READING BOROUGH COUNCIL

ADULT WELLBEING POSITION STATEMENT 2016

DRAFT FOR CONSULTATION

Foreword

We are pleased to present this Adult Wellbeing Position Statement, a framework for developing our services to meet our Care Act obligations and so prevent, reduce and delay care and support needs across the local population.

Reading Borough Council provides a great many services which support healthy independent living. These benefit the 'well' population as well as those who are at risk of needing care or who are living with established long term health conditions. This Position Statement sets out our approach particularly to supporting those residents who have current or emerging care needs, and supporting the unpaid or family carers who are helping to keep people well and independent. The Care Act gives us new responsibilities towards those who may need care or support, and our Adult Wellbeing Position Statement describes how we will fulfill these new responsibilities. Individual wellbeing is affected by a range of factors, and our approach recognises the impact of the places where we live, work and play as well as our health and social care provision.

The need to invest in preventative services to delay people's need for social care and health services is widely recognised as key to ensuring that care services are to be sustainable into the future. The challenge of reduced budgets alongside population growth means we need to achieve a significant shift in emphasis across parts of our service offer, and develop our understanding so that we can target our approaches ever more effectively. A major focus now is to identify, at the earliest possible stage, the most vulnerable people in our communities – those who are at risk of poor health and more likely to require social care. Reaching these residents must be a priority within programmes that promote people's capacity to maintain an independent lifestyle.

We are also committed to working better with our residents, and will be engaging service users, carers and others in developing our approach. We will continue to work with residents as we develop our analysis and plans so we ground our approach in the aspirations of the people of Reading. We will also continue to work with partners across health, social care, housing and other community services to offer a joined up approach to empowering people in Reading to live healthy fulfilled lives for longer.

The Position Statement will be accompanied by a high-level implementation plan for 2016-17, which will be refreshed in subsequent years and incorporated into our broader Health and Wellbeing Action Plan.

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Lead Councillor for Adult Social Care

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Lead Councillor for Health

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1. Introduction

Local authorities are facing challenging budget pressures, including increased demand across many service areas. We need to achieve a cultural shift so that our investment is increasingly directed at improving the wellbeing of Reading residents - that is, helping people to prevent ill-health and disability that is avoidable - rather than just treating the effects of poor wellbeing.

1.1 the national policy context

The Care Act (2014) brings in significant reforms to the care and support system, with a strong emphasis on improving independence and wellbeing. Similarly, the NHS Five Year Forward View (2014) sets out a new vision for health care, which brings the prevention of illness to the fore. Both documents highlight the importance of developing integrated models of care to achieve the changes needed for our care system to be sustainable into the future.

This drive towards more integrated care is taken forward through the Better Care Fund (BCF) initiative with local BCF plans in place from April 2015. The BCF transfers significant portions of NHS and social care funding (£3.8bn nationally for 2015-16) into pooled budget arrangements between local authorities and Clinical Commissioning Groups. The BCF includes a 'payment for performance' framework based on reducing emergency admissions to hospital. In addition, local BCF plans must set targets to reduce admissions to residential and care homes, demonstrate the effectiveness of re-ablement services, reduce delayed transfers of care, and show patient / service user satisfaction with care services.

1.2 the local policy context

In 2014, the Council articulated a new way of working with local people and across agencies in 'Capable Communites: a framework for change'. This sets out a commitment to achieving cultural change so that we can invest in tackling the causes of inequality rather than de premise that neither public services nor citizens have – on their own - access to all the resources necessary to deliver public goods. Social support within and between communities is recognised as being critical to physical and emotional wellbeing.

Also in 2014, the Council adopted a 3-5 Year Plan for Adult Social Care which:

- Puts Adult Social Care services within the context of the community and neighbourhood that the person who requires care lives within
- Sees service users who require support as being people who still contribute to their family and community
- Is centred on the person – not the convenience of service providers
- Promotes independence and focuses on what people can achieve

- Values and recognises the central part that carers play
- Safeguards people
- Promotes a good life and a good death

This set out a strategic direction for care in Reading which has, at its heart, practice that highlights re-ablement, recovery and rehabilitation and reduces dependency. Promoting wellbeing becomes key to managing demand under this model. The Council has committed to the effective development of universal services to include provision for people whose needs do not meet the threshold for specialist care services, drawing on community and neighbourhood based resources to help people with lower support needs (and their carers) to remain living at home safely.

'Narrowing the Gap' is Reading Borough Council's Corporate Plan for 2015-18 and sets the following priorities for the local authority:

- Safeguarding and protecting those that are most vulnerable
- Providing the best life through education, early help and healthy living
- Providing homes for those in most need
- Keeping the town clean, safe, green and active
- Providing infrastructure to support the economy
- Remaining financially sustainable to deliver these service priorities

1.3 the wellbeing principle

The Care Act creates a new statutory duty for local authorities to promote the wellbeing of individuals. This is a guiding principle for the way in which local authorities should perform all of their care and support functions. This includes individual assessments and support planning, but also the discharge of policy functions. The wellbeing duty is not therefore simply a framework for how to meet the needs of those who meet Adult Social Care eligibility criteria; it also directs how the Council should interact with local residents who have lower care or support needs, or who have a risk of developing care and support needs, in order to reduce the likelihood of their developing avoidable illness and disability.

Wellbeing as described in the Care Act is a broad concept. A holistic approach is necessary to understand individual wellbeing, drawing on the expertise which sits across Council services – and beyond. There are nine areas to consider, and these carry equal weight, although some will be more relevant than others to indivuduals at particular points in their lives.:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- participation in work, education, training or recreation;

- social and economic wellbeing;
- domestic, family and personal;
- suitability of living accommodation;
- the individual's contribution to society.

1.4 the prevention duty

Alongside the wellbeing duty, the Care Act creates some other general duties on the local authority. The general duty of prevention is:

- to provide or arrange services that reduce needs for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs; and
- to have regard to the importance of identifying service users and carers in the authority's area, irrespective of their need for services.

The prevention duty rests with the local authority as a whole, and is not confined to the exercise of particular functions, e.g. those performed by the social care and public health services.

1.5 the duty to co-operate

The Care Act also introduces the duty to co-operate, which is both a general requirement to cooperate as well as a specific requirement in the case of individuals. The duty to co-operate applies whenever the local authority considers that the integration of services will:

- promote the wellbeing of adults with care and support needs or the wellbeing of carers with support needs in its area;
- contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or;
- improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

Partnership, cooperation and integration need to be key components of a local authority's strategic approach to wellbeing. Wellbeing cuts across local authority functions, and will require new partnerships which draw on the assets of other public sector organisations as well as those in the private voluntary and independent sector.

1.6 our vision for adult wellbeing

Our vision is to narrow the wellbeing gaps in Reading so that adults affected by care and support needs can access early help and enjoy healthy and fulfilling lives.

1.7 our aims

Our key aims are to:

- Embed the wellbeing principle throughout the Council's functions
- Ensure Reading homes support wellbeing
- Harness the assets Reading has to prevent care and support needs from increasing
- Empower people with care needs to self care and to make positive lifestyle choices
- Support people to prevent their care and support needs from increasing
- Promote a re-abling approach across care services
- Ensure people with emerging care needs and unpaid carers can access services that work well together to support people's independence

1.8 objectives

Our key objectives are summarised below in three inter-related categories, often referred to as the 'prevention continuum'.

Prevent (primary prevention) – i.e. avoiding poor health and the development of care and support needs

Reduce (secondary prevention) – i.e. limit the deterioration in individual wellbeing as a result of illness, disability or frailty

Delay (tertiary prevention) – i.e. avoid, or at least delay, the need for intensive support for as long as is safe and appropriate

Prevent	Prevent physical inactivity
	Prevent overweight and obesity
	Prevent loneliness
	Prevent the development of long term conditions where there are known lifestyle factors which put people at risk
Reduce	Reduce the risk of falls
	Reduce the negative impacts of unpaid caring
	Reduce reliance on formal care services
	Reduce the need for hospital admissions
	Reduce delayed transfers of care
	Reduce hospital readmissions after discharge
Delay	Delay the need for people to access social care support
	Delay permanent admissions to residential or nursing care
	Delay self-funders' recourse to public funds

1.9 scope

Although many of the interventions described in this document have the capacity to benefit the entire population, our principal focus is on:

- adults with current or emerging care needs
- unpaid carers with current or emerging support needs

Many universal services contribute to wellbeing for our target groups, and are touched on in this statement. However, the focus is on targeted interventions which are likely to have the greatest impact on preventing, reducing or delaying the need for care.

The 'reduce' and 'delay' objectives are most obviously focused on those members of our community who are intended to benefit from this position statement. As far as the primary prevention ('prevent') objectives are concerned, this stratement will consider how approaches can be better targeted and tailored to reach the communities which are within scope.

This position statement builds on and complements several existing strategies as referenced above. It does not set out to replace these. Our Adult Wellbeing Position Statement is intended to promote a more cohesive approach to adult wellbeing across the local authority by bringing existing strands of activity together and identifying priorities to ensure we are as effective as we can be.

2. the evidence base

The evidence base on the outcomes of early intervention, prevention and enablement activities is relatively new and many of the research findings are largely indicative rather than conclusive. Establishing a clear causal link between targeted wellbeing interventions and improved health/care outcomes is a challenge. Developing local schemes against clear criteria will enable us to evaluate these and so develop our understanding of what works and where the benefits clearly outweigh the costs.

In 2008, the Department of Health published a review[1] of learning from projects designed to shift the focus of care onto preventative rather than reactive interventions. This drew particularly on the 'Partnerships for Older People Projects (POPPs)' programme and the 'Linkage Plus' programme. Although focused on promoting the independence and wellbeing of older people, the resulting guide was proposed as one which included transferable learning for other client groups. The interventions which were found to be most effective were:

- Age proofing mainstream services i.e. ensuring they are 'fit' for older people
- Having a range of wellbeing services
- Providing information for all
- Case finding i.e. identifying people who may be at risk
- Case co-ordination / service navigation
- Having a managed pathway for those not eligible for ongoing social care
- Building capacity in local neighbourhoods
- Providing re-ablement support
- Joint health and social care community support for people with long term conditions / complex needs
- Providing support to care homes
- Crisis response services / out of hours services
- Telecare and assistive technology
- Extra Care housing, and housing-related support
- A falls prevention programme
- Support for carers

Evidence from this review indicated that the savings effect seems to be most pronounced where interventions are specifically focussed on hospital avoidance, even though the individual projects may also improve people's quality of life, and be promoted as such (e.g. befriending, peer support). The POPPs evaluation in particular showed that practical help (e.g. small housing repairs, gardening, limited assistive technology and shopping) and exercise programmes increased people's health related quality of life by 12%. Hospital admission can occur when someone has reached breaking point because of a combination of circumstances. Simply fixing the main medical problem does not put the person back in a position to cope. The implication is that when an older or vulnerable person has had a

[1] *Making a strategic shift to prevention and early intervention: a guide* - DH (2008)

hospital admission they need a holistic discharge plan and associated action that addresses *all* the challenges they are facing to their wellbeing.[2]

Supporting people to manage their own healthcare has been found to improve health and quality of life, increase satisfaction and have a significant impact on use of services (visits to the GP can reduce by up to 69%; outpatient visits can reduce by up to 76%; A&E attendances can reduce by up to 54% ; hospital admissions and number of days in hospital may be halved; use of medicines and compliance is improved; days off work can be reduced by up to 50%). However, this requires long-term behaviour change, and initial training programmes for care providers and people with long-term conditions need to be followed up with ongoing support. Self-management support cannot be just an 'add-on' but needs to be embedded within care pathways and commissioning contracts.[3] Given that 30% of the population living with a long term condition account for 70% of health spending, increasing peoples' control and wellbeing through self management may be a cost effective way of working. However, the implication is that any self-management programme would need to be long-term and designed to sustain self-management over time.

The majority of people with learning disabilities make little or no use of formal care services. The extent to which they use social care services is dependent not on the learning disability as such but on additional physical, emotional and behavioural needs.[4] Interventions that address these early in their development can therefore reduce the need for adult social care and/or health supports in the future. Evidence points to a number of potentially effective preventative approaches which include annual health checks, early intervention with people who show development of behavioural difficulties, additional support to families / improving the health of carers, and increasing the opportunities for people to follow a healthy lifestyle.

Promoting the wellbeing of blind and partially sighted people can be effective in avoiding recourse to statutory care. This group has a greater than average propensity to experience depression and also to suffer injuries through falls. Blind and partially sighted people are more likely to live alone than are members of the general population and are more vulnerable to isolation. With early support more could lead independent lives, as described by the RNIB: *"[some] people just need equipment and someone to teach them right at the beginning, just to get them going, not somebody coming in all the time, like somebody who needs bathing and dressing."* [5]

Significant cost avoidance savings have been found for social care services from embedding enablement / re-ablement services into their operating models.[6] If care is required at the

[2] *Right Care First Time: Services supporting safe hospital discharge and preventing hospital admission and readmission* – Age UK (2012)

[3] *Avoiding Hospital Admission: What does the research evidence say?* Purdy, The King's Fund (2010)

[4] *Prevention and Social Care for Adults with Learning Disabilities* - Emerson et al (2011)

[5] RNIB submission to DH Review of FACS eligibility criteria (2009)

[6] *Putting People First Operating Models: learning from the early adopters* - ADASS (2009)

end of the re-ablement period people who have been through re-ablement also seem to be better equipped to take control of that care, i.e. they are more receptive to the concept of managing a Personal Budget, possibly because of their direct experience of a very bespoke approach. A study of social care re-ablement programmes[7] found that during the initial reablement period the cost exceeded that of conventional homecare. However, excluding the costs of the re-ablement intervention itself, the costs of social care services used by people in the re-ablement group were 60 percent less than those for people with conventional homecare services. Studies also show that the benefits of re-ablement for many people last up to and beyond 24 months.

Studies have shown that services that reduce loneliness have resulted in:

- fewer GP visits, lower use of medication, lower incidence of falls and reduced risk factors for long term care;[8]
- fewer days in hospital, physician visits and outpatient appointments;[9] and
- fewer admissions to nursing homes and later admissions.[10]

These emerging findings have led to growing interest in building community capacity as part of the broader 'care offer'.

In 2011, a team from the London School of Economics set out to explore whether building community capacity prevents or delays the need for social care, and whether the projects concerned could generate wider cost savings or economic benefits. Using 'decision modelling' to mimic the alternative pathways people might follow, this study showed that:

- timebanking schemes typically cost £450 per member per year but generate savings £1,300 per member per year;
- befriending schemes typically cost £80 per person per year and generate savings of £300 per person per year;
- community navigator schemes typically cost £480 per person per year and save £900 per person per year.

A review by NESTA in 2013[11] estimated that the NHS in England could realise savings of at least £4.4 billion a year if it adopted 'People Powered Health' innovations that involve patients, their families and communities more directly in the management of long term

[7] *Homecare re-ablement toolkit* – Care Services Efficiency Delivery, DH (2011)

[8] 'The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults – Cohen et al (2006)

[9] *Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomised, controlled trial* – Pitkala et al (2009)

http://biomedgerontology.oxfordjournals.org/content/64A/7/792.abstract

[10] Russell DW, Cutrona CE, de la Mora A, Wallace RB (1997) Loneliness and nursing home admission among rural older adults. Psychol Aging 12(4).

http://www.ncbi.nlm.nih.gov/pubmed/9416627

[11] The Business Case for People Powered Health – NESTA (2013)

health conditions. The financial business case for People Powered Health rests on two key shifts: firstly, mobilising the asset base that is patients, service users and their communities; and, secondly, reducing unplanned admissions to hospital and the requirements for expensive, acute care. Long–term conditions are a major strategic challenge for health systems around the world, and the NESTA review draws on international evidence suggesting that changing the way we work can improve health outcomes in all the most common long–term conditions, including diabetes, COPD, hypertension, heart disease and asthma. As a result, the costs of delivering care can be reduced. NESTA's calculations are based on applying best practice from around the world to England so as to reduce the healthcare budget by 7%.

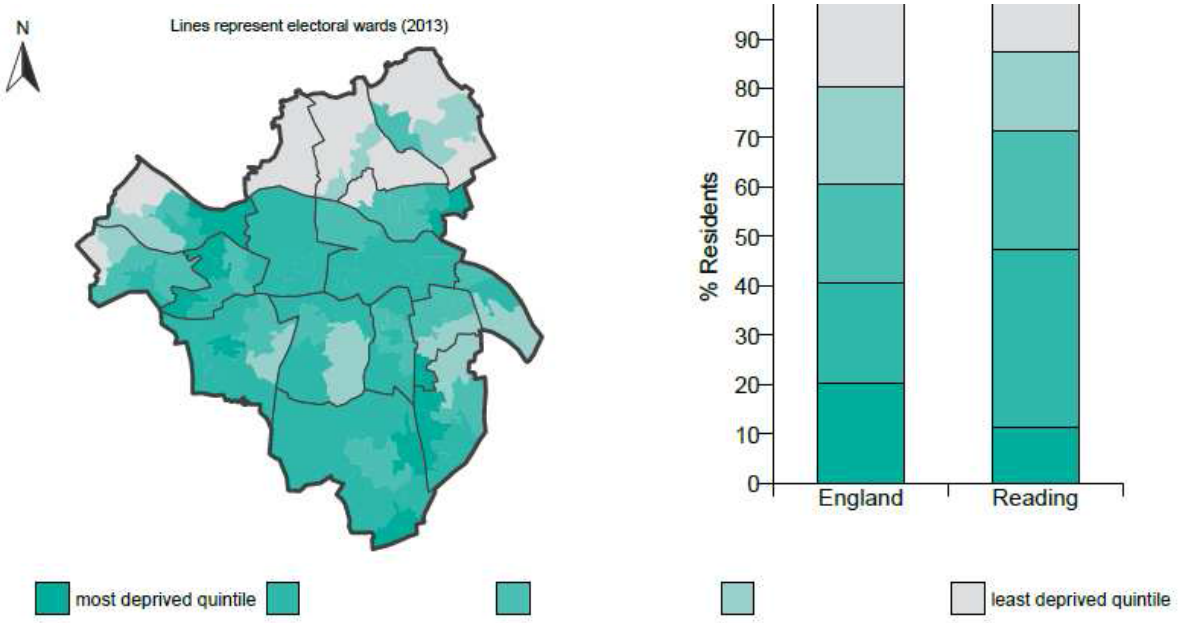
Although communities living in areas of deprivation have greater healthcare needs, the Marmot Review[12] found that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. Instead, actions must be "universal, but with a scale and intensity proportionate to the level of disadvantage". This is also known as "proportionate universalism". The POPP projects evaluation also demonstrated that interventions which address the whole population of older people, and not just the small percentage with complex health and social care needs, can reduce emergency hospital admissions and result in savings. For every £1 spent on the POPP services, there was an average £1.20 additional benefit in savings on emergency hospital stays. The implication is that some targeting of interventions to particular geographical areas / customer groups may be beneficial, but as part of a multi pronged strategy.

[12] *Fair Society, Healthy Lives* - DH (2010)

3. the local context

Poplulation

Reading has a population of 159,200 people living across 63,000 households. The overall health of the people in Reading is varied compared to the national average, as the borough is characterised by extremes of wealth and poverty in a small geographical area. Patterns of inequality are complex with poor outcomes for communities in some of our most deprived neighbourhoods.



Life expectancy in Reading from birth is currently 78 years for males and 83 years for females. These are both below the national and regional averages, indicating there is scope to improve health and wellbeing. There are also some significant differences between wards, with life expectancy being lower (by some 11 years for males – a significant health inequality) and emergency hospital admissions being higher in the more deprived parts of the borough. This helps us to identify how to target interventions to promote wellbeing, although sub-ward level analysis is needed to develop our approach further.

Reading has a younger population than the average for England. There is a smaller proportion of older adults living in the area compared to other localities, although this is less marked for over 75s. The overall population of Reading is projected to increase by 9% between 2011 and 2026. Although Reading expects to see a relatively small increase in the number of older adults in comparison to the average for England, the biggest increase will be seen in the very elderly who are at more likely to have one or more long term conditions. Currently 30% of people in Reading are living with a long term condition such as diabetes, COPD, mental health problems and dementia. There is a growing number of people with both physical and mental health needs.

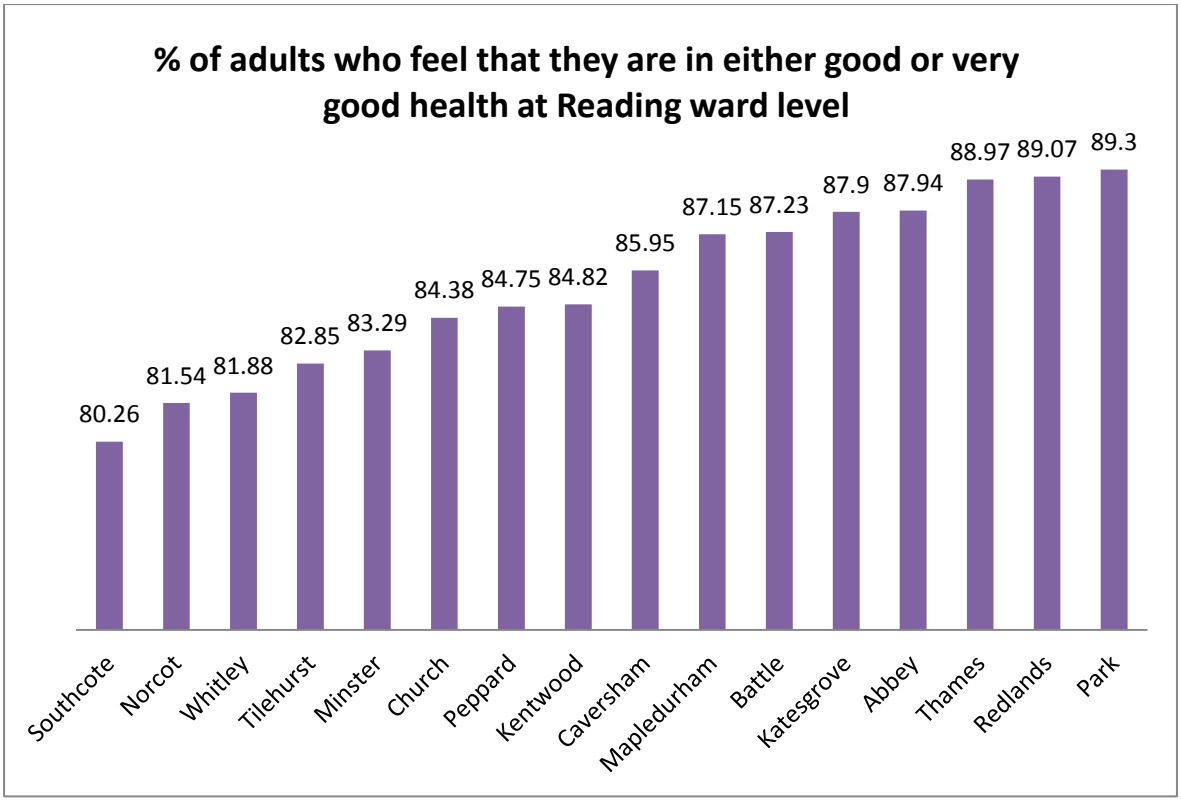
All in all, this means that Reading does not face such severe demographic pressures as other boroughs in terms of future care needs. However, the reduced life expectancy and, especially, the large gap in life expectancy between people living in the more deprived and most affluent areas, is likely to reflect a greater likelihood of poor health and dependency at an earlier age, especially in the more deprived parts of the borough. Unless we can reduce avoidable illness and disability then we can expect an increasing pressure on services as more and more people become dependent.

The chances of requiring a care service rises dramatically for those aged over 80, in part because an older person with a long term health condition is less likely that a younger person to be living with other(s) who are able and willing to support them to continue living independently. Our investment in carers' health is key here. We also have to factor in that children and young people with profound and multiple disabilities and across a range of neurological conditions is rising – these children will find their way into Adult Services over the next 10-15 years (and there has been an increase of 35% in the under 5s population over the last 10 years).

Perceptions of wellbeing

Two questions in the Census (2011) probed the general health and wellbeing of the usual resident population. These were questions asking people to report on their general health and on whether they felt that they were limited at all in performing day-to-day activities by health issues. Almost 90% of respondents living in Reading said that their day to day activities were not limited at all. This is higher than the national average and the average for the South East region. Over 50% of people living in Reading felt that they were in very good health with over 35% feeling that they were in good health. Again, this is higher than the national and South East average with fewer people from Reading reporting that they were in poor health. This is likely to be a reflection of Reading's relatively young population profile.

At ward level the highest levels of reported good/very good health were in Park, Redlands and Thames wards. This is particularly interesting as according to the Indices of deprivation Park is ranked 13, Redlands 11, and Thames 15. Southcote, Whitley and Norcot have the lowest levels of self reported good/very good health, and these are amongst the 6 most deprived wards in Reading.



Source: 2011 Census

The Public Health Outcomes Framework includes a measure of self-reported wellbeing and is identified as a key component of population needs assessments. In 2012, a sample of respondents aged 16 and over were asked four questions related to wellbeing - related to life satisfaction, happiness levels, feelings of anxiety and feelings of worthwhile. Results indicated levels of low happiness (30%) and low feelings of being worthwhile (24%) within the Reading population.

Long term conditions

The leading cause of death in Reading is cardiovascular disease, including heart attack and stroke. Lifestyle changes can reduce the risk of cardiovascular disease and so improve both life expectancy and healthy life expectancy. Although the prevalence of diabetes in Reading is currently below the national average, the rate is increasing. The rate of cancers in Reading is at around the national average, and has been for several years. In line with the rest of the UK, there is scope to reduce the rate by making lifestyle changes to reduce avoidable cancers. People in Reading are as physically active as people in other parts of the country – which means not active enough to reduce the risk of avoidable and delayable long term conditions, i.e. cardiovascular disease, diabetes, depression and dementia.

7,087 people in Reading aged between 18 and 64 are estimated to have a moderate physical disability and 1,928 are estimated to have a severe disability. These figures are expected to increase by 12% and 14% respectively by 2030. In 2013 there were 378 people registered as deaf (including 16 children); 424 people registered as blind (20 children) and 50 residents

registered with dual visual impairment and hearing impairment. During 2012-13, a total of 534 people aged 18 to 64 with a physical disability and/or a sensory need accessed Social Care services. Of these, 515 received community based services.

Learning disabilities and autism

Around 1,800 adults in Reading are estimated to have a learning disability rising to around 1,920 by 2020. Currently there are 554 people with learning disabilities living in Reading known to the Community Learning Disability Team, of which 437 are of working age. (These will be people who meet the threshold for Social Care involvement).

At September 2013 there were 92 adults eligible for Social Care services that had a diagnosis of Autism. Of these, 75 had a learning disability as well and one was known to Mental Health services. (This number should be viewed with caution as the recording of Autism is not always accurate within Social Care systems unless it is a primary disability). This forms a very small proportion of the total number of people in Reading who have an Autism diagnosis and the prevalence is thought to be increasing. Getting specific information and statistics about people with Autism is problematic. Historically many adults have had a primary diagnosis of other symptoms that have masked the Autism traits so they are recorded as having learning disabilities.

Mental health

There is a higher incidence of psychotic mental illness in Reading (affecting 29.3 people per 100,000 population each year) compared to the rest of the South East (19.8 / 100,000) and England as a whole (24.2 / 100,000). The prevalence of other mental illnesses in Reading is comparable to regional and national averages. Mental health provision does not reach all sections of the population evenly with those living in deprived areas, older people, and black and minority ethnic groups (BME) tending to face barriers to access. Stigma and discrimination may play a part in compounding these inequalities.

The number of people with mental health problems supported in residential care in Reading has almost halved since 2010, while those provided with programmes of care within the community has risen by 57%. This shift towards commissioning more community based services reflects service users' wishes to remain independent and in control of the support they require – which, for this group of people, may vary over time. 85% of people are being supported live in their own home or with their family. This is a high proportion compared to the England average of around 60%. Around 13% are in paid employment (again, higher than the England average).

1,535 people who are registered with GP Practices in Reading LA are recorded as having schizophrenia, bi-polar disorder or other psychoses. This equates to a significantly lower proportion of the population than the national average but a higher proportion than the

average in the NHS Berkshire West area (covering Wokingham, West Berkshire and Reading).

Drug and alcohol dependency

According to Public Health England, the estimated number of heroin and/or crack users in England and Wales has fallen since peaking in 2005-06 at 332,090 to 298,752 in 2010-11. In the same period, the estimated number in Reading has risen slightly from 1,271 to 1,363, with the rate per 1,000 population remaining stable (12.36 in 2005/6 and 12.38 in 2010/11). Reading has a high demand for drug treatment, with a higher rate of drug users amongst its population compared to other areas. Around 5.5 people in every 1,000 living in Reading were in drug treatment during 2012, a higher rate than the national average, the South East region and the average of local authorities with a level of deprivation similar to Reading's.

Alcohol-attributable hospital admissions in Reading have risen slightly over the past 5 years. They still remain below the national average and average for local authorities with similar levels of deprivation and are very similar to the averages for the South East. Around 600 in every 100,000 females and 1,000 in every 100,000 males in Reading were admitted to hospital for reasons considered attributable to alcohol in 2011.

Alcohol-specific hospital admissions for females have also increased slightly over the past 5 years, but decreased slightly for males. Figures are not large enough to tell if there has been a significant increase or if it is due to natural changes that have occurred in the data. Both remain below the national average and below the average for the South East. Around 140 in every 100,000 females in Reading were admitted to hospital for reasons considered specific to alcohol in 2011. The rate is much higher in males than females with around 300 in every 100,000 males in Reading admitted to hospital for reasons considered specific to alcohol in 2011.

Carers

12,315 Reading residents identified themselves as a carer in the 2011 Census, which was 7.9% of the Reading resident population. This is an increase on the 2001 census figures of 7.7% and shows that unpaid care has increased at a faster pace than population growth over the last decade. In 2011, most unpaid carers in Reading were providing 1-19 hours of care a week (66%). However, 2,599 carers were providing a high level of care at 50 or more hours of unpaid care per week.

13% of the population in Reading aged over 65 were providing unpaid care at the time of the Census. As the prevalence of health problems and disability is higher among this age group, providing a caring role may have an additional detrimental impact on the health and wellbeing of this group of individuals. Unpaid carers in Reading are more likely to suffer from poorer health with only 75.1% describing their health as "good or very good", compared to 86.5% of people who do not provide unpaid care. The likelihood of reporting poorer health rose with the number of hours of care provided as carers providing 50 or

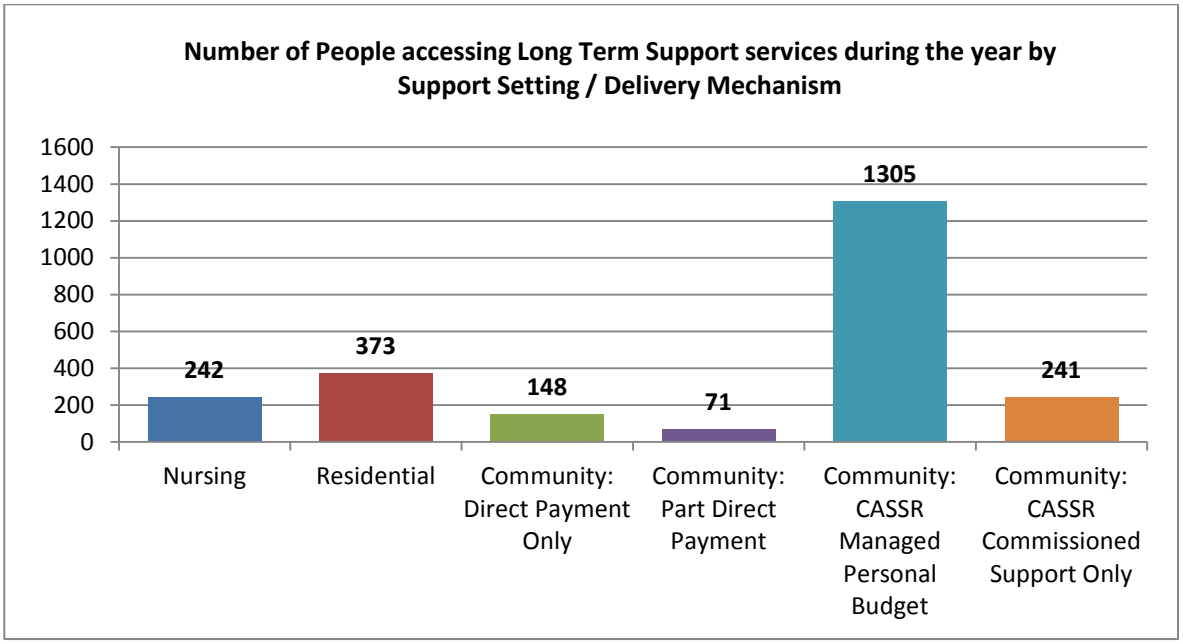
more hours of unpaid care a week were three times as likely to describe their health as "bad or very bad" compared to people who did not provide unpaid care.

Use of Adult Social Care

The number of people accessing Long Term Support from Adult Social Care during the year to 31st March 2015 was 2,380. Reporting requirements for Adult Social Care changed in 2014-15 which means direct comparisons cannot be drawn with previous years. The Long Term Support figures do not include the provision of Equipment and Adaptations or Professional Support, both of which are now recorded as Ongoing Low Level Support or Short term Support (other) depending on the nature of the provision. The Long Term Support figures also exclude short term residential respite which is now counted as Short Term Support (other).

For adults aged 18-24 accessing Long Term Support in 2014-15, the most common primary support need was learning disability (408 service users) followed by mental health support (381 service users) and then physical support/personal care (273 service users). For adults aged 65 or over, the most common primary support need was physical support / personal care (1,068 service users), followed by mental health support (98 service users), support with memory and cognition (80 service users) and then learning disability (33 service users).

The majority of people receiving Long Term Support are living in their own homes in the community and taking control over their support services through Personal Budgets – whether then managed by the local authority or taken by the individual as a Direct Payment.



Public Health services

Under its Health and Social Care Act 2012 responsibilities to improve the population's health, Reading Borough Council commissions services such as:

- health checks (for people aged 40-74 years, who do not have a long-term condition and who have not had a check in the preceding five years) to check for risks such as smoking; overweight and obesity; diabetes; and high blood pressure and to offer help in tackling these;
- smoking cessation services;
- programmes to encourage and enable people to be more physically active as part of their everyday lives;
- programmes to encourage and enable people to eat more healthily;
- sexual health services;
- programmes to promote mental wellbeing; and
- services for people who misuse drugs and/or alcohol.

Many of these programmes are aimed at the whole population, but there are often targeted approaches to reach communities at greater risk of poor health outcomes.

Voluntary, community and faith sector services

Investing in the right community support is a key part of the Council's plan to narrow the gaps between the quality of life enjoyed by different members of our communities. Reading's community providers play a significant role in promoting wellbeing in the borough - connecting communities, stimulating innovation and making a positive difference to people's lives.

Voluntary and community based organisations in Reading have a proud history of supporting people to enjoy healthy lives. Local organisations support people with long term health conditions, those who may need extra support as they get older, and people who provide unpaid care to friends, family and neighbours. In preparation for implementing the Care Act in Reading, we asked people to tell us what their priorities are for these preventative services. This feedback, alongside the population profiles taken from our Joint Strategic Needs Assessment, has been used to develop five 'wellbeing themes' within our Narrowing the Gap Bidding Framework. This Framework covers funding available from the local authority to support cross cutting corporate priorities relating to tackling poverty and thriving communities, as well as meeting Adult Social Care and Public Health outcomes. The aim is to develop this Framework in future years to reflect the emergence of joint commissioning arrangements with Clinical Commissioning Groups and neighbouring local authority partners.

The Council recognises its duties under the Care Act to ensure that local people have a good range of wellbeing services to choose from. Our aspiration is to continue to have a vibrant local market, which is resilient to funding challenges, working with us for the benefit of the Borough and providing grass roots services. There are over 900 voluntary and community

sector organisations listed on Reading Voluntary Action's local directory. In addition, there are 360 social action projects being delivered by faith groups in Reading.[13] These include debt advice, job coaching, delivering emergency food parcels and offering vulnerable people a safe place to belong and to build friendships.

We want to work closely with the voluntary, community and faith sectors through mutually beneficial partnership arrangements, and make sure that the services we support and commission through the sector are efficient, effective and delivered to meet the needs of citizens.

[13] *Cinnamon Faith Action Audit (Reading)* – Cinnamon Network (2015)

4. achieving our aims

Our seven key aims map onto our prevention objectives as illustrated below.

Wellbeing Aim	PREVENT	REDUCE	DELAY
Embed the wellbeing principle throughout the Council's functions			
Ensure Reading homes support wellbeing			
Harness the assets Reading has to prevent care and support needs from increasing			
Empower people with care needs to self care and make positive lifestyle choices			
Support people to prevent their care and support needs from increasing			
Promote a re-abling approach across care services			
Ensure people with care needs and unpaid carers can access services that work well together to support people's independence			

4.1 Embed the wellbeing principle throughout the Council's functions

Creating a new focus on wellbeing

We will establish a **Wellbeing and Prevention Delivery Group** to oversee the achievement of our agreed aims, to champion wellbeing across the authority, and to bring initiatives together in a cohesive way. The Delivery Group will be accountable to the Transformation Programme Board within the Directorate of Adult Care and Health Services, and will present progress reports to the Health and Wellbeing Board alongside proposing refreshes to the action plan.

Wellbeing interventions to prevent recourse to formal care will not achieve an instant impact. It is therefore essential that we see this Position Statement and its accompanying Action Plan as part of a long-term process, and refresh it as other strategic documents are updated, in particular the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, both of which are due to be updated in 2016.

The Adult Wellbeing Position Statement is currently part of existing budget plans. This includes drawing on funding allocated by the Department of Health to support Care Act implementation and the pooled Better Care Fund budgets which support health and social care integration plans.

We have developed a set of **principles to underpin our commissioning activity** so that promoting wellbeing and preventing the escalation of care needs is embedded in service provision across the borough. We will incentivise and reward support for wellbeing, and support the development of a network of enabling services that will:

- Help people to help themselves, make informed choices and decisions about their own
- lives, and be in control of their health and care
- Be tailored to people's individual needs and preferences
- Value and support the contribution of carers
- Harness and strengthen the contribution of local people in local communities
- Be responsive and make things happen for people in a timely way
- Reach people, including those in marginalised groups or who are isolated
- Be delivered in ways that make best possible use of health and social care resources
- Be sustained if they are shown to be achieving positive prevention outcomes

Developing a workforce for wellbeing

Many teams within the Council support people to make positive lifestyle choices and to maintain their commitment to their own wellbeing. Our ambition is to involve many more frontline staff in promoting people's wellbeing through our **Making Every Contact Count**

(MECC) programme. MECC is about building a culture of health improvement through the range of contacts the Council has with Reading residents. Every contact we have with individuals is potentially an opportunity to encourage someone to make a positive lifestyle change. Through MECC training, our staff will be equipped with the skills to seize these opportunities – asking questions about possible lifestyle changes at appropriate opportunities; responding appropriately when these issues are raised; and then taking action to signpost or refer people to the support they need.

In the first phase of our MECC programme, we will train frontline staff working across Adult Social Care and our Customer Call Centre. An evaluation of the first phase will inform the development of Phase Two, including the training methodology as well as how to target our next training round, reaching out to partner agencies as well as Council teams. Typically, MECC interventions encourage people to stop smoking, eat a healthy diet, maintain a healthy weight, keep alcohol consumption within safe limits, take more exercise or take care of their emotional wellbeing. Support with these issues can benefit any resident, but we are committed to ensuring that people with emerging care needs are reached through this programme.

Using a risk matrix approach, a cross agency Steering Group of Reading's Local Strategic Partnership will identify priority groups who could benefit from the Partnership's **Joined Up Front Line Delivery** project. Key partners from the police, the health service, the fire and rescue service, higher education, business and the voluntary, community and faith sectors are working with the Council to improve our ability to connect people to the right services at the right time. The Partnership has committed to developing a toolkit to enable effective cross-sector working, including information-sharing protocols; an evaluation of brief interventions based on local experience; and the development of a culture of advocating for customers across services.

4.2 Ensure Reading homes support wellbeing

Where people live can have a significant impact on their wellbeing, and poor housing can lead to a decline in both physical and mental health and so lead to the escalation of care needs. Accommodation costs in Reading are amongst the highest in the country and the provision of affordable housing continues to be the key strategic concern.

Housing Renewal Policy (Private Sector)

Within the boundaries of Reading Borough Council, the private sector represents 83.1% of households. The Private Sector Stock Condition Survey carried out in 2006 showed that the number of non-decent dwellings in the private sector is 20,500, consisting of 40% of the stock, of which 3,460 are occupied by vulnerable households. The Council uses the Housing, Health & Safety Rating System (HHSRS) hazard assessment tool to prioritise action, make homes safer and reduce accidents and in this way achieving the Decent Home Standard. The authority has adopted a **Housing Renewal Policy** that ensures funds are targeted to those residents in the private sector that are in the greatest need - older people, those on a low income or who are disabled.

Although it is primarily the responsibility of private sector owners to maintain their own property, some owners - particularly the elderly and most vulnerable - do not have the necessary resources to repair or improve their homes. Local authorities therefore have an important role to play in providing assistance in these cases. Reading's Housing Renewal Policy (Private Sector) sets out the criteria for accessing financial assistance through several schemes targeted at people who are older or in poor health, including the **Grant for Hospital Discharge** - for homeowners or private tenants to fund small adaptations to facilitate hospital discharge, and the **Flexible Home Improvement Loans** – for home owners aged 60 or over.

Home adaptations

Reading Borough Council works in partnership with a **Home Improvement Agency** which provides support and guidance to help people with adaptations, repairs or improvements to their home from grant applications through to completion of the work. If someone has limited mobility, they may need to adapt their home to make it easier to get in and around. A **Disabled Facilities Grant (DFG)** may help to pay for these adaptations – including things like wheelchair ramps, stairlifts or hoists or installing a downstairs bathroom. The Home Improvement Agency can assist people to apply for the means-tested DFG. We will be re-commissioning our Home Improvement Agency from June 2016 with clear targets to improve the customer journey and promote independent living for residents in need of support.

Through the Narrowing the Gap Bidding Framework, the Council is also re-commissioning a **handyperson service** to resolve hospital discharge-related work and emergency household repairs within 2 working days. This service will support older people and people with a long

term health condition. The currently commissioned handyperson service is well used and deals with 100-150 emergency service requests p.a. In addition to emergency repairs, however, there also appears to be an unmet need for non urgent repair work. We need to understand this better, and if necessary develop the local market to ensure that people who feel vulnerable on account of their age or state of health are able to access affordable small repairs services from trusted providers.

Tackling fuel poverty

Cold housing has a known detrimental impact on health - for example, circulatory diseases, respiratory problems and mental health are all affected by cold housing. In Reading the seasonal increase in the death rate has been rising for several years and we are committed to targeting support to keep warm and well more effectively on those who need it most. **Winter Watch** is an annual campaign administered by Reading Borough Council designed to provide support to fuel poor households and those at risk of the negative health effects associated with cold weather. In 2014-15, 177 residents were visited in their homes and 64% of people assisted had a long term heath condition. 55 homes were draught proofed and 17 applications were submitted for replacement boilers under the Government's ECO scheme. The 2015-16 campaign offers:

- A home energy check
- Referral to a draught proofing/ handyman service
- Information and help accessing energy efficiency grants
- Help to access an emergency payment where there is severe hardship associated with energy purchase
- Emergency measures/equipment – such as heaters and bedding
- Advice on how to switch energy supplier or change payment tariff

Winter Watch is being actively promoted through forums for older people, people with disabilities and carers to ensure those with care and support needs can benefit from the scheme.

Home safety

We work with the Royal Berkshire Fire and Rescue Service (RBFRS) to offer vulnerable adults a **home fire safety check**. People are more at risk from fire if they:

- are over 65 years of age
- live alone
- have mental health issues (including dementia or memory loss)
- have mobility difficulties
- suffer from hearing loss or are visually impaired
- abuse alcohol or drugs
- smoke heavily
- have a learning disability; or
- are hoarders

Under the scheme, an RBFRS representative will visit someone at home to assess the home for fire risk, with a view to fitting free smoke detector alarms if required. The representative will also discuss home escape plans and provide education advice to lower fire risk. The home fire safety checks provide a good opportunity not only to reduce fire risk but also to connect vulnerable adults to other services to improve their wellbeing. We are keen to improve our information sharing across agencies to make this scheme more effective and better targeted.

Citizens Advice estimates that around 4 million people a year are "scammed" in Great Britain, i.e. tricked into parting with money for things they don't really want or need. Research in 2006 by the Office of Fair Trading (OFT) found that while older people were no more likely to be scammed than other age groups, their financial losses were often greater. The Alzheimer's Society calculates that 15% of individuals with dementia (an estimated 112,500 people) have been victims of cold-calling, scam mail or mis-selling. Scams can have a devastating impact, including mental illness and the physical manifestations of long-term stress, as well as reducing people's confidence and skills to maintain independent living. Reading's **Trading Standards** service works with people identified as having been, or at risk of being, scammed or pressurised through doorstop selling and helps equip people to avoid future financial abuse. Our outreach programme includes talks to groups, to raise awareness of the issues as well as individual visits. We will build on this by with partners to explore how we can develop a more co-ordinated and proactive response.

An important part of maintaining independent living is being able to keep a home clean and clear of waste. The Council offers an **Assisted Collection** service as part of its Refuge & Recycling provision. This is for Reading residents who are unable to move their bins on account of their age, illness or disability and have no one at their property to help them with this task. Residents who have joined the Assisted Collection scheme are a priority group to reach with other wellbeing services given the majority are managing a long term health condition alone. We will develop this within the Council next year, and explore options for information sharing protocols with partner agencies to make the most of this targeted approach.

<u>Homelessness</u>

For some of the Reading population, the priority need is to get into a home and away from rough sleeping. Rough sleeping has a marked detrimental effect on both physical and mental health and, nationally, the average age of death of someone sleeping rough is 47 years for men and 43 for women. Many rough sleepers have complex needs across mental health, physical health and drug and alcohol misuse issues. They also may not have the skills to manage a tenancy or live independently. Those who are homeless also face significant barriers to access health services, being unable to register with regular services due to being unable to provide details of a residential address. The **Homelessness Pathway** is funded by Reading Borough Council and is designed to help people develop the skills and confidence they need to move from being homeless. The Pathway offers three stages of accommodation with different types of support.

Stage	Example of Support Offered	Support Goals
One	24-hour, intensive support	Opening a bank account; applying for benefits and learning to budget; registering with a GP to deal with any drug or alcohol problems
Two	Support during the day time	Registering to vote; developing hobbies; dealing with debts
Three	A minimum of one hour's support every fortnight	Opening a Credit Union account; saving towards a deposit; working towards training or employment

Housing options for people with care needs

The Council is developing an **Accommodation with Care Strategy** to bring together a number of initiatives to assist older and disabled people to maintain their ability to live independently in their own home for longer, including our Extra Care development programme and the Supported Living Accredited Select List.

The Council also offers assistance to older people through the **Should I Stay or Should I Go** scheme. When an older person is identified who is having difficulty in maintaining a safe and habitable home, Council officers will help that person explore their options around housing assistance and different types of accommodation. Going forward, we will explore how we can reach more people in need of this type of support, including developing referral protocols with partner agencies.

4.3 Harness the assets Reading has to prevent care and support needs from increasing

Reading Sports & Leisure

Over 750,000 people use the Council's sports and leisure facilities across the town each year. This includes gyms, pools, exercise classes for all abilities at studios across Reading, and a wide range of outdoor venues for ball or racquet games, and skateboarding. A key driver for the provision of high quality leisure facilities is to promote the health and well-being of the population. Taking part in sports and leisure activities is a good way to build social networks, self esteem, physical and emotional resilience, and the Council offers opportunities for all residents to enjoy these benefits. Staff are trained to assist people with additional needs, and where people need extra one-to-one support to take part in activities they are welcome to attend facilities with a carer or Personal Assistant. There are adapted classes for people with mobility or other health issues, and discounted activities for people who are aged over 60 or have a disability.

Following a review in 2015, the Council has committed to a modernisation programme which will ensure that leisure and recreation services can remain open whilst the Council invests in facilities, undertakes feasibility work and secures additional funds and support to undertake improvements and provide new leisure facilities within the town. New facilities generally result in increased level of use and participation in the communities where they are located. In turn this provides more opportunities to target specific initiatives to increase engagement and participation from those who have various health conditions that can be ameliorated through exercise and well-being programmes.

The **Pathway Exercise Referral Scheme** is aimed at patients with specific medical conditions (e.g. obesity, cardiovascular disease, asthma, diabetes, depression and stress, arthritis, COPD, stroke, MS) who require a referral from their doctor to take part in supervised activities, or for those who are at risk of developing coronary heart disease. People on the Pathway scheme are supported by specially trained coaches and instructors to take part in activities such as swimming, health walks, cycling, circuit training, chair based exercises and aqua mobility. A scheme co-ordinator works with health professionals and doctors surgeries across Reading to refer patients with existing health conditions to supervised activities.

People who need support and encouragement to take part in exercise pre-treatment, undergoing or post treatment for cancer can join the **Cancer Wellbeing exercise programme**. This is made up of exercise classes designed specifically for people who have been affected by cancer, and whose quality of life can be maintained or improved through taking part in regular, supervised activity. Classes are taken by a cancer rehabilitation qualified instructor. RSL also offers a **Cardiac Rehabilitation programme** as a follow on from a hospital based physical activity rehabilitation programme. This is specifically for people with Coronary Heart Disease, who are recovering from a heart attack or heart surgery.

The **Stay Active programme** is aimed at the over 50s and runs one morning a week at Meadway Sports Centre. Older people are assisted to enjoy activities such as badminton, table tennis, exercise classes, walking, basketball, swimming and gym use. The sessions are very popular, and the Council is looking to expand the programme over more days and possibly additional venues.

The **Reading Walks** programme includes a series of weekly walks and seasonal walk trips lead by qualified walk leaders. The programme objectives are: engaging with older and isolated people in the community; increasing people's physical activity levels; increasing people's independence and discovery of their local community and green space; and decreasing social isolation. Although any adult can join the Reading Walks programme, activities are promoted to residents at greater risk of developing health problems so that the programme contributes to reducing health inequalities across the town. The Reading Walks co-ordinator post is funded for a fixed term, and plans will be developed to exit from or to develop the programme following a review in 2016.

Partnership working with other sports and leisure providers

Sport in Mind is a mental health charity founded to provide people experiencing mental health problems with the opportunity to play sport and physical activity in a supported environment. Reading Borough Council, in collaboration with neighbouring authorities, is funding a Sport in Mind co-ordinator to work across Berkshire promoting sport and physical activity to promote mental well-being, help aid recovery, improve physical health, encourage social inclusion and empower people experiencing mental health problems to build a positive future for themselves. This is a new post which will be monitored closely to ensure we learn from better-than-expected outcomes and can correct poorer ones quickly.

Rivermead Leisure Centre is situated just north of the town centre and is managed by a social enterprise partner, GLL. The centre includes a pool, several gym areas and ball courts, a café and rooms of various sizes which can be hired out on a regular basis or for events. As Reading has a number of town centre gyms which are popular with working age adults, GLL has taken the decision to focus on a different target market for Rivermead – older people and young families. GLL is creating an older people's lounge at the Rivermead site to encourage more older people to use the Centre's facilities, and is keen to work with the Council and local voluntary sector providers to offer a wider range of services from the Rivermead site for people of all abilities. The Council will be re-locating its day activities with care service to Rivermead in autumn 2016 after re-developing an unused wing of the Centre. The aim is that this partnership will widen the range of activities available to people with complex needs and also encourage more family carers to access fitness and wellbeing services whilst those they care for are receiving respite care within the Centre.

Reading Museum

Reading Museum is open Tuesdays to Saturdays and entry is free of charge. The Museum is relaxed and informal, and staff are very happy to help those with additional needs to

discover more about the displays. This includes organising **special tours for adults with learning disabilities and/or autism** which are arranged in partnership with local colleges. **Magnifying glasses and torches** are available for loan, and **large print** information sheets are available. There are also a number of **tactile displays**, including raised images of the Bayeux Tapestry which can be accompanied by an **audio guide**. The Museum also has a community engagement programme to take projects out to groups who might find it harder to engage with resources at the Museum premises.

The Museum operates a **Memory Box** scheme, and has over 40 collections designed to spark recollections amongst older residents. Original objects, photographs, documents, smells and sounds draw the user back in time and place and help to stimulate conversations. The boxes are delivered in partnership with Reading Mobile Library Service. Many older people enjoy reminiscence as a way of affirming their identity and personal history. For people with dementia, reminiscing is a way of conversing more easily than trying to engage about recent topics. Having the opportunity to reminisce therefore maintains skills and confidence in social interaction for longer. Alongside the Memory Box scheme, the Museum offers **Reminiscence Training** to help care workers and others make best use of the boxes. Reminiscence Therapy has been shown to be helpful in reducing depression and anxiety, helping individuals come to terms with growing older, and encouraging older people to regain interest in past hobbies and pastimes, especially people who are confused or disoriented. The Memory Boxes were loaned out for 12,600 user sessions last year, and most care homes in the area now have a member of staff who havebeen on the Reminiscence Training course. A future area for development is to raise awareness of the scheme and resources with other care providers.

Library services

As well as being a place to borrow books, CDs and DVDs, Reading libraries also offer **free internet access** for members for up to two hours a day. Staff and volunteers can assist people to make use of online facilities. The libraries also host several book clubs and writing groups, as well as offering book collections to support external book clubs. These resources can help develop social contacts. There is a **reading group for visually impaired people** at Central Library: members listen to books on MP3 discs rather than reading the printed version. In addition, there is no charge to people who are blind or visually impaired for audio book loans.

All of Reading's libraries are fully accessible to wheelchair users. However, Reading residents who have difficulty visiting their library can request the **Home Visiting Service**. The mobile library van takes 2,200 books to care homes, sheltered housing, day centres and other establishments around Reading and is fully accessible. People registered to use the service normally receive a visit once every three weeks. Volunteers often stay for a drink and a chat while dropping off books, and in this way the service includes an element of befriending. These regular visits by volunteers to people who find it hard to leave the house also provide an opportunity to offer other wellbeing services / checks, and we will consider how to make best use of the service within our Joined Up Front Line Delivery project (see above).

4.4 Empower people with care needs to self care and make positive lifestyle choices

Improve access to preventative health services

The **NHS Health Check** programme systematically targets the top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. It is primarily a health improvement programme offering an opportunity to engage people aged 40-74 in discussions about healthy lifestyles before they get sick and goes on to help them to take control of their health and take action to avoid, reduce or manage their risk of developing future health problems.

The majority of Reading GPs have accepted contracts to deliver the Health Check programme and eligible patients registered with these practices will be invited for a health check once every five years. The Council's Public Health team manages the programme, including raising awareness of the entitlement to a health check and its value. The Health Check programme targets the age range in question because evidence shows that this group face the highest risk of developing cardio vascular problems if they make poor lifestyle choices. People with various pre-existing conditions are excluded from the programme, and there is currently no mechanism for adding other 'at risk' groups, e.g. people with care needs or carers. Working in partnerships with the CCGs, we will explore options for developing the Healthcheck programme to increase its preventative impact.

Residents over the age of 75 have a **named accountable GP**. One of the responsibilities of the accountable GP is to provide a health check on request where an examination hasn't been performed in the preceding 12 months. There is a local commitment to develop care plans following a face to face consultation for 50% of over 75 year olds who are also in the top 2% risk category for hospital admission. The named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP).

The Council's Public Health Team has supported the **national flu campaign** to encourage those in vulnerable groups to take up the offer of a free flu vaccine, ie. pregnant women, those aged 65 or over, those aged under 65 with long-term conditions, and unpaid or family carers. An annual flu jab is the most effective way to reduce the likelihood of developing pneumonia or other severe chest infections by preventing flu. The adult flu vaccine is available from GPs and pharmacies to those in groups at particular risk of infection and complications from flu.

Putting emotional wellbeing on an equal footing with physical wellbeing

Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012. However, people with mental health problems have a significantly different level of contact with health services compared with other patients. In 2011/12:

- 78% of mental health service users accessed hospital services compared with 48% of non-mental health service users; and
- 71% of mental health service users admitted to hospital were classified as an emergency compared with 40% of non-mental health service users.

In an attempt to address this discrepancy, a group of national mental health organisations have issued the **Local Authority Mental Health Challenge** to support and encourage councils to take a proactive approach to mental health. Reading Borough Council has signed up to the Challenge and nominated a member 'champion' to lead this locally.

The Council continues to provide funding support for **Reading Samaritans** who offer a 7 day phoneline and drop in service to provide listening support to people who are in distress. This includes, but is not confined to, people who are feeling suicidal. There has been a recent increase in the suicide rate in Reading, and the Council is funding various initiatives to raise awareness of support for those who may be severely depressed and considering this course of action. Funding has been put into the **CALM (Campaign Against Living Miserably)** programme to raise awareness of mental health support for middle aged men, who are particularly at risk.

The Council also provides funding support to the **Mothertongue** multi ethnic counselling and listening service. The charity offers holistic support to people who are heard with respect in their chosen language. Mothertongue also offers professional development to staff and volunteers from other agencies, and helps to bridge language gaps to help people overcome barriers to accessing the support they need. In partIcular, there is a strong working relationship with Berkshire's IAPT[14] service, Talking Therapies. In 2014-15 Mothertongue delivered 1,476 hours of counselling to 46 clients per month (on average). They saw clients from over 39 different ethnicities and delivered counselling in 12 different languages. The Mental Health Interpreting Service provided 682 hours of interpreting in nine languages.

We are currently developing our **Mental Health Commissioning Strategy** for Reading, and will ensure this reflects the need for preventative services to promote emotional wellbeing as well as support to manage mental ill health.

Promoting self care,

Reading's **Better Care Fund plan**, endorsed by the Health and Wellbeing Board in 2014, sets out a joint commitment from the local authority and the Clinical Commissioning Groups to

[14] Improving Access to Psychological Therapies

promote self-care, support people to take more responsibility for their health and wellbeing and make decisions about their own care. A web based tool has been deployed in Reading to promote joint care planning between individuals and doctors and will be built on to deliver further self-care initiatives.

The Council works with Reading's various condition specific support groups within the voluntary and community sector to enhance opportunities for peer support and learning from others' experiences. Through the Narrowing the Gap Bidding Framework, the Council is commissioning services to **facilitate peer support and/or enablement training** for adults affected by long term health conditions (and their families where relevant). Specific services are being commissioned to support those affected by dementia, visual impairment, hearing impairment, autism, physical disability, Multiple Sclerosis and Parkinson's Disease. In each case, providers will have clear targets to deliver services which enhance people's resilience. Service users will be supported to establish contact with others affected by similar long-term health conditions; to share and benefit from one another's knowledge; where relevant, take part in social skills training; and learn the basic skills of self-management. A **self advocacy** service is being commissioned for adults with a learning disability so they are supported to have a voice in their community, choose their support, and shape the services they use. Through this self advocacy provision, we will give service users the tools to take better charge of their own wellbeing.

New Directions

New Directions is Reading Borough Council's Adult Learning Service. It provides a wide range of part-time courses for adults in the Reading area. New Directions has 3 main centres - in Caversham, Reading Central Library and South Reading - and also runs courses at the Avenue in Tilehurst, from Children's Centres and from a number of local community venues. Each main New Directions centre has free job searching facilities. New Directions was rated 'Good' in an Ofsted report published on January 5th 2012.

Lifelong learning can yield significant health and wellbeing benefits for individuals. Keeping mentally active can reduce and delay the risk of certain long term health conditions, e.g. dementia in older adults. Learning a skill such as a language or a handicraft can promote general well-being and mental health. Moreover, attending classes gives people social contact, with the opportunity to make new friends, and so reduce loneliness and isolation.

New Directions offers a range of courses for the whole community which promote wellbeing. These include the free **Eat for Health** and **Kids Cooking for Health** cookery courses; plus a range of arts, crafts and complementary therapy courses, IT and language courses, including English as a Second or Other Language (ESOL). There is already some targeted marketing of these courses to reach people with greater needs, such as a free ESOL course for expectant mothers and waiving the fee for IT confidence building courses for people receiving Job Seekers Allowance. There is scope to do more to encourage take up of these courses by people with long term health conditions, however.

In addition, New Directions has a suite of courses for adults with **Supported Learning** needs. This includes cookery, IT, pottery, photography. There is a **Confidence Building** class for people with low self esteem or mental health needs, and an **Adults with Dyslexia** awareness course. These courses are already marketed to target audiences, but could attract a wider learner group through the development of key partnerships and exploring other options for delivery in the community.

In the last academic year, 552 people aged 55 or over took a New Directions course, and 113 of these were over 70 years of age. 666 learners disclosed a disability or long term health condition as set out in the table below.

Long term health condition	No. of learners
Visual impairment	16
Hearing impairment	32
Disability affecting mobility	30
Other physical disability	14
Other medical condition	81
Emotional / behavioural issues	14
Mental health issues	69
Learning difficulty or disability	265
Temporary disability after illness	9
Asperger's Syndrome	14
Multiple disabilities	114
Other	8
TOTAL	666

Reducing loneliness

Ensuring people with care needs have opportunities to enjoy social contact is a key component of our approach to wellbeing. There are clear links between loneliness – which is subjective and relates to individual levels of need for social contact - and depression, hypertension, and cognitive decline. The known risk factors for loneliness are: living alone, not being in work, poor health, loss of mobility, sensory impairment, language barriers, communication barriers, bereavement, lack of transport, living in an area with poor access to public toilets or benches, lower income, fear of crime, and living in an area with high population turnover. Some of these factors are directly linked to disability or long term health conditions, whilst others will tend to correlate – e.g. older people are more likely to experience bereavement, disabled adults are less likely to be in work.

In 2013, the Council launched a **Neighbourhood Day Opportunities for Older People** initiative to facilitate the engagement of socially isolated older people, and older people at risk of isolation and loneliness in social and peer groups. A full-time Neighbourhood Coordinator was appointed in November 2013 and joined by a full time assistant in

November 2014. The Neighbourhood Team has supported the development of a wide range of community activities, principally for older people, but meeting the needs of adults with a range of long term health conditions or vulnerabilities, including mental health needs. The team's work has included establishing four thriving **Over 50s clubs** in Caversham, Southcote and Whitley and a town centre afternoon tea and dance session, all of which are run by volunteers and located in community buildings.

The Neighbourhood Team works to increase older people's involvement in activities which promote physical, mental & emotional wellbeing. Their aim is to build older people's personal resilience to mitigate against the risks of loneliness in older age. By identifying gaps in service provision, and developing solutions in partnership with other agencies, the team develops **volunteering opportunities** as well as 'services', and whilst these opportunities are open to all, they are typically filled by older people or people with long term conditions. Our upcoming commissioning strategies for older people, mental health and learning disabilities will address the need to build community capacity to offer strong social connections for people with various health needs, and how best to develop the Neighbourhood Team.

There is a wide range of social opportunities in Reading for older people and people with long term health conditions. Voluntary and community groups offer in excess of 40 lunch clubs (e.g. Age UK, the Pakistani Community Centre, the Indian Community Association) and over 20 befriending services (e.g. Age UK, Engage Befriending, ENRYCH Berkshire). Retirement clubs such as Firtree offer activities such as dancing, singing, talks and games, and there is a varied programme within Age UK's Active Living scheme. There are also approximately 60 faith-based services aimed at reducing social isolation.[15] The level of support and care available within these services varies, but people who are eligible for Adult Social Care would, subject to a personal needs assessment, have the option of engaging a Personal Assistant to help them access these community services.

Through our Narrowing the Gap Bidding Framework we are commissioning six new services to **connect people and communities to reduce loneliness**. These services will give people opportunities to take part in one to one or larger group leisure activities that promote physical & emotional wellbeing, promote independence, and develop people's skills and personal resilience. The services will include some outreach provision for people who find it hard to engage with services. Services will be commissioned to support:

- People whose first language is British Sign Language and people with an acquired Hearing Impairment
- People with a Learning Disability or who are on the Autistic Spectrum
- People with a Physical Disability
- People with a Visual Impairment
- Isolated members of minority ethnic communities
- People who are becoming frail or isolated through old age or the effect of long term health conditions

[15] Cinnamon Faith Action Audit (Reading) - 2015

Transport

Good transport planning can have a strong influence on promoting healthy lifestyle choices. Enabling people to incorporate walking and cycling into their daily routine helps to raise levels of physical and emotional wellbeing, whether people take these journeys alone or in groups, although in the latter case there is often the added benefit of developing social networks. Keeping vehicle usage down contributes to air quality which benefits all residents, but vehicular transport still has an important role to play, particularly for people with care needs. Accessible transport services help people with care needs to have greater choice and control over making use of other community facilities.

Our **Highways Maintenance** service, which includes street lighting, and our **Street Cleansing** service both work to develop the 'walkability' of Reading and to reduce actual and perceived risk so as to encourage vulnerable groups to use pedestrian routes. We adopted a new **Cycling Strategy** in 2014 incorporating commitments to a new and improved cycle infrastructure; a cycle hire scheme; increased cycle parking facilities; and positively promoting the benefits of cycling in a compact urban area such as Reading.

When people with care or support needs do need to use vehicular transport, there are accessible options to choose from in Reading. The award winning **Reading Buses** is a wholly owned arms length trading company, which uses a low-floor, wheelchair-accessible fleet. All buses have an entrance ramp and many can be lowered to the kerb to allow easier access. Wheelchair users have priority over all other passengers in using the dedicated wheelchair space inside each bus. Vehicles on frequently used routes are colour coded, making it easier for people with limited visual or cognitive ability to find the bus they need.

For people who cannot use the public bus service, there is the **Readibus** Dial-a-Ride door to door bus service for people with restricted mobility. Specially trained Readibus drivers are able to meet the additional support needs which some people have to be able to use their buses. The Readibus service is funded by Reading Borough Council and operates 7 days a week up to 11pm. A programme of scheduled trips to shopping centres and excursions wider afield operates alongside the on-demand service. In 2013-14, Readibus supported 3,500 people to take 169,000 journeys. That represented a 3.1% increase (an extra 5,000 journeys) compared to the previous year, and 643 new users registered with the service in that year.

The Council also operates an in-house assisted transport service for people who need assistance to get to and from day activities. The Council plans to re-commission all its assisted transport in 2016-17 to put in place a service which offers fair access and gives priority to those in greatest need.

Reading Borough residents over 60 years of age are entitled to a pass allowing free travel on all local buses between 9am and 11pm Monday to Friday and at any time on weekends and bank holidays. The **Reading concessionary pass scheme** allows older people free travel from earlier in the day than the national scheme requires. The Reading pass can also be used for concessionary travel outside Reading but only after 9:30 am. Anytime concessionary travel passes are available to residents who cannot hold a driver's license on medical grounds or

who suffer from certain disabilities which seriously impair their ability to walk. **Companion passes** extend the concession to carers travelling with someone who has an eligible disability.

The **Blue Badge** Scheme gives people with severe mobility problems better access to goods and services by allowing them to park closer to their destination. The scheme is open to eligible disabled people whether they are a driver or passenger. There are currently 5,503 Blue Badges in circulation in Reading, and 1,725 applications were processed last year. There is scope to streamline the application process and reduce the size of the Reading application in line with the Council's digital strategy and bench marking against other local authorities.

4.5 Support people to prevent their care and support needs from increasing

Information & Advice Services

Ensuring that people with care and support needs can access reliable high quality information about local services is a priority. This empowers people to make good choices about maintaining their independence, and the Council is developing a separate Information and Advice Strategy to take this forward.

In the 2014-15 Adult Social Care Outcomes Framework return, 77% of people who used services[16] in Reading reported they found it easy to find information about services. This is slightly higher than the average for similar local authorities and the England average (both 75%), but a fall of two percentage points compared to survey results for Reading the previous year. A new measure of carer satisfaction with information provision was introduced in 2014-15. Only 63% of Reading carers surveyed reported they found it easy to find information about services, which is lower than the results for similar local authorities (65%) and the England average (66%).

The Council established **ReACT (Reading Adult Contact Team)** in 2010 as a single point of access for Adult Social Care. ReACT consists of a team based in the Council's Call Centre to help callers identify and access low-level services, and a team that supports professionals and residents by co-ordinating referrals for Adult Social Care support. ReAct takes calls Monday to Friday from 9:00am to 5:00pm. Mystery shopping exercises were used to identify strengths and weaknesses of the ReAct service in its early days and help to develop the service. Further mystery shopping exercises will be used in future to gauge how well the service has adapted to the new Care Act provisions, particularly adopting the wellbeing principle as a foundation.

The Council also produces a range of leaflets about its Adult Social Care services. These are available as downloads from our website or in printed form. We will be re-formatting the Adult Social Care leaflets into factsheet form to make them more accessible electronically in line with our Digital by Design policy. We are also working with care partners including our User Reference Group to rationalise the **Adult Social Care factsheets** into a more focused set of resources based on "trigger points" when information and advice about care and support are most relevant to people. We recognise that people's needs for information and advice change over time, and too much information can be as unhelpful as too little when people need to make important decisions about care, often at a stressful time.

The **Reading Services Guide (RSG)** is the Council's online directory of local services. It was launched in 2014 as a more user-friendly and accessible tool than the Council's previous

[16] Adult Social Care services

online directory of services. The RSG is wide-ranging, and entries are organised under the following categories:

- I am looking for information, advice and support
- I am looking for things to do
- I am looking for work or training
- I look after someone (carer)
- I need help to live at home
- I need information about housing options and care homes
- I want to get out and around
- I want to stay healthy and well

The number of unique visits to the RSG continues to grow. From April to September 2015 the average number of visits per month to the RSG was 43,428 compared with 36,367 from the same period in 2014. 92% of users surveyed in 2015 thought that the information contained in the Reading Services Guide was easy to understand, accurate and up to date, useful and appropriate. Officers continue to improve the RSG by enhancing the existing information – including adding information sheets based on relevant 'life episodes' - and increasing the number of entries. The Council also works closely with providers to support them to maintain their entries and so promote their services to new users. However, there is scope to increase awareness and usage of the RSG, and in particular to promote its functionality, such as the translate, print and text options for personalised shortlists. The Council is also keen to explore options for the ongoing maintenance of RSG, including closer working with partners to harmonise processes and drive out greater efficiencies.

Throughout 2015, there was extensive consultation with the public and community providers about a refreshed approach to commissioning community services, including services to promote and support wellbeing. Through the Narrowing the Gap Bidding Framework, the Council will commission a new service to provide **targeted information and advice for people with current or emerging care and support needs**. This service will be in place from June 2016 and will provide support for people who are unable or unwilling to use the RSG unaided, and will help people to understand:

- the care and support system
- the types of care and support, and the choice of care providers available in the Reading area
- how to access the care & support services available locally
- how to access independent financial advice on matters relating to care and support
- how to raise concerns about the safety or wellbeing of an adult with care and support needs
- how to access other services to promote physical and emotional wellbeing
- how to give feedback to help improve and develop the Reading Services Guide and other information sources.

The new service will encourage people to make future enquiries more independently where this is realistic, but will also assist those people who may need more support to make use of the information in the RSG. This may include, for example, assistance with form-filling or home visiting.

The Council has also worked with its neighbouring authority in West Berkshire and with the local Clinical Commissioning Groups to re-commission carers information advice and support services. A new Reading-specific service will be in place from April 2016 to provide a **targeted information and advice service for carers.** This service will:

- provide carers with information and advice to support their physical and emotional wellbeing, and support carers to navigate other information resources;
- offer advice and support on carer specific issues and entitlements, including financial entitlements and rights in employment, and signposting to other relevant services.
- support carers to access breaks via awareness raising and signposting.
- support more accurate referrals of carers into key support services, including raising awareness of:
  - The right to a carer's assessment delivered by or on behalf of the local authority
  - Carers' entitlements to personal budgets
  - Access to health-checks
  - Support for carers to develop emergency /contingency plans

The Council's information and advice responsibilities under the Care Act cover everyone with care and support needs. In particular, the Care Act widens the Council's responsibility to ensure people who fund their own care and support can access information and advice.
The Council has entered into a partnership arrangement with **My Care My Home** in order to meet its statutory duty to ensure that people are supported to get access to financial information and advice to help them plan for paying for their care. From April to September 2015, 36 referrals were made to the service. From these referrals, 6 people chose to go on to access specialist independent financial advice which they paid for themselves. Feedback from users of the service has been very positive, but we need to increase the referral rate to ensure Reading residents understand their financial entitlements and options in time to plan effectively for meeting their needs.

Assistive technology

Assistive technology refers to devices or systems that support a person to maintain or improve their independence, safety and wellbeing. Using new technology can enable more people to take responsibility for their health and manage their conditions. Devices such as smartphones and tablets, coupled with widespread internet coverage, are making technology ever more accessible. However, while many assistive technology devices are electronic, the term does not just refer to high-tech devices.

Telecare is equipment and services that support someone's safety and independence in their own home. The equipment can sense risks such as smoke, floods and gas, can remind someone to take pills and even call for help if the user falls. A help centre can be contacted automatically if any of these problems occur in the home. If needed, the help centre can arrange for someone to come into the home or can contact the user's family, doctor or emergency services. The system can also warn users of problems by sounding an alarm, flashing lights or vibrating a box which can be kept in a pocket or under a pillow.

Environmental Control Systems can enable people to operate everyday domestic appliances and mechanisms by remote control from a display panel. Mechanisms that can be operated include door and window openers, electronic curtain rails and blinds. Appliances that can be operated include lamps and lighting, televisions, telephones and heating. Environmental control systems vary considerably in their capabilities. Some only turn one or two devices on and off while others control a range of settings for several devices.

If we are to make best use of assistive technology, however, then we need to develop understanding of how this technology can be used - amongst our workforce and our local residents. The Council has created a new **Assistive Technology Lead** post to progress this. This officer will be:

- working with stakeholders to develop Reading's vision for assistive technology
- scoping and clarifying Reading's requirements for the Berkshire Wide Equipment contract to feed into the upcoming tendering process
- preparing an action plan to further embed and maximise opportunities posed by Assistive Technology, including telecare, into personalised support packages.
- Developing an options paper on increasing equipment recycling rates both in the short and long term, and implement short term actions to improve recycling rates and generate savings/offset overspends
- Reviewing the role of Occupational Therapists and the assistive technology/minor adaptations pathway, and identifying opportunities to refocus expertise away from issuing small pieces of equipment towards more specialist solutions
- Developing options for an equipment self serve offer

<u>Supporting carers</u>

Reading Borough Council recognises the vital role carers have played and will play in supporting adults with disabilities, frailties or long term health conditions. There is a clear need to invest in sustaining caring relationships which enable many people with support needs to live as independently as possible. Carers are also an 'at risk' group in terms of wellbeing because of the strains caring can place on physical and emotional health. It is important we secure maximum value and impact from the services we commission to provide carers with assistance in areas such as health and wellbeing, and access to a life outside caring.

In addition to ensuring carers have access to information and advice services as described above, the Council's offer to unpaid/family carers also includes the offer of a **Carer's Assessment** - to all carers on the appearance of need. The Care Act requires us to be more proactive in identifying carers and offering carers' assessments. This continues to be taken forward operationally and through wider public and partnership work, including publicity and events at Carers Week and Carers Rights Day in 2015. Awareness of the entitlement is increasing, and in the first 6m of 2015-16 the number of Carer Assessments carried out was double the number completed for the same period in the previous year.

The Care Act also sets out national eligibility standards for carers for the first time and gives carers the right to services in their own right – a **Carer's Personal Budget** - if they meet the national criteria. Prior to April 2015, Reading already offered direct support to carers in the form of a Direct Payment scheme based on 'banding' the impact of caring. A similar approach has been retained as one of the ways in which eligible carers can have their support needs met now. The Council continues to offer a range of services to promote carer wellbeing, keeping processes proportionate from very light touch through to more detailed support planning for carers with more complex needs.

Together with the Reading Clinical Commissioning Groups, the Council is commissioning a new service from April 2016 to **support carers to manage caring**. This service will:

- Support carers to prepare for a Carer's Assessment or to complete a self-assessment.
- Support carers to take best care of their own physical, mental and emotional wellbeing, including responding to the findings of a health-check assessment.
- Support carers to develop emergency contingency plans.
- Support carers with end of life care planning in a timely and co-ordinated manner alongside other necessary organisations.
- Identify training needs of carers and developing access to appropriate provision.
- Reduce, prevent or delay carers' need for more intensive support or active referrals to services.

Again working with the local Clinical Commissioning Groups and also with our neighbour authority in West Berkshire, the Council is also re-commissioning services to **support, enable and empower carers to enjoy a life outside of caring**. New services for Reading and for West Berkshire will be in place from April 2016 to:

- Facilitate and develop mechanisms and opportunities for carers to offer and benefit from peer support.
- Support carers to access work, remain in work, or access community/voluntary activities by encouragement and signposting.
- Identify and enable socialisation opportunities for carers.

Through the Narrowing the Gap Bidding Framework, the Council has re-commissioned community services which **support carers to take breaks**. New services will be in place from June 2016 for adults who rely on unpaid carers and their carers, including families unable to access these services via Personal Budgets. Services will enable carers to:

- Take planned breaks from caring
- Maintain wider social contacts
- Access peer support
- Take part in social activities with the person they care for

We will be re-commissioning **Short Breaks for Disabled Children** after completing our new Short Breaks Strategy, which will include our priorities for ensuring carers of disabled children can get breaks from caring.

Another way that carers can get a break from caring is by the person who normally relies on that carer using their Personal Budget to purchase **respite care.** We encourage carers to take part in the Needs Assessment or Review of the person they care for so that the carer's input can be properly understood and taken into account. This can be through having a joint

Needs Assessment and Carers Assessment if everyone agrees to this, or we can carry out separate assessments and then talk through with everyone how we can take a whole family approach to Support Planning. Respite care can take many forms – from short stays in a residential setting through to care at home or support to take part in a community or social activity.

A Berkshire West Carers Commissioning Forum (BWCCF) has been formed to oversee the future commissioning and development of carer support across Berkshire West. This is one of the enabling work streams within the local health and social care Integration Programme, and the aim is to move towards single pot funding for all carer support across the West of Berkshire and to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries. The BWCCF leads on the development of strategic plans and commissioning arrangements for supporting carers, and also informs the development of other plans and arrangements which have the potential to improve outcomes for carers. The BWCCF is developing a **Berkshire West Carers Commissioning Strategy** which will be published next year, supported by local Action Plans for carers.

4.6 Promote a re-abling approach across care services

The Council has committed to helping people continue to live in their neighbourhood and community where this is feasible and affordable. We will seek to reduce admissions of people to residential care where we can safely meet their assessed needs in a community based setting. We will no longer admit any older person direct from a hospital bed to a residential care home unless there is a longer term social care assessment in place that shows this is the right setting for that individual. We will always ensure that the assessment is offering more than just a response to a current crisis and that each person is getting the right health, housing and other support alongside their social care. If a person is now in residential care and an assessment indicates that they may be able to live in the community we will give them the opportunity to try that option.

All of the care services the Council commissions will be based on the principles of re-ablement, meaning providers will be expected to work with people to assist them in doing more for themselves. Over time, this should mean that some packages of care will decrease as people meet their own defined outcomes in achieving greater independence.

Changing the conversations we have with people who approach us

Making wellbeing the basis of our conversations with people who approach Adult Social Care represents a significant change in the way we work. We need to shift away from professionals identifying needs which can be met by services and start by empowering people to make best use of their personal, family and neighbourhood strengths to enjoy a better life.

We are trialling a new way of working called '**Right for You'** to embed this cultural change. Under the Right for You model, we aim to connect people to their local community and resources and so support them to help themselves. At times when people are in crisis or need short term help, we will offer an immediate 'emergency plan' and work closely with people to see this through. We will not attempt to make long term plans with people while they are in crisis, but if they need ongoing support then when the time is right we will support them to make use of a Personal Budget to take control of getting the life they want. The Right for You teams are capturing a wealth of data about community assets which is being used to develop our preventative information offer to all residents via the Reading Services Guide, and inform our future commissioning and community development work.

Outside of the Right for You pilots, our Social Care assessment tools have been revised to meet Care Act requirements, including recording **impacts on a person's wellbeing** as part of determining eligibility for services based on the national criteria. People making contact with Adult Social Care for the first time are offered a self-assessment option or the opportunity to be put through to an advisor to discuss their situation straight away. If people are shown to be ineligible for Adult Social Care support at this stage they are provided with information and advice about services available in the community that could support them, including information on accessing the Reading Services Guide so they are equipped to make their own future enquiries. Equally, if someone is eligible for support,

preventative or wellbeing services are still considered as part of the whole package of care. We undertake regular file audits to ensure wellbeing is being properly considered within assessments and reviews.

Re-ablement service

This specialist service offers up to six weeks of intensive therapy, care and support designed to help someone regain their independence. Re-ablement is offered to people who:

- have been inactive for a while following an illness, injury or surgery;
- are finding it increasingly difficult to cope without help from others because of a general deterioration in health; or
- have been dependent on care and support services for a while and would like the opportunity to see if they can regain all or some of their independence.

Re-ablement support is based on very individualised plans to promote wellbeing which can include:

- physiotherapy to help improve strength and mobility
- Occupational therapy to help people relearn skills or find new ways of doing things using equipment, gadgets or adaptations to the home
- Support to help someone manage personal care (washing, dressing etc) and day-to-day tasks (like shopping and cooking)
- Health care and advice
- Any other therapies and help which are identified

Re-ablement services are always provided in a home based setting. This is usually someone's own home or, if appropriate, we may offer a short stay in a residential intermediate care centre. Progress is reviewed regularly and the personal plan is adjusted as people achieve their agreed goals. Most people do not need any ongoing support once their re-ablement service ends. Others only require a small amount of ongoing support.

Home from hospital service

Through our Narrowing the Gap Bidding Framework, we will commission a service to support people to **re-settle at home following a period of hospitalisation**. The service will support adults who are aged 65 or over and/or adults with a diagnosed long term health condition. When someone who has been admitted to hospital as an in-patient is being discharged home, the 'Home from Hospital' service will be contacted to support those who live alone or rely on an unpaid carer. The service will support people in their re-enablement at home and reduce the risk of re-admission to hospital.

End of Life Care

End of life care (EOLC) is the care experienced by people who have an incurable illness and are approaching death (likely to die in the next 12 months). Good EOLC enables people to live in as much comfort as possible until they die, and to make choices about their care. It is about providing support that meets the needs of both the person who is dying and the people close to them, and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support.

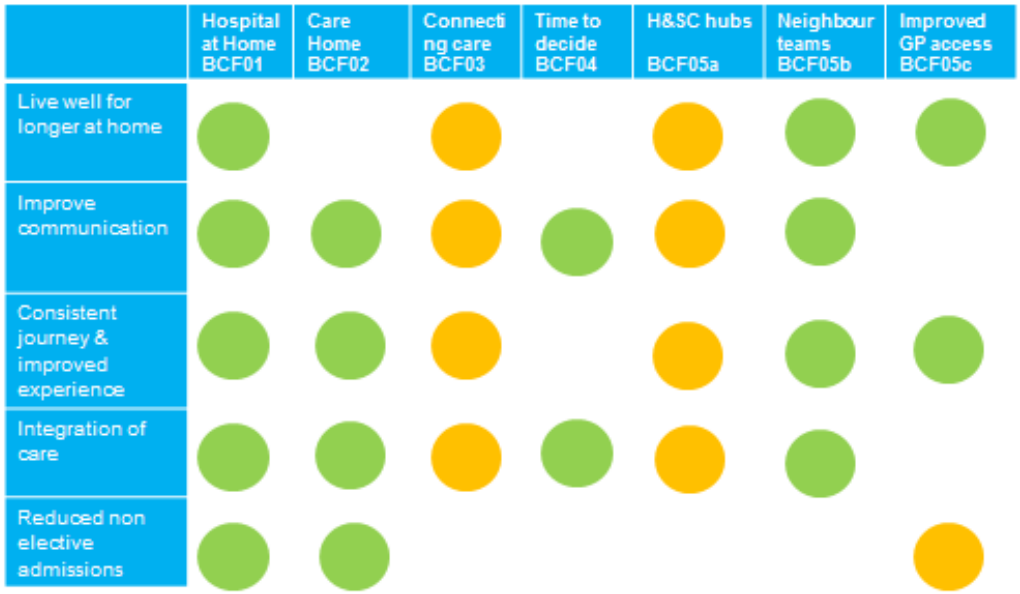
The Reading Health & Wellbeing Board has agreed for a Reading **End of Life Steering Group** to be established, looking at how end of life care can be communicated. The group will map local services and develop services within nationally recognised frameworks, particularly 'Gold Standard Framework - Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'. The group will work towards a "Call to Action" event to coincide with national **End of Life Care Week** (June 2016). This will be based on the following ambitions:

- Each person is seen as an individual
- Each person gets full access to care
- Maximising comfort and well-being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

4.7 Ensure people with care needs and unpaid carers can access services that work well together to support people's independence

Through the Integration of health and social care services in Reading, our **Better Care Fund** (BCF) programme aims to:
· Ensure that Reading residents feel empowered and supported to live well for longer in their own home
· Improve communication between the individual, their family, carers and health and social care professionals
· Provide a positive patient/service user journey and experience of care which is consistent and efficient, through the whole system throughout the whole week
· Provide easily accessible care, seamlessly across health and social care
· Reduce avoidable unplanned admissions to hospital

Reading's BCF plan is designed to target key pressure areas and populations in Reading, and focuses on areas where it has been identified that care can most be improved by integration, based on local experiences and the wider evidence base. The programme is intended to shift more care back into the community and people's own homes, and away from acute settings where people are less likely to be re-abled to maximise their independence.



The diagram above shows how the various Better Care Fund schemes are intended to impact on programme aims. (Direct impacts are shown in green and indirect impacts in gold.)

The **Hospital@Home** service will be developed to support patients that require initial intensive 24-hour support and treatment but can then continue to be managed at home by being discharged after a few days into traditional community care provision.

The **Care Home** scheme will enhance the capacity of care home staff to support people with multiple health conditions and complex needs. Taken together, the various elements of the scheme will promote a shift towards more planned and less reactive care, the latter being notoriously more resource intensive.

The **Connected Care** project seeks to ensure health and social care professionals have access to accurate and timely information regarding patients by facilitating the sharing of information. IT interoperability is critical to improving the quality and experience of care that patients receive, removing silos to ensure that health professionals have access to comprehensive records, and that patients only have to tell their story once.

The **Time to Decide** (also known as **Discharge to Assess**) service will afford patients coming out of hospital a better opportunity to evaluate long term care options. This is expected to reduce the number of permanent admissions to residential care, which are more costly care options than discharge back to a home setting.

Health & Social Care Hubs are intended to offer a single point of access into local care services for health and social care professionals initially, and eventually patients, to help ensure everyone receives the right care at the right time and is not cared for in ways which promote dependency when they should be being enabled to regain skills and strengths.

Neighbourhood Cluster Teams (NCTs) are multidisciplinary teams of health and social care professionals who will be allied to GP clusters or hubs across Reading. The Neighbourhood Cluster Teams NCTs) will integrate health and social care teams across the week to respond to local patient/service user need providing early interventions through care planning to reduce the need for admission to hospital and facilitate discharge. Community services are being reconfigured to support the Neighbourhood Cluster approach with both a **Social Prescribing** and a **Living Well Co-ordinator** scheme being piloted in Reading currently. Both schemes are designed to connect people attending GP surgeries to a wider range of facilities to support their overall wellbeing and moving away from a purely clinical response.

The **Improved GP access** scheme will expand the availability of GP services in the evenings and at weekends. Pilots have commenced, focussing initially on Saturday mornings, and this service will ultimately include both routine and urgent appointments. It is expected that the urgent appointments will alleviate the pressure on urgent care and prevent avoidable admissions. In addition, the availability of GPs at weekends should also facilitate more timely patient discharge.

We are about to embark on the second phase of our Better Care Fund plan.