and support people and ideally prevent admissions to hospital settings. Approximately 80% of people experience independence or a reduction in long term care needs immediately following a period of reablement. To reflect the national shift in focus from acute to intermediate care, the BCF 26/7 will also adopt an amended ASCOF measure relating to longer term success of reablement in ensuring people remain at home, rather than in another setting, after 12 weeks. In 2023-24, we achieved 86.3% - better than the England average – against the similar ASCOF measure. Data issues mean we do not have a more recent figure, but this will be addressed as part of reporting for BCF in 26/7.

29.   Our performance against national BCF metrics for people who are discharged from hospital to their normal place of residence has been historically below local BCF targets and the England average. This metric has been removed from BCF reporting for 26/7, likely following feedback from systems that the metric does not account for longer term outcomes following discharge – unlike the metric relating to reablement outcomes after 12 weeks in paragraph 28. We are actively working with partners to reduce the length of stay for people medically optimised for discharge across all discharge pathways to ensure they can return home as soon as possible. We also work with voluntary sector partners, such as Age UK Oxfordshire, on services such as **Urgent Community Links,** which offers non-medical support to enable a faster discharge. Other services include a smaller discharge support service with

Age UK Oxfordshire for the Abingdon and Wallingford Community Hospitals, providing support both in the hospitals and in the community following discharge.

30. **Dementia diagnosis**
We remain slightly below target on diagnosing older people with dementia (63% - equating to 6202 people in total - against our target of 65.6% in 2025). A system-wide discussion has started to help us understand the services and variances across the Thames Valley Integrated Care Board (ICB) footprint. There is a detailed action plan to improve the diagnosis rate which includes projects to improve coding and to improve and standardise hospital pathway; dementia advisors being embedded into the system; Dementia Oxfordshire contract; developing support to informal carers; providing appropriate care in care homes and whilst in hospital and providing appropriate support to people with complex dementia. A contract has also been developed to support discharges from hospital for people living with complex Dementia.

31. Following a successful tender, Age UK Oxfordshire has again been awarded the contract for the **Dementia Support Service** which is due to start imminently. This service supports people with dementia and their carers in the community, providing support and education. Since 2021, the service has experienced an increase in demand, around 9.5% each year. Approximately 75% of people living with dementia in the community are being supported by the service (excluding people in care homes). The service supports people with mild cognitive impairment and their carers to ensure we can support more vulnerable people in Oxfordshire. Referrals for this element from Memory Clinics are consistent and the new contract will see more engagement with GPs to raise the profile of this support offer.

32. **The Council and the ICB (via NHS Continuing Healthcare) continue to manage permanent Care Home admissions for people aged 65 and over**
Care home placements are only used for people who can no longer safely remain in their own home, and primarily for those with nursing and/or specialist needs, such as dementia.

- We have been reducing permanent care home admissions for older people in recent years. Progress against the BCF metric for care home admissions in 25/6 has been on target at 609 admissions at Q3 against a full year target of 722. We also remain one of the higher performing Local Authorities nationally for this metric, ranking 37 out of 151 Local Authorities.

- There remains a significant issue of people choosing to admit themselves to care homes when there may be opportunities to continue to live in their own homes. Following evidence that several self-funders self-admit to care homes due to having limited information and support, we have undertaken a project to further support this cohort to make informed decisions about their care. We have developed communications, guides and created Google search adverts linking to useful resources. Between September and November these adverts were seen over 22,000 times.

- We also offer support in alternative settings, such as Extra Care Housing. As mentioned in paragraph 16, we have seen an increase in care hours delivered through these schemes over 25/6 and we have opened a new scheme – Fern Meadows – in Faringdon to reflect our ambition to further support people in their communities.

Proposed changes to Shared Outcome 5.2

Metric	Proposal	Rationale
5.10 – Percentage of people discharged from acute hospital to their normal place of residence	To be reviewed	Note no longer measured in BCF 26/7 – opportunities to focus on longer term outcome metrics

Shared outcome 5.3. More older people empowered to take part in decision making about their own health and wellbeing

33. There are a range of services and support available to help people have control over their lives and have access to information and advice they may need. Some of these services focus on providing information, advice and signposting, and some are more specialist, such as direct payments or specialist advice services.

34. Oxfordshire County Council has a specialist **Direct Payment** Advice team which supports current and potential direct payment users, representatives and colleagues across the county to work through what type of direct payment people would prefer and can assist with employed/self-employed personal assistants and signpost to other third-party suitable options. In 2024-25, 16.2% of older people using social care received a direct payment in Oxfordshire, which is 2.6% higher than England average.

35. Another way of empowering people to make decisions about their own health and wellbeing is to provide them with information about support available. Our online directory, **Live Well Oxfordshire** aims to enable people to live safe, healthy and independent lives and be a part of their communities through a comprehensive directory. Currently over 2,600 groups, health, care and community services and activities are listed in the directory alongside a range of information pages. There is also a 'What's on Calendar' function for people to easily see when activities and events are happening in their local area.

36. From September 2024 to August 2025, visits to the Live Well Oxfordshire online directory rose by over 21,000 compared to the previous year. There are plans to introduce 'Care Finder', which will assist people to find care solutions using the online directory through answering a series of questions and filtering results accordingly. This will help people search and source their own care in their own time.

37. We know that many Oxfordshire residents experience financial difficulties relating to benefits and not everyone is claiming what they are entitled to. To help with this, we commissioned Age UK Oxfordshire to deliver the **Specialist Advice service**. The service started on 1 November 2024 and in its first year reached 2,914 people. The new online Oxfordshire Advice Navigator portal was used over 4,100 times. As a result, the service has secured £3,738,548 worth of reduced debt and increased benefits. The service has a particular focus on people living in the most deprived areas of Oxfordshire who are most likely to experience inequalities, and people with protected characteristics.

38. The service includes preventative training for people in communities before they reach a crisis point, including sessions on money management, budgeting and awareness raising for sources of support. 84 people benefited from this in year one and we are working to increase this in year two.

Update on Age Well Priority 6: Strong social relationships

Shared outcome 6.1. More connected communities and closer links between health, social care, and community-centred interventions, ensuring no age exclusions

39. Social contact is fundamental to health and wellbeing. People who feel connected to their communities and able to access support are less likely to require formal services. In 2024–25, 38.5% of older people receiving social care said they had as much social contact as they would like, which is below the England average of 43.1%.

Unpaid carers

40. In addition to convening our all age unpaid carers strategy, we commission **Carers Oxfordshire** to support unpaid carers, offering assessments, advice, training, peer support and short breaks. We are working with the service to further improve carers' social contact.. Unverified data relating to the latest ASCOF unpaid carers survey suggests that people are reporting an improved experience, but with continuing issues regarding access to social contact. We will review this data when it is confirmed together with comparator data from the rest of England to help identify learning opportunities.

Community assets

41. Community assets and informal support play a vital role in keeping people safe and well. Since 2022, the **Community Capacity Grants** programme has supported grassroots voluntary organisations to fill gaps in local provision, increase volunteering and collaboration, develop innovative approaches (including tackling digital exclusion), and reach people who struggle to access traditional services. Grants are delivered through Oxfordshire Community

Foundation (£5,000–£20,000) and OCVA/Community First Oxford (up to £5,000). To date, £1m has been awarded to 179 projects, delivering over 2,500 sessions and reaching more than 23,000 people.

42. We also commission **Age UK Oxfordshire's Community Links Service**, where Community Connectors help people access local support and remain independent. Between January 2023 and October 2025, 46% of people referred no longer required Adult Social Care intervention.

43. **Local Area Coordination (LAC)** offers flexible, preventative support without referrals or thresholds, helping people use their strengths and connect locally. Since 2024, LACs have supported over 200 residents, with 121 receiving longer-term support. Outcomes include improved mental health, stronger social connections and reduced reliance on statutory services, contributing to lower loneliness and isolation. We have also bid to undertake an evaluation exercise in partnership with NIHR to establish the impact of the model in Oxfordshire.

44. **Social prescribing** provides a non-medical route into community support alongside clinical care. In 2022–23, over 7,700 people aged 50+ were referred, with reported improvements in health, wellbeing and quality of life.

45. **Proposed metric changes for Shared Outcome 6.1**

Metric	Proposal	Rationale
6.11 - Number of social care users accessing community-based support for health and care needs in the year	Keep – methodology to be reviewed	The national methodology for calculating this measure has been changed
6.12 – Volunteering rates	To be reviewed with Public Health	National data no longer collected – opportunities to report locally
6.13 – People supported by social prescribing	To be reviewed	National data not available – opportunities to report locally

Priority 6.2: Better understanding of the unique strengths and challenges of living in Oxfordshire's rural areas

46. Oxfordshire is the most rural county in the South East. We do not find significant differences in social care satisfaction between urban and rural areas of Oxfordshire. However, people in rural areas report more likely to be lonely and less able to get out of their house. Supporting our rural

communities via the range of services and community assets covered above is key to understanding the opportunities and barriers these residents face. In addition, understanding rural inequalities in Oxfordshire beyond the 10 most deprived wards in the county is a key project as part of the Marmot Place Programme.

47. Oxfordshire County Council has identified **digital inclusion** as a priority to ensure everyone has the chance to access and use digital technology. It involves giving people the tools they need, like computers and the internet, and teaching them how to use them. This way, everyone can benefit from what's available online - like information, education, jobs, and staying in touch with others. More details are outlined at Digital inclusion | Oxfordshire County Council and Digital Infrastructure Programme.

48. In addition to other support available in our communities, we run Digital Cafés initiatives in Oxfordshire to support people to use digital tools. Full details of the Digital Café sessions available throughout the county can be found on our Live Well Oxfordshire website Digital Cafes - Oxfordshire.

49. **Proposed metric changes for Shared Outcome 6.2**

Metric	Proposal	Rationale
6.21 – Proportion of people who volunteer regularly or occasionally	To be reviewed	Source data likely from one-off surveys – regular indicators to be determined
6.22 Impact of rurality on access to services and satisfaction		
6.23 Proportion of older people using the internet		

Next Steps

50. There is a range of ongoing work to support older people in Oxfordshire and address the Age Well priorities of the Health and Wellbeing Strategy. We are currently reviewing the indicators included in the Outcomes Framework to ensure they reflect updated local and national priorities.

51. Some of the performance indicators focus on long-term wellbeing, which may be achieved through a specific programme, service or intervention or a combination of several system-wide initiatives. In these instances, it can be difficult to establish clear causal relationships between commissioned services and performance metrics. However, we are working to evaluate value for money and impact on all services.

52. The development of neighbourhood approaches will further enhance social care, health and voluntary sector working together to support people, and we see this as an opportunity to further align how we support older people in Oxfordshire and their carers.

53. Oxfordshire becoming a Marmot place is an opportunity to further understand the impact of rurality on our older population and how we can further improve how we support rural communities.

Corporate Policies and Priorities

54. Adult Social Care's priorities are shaped by our corporate vision and priorities, with particular focus on tackling inequalities in Oxfordshire and prioritising the health and wellbeing of residents. This work also aligns with the Oxfordshire Health and Wellbeing Strategy and the BOB ICB strategy.

Financial Implications

55. There are no financial implications that the Health and Wellbeing Board is asked to note in relation to this report. As detailed within this update, the pooled budget, BCF and other existing budgets are being utilised to deliver against the above priorities.

    Comments checked by: Stephen Rowles, Strategic Finance Business Partner, stephen.rowles@oxfordshire.gov.uk

Legal Implications

56. This report provides key updates to the Health and Wellbeing Board in relation to the Council's statutory functions to improve the health and wellbeing of the Oxfordshire population. The Council's statutory functions derive from a variety of legislation including Part III of the National Assistance Act 1948, the National Health Service and Community Care Act 1990, the Care Act 2014 and the Health and Social Care Act 2012.

    Comments checked by: Jayne Pringle, Principal Solicitor (Contracts), Jayne.Pringle@oxfordshire.gov.uk

Equality & Inclusion Implications

57. Equity in experiences and outcomes is a key priority for Adult Social Care arising from our statutory duties under Care Act 2014 and CQC Assurance Framework.

58. Equality and inclusion are key pillars of how we support older people in Oxfordshire and are supported by activities covered in this report.

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Annexes: Annex 1: Performance Report 25/6

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