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Taking pride in our communities and town

Date of issue: Thursday 11th January 2018

MEETING	**HEALTH SCRUTINY PANEL** (Councillors Rana (Chair), Smith (Vice Chair), Ajaib, Chaudhry, M Holledge, Qaseem, A Sandhu, Sarfraz and Strutton)
DATE AND TIME:	THURSDAY, 18TH JANUARY, 2018 AT 6.30 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
DEMOCRATIC SERVICES OFFICER:	NABIHAH HASSAN-FAROOQ
(for all enquiries)	(01753) 875018

SUPPLEMENTARY PAPERS

The following Papers have been added to the agenda for the above meeting:-

*Items 7and 8 was not available for publication with the rest of the agenda.

PART 1

AGENDA ITEM	REPORT TITLE	PAGE	WARD
7.	Adult Social Care- Local Account 2016-17	1 - 28	All
8.	Recovery Colleges	29 - 34	All

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Slough
Adult Social Care

Local Account 2016/17

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Welcome

Welcome to your local account of Adult Social Care 2016-17. After listening to our local residents, we have taken a different approach and produced a shorter report this year. It will tell you about:

- the challenges and opportunities within Adult Social Care
- how our vision and changing approach is responding to these challenges and opportunities
- who we have supported, some of our achievements, as well as what we need to continue to improve on
- how our Adult Social Care budget was spent
- our priorities for next year.

Our residents have told us they want this edition to have a greater focus on the voices and experiences of people who use services. Therefore we have not included detailed information about Slough; however it is available to read here.

Since last year, the council's Five Year Plan has been refreshed. It sets out our vision for Slough as 'growing a place of opportunity and ambition', **firmly** putting people at its heart. One of the outcomes within the plan is:

"Our people will become healthier and will manage their own health, care and support needs".

How Adult Social Care is delivered within Slough supports our Five Year Plan which recognises the strengths, connections and aspirations of individuals. It also encourages communities to become stronger and more resilient through our continued investment in preventative services and valuing our partnerships. We have also refreshed our values to ensure a greater focus on people.

In the local account for 2015-16, we said we would:

Develop preventative approaches to ensure that vulnerable people become more able to support themselves

Build capacity within the community and voluntary sector to enable a focus on supporting more people to manage their own care needs

Put in place new models of social care for adults where direct payments will be the norm

Develop existing safeguarding arrangements to ensure people are at the centre of the safeguarding process and are supported to manage any risks

Support health and social care integration

Change our procurement, commissioning and contract management arrangements.

We have made progress in what we said we would do through collaboration with staff, partners, communities and local residents. It is through these strong partnerships that we will continue to build and embed our strengths based approach of delivering Adult Social Care in Slough.

I hope you find this document useful and welcome feedback to help us develop a meaningful format for the local account as we move forward with our commitment to adopting a more co-productive way of working with our local communities.

Councillor Natasha Pantelic Cabinet Member for Health and Social care

Our challenges and opportunities

Our challenges and opportunities in Adult Social Care include:

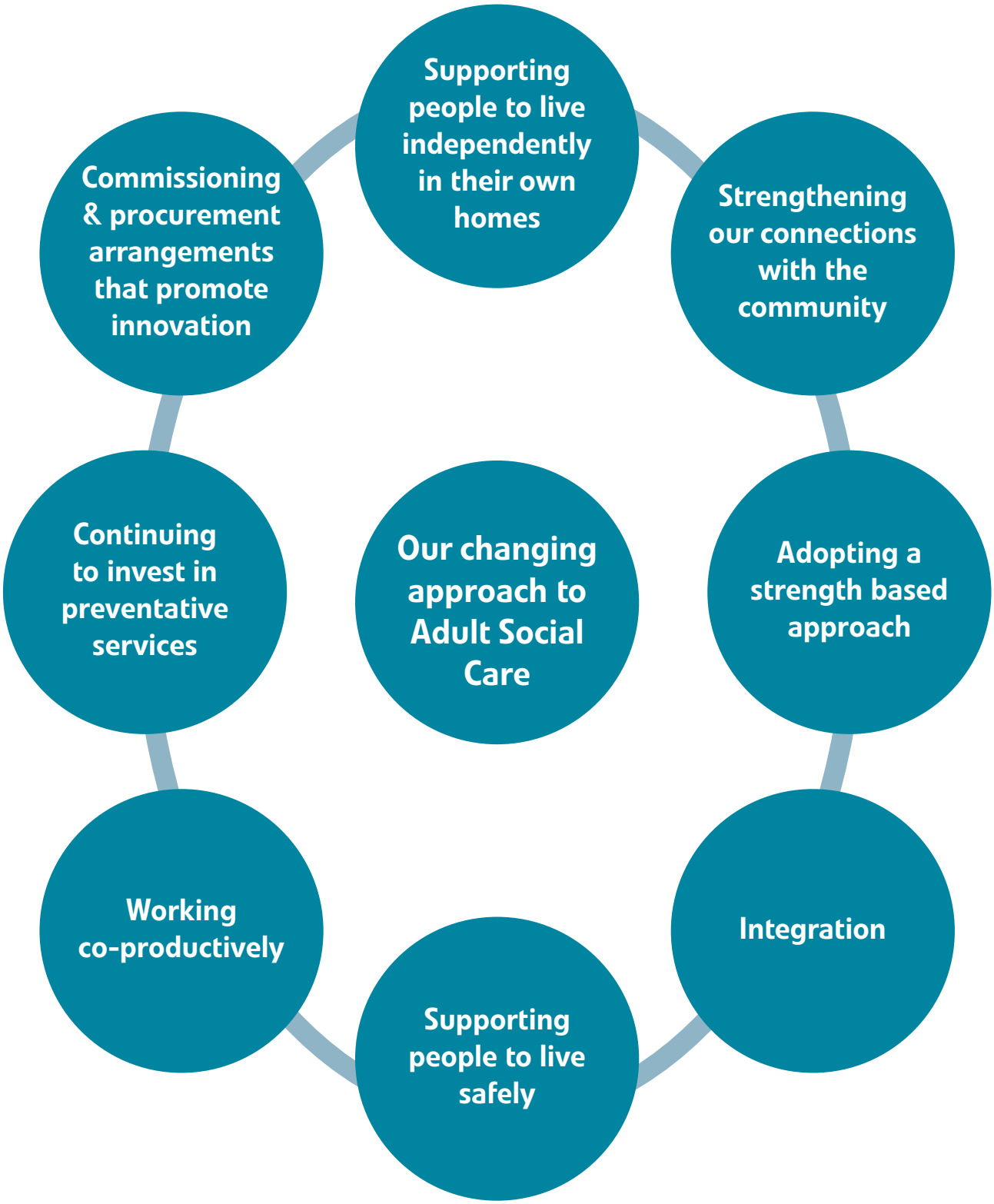
- A growing and ageing population with more complex long term health issues. The population of Slough is expected to rise from 140,000 in 2011 to 150,800 by 2020. Currently approximately 1,030 people aged 65 or over are living with some form of dementia. This is expected to increase to 1,090 by 2020 and to 1,480 by 2030. An estimated 44 per cent of the population over the age of 65 in Slough have a hearing impairment and 12 per cent of those will have a moderate or severe visual impairment.
- Our residents are telling us they want more choices to enable them to have safe, fulfilling lives that promote independence.
- A move towards integration between health and social care services. Slough Borough Council is part of the Frimley Health and Care Sustainability and Transformation Partnership (STP), which brings together over 30 statutory organisations across health and care to create a sustainable care and support market which helps people to remain as healthy, active, independent and happy as they can be.
- Working in a more focused, creative and innovative way with our partner organisations including the voluntary sector in order to respond to the continued pressures on public finances and reductions in public sector spending.

Our vision and approach

We have reviewed our vision and approach within Adult Social Care to respond to these challenges and opportunities. It will support our residents to develop their strengths, skills and support networks, to enable them to live as full and independent lives as possible. Connecting people to their communities is at the heart of our new way of working.

To improve the outcomes of our residents and their carers by enabling people to do more for themselves, focusing on people's strengths - even at crisis points in their lives, by connecting them to their interests, communities and a network of well being, care and support services.

Our changing approach within Adult Social Care in 2016-17

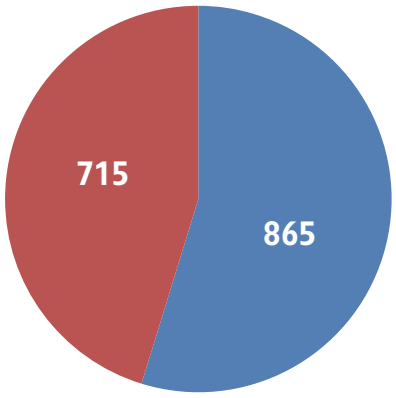


Supporting people to live independently in their own homes

We have done this in a number of ways. We have:

- issued 1,100 people with a range of telecare equipment tailored to their needs so they can live more independently and with dignity. This includes sensors, pendant alarms and monitoring devises. A total of 7,452 pieces of equipment were issued
- supported 784 dementia patients through the Slough Memory Clinic
- enabled 295 dementia clients and their families to access local services including information and advice
- enabled over 500 people to continue to live in their own homes through home care support
- responded to 4,673 contacts, 1,735 of these contacts resulted in a new case
- reviewed 936 people to ensure the services received are still appropriate to support needs
- supported 11 people with learning disabilities to move into supported living accommodation
- completed 410 carers assessments
- supported 1,580 people through reablement, which helped either a smooth discharge from hospital or prevented admission to it
- provided 360 people with a direct payment enabling them to have greater choice about the type of support they received.

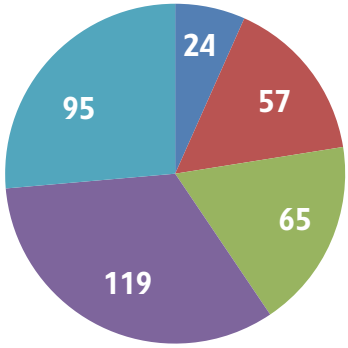
Reablement



Support from the Re-ablement, Rehabilitation and Recovery team helped improved the quality of life for Mrs K

Mrs K is aged 75 with serious health and mobility problems. Her deteriorating health resulted in her becoming increasingly dependant on her daughter in law to help with her personal care, including bathing. Following an occupational therapist assessment, a range of assistive aids were identified to help Mrs K regain her independence and manage her personal care, including showering. She was very pleased that she was able to regain her dignity and pride in looking after herself. The adaptations also helped reduce recurring infections as she is now able to wash frequently.

Direct Payments 2016-17



Read the words of local residents describing how a direct payment has helped them have more control over their lives

Mandip

I am a single mother with young children and experience excruciating spinal pain a few days each month. I am able to care for my children most of the time; however on the days I am in pain I have difficulty walking and am unable to take them to school. An officer from the council visited and explained how direct payment works and might help me. I agreed this would be the best option as it means I could use this flexibly to pay for support when I am unwell. I used my direct payment to purchase a mobility scooter. This is meeting my current needs as I can take my children to school.

Richard (written by his mother)

When Richard began to receive his support through direct payments, his life improved dramatically. Due to his autism, he lacked social skills making socialising difficult and preventing him from making friends. As a young man he was embarrassed to be 'tagging along' with his parents to social events. He was a lonely and unhappy young man.

Once the direct payments were in place, he was able to employ two personal assistants (carers) of his own age. They accompany him to social events and encourage him to mix with others and form friendships. One of them luckily shared his passion for horror films so he was able to visit the cinema on a regular basis. He is also able to talk to them about issues he would find difficult to discuss with his parents. Richard is much happier now he has a social life, and a small group of friends.

Susan

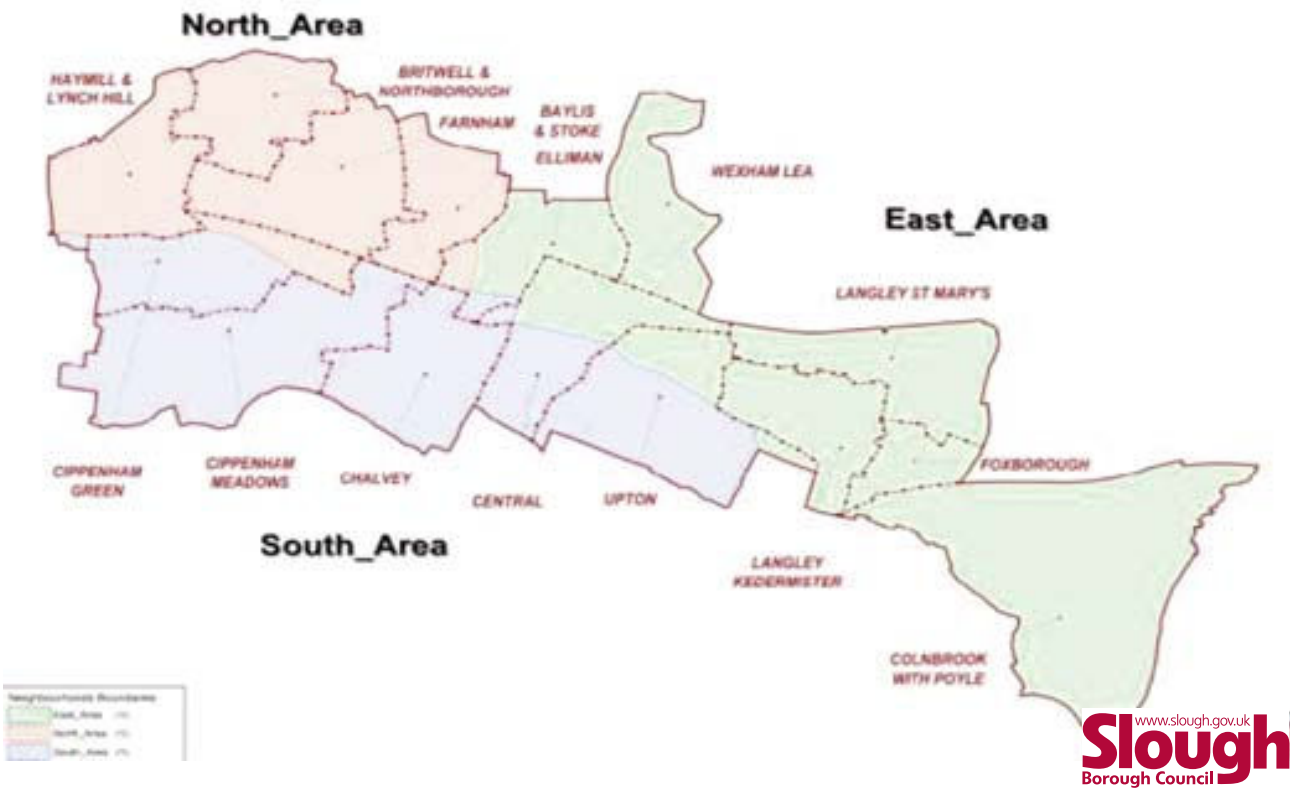
I care for my husband. A direct payment meant I could pay for a plane ticket to attend a family wedding. This would not have been possible without it. I was also able to have a break from my caring role.

Strengthened our community connections

As a council we have said we recognise the value of strong and resilient communities. We are also aware that we need to be more responsive to the residents who use services as well as be more closely connected to our neighbourhoods. During the year we talked to our partners, people that use services and communities about how best to do this. The outcome of this has been to re-model our Adult Social Care Teams into North, East and South (which includes Wexham Park Social Work Hospital Team) localities, each supported by the re-ablement, rehabilitation and recovery team. The Community Team for People with Learning Disabilities has remained unchanged and continues to work across the town. Our new model was introduced in April 2017.

Developing closer connections with our communities has meant we will be better placed to help them promote their valuable assets and services to local people. We have already begun this work and it is our intention to strengthen this support to enable communities and individuals become more resilient and resourceful.

The map below outlines the wards covered by our newly formed locality teams



Supporting our communities to become more resilient

During the year, the Adult Social Care Commissioning Team worked with local residents and community leaders within Langley neighbourhood to find ways to enable it to become more self reliant and independent of the council. This involved mapping local assets and creating a directory of the activities, groups and organisations for residents. It then led to the formation of the 'Langley Community Network', a constituted body which is now seeking external funding from other sources in order to:

- maintain and update the directory of information and activities for the Langley community
- facilitate networking opportunities for Langley residents, groups and organisations
- support events for the Langley community.

Hear from Angela, an active member of the network:

"I think the local directory has helped enormously. It's been shared all around Langley; doctors surgeries, dentists, wherever we could think of. I think we've seen a big number of referrals to different activities that we would never have seen before. It's helped people to socialise and be less isolated. It's also been useful to meet people from other organisations and it helps us know where to go - there is an enormous amount of people doing things in the community that you would never know about. I think it's made a big difference locally."

Adopted a strength based approach

During the year we piloted a new strength based approach with people seeking support from our Adult Social Care Teams. This moves away from a traditional assessment that focuses on individual deficits or needs. Instead, it is person centred, swift and proportionate, focusing on how people want to live their lives. It involves a dialogue with people about their individual aspirations, strengths and community connections. It will also ensure people in crisis have access to the necessary support to help recovery, and where ever possible, reduce or delay the need for long-term residential or nursing care.

This strength based approach determines the level of services based on a 3 tier conversation. The three conversations are:

Conversation one: How can we connect people to information and informal support systems that help them get on with their lives? People and families are experts in their own lives and what will work. We need to help them connect with communities and local resources that will make this happen.

Conversation two: When someone is in crisis, their life is unstable or their independence is at risk, we will work with them to understand:

a) what needs to change quickly

b) how can we help that change happen

c) how can we stick to these people and families 'like glue' for a short period of time to maximise success

d) how can we leave people in a better place, being more resilient, less in crisis?

Conversation three: Only when the previous two conversations have been exhausted will staff be required to explore longer term support arrangements based on a fair personal budget, what a good life looks like to the person, and how best we can we help them invest all their resources (including their money) in getting the best life they can.

This new approach has now been embedded within the Adult Social Care Teams.

CC supported through a strength based approach

Meet CC

CC was supported through a strength based conversation. This involved agencies working together offering information and advice, specialist equipment to add mobility as well as ongoing support. Importantly, CC's community, family and friends helped build her support as they knew her best, including when she was at her most vulnerable, where to find her.

"My name is CC. Before my diagnosis with multiple sclerosis I was the founder of Recycled Teenagers, which supports elderly people in the community where I live. I used sign language to communicate with people who were deaf. I also loved to walk. Since my diagnosis, I had increasing problems coping with my life. I eventually requested support from Adult Social Care after being burgled on 10 occasions. I now feel more motivated and valued in my new life in extra care housing I am utilising my talents including using sign language which helps build other people's confidence in the process."

Continuing to invest in preventative support

We continued to invest in the voluntary sector through the SPACE (Slough Prevention Alliance Community Engagement) contract.

During 2016-17, over 40 charities and community organisations led by the Slough Council for Voluntary Services worked together to provide coordinated, innovative and enhanced services to residents. SPACE identifies and navigates people to local preventative services as well as supporting community capacity building. These include the Wellbeing Prescription service, Carers Support as well as Information and Advice. Other services on offer during the year included lunch clubs, forums, therapeutic gardening, 'get active' programmes and a good neighbour's scheme. SPACE also offered a variety of volunteering opportunities to 292 local residents which help people connect to their communities, develop skills and helps tackle loneliness and isolation.

A homeless woman supported by Shelter, the Slough Advice Centre
A taxi driver contacted the Advice Centre about a distressed woman who was unable to speak very much English. She had been made homeless after being ejected from her rented accommodation by her abusive partner. Shelter helped her find overnight accommodation and then transported her to a refuge out of Slough to enable her to move away from the abusive partner and get the support she needed.

A resident describes the support she received from Destiny Support (a SPACE associate)
When my husband passed away, I was receiving letters about his debts. I was in distress because I was grieving and had to deal with all the letters asking for money I did not have. Destiny Support helped me with deal with all the letters and now I don't receive any letters about the debts!

Public Health

Our Public Health Team commission preventative services to support residents to mange their own health. They help reduce risk factors such as obesity and smoking as well as to identify and address conditions including diabetes.

The preventative programmes delivered in Slough include:

- **Smoking cessation**
  A four and twelve week intervention programme targeted at groups and areas of high prevalence. Slough's four week quit rate in 2016/17 was 70.64 per cent [741], compared to a South East average of 52.33 per cent and an England average of 50.69 per cent.
- **National Diabetes Prevention Programme**
  Over 1,000 residents in Slough with a high risk of developing type II diabetes were supported to attend one of the five evidence based behavioural change programmes running across Slough.
- **Cardiowellness4Slough**
  A new one stop shop to access public health prevention programmes in Slough was launched during the year. Slough residents are triaged to services that will help reduce the risk, or prevent cardiovascular diseases.
- **Annual health checks**
  3,430 eligible people were invited for an NHS health check and 2,305 eligible people received a health check. The uptake was slightly lower than the South East.
- **Flu jabs**
  26,550 Slough residents had a flu jab at their GP surgery of which 9,679 were aged 65+ and 339 registered as carers.

Ajay, aged 65 years describes his experiences of Cardiowellness 4Slough. He successfully lost weight through the support of the programme

"After attending the Cardiowellness 4Slough launch in January, I decided to join Eat4Health to find out how to improve my eating habits and lose weight. I enjoyed most of the course, especially what I need to eat to maintain a healthy balance and how much exercise I should be doing. I would strongly recommend this service to anyone."

Drug and Alcohol Service

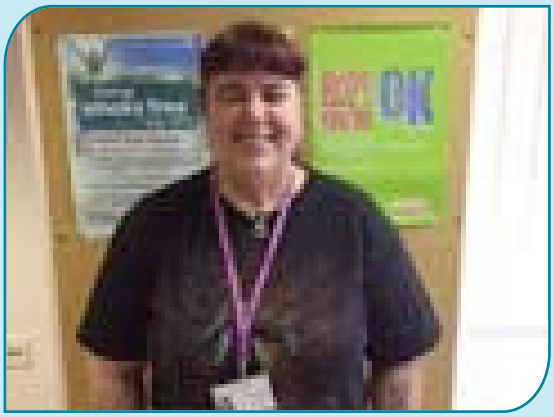
In 2016/17 we re-commissioned substance misuse treatment services using an innovative approach for which we won a national award. People with drug and alcohol problems were involved in designing the new service. Turning Point was appointed to deliver a recovery focused service which supports individuals to become more resilient. They have been relocated to a newly refurbished premises. An exciting addition to the new service is the online wellbeing cloud. This enables people to access information, advice, online screening and interventions and they can either refer themselves, family or friends to the service.

Support for people with mental health problems and their carers

People with mental health problems and their carers continued to receive support through Hope Recovery College, commissioned by Slough Borough Council in partnership with the NHS. The college provide hope, opportunity and control for every person using mental health services, as they embark on their recovery journey. A range of courses, activities and workshops were offered, helping and supporting people to achieve their goals and manage their mental health on a daily basis. The college offers peer support through mentor training. During 2016-17:

- 658 people were enrolled in the college
- 91 courses were delivered focusing on recovery, life skills, employment and peer support
- 31 people were trained as peer mentors
- 53 people were supported back into to work through the Independent Placement Service (IPS)
- Carer training programmes were in place focusing on a range of themes including understanding medication, healthy living, substance misuse, dealing with challenging behaviour, coping with stress and carers' rights.

Sharon tells us about her experience as a peer mentor with Hope College:
"My experience has been both rewarding and satisfying. I think being a peer mentor has helped with my self-esteem. I feel so much more confident due to having to communicate with others and feel I now finally have a purpose and sense of achievement after being involved in a project or running a course."



Support for carers

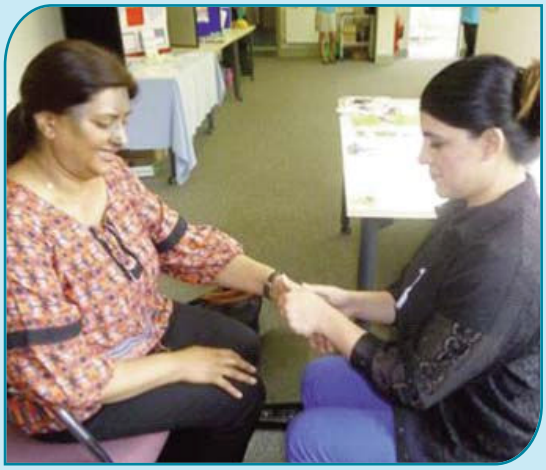
Carers are supported by Slough Carers Service (part of SPACE) and their partner organisations. This model supports our strategic approach of creating a community where carers are identified and valued and able to form meaningful social networks and peer support. SPACE partners have enabled carers to access support, information and advice through regular groups, forums, training, newsletters and a website. It also organised a range of activities during Carers Week including advice, healthy exercise and pamper sessions, as well as celebratory lunches.

Slough carers also accessed free digital resources developed by Carers UK to help promote their own personal resilience as well as an app to help share the responsibility of caring https://carersdigital.org/ (access code is DGTL4366).

Voices of carers talking about Carers Week:

"I am pleased that I was able to attend the event as my caring role sometimes makes it difficult for me to get out into the community. I was able to chat to the team about my concerns. Being able to sit and take some time to chat to other carers was really nice"

"Thank you for my reiki! Who would have thought that peace and tranquillity could be found in the heart of Slough - great session!"



Telehealth

Our telehealth service has expanded during the year to include a monitoring service for people with diabetes to help them manage their own health.

Healthwatch Slough

Highlights from our locally commissioned Healthwatch, the consumer champion for health and social care for the year include:

- reaching 55,651 local people on social media
- offering over 200 hours of volunteer time
- visiting over 55 local services
- reporting on a wide range of issues ranging from vulnerable patients use of the walking centre to female genital mutilation
- speaking to 150 people as part of the Access to Health and Care information project

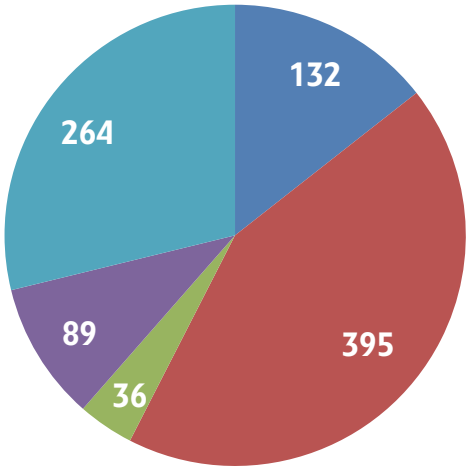
How Healthwatch Slough influenced a local review

Annie is a 98 year old female, living along at home in Slough but supported by her family and friends. She has an active social life, regularly attending her local church and community café. Annie can walk but is unsteady on her feet so she uses a frame to aid stability. She has suffered bouts of depression in the past. Annie had a hospital admission following a fall early summer 2016, this resulted in a number of complications and a deterioration in her physical and mental health. After being discharged from hospital, Annie was bed bound. As a result of deteriorating health she had two further re-admissions to hospital. Annie's friend wrote to Healthwatch Slough in desperation about the lack of coordination between the health and care services involved with Annie.

Healthwatch Slough compared Annie's experience with the East Berkshire New Vision of Care (an agreed integrated care model developed by patients and partners in East Berkshire). The case was presented by Healthwatch Slough at various partnerships networks to highlight the real experiences of a local vulnerable resident. The lead clinician for Primary Care then asked for an in depth review to be carried out involving each of the organisations concerned so lessons could be learned and improvements made across health and social care.

Advocacy

916 issues were dealt with by our commissioned advocacy service in 2016-17 on a wide range of issues covering five categories listed below:



How advocacy helped Danny, a 19 year old man with a learning disability take more control over his life

Danny was living with his parents but wanted more independence. An advocate worked with him to review his support plan and discuss various options, including supported living. After visiting different types of accommodation, Danny decided that he wanted to remain at home but would like to do more independently. The advocate helped Danny request a review by his social worker including his current support hours.

His request for more support hours was then approved by panel. Danny felt his views were listened to and his is now happier. He is still living at home but able to access support that promotes his independence and positively promotes his wellbeing.

Promoting innovation through commissioning and procurement

We have introduced the Dynamic Purchasing System (DPS), a new and more straightforward model for tendering adult social care services. This has streamlined procurement and enables providers to come forward with innovative ideas to develop services. They are also no longer required to complete lengthy tender documents for each new commissioning activity they have shown interest in. Instead, providers meeting the required standards will automatically be contacted to tender for business opportunities in the areas they have registered an interest.

The DPS offers greater flexibility in determining how we procure, ranging from outcome based specifications with high levels of supplier input into the design of the service, to more prescriptive tenders. It will be used to commission whole services for groups of people to services for specific individuals. This approach was adopted when we commenced the procurement of domiciliary care support services during the year. The new provision has been developed to promote independence and dignity amongst the most vulnerable within our communities through more timely visits, enhanced reablement opportunities and improving billing arrangements.

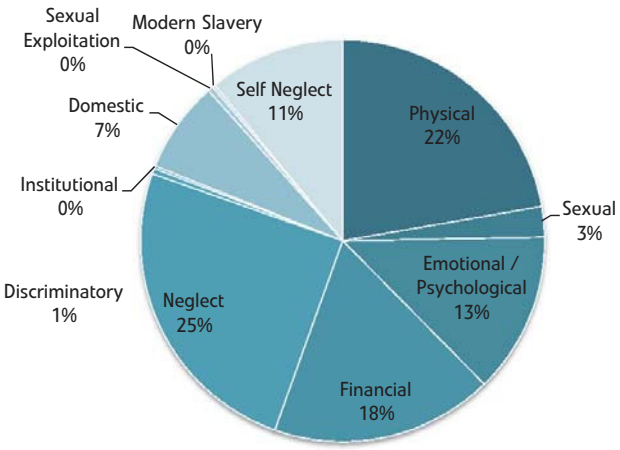
Success for the Adult Social Care Commissioning Team

In 2016-17 the Commissioning Team celebrated success after winning a number of national awards for innovative practice in how it commissioned and transformed a range of adult social care services. This included Hope House and the Drug and Alcohol Treatment services.

Supporting people to live safely

Ensuring the most vulnerable adults in our community are supported to feel and live safely remains a high priority. 284 individuals were subject to safeguarding enquiries during the year for a range of reasons identified below.

Slough 2016-17 enquiries by categories of abuse



266 Deprivation of Liberty (DoLS) applications were received during the year. Of these:

- 50 per cent were granted
- 27 per cent were not granted
- 15 per cent were withdrawn
- 3 per cent haven't yet been processed.

64per cent of the applications received relate to people with mental health needs, 15 per cent with learning disabilities, 13 per cent with physical disabilities and the remaining, other types of disabilities.

In 2016-17 we delivered a range of safeguarding training including:

- Safeguarding Adults Level 1 face to face training to 127 people from Slough Borough Council and our partner organisations, including the voluntary sector
- Bespoke training to 120 people from partner organisations
- Adults Level 1 eLearning to Slough Borough Council staff and partners
- Safeguarding training to every taxi driver licensed in Slough to help them recognise and respond to concerns about adults at risk and child sexual exploitation.

Other developments to help safeguard people include:

- **The Safer Slough Partnership** has taken a lead in tackling modern slavery (a category of abuse included in the Care Act 2014) through a comprehensive, multi-agency action plan, reviewed regularly. Awareness training was delivered to over 100 professionals and volunteers in Slough, including Adult Social Care staff. A pathway is in place to support the identification and reporting concerns of potential victims of modern slavery. Adult Social Care has forged stronger links with the Community Safety Team, ensuring consistent and appropriate responses where there are concerns about modern slavery and exploitation.
- **The Channel (multi-agency) Panel** which supports the Prevent Strategy, is now chaired by Adult Social Care. Any adult that comes to the attention of the panel that has been identified as displaying extremist or radicalised behaviour will be managed jointly through the expertise of both Adult Social Care and the Prevent Coordinator.

Read about Harry

Harry, aged 86, lives alone and is very isolated, without family or friends. He was admitted to Wexham Park Hospital after becoming frailer, experiencing deteriorating health and a number of falls. Upon his discharge from hospital, Harry was supported at home by a team care workers. It was then that he became extremely anxious, confiding to one of the workers that he feared losing his tenancy, had increasing debts and was unable to buy food. The carer worker then contacted Adult Social Care and as part of the enquiry, it came to light that Harry had been befriended by a woman, who over a period of months had gained his trust and used his debit card to empty his bank account.

After some encouragement, Harry eventually agreed to contact the police. Harry did not have the ability to protect himself from someone he believed was his friend and in a position of trust. He was also vulnerable to further attempts of exploitation. Harry's bank card was cancelled and a new one replaced by the bank. The woman was interviewed by the police and safety measures were put in place to prevent her from having further access to Harry's finances and property. Harry remains living in his flat and with help of a volunteer, has been empowered to take back responsibility for his own finances and is less isolated.

Managing Joe's risk

Joe, aged 22, came to the attention of the Channel Panel after being overheard in the town centre shouting extremist language: talking about bombs and killing people. He was discussed at the Panel and it was agreed that his behaviour warranted further investigation. Through this, it came to light that he had an obsession with bombs, weapons and people being killed on the internet.

At the next Channel Panel meeting it soon became apparent Joe was suffering from mental health problems and autism. He gets very anxious and agitated whilst watching such clips on the internet and starts shouting obscenities. Joe's risk is now being managed through the Community Mental Health Team.

Adult Social Care successfully awarded funding

We successfully secured Department of Health funding following a bid to pilot and promote the use of technology to improve the lives of people with learning disabilities. 15 people with learning disabilities will be trained to use a range of technology that will help promote their fitness and live safely and independently in the community.

Working co-productively

We recognise the value and importance of developing more equal partnerships between people who use services, carers, communities, partners and the council. Working co-productively will ensure resources are targeted effectively to improve the outcomes for our residents.

'Slough Fest' was an example of this; where we collaboratively planned a celebratory mental health awareness event, attended by 450 people. A range of activities were enjoyed including music, drama, poetry, art and dance. The theme of the event was 'community of communities', bringing people together in Slough as an enabling town, sharing a common purpose and experience.

Another example is **Speak Up**, a training programme co-developed and delivered by people with learning disabilities. This training supports the co-produced Slough's Learning Disability Plan 2016-19, which promotes understanding and awareness about learning disabilities.

The trainers received bespoke specialist training from a learning disability service to support them to develop communication and public speaking skills. In 2016-17, Speak Up delivered training to 70 people from both the council and partner organisations.

Hear from our Speak Up trainers

Gurpinder "I have found being part of the Speak Up training a positive experience, as it gives me an opportunity to give others a little idea of what it is like to have a disability."

Ajay "Speak Up helps me to be organised, helps me with planning and with feedback. It also helps me to be more confident informing people about my disability. Speak Up helps me to help lots of other people."

Michael "Speak Up has helped me a lot to come out of my shell, and helped me to become a more confident speaker. When I worked at B&Q every morning we had a team briefing and I was always afraid of speaking so would hide at the back because I am not a good speaker at the best of times. But being part of Speak Up has made me more confident and I now feel more able to speak to groups of people."

Karen "My name is Karen. I have attended Speak Out forum since its been running. I really enjoy coming to Speak Out as it gets me out the house and meeting with other people with a learning disability. I also enjoy the teas and coffees! I learnt First Aid and really enjoyed it, it really inspired me. It would be nice if we could advertise Speak Out for more people to come."

Integration

The move towards integration between health and social care is progressing through the creation of the STP, to create a sustainable care and support market to help people remain as healthy, active, independent and happy as they can be.

Alongside this, we continued to utilise the Better Care Fund to deliver preventive support for members of our community including carers so they can be effectively supported to remain in their own homes in the community.

Key achievements to support integration during the year include:

- **Developing specialist stroke support services**
  In partnership with the Royal Borough of Windsor and Maidenhead this specialist service provides support to stroke survivors and their families' resident in Slough, Windsor and Maidenhead. The main outcome is to reduce the risk of future episodes through increased awareness and understanding of the risk factors involved, and how to reduce the risks through preventative action. The service also supports survivors and carers to adjust to life following a stroke.

- **Developing the single point of access integrated hub**
  Slough has worked with health partners to develop the Berkshire Integrated Hub (BHFT) to process Adult Social Care referrals made by Slough GP's for Slough residents on behalf of Slough Borough Council. The integration of the social care front door with the Berkshire Integrated Hub is the first step to enable a more joined up health and social care service, to improve coordinated care for Slough adult residents. This is a key deliverable funded through the Better Care Fund, ensuring patients receive the right care, at the right time and at the right place.

  The Berkshire Integrated Hub will:

  - improve co-ordination of care
  - improve customer experience
  - maximise independence and delay the need for care
  - increased access, choice and control.

- **Developing East Berkshire specialist service for younger people with dementia**
  The Slough Memory Clinic staff, carers and patients in conjunction with the charity, Young People with Dementia (YPWD) helped develop an innovative service to support the increasing number of young people in East Berkshire with early onset dementia. This new service is funded collaboratively by East Berks Clinical Commissioning Group. Pathways and processes are now in place, offering increased support for younger people with dementia as well as their families. Specialist supervision is also now available for staff. Our integrated health and social care team are also hosting an Admiral Nurse for the carers of younger people with dementia in East Berkshire.

- **Slough Memory Clinic accredited by the Royal College of Psychiatrists**
  This required working with the Memory Services National Accreditation Programme (MSNAP) to assure and improve the quality of the service for people with memory problems and dementia, as well as support for their carers. This involved engaging staff, service users and carers. The accreditation status assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. It is also endorsed by the Care Quality Commission.
- **Re-modelling in-house day opportunities for people with learning disabilities**
  The new locally based model supports 81 people with learning disabilities within three community resources. The emphasis is about promoting social integration through community connection. New opportunities include working with Clear Conscience, a social enterprise, offering a recycling service to London hotels. People are also supported through the Active Slough Team to promote physical and emotional wellbeing, utilising open spaces in Slough.

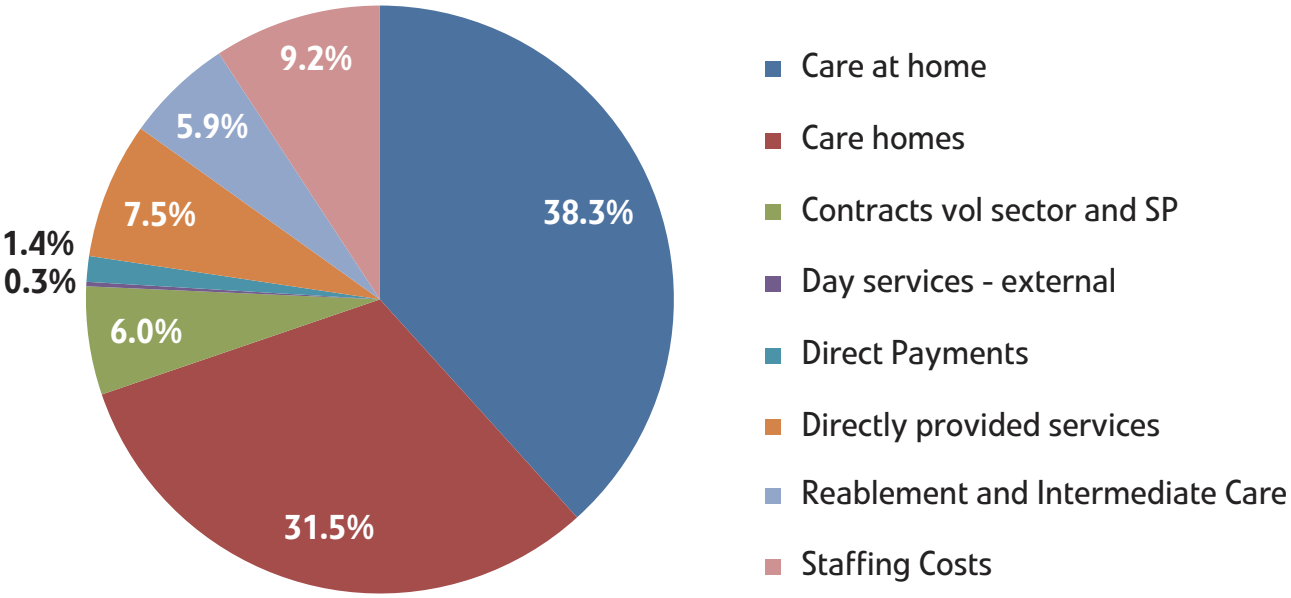
Slough Employment Service

This service supports people with disabilities find paid and voluntary work through community partnerships. Richard and Kenny have been volunteering at Wexham Park Hospital, doing a range of task including maintaining the garden spaces. The Sunflower Garden, designed for patients with dementia was awarded second prize in Slough in Bloom. Our volunteers were invited to the ceremony.

Adult Social Care budget

Our annual budget for Adult Social Care for 2016/17 was approximately £32.4 million compared with £36.3 million the previous year. This was spent on a variety of services delivered either directly by the council or through the independent and voluntary sector. These services helped residents meet their care and support needs, maintain their independence and support them to be safe from harm. We delivered our required savings during this year in a variety of ways, including reviewing the packages of those accessing support as well as our charging polices. We have also remodelled the way services are delivered and reduced the numbers of people living in residential and nursing homes, supporting them instead to live as independently as possible in their own homes. More people are also supported through Direct Payments.

Adult Social Care Budget

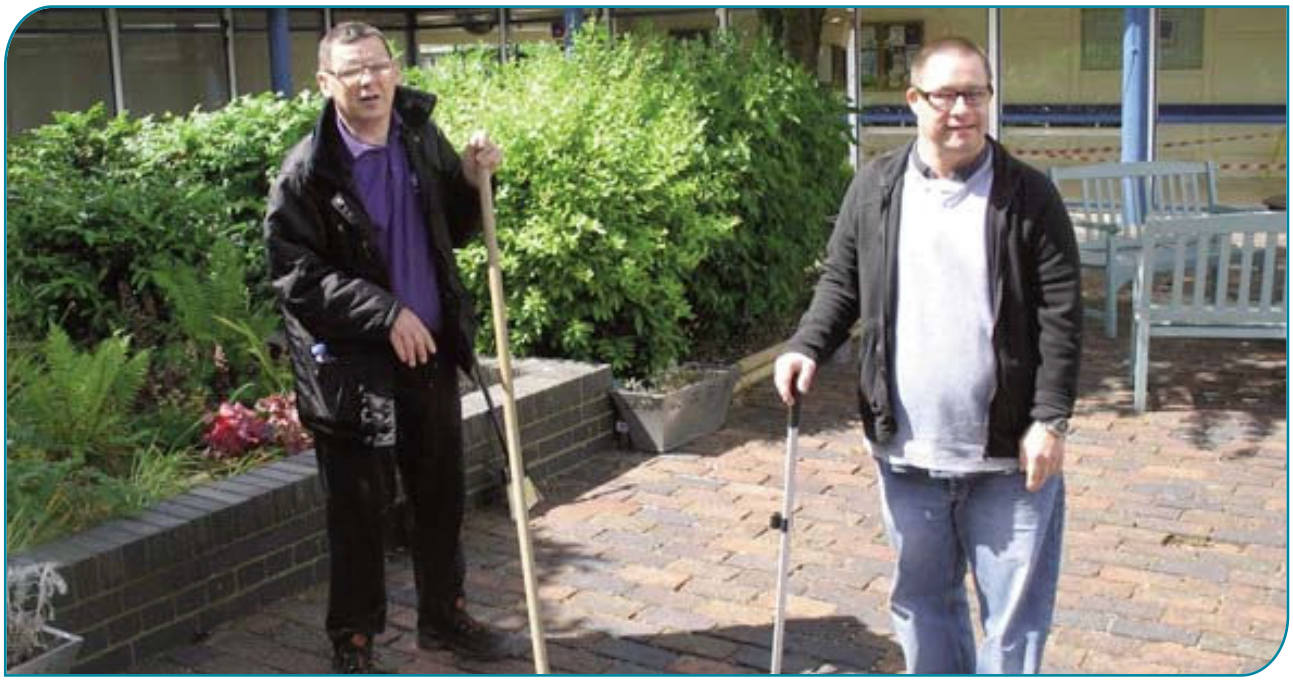


How did we do?

The Adult Social Care Outcomes Framework (ASCOF) set priorities for care and support, and is used to measure progress and strengthen accountability. Listed below is a summary of our progress since last year.

We know we need to continue to make improvements in order to respond to what the users of services are telling us about the support they receive.

What has improved?	What needs to get better?
• More people using social care services reported feeling safe. • Increased number of carers receiving a direct payment. • Increase in the proportion of people who use services, that reported they had as much social contact as they would like. • Increased proportion of people who use services, and receive direct payments. • More adults with a learning disability living in their own home or with family. • Increase in proportion of carers who find it easy to find information about support.	• Overall satisfaction of carers with social care services. • Improve quality of life for carers. • Increase numbers of adults with a learning disability of working age into paid employment. • Increase the proportion of carers having as much social contact as they would like. • Increase the proportion of service users who use services and feel they have control over their daily lives. • Overall satisfaction of people who use services with their care and support.



Priorities for 2017-18

Our focus for next year will be to:

- continue to promote preventative activity including social prescribing to help residents live more active, independent and healthier lives
- support people who struggle with social isolation
- continue to target key groups and individuals most at risk of poor health and wellbeing to take up health checks
- work with local NHS to develop our Frimley Sustainability and Transformation Partnership
- continue to support more people to manage their care and support needs through direct payments
- continue the development of our asset based approach and conversations with our residents
- ensure that our residents get the most benefit from the range of new leisure and community services
- ensure there is a co-production approach in all the work we do
- roll out the single point of access integrated hub
- re-launch the Safe Place Scheme
- develop new voluntary sector and prevention strategies.

This document can be made available on audio tape, braille or in large print, and is also available on the website where it can easily be viewed in large print.

Slough Adult Social Care Local Account 2016/17

If you would like assistance with the translation of the information in this document, please ask an English speaking person to request this by calling 01753 690444.

यदि आप इस दस्तावेज में दी गई जानकारी के अनुवाद किए जाने की सहायता चाहते हैं तो कृपया किसी अंग्रेजी भाषी व्यक्ति से यह अनुरोध करने के लिए 01753 690444 पर बात करके कहें.

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚਲੀ ਜਾਣਕਾਰੀ ਦਾ ਅਨੁਵਾਦ ਕਰਨ ਲਈ ਸਹਾਇਤਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਸੇ ਅੰਗਰੇਜ਼ੀ ਬੋਲਣ ਵਾਲੇ ਵਿਅਕਤੀ ਨੂੰ 01753 690444 ਉੱਤੇ ਕਾਲ ਕਰਕੇ ਇਸ ਬਾਰੇ ਬੇਨਤੀ ਕਰਨ ਲਈ ਕਹੋ।

Aby uzyskać pomoc odnośnie tłumaczenia instrukcji zawartych w niniejszym dokumencie, należy zwrócić się do osoby mówiącej po angielsku, aby zadzwoniła w tej sprawie pod numer 01753 690444.

Haddii aad doonayso caawinaad ah in lagu turjibaano warbixinta dukumeentigaan ku qoran, fadlan weydiiso in qof ku hadla Inriis uu ku Waco 01753 690444 si uu kugu codsado.

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 18th January 2018

CONTACT OFFICER: Geoff Dennis, Head of Mental Health Services

(For all Enquiries) (01753) 690590

WARD(S): All

PART I

FOR INFORMATION

RECOVERY COLLEGE - A PREVENTIVE MENTAL HEALTH SERVICE IN SLOUGH.

1. Purpose of Report

This report provides the Health Scrutiny Panel with information on a local commissioned service, which promotes positive mental wellbeing and prevents mental ill health. The report is submitted in response to interest raised by the Panel regarding the Recovery College as a preventive service in Slough.

2. Recommendation(s)/Proposed Action

The Panel is requested to note and comment on any aspects of the report.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

Improving mental health and wellbeing is one of the key priorities within the Slough Joint Wellbeing Strategy 2016-20. The Strategy notes the prevalence of mental health problems, with 1 in 4 people likely to be affected at some point in their lives. It also highlights the growing trend of social and lifestyle stresses impacting upon wellbeing, with a corresponding increase in problems ranging from mild anxiety through to depression and psychosis. The Strategy also highlights the heightened risk of social exclusion, unemployment, poor housing, isolation and poverty for people with a serious mental illness, alongside the risk of poor physical health. This report also focusses on preventive services for adults which contribute to tackling loneliness and isolation, which is noted as a key issue impacting upon health and wellbeing.

(a) Slough Joint Wellbeing Strategy Priorities

Slough Joint Wellbeing Strategy (SJWS): Priority 3: Improving Mental Health and Wellbeing.

The strategy notes the imperative to actively promote opportunities to improve mental wellbeing, particularly as a large proportion of residents do not seek help despite high levels of mental illness in Slough. Slough's

ambitions to both prevent mental ill health developing, as well as respond effectively to any emerging mental health problems is noted as a key ambition.

(b) **Five Year Plan Outcomes**

Outcome 2 of The Five Year Plan 2017-21 describes how communities will be engaged in initiatives to support Slough residents to become healthier and to manage their own health, care and support needs. This will be done with recognition of inequalities which can impact upon health outcomes, as well as an understanding of the wider social determinants which can impact upon health and wellbeing.

4. Other Implications

(a) **Financial**

There are no immediate financial implications arising from this report, as it details services which are currently provided through existing commissioning arrangements.

(b) **Risk Management**

This report is for information only and there are no immediate risks to be considered.

(c) **Human Rights Act and Other Legal Implications**

There are no Human Rights Act Implications. All services are provided with respect to individuals' rights and preferences. Legal frameworks including Mental Capacity Act 2005 and Mental Health Act (1983, amended 2007) are applied where indicated.

(d) **Equalities Impact Assessment**

Equalities Impact Assessment is applied to all commissioned and established services where they are formally provided or commissioned by Slough Borough Council or Slough CCG.

(e) **Workforce**

An ongoing challenge to mental health service delivery is the shortage of appropriately qualified and /or registered health and social care practitioners, which is well known locally and nationally. Community and voluntary sector initiatives are a crucial element of the overall preventative offer in Slough and increasingly opportunities are being sought for joint approaches and innovative workforce solutions. Peer mentors and 'Experts by Experience' are also key roles within the new workforce.

5. Supporting Information

The importance of prevention in mental health

(a) There is a spectrum of services available to Slough residents representing a mix of both reactive and preventative services. It is difficult to quantify the balance of such services as much preventive work is done at community level without reference to formal mental health service provision.

(b) Prevention is a crucial factor in creating sustainable modern mental health provision and is seen as the only way lasting change can be achieved. Prevention is a key foundation of current policy and legislation including the NHS Five Year Forward View 2016 and the Care Act 2014.

(c) NHS England Mental Health Taskforce notes that 75% of people experiencing mental health problems are not using health services. This may be due to stigma, inadequate provision and people using their own resources to manage their mental health. In many cases, solutions are likely to be best provided outside mental health services, and the development of 'mentally healthy communities' depends upon contributions from, for example, workplaces, families, community groups and schools, and importantly with involvement of people with lived experience of mental ill health.

6. Prevention Initiatives: national and local

(a) A Prevention Alliance was convened by Public Health England (PHE) in 2016, representing a broad spectrum of voices, including a strong representation from community sectors and agencies. The Alliance will continue to evolve, and the Mental Health Foundation has been commissioned to summarise the available evidence in relation to preventive mental health.

(b) Public Health England is also leading on the development of a Prevention Concordat for Better Mental Health. Similar to the Crisis Care concordat, this will involve multi-agency stakeholders, and a key set of actions across a local area which are selected on the basis that they can make a lasting impact to prevention and mental health promotion.

(c) Locally, Slough Public Health team has promoted many initiatives including training in Mental Health First Aid, access to MH4Life materials, and some local workplaces have signed up to initiatives such as 'Time to Change' a movement aiming to address stigma and discrimination for those experiencing mental illness.

(d) In line with the Care Act 2014, 'Prevention planning' has become a key element of adult social care and mental health care, with advice and signposting to individuals to address primary and secondary prevention. This includes asset based conversations and an increase in the use of direct payments and personal budgets. Slough has successfully introduced this methodology alongside the Recovery College and which has allowed for bespoke learning opportunities to be developed and delivered.

(e) Suicide prevention is identified as a key area for focus. Berkshire's multi agency suicide prevention strategy was developed in 2017, in line with the requirements outlined in the Five Year Forward View for Mental Health, which identifies an aspiration to reduce suicide by 10% in all areas. Berkshire Healthcare NHS Foundation Trust (BHFT) has committed to the 'Zero Suicide' initiative, implementing a raft of actions to avoid preventable death by suicide and ensure that there exists effective learning opportunities in all cases. PHE and Samaritans have published prevention and post-intervention toolkits in March 2017. Some of Berkshire's suicide prevention initiatives will be presented at the Regional Suicide Prevention and Intervention (SPIN) conference in September 2017.

7. Slough Borough Council commissioned services for MH prevention

Slough Borough Council commissioned Hope Recovery College in 2015 in partnership with BHFT. A Recovery College is a place where service users can attend courses and workshops which are co-facilitated and co-created by people with lived experience, in order to learn how to better manage their mental health problems. It uses an educational paradigm which complements traditional treatment approaches (Ashcraft and Anthony, 2005). Recovery Colleges were born out of the recovery movement which has a strong focus on the service users own personal journey. This means that mental health professionals are required to focus less on symptom reduction and more to empower the service user to find a satisfying and meaningful life. Recovery is about an individual having a life which is no longer dominated or centred on their illness or disability. The person's life is determined by enabling them to reach their full potential. Hope College includes various pathways and projects within it which will be detailed below:

Life-skills
The pathway includes social based activities to link students with the local community. This includes a weekly activity timetable which runs throughout the year and includes sports sessions as well as support groups.

Recovery
This pathway aims to help students understand their mental and physical health issues and treatment options, teaching them how to manage their own difficulties. Courses and workshops include; 'planning your hope college journey' and 'improving self-esteem.'

Peer Support
This pathway enables clients to become trained volunteer peer mentors (VPM). This involves attending a 10 week training course which includes subjects such as understanding boundaries, confidentiality and communication skills. Once they have graduated they are then involved in co-developing and co-facilitating courses within the college, representing the CMHT and offering their own experiences to guide services and also they can work with service users on a one-to-one to offer mentoring support.

Working towards Recovery
The pathway is all about links to paid employment. It introduces the students to the Employment service in Slough. This uses the individual placement and support (IPS) model. The pathway includes workshops designed to increase motivation to work and access to an employment specialist who they can work with on a one-to-one.

Support for Carers

We are now privileged to have a full time carer pathway lead in post. Hope College is open to carers and family members of students and are encouraged to attend courses. The carer pathway lead is responsible for conducting carer assessments, offering 1-1 interventions and running carer workshops through Hope College. This involves delivering:

- A carer café which is held once every 2 months. This offers a relaxed atmosphere where carers can receive peer support from other carers, as well as mental health professionals. There are also opportunities for training, information sharing, signposting, and pampering.

- The carer training programme. This occurs twice per year on average. This is an evidence based training programme where carers receive psychoeducation around understanding medication, healthy living, substance misuse, communication skills, dealing with challenging behaviours, problem-solving, relapse prevention, coping with stress and carers' rights and welfare.

- A carer database has been developed for those who have given consent. This enables the team to contact carers about events, training, and any activities that are relevant both in Slough and the wider Trust area. They are also encouraged to participate in training e.g. being co-facilitators etc.

- The care pathway lead attends board meetings including the Carer Partnership Board in Slough which has the aim to promote greater attendance and participation by carers. They also attend the BHFT Carer Strategic Development Group which aims to implement the Carer Strategy across the Trust. Finally they sit on the Triangle of Care (TofC) action plan group. This aims to implement and adhere to the standards set by the TofC.

- The CMHT has a comprehensive carer noticeboard which is regularly updated with information, events, training and advice.

Outcomes from March 2015-December 2017.

Outcomes	Total Numbers
Students Self Enrolled (not incl. referrals)	615
Courses Delivered	163
Students Referred/Self Referred Employment Service	210
Job Outcomes	55
Trained Volunteer Peer Mentors	28

8. Comments of Other Committees

This report is based on a report submitted in August 2017 and which described preventative services in Slough, the report generated much interest about the Recovery College approach and a request was made for more a detailed report to be submitted for January 2018. The offer was made and accepted by the panel for Peer Mentors from the college to attend the meeting in January to give first-hand accounts of the actual experience they have personally had of the college and of treatment as a whole in Slough.

10. Conclusion

There has been significant national attention in recent years on the importance of prevention and earlier intervention, as well as the vital role played by the community and voluntary sector. This has been reflected in legislation and policy guidance and is included in the Slough Five year Forward View. The recovery model outlined in this report and with the focus on peer mentors, experts by experience, as a primary part of the inclusion strategy for building community capacity and resilience has proved to be a significant intervention. Slough has achieved a high level of engagement and with excellent outcomes with the development of Hope Recovery College, and this approach supports independence and a route out of mental health services. The chosen methodology has opened up so much potential for the client group and including fifty-five people supported back in to work over the last 12 months. We are currently developing a more comprehensive Social Prescribing service with our partners in the voluntary sector and with the intent of utilising peer mentors. The initiative will capitalise on the positive contribution peer mentors are making to the Slough community and support access to employment opportunities for the people involved.

All of the evidence to date suggests this area of service delivery has proved so successful and we are hopeful that we can further develop the college to meet the needs of older people currently in mental health services too. The further development of the approach does require more investment to continue with the positive outcomes that are being achieved and as we build a ‘whole town’ approach to positive mental health for all. The indicators of new investment this year are promising and when we compare the services we have developed with other areas it becomes clear we have grown services which are truly meeting the needs of our community.

11. Appendices Attached

None.

12. Background Papers

None.