Royal Borough of Windsor and Maidenhead

Joint Health and Wellbeing Strategy

April 2016 - March 2020

healthwatch Windsor, Ascot and Maidenhead

NHS England

Windsor Ascot and Maidenhead Clinical Commissioning Group

NHS Bracknell and Ascot Clinical Commissioning Group

The Royal Borough Windsor & Maidenhead

Foreword

It has been a time of great change since the creation of the first Joint Health and Wellbeing Strategy (JHWS) in the Royal Borough. There have been many developments across the health and social care sector, all of which have the ultimate aim of improving outcomes for people. We have met those challenges by working together and within the challenging constraints of our financial pressures.

We are able to build on the success of the first JHWS, such as reducing falls and helping people to improve their health. The areas where the evidence and residents have identified that they would like us to focus are what we are prioritising again for this refresh. This ensures that residents are able to continually be the voice for how, through our joint actions, we will make a real difference to health and wellbeing for all.

It is the aim of the Health and Wellbeing Board (HWB) to ensure that the Royal Borough continues to be a great place to live, work, play and do business. Empowering residents to improve their own health status and sense of wellbeing underpinned by responsive and effective services is a key factor in ensuring that this aim continues to be a sustainable reality.

Signatures Here

Cllr David Coppinger – Lead Member for Adults, Health and Sustainability, Chair of the HWB

Dr Adrian Hayter – Clinical Chair for Windsor, Ascot and Maidenhead CCG, Vice Chair of the HWB

Dr William Tong – Clinical Chair for Bracknell and Ascot CCG

The Royal Borough Windsor & Maidenhead

Introduction

The Health and Wellbeing Board (HWB) is in place to ensure there is collaboration between Windsor, Ascot and Maidenhead CCG, Bracknell and Ascot CCG, the NHS, Council services and Healthwatch WAM representing the wider community. The Board brings together local leaders to ensure services are in place that deliver high quality care for all and empower residents to have healthy lives and increased sense of wellbeing. Empowering residents to make informed choices and having the correct support at the appropriate time and in the right place ensures that services can meet demand in a sustained way.

This Joint Health and Wellbeing Strategy (JHWS) sets out how some of the key local issues will be addressed. All of the actions identified in this document will improve outcomes for residents. Shared planning through the HWB will achieve the best possible results for residents.

The three themes and twelve priorities do not reflect every need in the area, but identify specific actions to be undertaken to deliver improvements. They support resident choices and are a tool for partners to place key health and wellbeing issues within their priorities and strategic plans.

The Royal Borough
Windsor & Maidenhead

Our Vision for 2020

‘The Royal Borough will be a healthy place to work, live and play where residents are enabled to be independent’

This vision was developed by the Health and Wellbeing Board (HWB) which brings together the partnership of Health and Social Care stakeholders.

The Strategy is relevant to all residents and organisations in the Royal Borough. It highlights the health and wellbeing priorities for the Royal Borough to improve on for the benefit of residents. It outlines a plan for how to do this to promote health, wellbeing and quality of life to the high standard residents would expect.

Crucially, it asks residents and organisations to get involved in delivering the strategy and explains how this can be achieved. We are aiming to be holistic and integrated to use the strengths of our local systems, including the voluntary sector and residents themselves to achieve the best possible outcomes for all.

The Royal Borough Windsor & Maidenhead

New for Health and Social Care Services

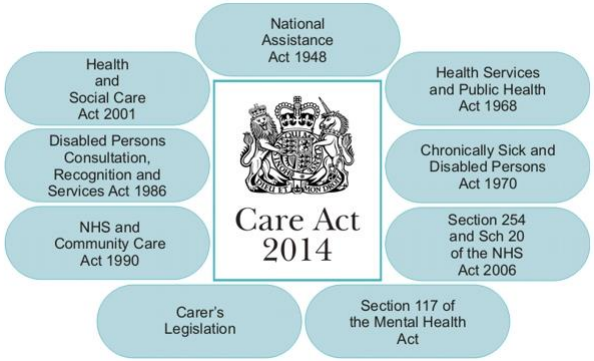
These are the key different national policy changes that the refreshed Strategy has taken into consideration.

The NHS 5 Year Forward View – a long term plan for the NHS that is aligned with the NHS Mandate, a governance document that is updated every year and details the overarching plans for the Department of Health and NHS.

The Children and Families Act 2014 – made changes around adoption, family justice, children with special educational needs, anti-natal care (after birth) and updated the rights of working parents and the rights of the child if parents separate

The Better Care Fund – supports integration of health and social care through pooling budgets. The aim is reduce demand for emergency, acute and residential care by enabling people to remain in or closer or home and reducing the number and length of hospital stays.

The Care Act 2014 – sets out how people's care and support needs should be met, confirmed the right to an assessment for anyone, including carers and self-funders, in need of support and set out that eligibility for services will be the same across England.



The Royal Borough Windsor & Maidenhead

New for Health and Social Care Services

For more information on the changes you can visit www.england.nhs.uk or www.rbwm.gov.uk/ or www.windsorascotmaidenheadccg.nhs.uk/

As well as implementing the national changes, there are a number of local improvement programmes:

- **A New Vision of Care** – is a project covering East Berkshire which aims to put in place a new model of care for people with complex needs in order to help avoid unnecessary admissions to hospital and care homes. It will include supporting people to change to healthier lifestyles, using technology to help identify and monitor changes in conditions and providing care for people where they live from a multi-skilled team with their GP and practice at its core.

New Vision of Care
Bracknell
Ascot
Maidenhead
Windsor
Slough
Chiltern

- **Connected Care** – is the development of new technology to enable key health and social care information to be shared, with the resident's permission, to help them get the treatment they need at the right time, especially in urgent situations.

CONNECTED CARE

- **New models of Primary Care (GP) Services** – Project to look at the way that Doctors Services are delivered across the local area, including out of hours and as "hub" sights across the borough to deliver a wider range of efficient GP lead services to residents

The Royal Borough
Windsor & Maidenhead

Where we want to be by the year 2020

As a carer I know the warning signs and am aware how I can get help

I took my ill child to the GP on Friday night instead of going to A&E

I have one point of contact for my health and care needs and I don't have to tell my story more than once

As an older person I have all of the information I need to live a fit and active life.

The outcomes that have been identified here are what you have told us you would like to have in the future. They form the basis of our plans to integrate services in priority themed areas as detailed in this document.

My child with severe learning disabilities is in high quality residential care close to home

I have all of the information I need to manage my long term condition and my quality of life is good

I feel in control of my care and my carer and family have been involved in developing my shared care plan

My family, carer and professionals are linked up through technology

I am actively engaged in the community and there are a range of activities I can participate in

The Royal Borough Windsor & Maidenhead

The Framework – 3 Themes and 12 Priorities Provide the Framework for Action

Theme 1 - Supporting a Healthy Population

- **Priority 1 – Enable more children and adults to be at a healthy weight**
- **Priority 2- Lower risky levels of alcohol intake.**
- **Priority 3 - Get more people to be more active more often**
- **Priority 4- Empower people to be educated to 'Self Care'**

Theme 2 - Prevention and Early Intervention

- **Priority 5 – Enable a reduction of levels of cardiovascular disease**
- **Priority 6 -Support people to have early diagnosis of dementia**
- **Priority 7 – Support adults and children with mental health needs**
- **Priority 8 – Assist and empower people with long term conditions**

Theme 3 - Enable Residents to Maximise their Capabilities and Life Chances

- **Priority 9 – Facilitate participation in education, training, work, social and community activities**
- **Priority 10 – Support carers of all ages**
- **Priority 11 – Enable health and wellbeing through regeneration and sustainable planning, including housing**
- **Priority 12- Health and social care services deliver independence outcomes**

These themes and priorities have been developed with and for residents to enable the HWB to focus its resources to improve health and wellbeing for all.

The Royal Borough Windsor & Maidenhead

The Royal Borough – the People and the Place

About the Royal Borough:

- Total population of 146,300 with expected growth to 155,800 by 2020, of which 29,800 will be over 65 years
- Land size of 79 square miles
- 64,000 + households
- Employment rate at 79.4% better than the national average of 73.5%
- Two CCGs, three hospitals and 22 GP Practices
- Between April 2012 – March 2015 there were 97,903 emergency admissions to hospital for residents of all ages (adults and children)
- There are four ward areas considered to be the most deprived in the local area – Clewer North, Belmont, Furze Platt and Oldfield

Health and Public Health:

- Average life expectancy at birth 81 years for men and 85 for women, better than England average
- Main cause of premature death is cardiovascular disease, strokes, heart disease and cancer, but still less than national average
- As an area, the Royal Borough performs in the top 25% of all Councils for 32 national public health indicators, other than incidence of malignant melanomas, hip fractures, winter deaths, infant mortality and deaths / injuries on the roads. In these areas our performance is within England average
- Falls in older people needing hospital treatment forecasted to increasing to 658 by the year 2020

Children and Young People:

- 19,000 pupils accessing education in 65 schools
- 73% schools rated as good or outstanding by OFSTED
- 13 Childrens Centres and 9 Youth Centres
- Corporate parenting responsibilities for the Council to 110 children
- More than 150 families with multiple needs

Adult Social Care:

- Support to 750 16-64 year olds and 2,000 aged 65 years and over
- 39 residential and nursing homes in the area
- Integrated teams for people with learning disabilities and mental health to cover health and social care needs
- Intermediate care – close to 55% of people who receive rehabilitation services go back to complete independence

The Royal Borough Windsor & Maidenhead

Our Successes

The success of the previous Strategy is measured by the direct impact it has on residents' health and wellbeing

Previous priority	The target/baseline	Where we are now
Support people to stop smoking	Target of 800	866 successful quitters
Number of healthchecks taken up by residents	Target of 3,000	3,165 healthchecks completed
Reduction in falls by older people	Reduce by 10% (from 156 per 100,000 of population)	Falls reduction of over 10.1%
Improve the home environment for residential services specialising in dementia care	Application submitted to central government	£847,000 grant awarded and all 17 care home environments improved
Adoption placements completed within timescales	100%	100%
Number of homelessness prevention activities made	Target of 800	1,137 different interventions completed
Increase number of people who say they are able to manage their condition	Increase the number from 50.3%	Increased to 59%

Case Studies

Benefits of technology to promote independence:

The following are real-life examples from the local area

- ✓ Mrs F has a risk of falls due to unsteady gait after a hip replacement. A range of telecare services put in place to prevent residential care being required, both to reduce the risk of falls actually happening and related hospital admissions, but also to enable help to be summoned quickly if Mrs F did fall. The equipment has enabled Mrs F to live safely at home and supported Mrs F's carer to have a less isolated life and more freedom to do activities to enhance wellbeing due to knowing that help can be contacted quickly if it is required and the carer is not physically there.

- ✓ Support for a couple where the husband has dementia and has a new behaviour of wandering, only discovered after a neighbour knocked on the front window to say that they had seen the husband walking down the road on his own. The front door was open and no one had heard him leave. After nearly an hour outside he was found safe but very cold and tired, it was a real shock for his wife as he had not done this before. Now there are brackets fitted on the front door so an alarm goes off when it is opened, which goes through to a monitoring station. This has given her re-assurance that he cannot just leave the house, so she can go about her daily living such as have a bath/shower or even just go to the toilet, without worrying that he will leave the house and no one will know or help him.

The Royal Borough Windsor & Maidenhead

Case Studies

Benefits of Homeshare:

Mr T is 77 years old and has a Homesharer called Q, 20, with whom he has shared his home since September 2014. Whilst T is very fit, active and enjoys a busy life, he does feel lonely, particularly during the long winter months. His family were also concerned about him living alone in a large house.

As part of the Homeshare arrangement Q shares the cooking and they eat together most evenings and hold lively debates on current topics. Q also helps out with some gardening and DIY tasks. They both watch the evening news together most nights and T says *'It's good to have the house used more fully and to share meals together in the evenings'.* Q is taking time out from his University course to gain valuable work experience and Homeshare has not only provided him with affordable living accommodation but has, in his own words, meant *"I don't come home and sit in a rented room on my own anymore".*

Joint Mental Health Services Support Group:

Mrs P came to the service feeling very low and with anxiety around people, impacting on inability get to a job and causing isolation. Support from the mental team has enabled Mrs P to apply for a job that does not involve large amounts of interaction with others and develop personal coping mechanisms when she starts to feel anxious. Mrs P believes that the support of the mental health services is a huge factor in her ability to maintain employment and promoting her own self belief

Action Plan

Priority 1	Adults and children at a healthy weight
Why is this important?	**What will we do?**
Obesity is one of the main lifestyle factors that influence health status. From the local Health Profile (2015) adults with excess weight is measured at 60.2% with obesity levels at just less than 6% compared to 9% nationally. For children 31.3% year 6 have excess weight (England average 33.5%) with 16.6% being obese (England 19.1%).	1. Encourage use of the leisure centres through a range of offers / incentives that appeal to all ages and throughout the year. 2. Encourage residents to get more physically active through promoting the use of outdoor spaces 3. Promote healthy eating through a public health campaign, including targeting at school children and through children's centres. 4. Have a specific awareness raising campaign of health, nutrition and portion sizes so that residents have the knowledge of how to make healthier choices easier
How will we measure success? 5% or less of children in reception year overweight/obese 28% or less of children in year 6 overweight/obese 55% or less of adults with excess weight	

Action Plan

Priority 2	Lower risky levels of alcohol intake
Why is this important?	**What will we do?**
Harmful levels of drinking is associated with a wide range of conditions, including brain damage, poisoning, liver disease, breast cancer and poor mental health. Alcohol also has a role in accidents, violence, criminal behaviour and other social behaviour problems. Currently the number of residents at just over 46% who complete treatment (rather that drop out) is above the England average of 39.17%.	1. Pro-active promotion campaign to increase awareness of alcohol harm, especially targeting at risk groups, including older people as a part of the tackling loneliness agenda and younger people, to reduce levels of risky behaviour. 2. Recommission alcohol treatment services under the new specification guidance so that the number of people who complete the treatments (rather than drop-out) increases. 3. Work with stakeholders to manage the impacts of anti-social behaviours, including those relating to the night-time economy and needing unplanned medical attention

How will we measure success?

Maintain and aim to increase the number of people who complete alcohol treatment to above 46%

Deliver targeted campaigns that encourage harm-free drinking levels

Reduce anti-social behaviour and alcohol related medical treatment through working with partners

Action Plan

Priority 3	Get more people to be more active more often
Why is this important?	**What will we do?**
People who are active have a lower risk of cardiovascular disease, stroke and heart disease as well as reported improvements in mental health and sense of wellbeing. In England 6% of all deaths have lack of physical activity as a direct factor and it is considered to be leading lifestyle factor for cardiovascular disease, heart disease and strokes. Nationally 27.7% of people say they are inactive (less than 30 minutes of activity in a week)	1. Refresh and refocus the Prevention Strategy and action plan so that the broad lifestyle influences on risk of reduced health status are addressed, including encouraging residents to think about weight, activity and diet. 2. Facilitate a range of opportunities for people that encourage activity and participation, particularly utilising outdoor space and through community hubs, including the national Fit4Life and One You campaigns 3. Scope and develop a range of GP referral schemes to enable those who would benefit from a medically supported programme of activity to access appropriate services

How will we measure success?

The number of people who are physically inactive reduces from 21% of the local population

Look at the use of referral schemes and increase how they are utilised and track outcomes of those who use them.

Action Plan

Priority 4	Empower people to be educated to self care
Why is this important?	**What will we do?**
Empowerment and self efficacy are key factors to support people in making healthy choices and increasing their own sense of wellbeing. Key information giving based on local needs and to targeted groups, particularly those with a long term condition (LTC) can influence the success of improving outcomes.	1. Refresh the Prevention Strategy and associated action plan to develop a range of self care activities which cover areas where the evidence from the Joint Strategic Needs Assessment, and the national Outcome Framework measures show other areas where residents could benefit with a focus on having the information to self care, including; • Long term conditions management • Mental health promotion • Falls prevention • Seasonal impacts on health and wellbeing • Smoking cessation for targeted groups • Awareness of how to reduce risk of malignant melanoma 2. Develop a self-care health improvement programme that identifies actions that can be taken across the life-course

How will we measure success?

Increase the number of people who have a long term condition who say they are confident to self manage from 59%

6 specific mental health promotion activities

Reduction in number of falls related A&E admissions to make a total reduction of 11%

Specific campaigns to promote weather related self care actions

Continued reduction in smoking cessation from 12.1% as the amount of smoking adults

Incidence of skin cancer diagnosis are reduced from 18.1 per 100,000 of population (England average 18.4)

Action Plan

Priority 5	Reduce levels of cardio-vascular disease
Why is this important?	**What will we do?**
Cardiovascular disease (CVD) is the second leading cause of death in England (27%) and is a term used to cover conditions of the heart and circulation system. Locally we perform worse than the England average for hospital admissions for CVD related concerns.	1. Promote the best way to reduce risks specifically associated with lifestyle factors, including a healthy heart programme 2. Work with the NHS to refresh the CVD care pathway covering health and social care. 3. Encourage people at risk to have a Healthcheck which identifies key risk factors. 4. Support people who have a diagnosis of CVD to manage their condition and to develop a condition plan, including what could support them to reduce risk of emergency admission
How will we measure success? Reduced number of emergency admissions into hospital due to CVD as the primary reason to be more in line with the national average. More people who are eligible being offered a Healthcheck (14% locally compared to 19.7% of England average).	

Action Plan

Priority 6	Support people to have an early diagnosis of dementia
Why is this important?	**What will we do?**
In England 1 in 3 people aged 65 and over will have a diagnosis of dementia, and with the demographic growth of people living longer. It is forecasted that by 2020 locally 2,327 people aged over 65 will have a diagnosis and 41 younger people having a formal diagnosis.	1. Refresh of the joint dementia strategy and action plan, which includes the specific details actions to support residents and their families with dementia, which is lead by the Older Persons Mental Health Subgroup. 2. Extend the dementia advisor support services to enhance the support available to residents, especially those who are newly diagnosed and to share the learning of the services to other professionals who are able to assist those with dementia and their families 3. Increase the number of people who are on the dementia register, and therefore receiving specialist services in line with the forecasted growth of population

How will we measure success?

Monitoring and reporting on the dementia strategy an action plan activities.

Increase the number of people who receive a service from the Dementia Advisor from the current number of 158 (as at March 16)

Increase the number of people on the dementia register from 1,151 people, as at March 2016, in line with forecasted predictions in population changes

Action Plan

Priority 7	Support and empower adults and children with mental health needs
Why is this important?	**What will we do?**
3% of the population report having a long term mental health problem with 15,542 people aged 16-64 forecasted by 2020 to have either a common mental health disorder (14,465) personality disorder (404) antisocial disorder (314) psychotic disorder (359). School-age boys are more likely (11.4%) to experiencing mental health problems than girls (7.8%). With 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. In 2013/14, 33 children aged 0-17 were admitted into hospital for a mental health condition. Admissions locally increased in 2013/14 to be higher than the national rate for the first time.	1. Review and enhance local mental health services in line with the national Mental Health Crisis Care Concordat 2. Have a range of mental health promotion activities and campaigns that both support people who have a condition, but also reduce the stigma of mental health conditions to the wider population, this will include hard to reach groups. 3. Proactive assessment of the services available and the level of mental health needs for children and young people and look at how other services can support and encourage mental wellbeing (e.g. Childrens Centres) 4. Work with other service providers (e.g. housing and leisure services) to enable them to identify the way they can support residents with common mental health concerns improve their wellbeing

How will we measure success?

Work across health and social care to deliver integrated crisis care mental health services

Reduce the number of children and young people admitted into residential mental health services from 33 per year.

Deliver a range of mental health promotion activities based on local needs, aim to reach 200 in depth interactions and disseminate information to over 600 individuals

Action Plan

Priority 8	Support and empower people with a long term condition
Why is this important?	**What will we do?**
Long term condition (LTC) is an umbrella statement for a variety of health conditions that do not have a cure, but can usually be managed with support. 59% of the population within WAM CCG boundaries with a LTC stated that they were supported enough to manage their condition, which is slightly lower than England average. This can be supported through telecare and telehealth support which enables independent living and self efficacy	1. Develop a self care programme for people who have a condition to be empowered to manage it. 2. Develop a technology enabled care strategy and action plan to support people who have a long term condition live at home safely and be able to monitor and respond to their own health status changes. This will be overseen through a Telecare / Telehealth specialist group which will develop refine and test the latest technologies. 3. Ensure that residents with a long term condition receive holistic reviews of their condition, medication, pain management and life circumstances through integrated care planning.

How will we measure success?

Increase in the number of people who say they are supported to manage their own condition from 59% to 62%

Working and aligning with the technology enabled care action plan and reducing any barriers that have been identified

Develop a LTC self care programme with people who have a LTC so that the resident voice is involved with care planning.

Action Plan

Priority 9	Facilitate participation in education, training, work social and community activities
Why is this important?	**What will we do?**
These are the areas that impact on health and wellbeing status, as wider determinations of health. Locally 45.9% of people with a learning disability have employment, which is better than England average of 33.1%. *For people with a mental health condition 26.9% of residents have employment, which is slightly worse than the England average of 33.9%* *Participation in education, training or employment for children leaving care is hugely impacting on life chances and therefore increasing this number from 70.6% locally is also a priority.*	1. Work with specialist employment agencies to enable people who need extra support to gain employment have access to work 2. Work with local small and mediums sized enterprises to facilitate work experience opportunities 3. Work with local businesses and groups to enable employers to promote the wellbeing of staff, including reducing stress and physical movement, especially for those who are desk based / static in their job roles. 4. Using technology to support carers monitor the wellbeing of the person they are caring for from a distance or when away from home.

How will we measure success?

Achieving higher employment rates for vulnerable groups, learning disabilities of 48% and mental health to 30% through developing specialist employment support services.

Feedback and levels of participation from local businesses and stakeholders in activities / campaigns that support improved staff health and wellbeing status

Action Plan

Priority 10	Support for carers of all ages
Why is this important?	**What will we do?**
Approximately 13,125 residents have identified themselves as Carers in the 2011 Census, and this is likely to be an underestimate of the true number. This has increased by 15.1% since 2001, much faster than the rise in the overall population (8.2%). Carers make up 9.2% of the total local population. *There were 750 carers under 25 in the Royal Borough identified by the 2011 Census (1.8% of the under 25 population), including 225 aged under 16 years. 20% carers report being in 'not good' health, compared to 12.5% of non-carers. Almost a third of people providing 20 + hours of unpaid care per week report being in 'not good' health; this increases to just over half of carers aged 65 and over (40.3% for non-carers aged 65 years or over).*	1. Provide good quality information and advice 2. Provide support for carers to enable them to find their way to the professional who can best help them 3. Provide opportunities for carers to take a break from caring 4. Increase the number of carers identified 5. Improve the overall health and wellbeing for carers 6. Support carers in education, employment and life chances 7. Ensure that carers from diverse communities are supported (Carers' Strategy)

How will we measure success?

Improved rates of access to employment for carers
More carers reporting that they are in good health
Carers reporting that they have as much social contact as they would like to have
Monitoring the implementation of the Action Plan

Action Plan

Priority 11	Enable health and wellbeing through regeneration and sustainable planning, including housing
Why is this important?	**What will we do?**
Each local authority area is required to have a Local Plan to manage development for the area. Included within that is the enabling of health and wellbeing activity and behaviours. This can include for example, areas being dementia friendly, meeting housing needs of the population, reducing the risk of injuries on roads and enabling access to green spaces. Only 1.16% of residents report they utilise outside parks and green spaces for purposes of exercise or wellbeing, low compared to England average of 17.1%. Number of people killed / seriously injured on roads is higher than national average of 39.3	1. Implement policy and measures to improve health with developments and housing needs, including spatial planning, licensing and increasing opportunities for communities to come together. 2. Develop an affordable housing model for the regeneration programme for the borough 3. Work with local communities to enable local vulnerable people to be able to live safely in areas that meet their needs 4. Utilise the green spaces that are available through facilitating local use of the available land for wellbeing activities 5. Work with highways and other partners to examine the road safety needs and records so that actions can be taken.

How will we measure success?

Develop an affordable housing action plan that responds to residents needs.
Increased number of people who use services saying they feel safe from 67.45%
Increased number of residents participating in green space activities
Reduced number of road deaths or serious injuries from 39.6 per 100,000 of the population

Action Plan

Priority 12	Health and social care services deliver independence outcomes
Why is this important?	**What will we do?**
Maximising independence outcomes will have a significant impact on reducing dependency on services, enhancing personal wellbeing and enabling people to have a usual life experience. The number of people who reach full independence after going through rehabilitation / intermediate care services increases (from 889 individuals 2013/14). Prevention and wellbeing services that support independent living, including reduced delayed transfers of care out of hospital are also developed through the Better Care Fund.	1. Develop and refine the outcome based commissioning (Care and Support at Home) project, which promotes independence for residents 2. Shape the intermediate care services across the borough to support people to regain and maximise the potential for independence and reduce dependency on services 3. Reduce the number of delayed discharges from hospital (where someone is medically fit to leave) by having a range of support services available that enable people to recover from illness at home with the right support 4. Identify those residents who may just be starting to struggle at home and offer a personalised support package

How will we measure success?

Reports on individual outcomes achieved through the Care and Support at Home project and the number of people who achieve their outcomes increases year on year

Increased in the number of people who return to full independence through intermediate care services, both community and residential intermediate care services

Use of lower level support services that support people who are just starting to struggle at home and assessment of effectiveness of that service.

Together we can achieve

Our Commitment: To…

- ✓ …put residents / patients outcomes at the centre of our shared planning
- ✓ …work to outcomes that support health and wellbeing for all
- ✓ …ensure that safeguarding and best practice is promoted in services
- ✓ …work together in an efficient and sustainable way to have quality and effective services
- ✓ …have services that characterised by dignity, equality, respect and accessibility for all
- ✓ …engage and listen to residents and patients for improvements in services

Your Contribution: To...

- ✓ ….think about the different things you can do to improve your own health and wellbeing status
- ✓ ….register with a Doctors Surgery / GP so that you can get the right help at an early stage
- ✓ ….access and use the information and advice that is available where there is a health or wellbeing outcome that you may need support to achieve
- ✓ ….respect the staff and services that are available and to utilise them appropriately, so that resources are able to support and help as many people as possible
- ✓ ….complete prescribed treatments and keep appointments, or cancel them with as much notice as possible

The Royal Borough
Windsor & Maidenhead