Promoting Wellbeing

These services aim to prevent, delay or avoid people entering into formal social care or health system, by enabling people to manage their own health and wellbeing. Wellbeing services are universal, based in local communities and utilise local resources. They address the issues that lead to people entering into formal care systems, such as social isolation, falls and carer breakdown. Access to good quality information and advice will be the cornerstone of our wellbeing offer, enabling people to identify and access the support that they want in order to keep living fulfilled lives.

Our ethos will be **'a life not a service'**; this is based on consistent feedback that current models of support fit people into a narrow band of available services; whereas future support needs to be more personalised to enable people to achieve the outcomes that matter to them.

GPs and other health/social care professionals find it difficult to keep abreast of all that is available in the community to support people's wellbeing. We will develop models of support that enable people to access the resources in their local community that keep them informed connected active and well. We will be exploring how social prescribing models supported by one to one support from care navigators can use techniques like guided conversation to help people think about their needs and get the support they require. We will investigate how we can support people to plan for later life and be more in control of their care and support needs.

People do not know what is available either through commissioned support in the voluntary sector or provided via other groups such as churches. We want to develop Community Hubs which will be local information and advice hubs that are in prominent and visible locations, where people can pop in for advice and support.

Social isolation and loneliness is a huge issue central to our model will be developing schemes which help people connect for mutual support, activity and fun, keeping people connected keeps them well!

We will work with and through the community and voluntary sector to maximise use of our combined resources, using tools such as asset mapping to ensure traditional and non-traditional types of support for part of our wellbeing offer. Our focus will be on building community capacity and resilience in communities and levering in non-traditional providers to improve the range of support offered.

Promoting Independence

These services also aim to prevent or delay people entering into formal care systems by providing short-term support that provides the best long-term outcome for an individual. For some people, these consist of short term interventions that enable people to recover from episodes of ill health or injury and to return to their previous level of health. For other people, especially those with a long term condition or a

disability, these may be fixed term services that provide training and skills development that maximises independence and enables people to live as independently of formal care systems as possible.

Community Hubs will offer therapy services and provide access to assessment and advice regarding the equipment and assistive technologies. We will look to integrate Occupational Therapy services provided by KCC and the Community Health Trusts whilst maximising the opportunities of the newly jointly commissioned community equipment provider, NRS. This will improve access, optimise services, and remove the risk of duplication and variation in assessment and provision; making easier for people to get the equipment that helps them remain independent and well.

Our plans are to bring together KCC's enablement service and Community Health Trusts intermediate care services. To ensure people have rapid access to short term therapeutic interventions that prevent hospital admission, support recovery from illness and enable people to get back on their feet. The service would be designed to support people with complex needs including those with moving and handling issues i.e. double handed care and importantly people living with dementia. The service would respond rapidly to support people to stay out of hospital and through the CHOCs will be aligned to the paramedic service.

The service will prevent acute admissions and support timely and effective discharges and will work on the understanding and belief that '***your own bed is best',*** and that in most cases people are more comfortable in their own homes and therefore recover and regain their independence more quickly if good quality therapeutic support can be provided in their own homes.

Supporting and Maintaining Independence

We know that some people will need ongoing support to remain living in their own homes and communities. Services must support people to maintain wellbeing and self-sufficiency keep them safe and enable them to live and be treated with dignity. Our primary aim must be to enable people to live in their own homes, stay connected to their communities and avoid unnecessary admissions to hospitals or care homes.

We plan to investigate and develop a nurse led homecare service which brings together KCC commissioned homecare services and the Community Health Trust nurses. To provide an outcome focussed flexible and responsive specialist services to support people living at home. This model offers a real opportunity to develop a workforce model that is fit for the future, and which explores the opportunities to train and develop carers and health care assistants and nurses to deliver holistic care focused on patient need. For example, this may include training domiciliary care workers and carers to carry out medical procedures such as insulin injections for

insulin dependent people in receipt of home care, and who would otherwise require daily nursing visits.

We will provide wrap around holistic support for people with more intense/complex needs. Key to this model will be a trusted community worker who is given the resources to build a team or circle of support around that individual. This will support specific high risk individuals including those with dementia or very unstable long term conditions.

Integrated enablement and homecare services will also provide peripatetic support to care homes in the area, the teams will in reach to local care homes to provide specialist support for residents and to help staff develop skills and confidence.

Developing an integrated workforce strategy is an essential element of our plan. We must ensure that there is a genuine career pathway across an integrated health and social care system. That we encourage young people into careers in supporting them to gain qualifications and skills. Links with local higher education collages and schools will be nurtured and improved.