



## **ADULT SOCIAL CARE, HEALTH AND HOUSING OVERVIEW AND SCRUTINY PANEL**

**05 JUNE 2018**

### **SUPPLEMENTARY PAPERS**

**TO: ALL MEMBERS OF THE ADULT SOCIAL CARE, HEALTH AND HOUSING  
OVERVIEW AND SCRUTINY PANEL**

These presentations were delivered at the meeting.

Alison Sanders  
Director of Resources

	<b>Page No</b>
<b>8. CONVERSATIONS APPROACH</b>	3 - 10
Melanie O'Rourke, Head of Adult Community Team, to attend the meeting to present an update on the Conversations Approach e.g. where we are now and what outcomes have been achieved.	
<b>10. QUARTERLY SERVICE REPORT (QSR)</b>	11 - 18
To consider the latest trends, priorities and pressures in terms of departmental performance as reported in the Quarterly Service Report for the fourth quarter of 2017/18 (January to March) relating to Adult Social Care, Health and Housing. An overview of the key issues relating to the first quarter will be provided.	

*Panel members are asked to give advance notice to the Governance and Scrutiny Team of any questions relating to the Quarterly Service Report where possible.*

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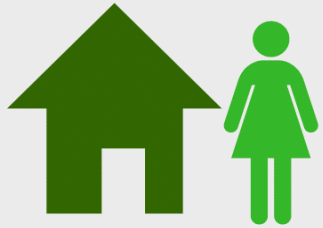
# Our Vision For Adult Social Care & Health



## Healthy, Safe, Self-Reliant Communities

# Case Study 1 - Community Connectors

## About Betty



**90 years old and lives alone**



**Multiple health conditions means she cannot get out**



**Feels very low from being lonely**



**Wanted a care package although she could manage slowly**

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**Community Connectors visited and explored what was available locally**



**Now**



**Regularly attending lunch club**



**Has a befriender**



**Taken up adult colouring in as a hobby**



# Case Study 2 - Community Connectors

## About Annie



19 years old



Has Downs Syndrome



Will start college in September but is not confident in how she will get there

Visited by Community Connectors



Worked together on traffic awareness



Worked on which stop to get off at



After several attempts Annie is now confident to get to college on her own



# Case Study 3 - Community Connectors

## About Madge

**74**  
years old

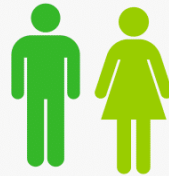


Suffers with  
**COPD**



Suffers from anxiety  
and depression  
relating to  
bereavements

Visited by  
**Community  
Connectors**



Madge was referred to  
bereavement counselling  
which she now attends



Has joined  
'Friends in  
Need' for  
people  
experiencing  
depression



Volunteers  
at a local  
group and  
working as  
a befriender



Will be attending  
**Community Connectors  
Coffee Mornings**

Madge is feeling  
more positive





# Case Study 4 - ICS Assessment

## About Gladys



Referred to hospital after fall



Identified need for care after discharge



ICS set up on discharge

ICS calls twice a day



Gladys and Care Coordinator agreed goals:



Confidence in the shower



Confidence to prepare meals



Able to empty commode

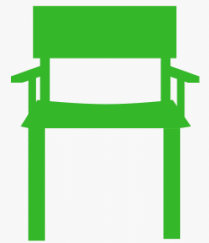


After 1 Week

Gladys no longer needed help in the evening - evening call cancelled



A shower seat and perching stool were provided



After 3 Weeks

Gladys cancelled all calls as she felt confident to manage independently



# Conversations Model Pilot – Customer Feedback

## Conversations Pilot Outcomes

"Good that all the input happens at once and not over lots of meetings. I have already started to go to one new group"

"Chris made everything understandable. I like the way Chris put things"

"Bracknell has been good to me"

- ✓ 22 cases through to completion
- ✓ 68% were new or new enquiries
- ✓ 4 feedback interviews were completed
- ✓ 3 uses of the Early Help Fund Card (Washing Machine, Train Ticket, Mobile Phone)
- ✓ £425p/w costs avoided through pilot interventions

Cases concluded at	#	%
1st Conversation	16	72.8
2nd Conversation	4	18.1
3rd Conversation	2	9.1





# Thanks For Listening

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## Any Questions?

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# Public Health



**The end of 2017/18 marked the third anniversary of our community development approach to Public Health.**

**Initiatives that involve community partnership have proving overwhelmingly popular (eg: physical activity groups).**

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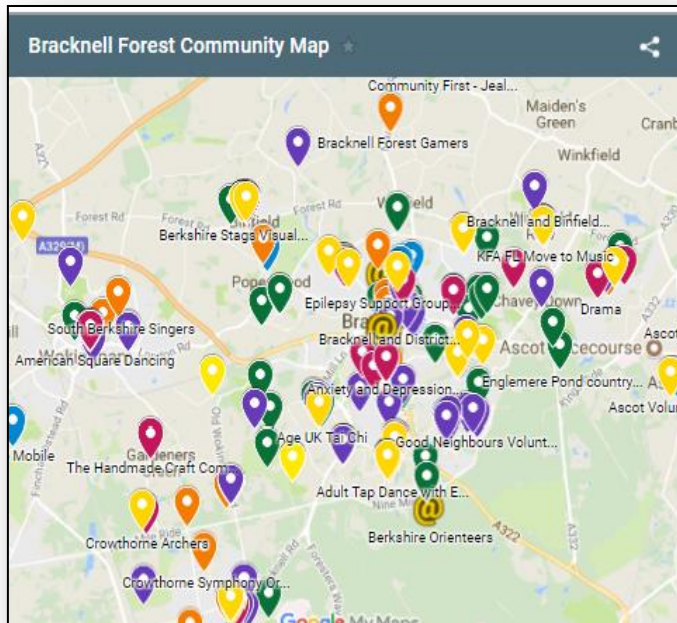
**More structured, 'treatment' type programmes that are structured according to PHE guidelines (ie: not co-designed in partnership with residents) are less popular.**

# Enable community asset based provision



# Improving access to community support

## Online Community Map



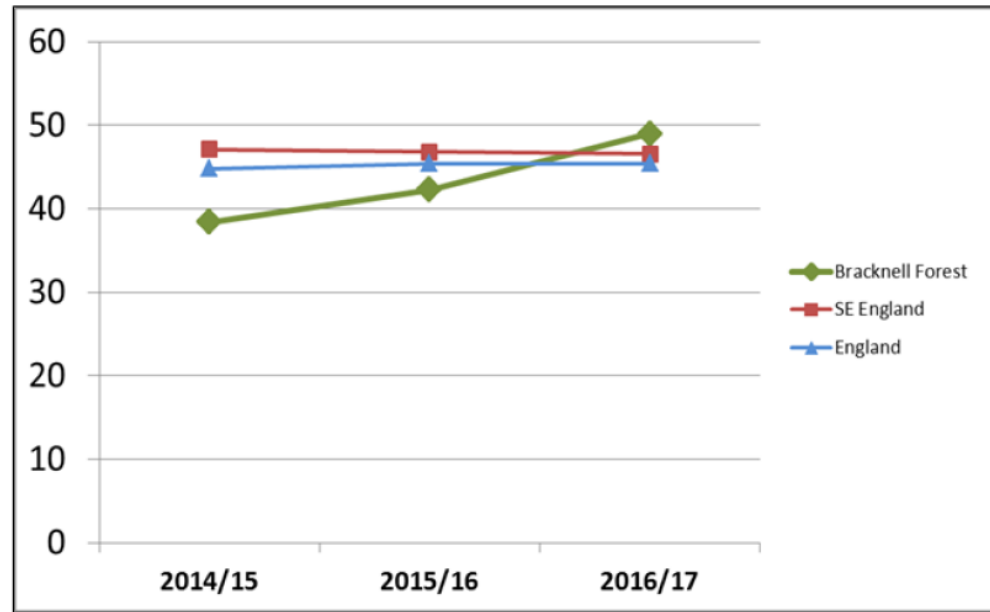
## Community Connectors & Social Prescribing





We have seen a rise in the number of people reporting that they have as much social contact as they want.

This has an impact not just on personal health but also on service demand.

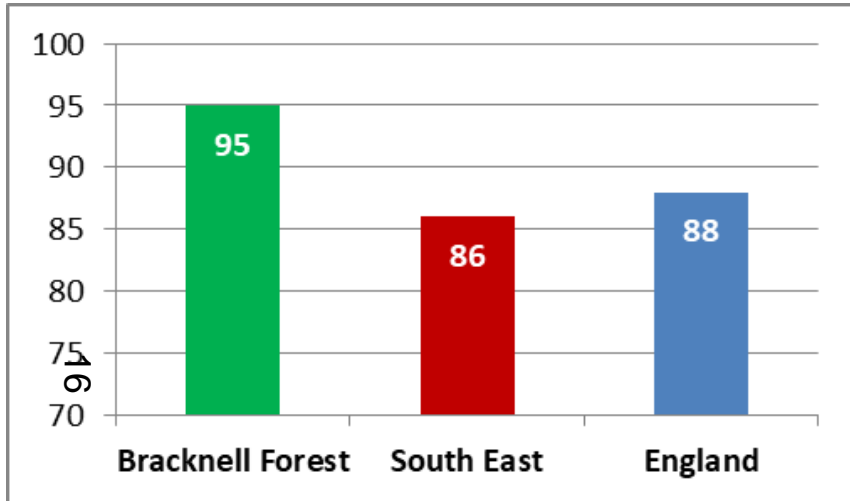


	Bracknell Forest	SE England	England
2014/15	38.4	47.1	44.8
2015/16	42.3	46.8	45.4
2016/17	49.0	46.6	45.4

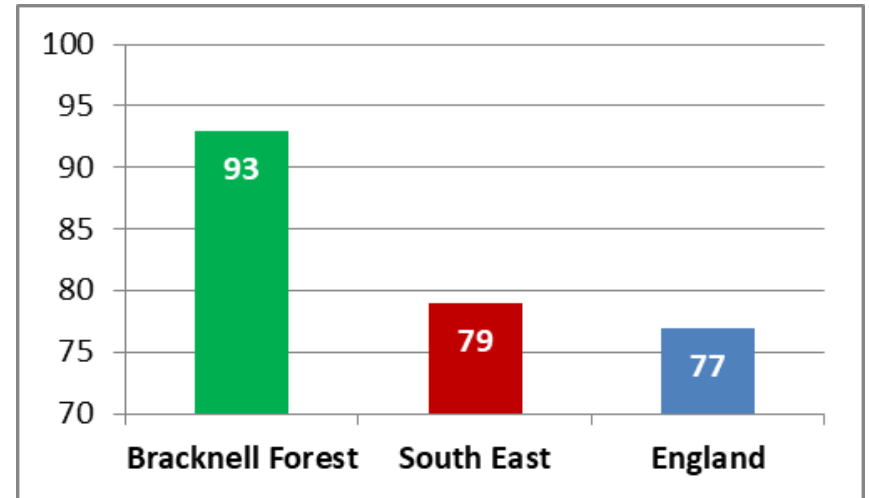
Our work on community development has gained national attention. It was featured by National Centre for Mental Health website and a delegation of Cllrs from Medway will be visiting in July to see our approach first hand.

# Health Visiting & Child Development

## New Birth Visit Completion

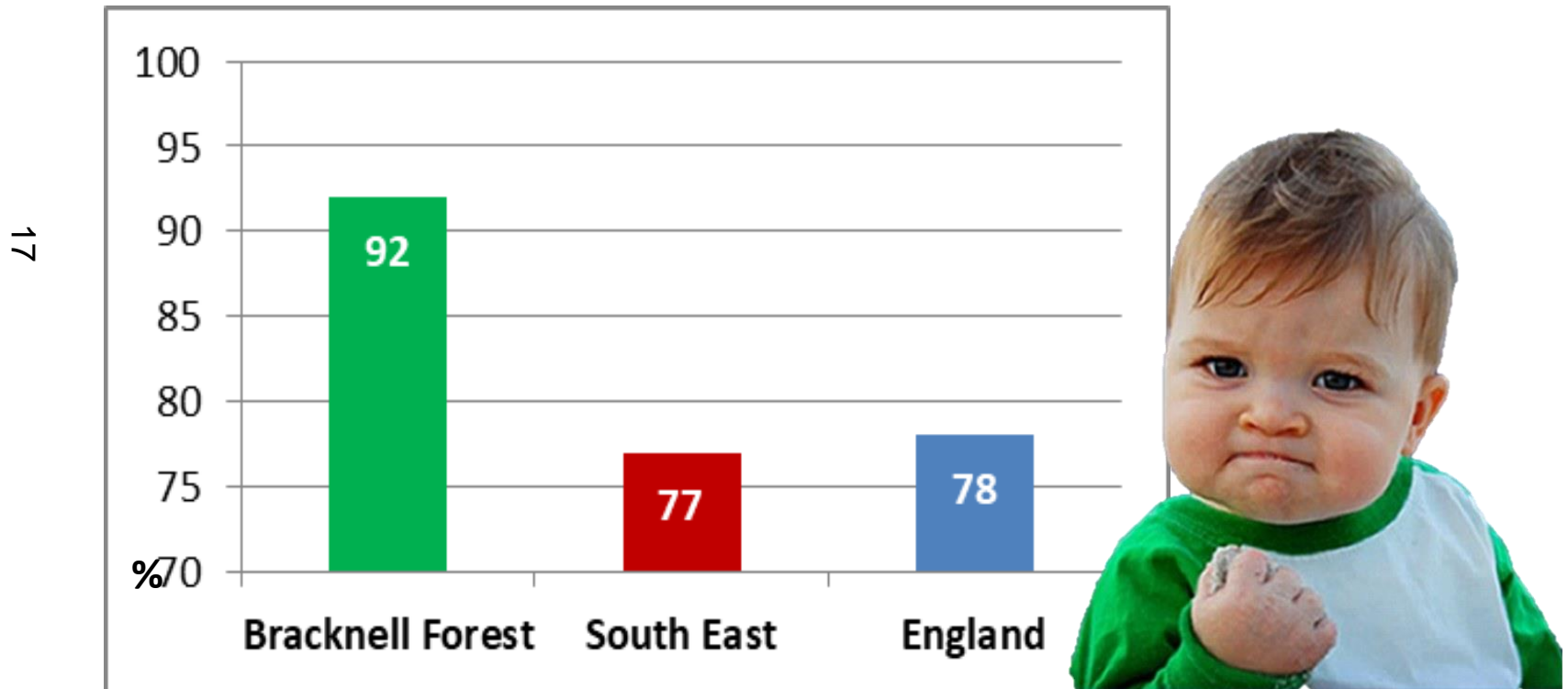


## 12 Month Review Completion



## Proportion (%) of 2 year olds at or above the expected level in all areas of child development.

NB: This includes: communication skills, motor skills (gross and fine), problem solving and personal-social skills.



Data published May 2018, NHS Digital.



