**Comments for draft principles – Improving community health and care services – older people**

Overall

1. As this is an Oxfordshire CCG piece of work – there is a need for this piece of work to link directly and make connection to the Oxfordshire 2050 plan, in development and out for consultation at present - Theme 3 Creating strong and healthy communities. This the more system planning process
	1. If this is not done, then there needs to be direct links by the CCG and or Community Service provider with each Director of Planning and Development (housing) in each of the district and City councils, so that there is a direct link between housing need for the elderly and this health and Care community services plan, to ensure the prevention agenda for older people is an actual reality (this is not explicit in the plan)
* For example, older people with a range of long-term conditions could be supported to live and be cared for in their own homes if there were, downsizing for housing opportunities, builds that include the flexible option to have downstairs bathrooms and bedrooms on the ground floor and equally more accessible housing input to make adjustments to current homes beyond the OT brief. There needs to be a much better link to Prevention and Public Health services

**Draft Principles for Health and Care needs of older people – community services; suggestions**

**Many of the draft principle statements are not principles and there is very little that is transformative or innovative**

1. **Older people and Prevention:**

Providing upstream planning ahead for care opportunities and for the process of moving from active/invasive/life sustaining treatment to end of life care.

This should include discussion and planning for housing options

(There are a range of clinical indicators and life situations indicators that could be used by community services to initiate/trigger such conversations and actions. Or this could be part of the Public Health agenda and a journey of care and providers mapped out for patients and their carers (also missing from the plan)

Providing services to address the mild cognitive changes, pre changes to any dementia pathology, such as how to manage changes in cognitive processing and decision making for everyday life and living. Variety of ways of achieving this

Providing services that address how to keep and maintain physical and mental health and wellbeing (link to whole range of available voluntary sector and social prescribing and is more than these)

1. **Provision of Input and support for family and carers**

Such input is vital if older people with health and care needs are to live at home

1. **Use of connected and joined up working and communication**
2. **Use of digital technology in many forms**

Implementation of this across the community services one action required in the plan, this could be to provide interventions to manage loneliness and isolation, **alert** systems, how older people access and receive care and much more

1. **Equality of care and access to care**
2. **Maximising available and accessed resources**
3. **Developing workforce and expertise suitable for a range of patient and care circumstances in ways that meet demand**

Rewording of the draft principles to address the rest of the agenda for older people

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