Slough
Adult Social Care

Local Account 2017/18

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Slough
Borough Council

Welcome

I am very pleased to welcome you to your annual local account of adult social care for 2017/18. It will provide you with an update about some of our achievements during the year, as well as a summary of our continuing challenges. It will tell you about how we are facing these challenges by having priorities in place that are aligned to national policy drivers as well as the council's ambitious Five Year Plan *http://www.slough.gov.uk/council/strategies-plans-and-policies/five-year-plan.aspx*.

Our Five Year Plan outlines our commitment to ***putting people first***, through ensuring our communities and people are at the heart of everything we do. We said we will do this through strong communication and engagement with people. It is therefore really important we continue to really listen and respond to what people using adult social care services have told us about their experiences.

In the 2016/17 Local Account we outlined the rising demand for adult social care services against a backdrop of reducing resources. We shared how we are responding to this through adopting a preventative strength based approach within adult social care. This approach is based upon really valuing and promoting the unique strengths, connections and aspirations of individuals as well as the communities they are part of.

We recognise that it is only through strong partnerships and collaboration with all our partners, including the NHS and the voluntary and community sector that we will be able to meet the second priority within our Five Year Plan which is ***'Our people will be healthier and manage their own care needs'***.

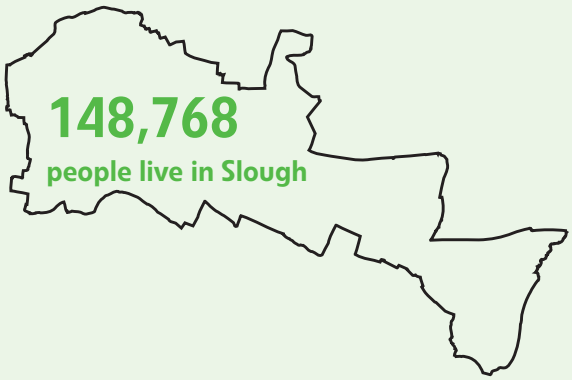
As well as creating an environment which promotes individual and community independence and resilience, we also have a duty to continue to safeguard the most vulnerable in our community. It is therefore important we deliver sustainable services to support these people. We will wherever possible help them to live as safely and for as long as possible in their own homes. This will mean continuing to have individualised support in place which will include the growing use of assistive technology and direct payments.

Our continued challenges have also brought new opportunities for us to work differently and more closely with our community. We are really excited about working in a more co-productive way with people that use services, their carers and partner organisations. We will strive to work in a more innovative way through having more equal partnerships in place, whereby we will really listen to and value experiences that can help us find shared solutions.

Alan Sinclair
Director of Adults and Communities

About Slough: Our people

People



Ethnicity

The 2011 Census showed Slough to be one of the most ethnically diverse local authorities outside of London with 46% of the population identifying as White British or White Other, 40% Asian or British Asian, 8.6% Black or Black British and 3.4% mixed race.

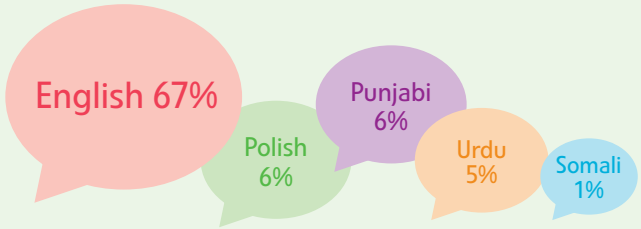
42,180 under 18s — 28%

91,973 people aged between 18 & 64 — 62%

14,615 people aged 65 or older — 10%

The average of over 65s for England is 19%

Main language



Health

	Life expectancy in Slough for men is 59.6 years, whereas 63.3 is the national average.
	Life expectancy in Slough for women is 59.5 years, whereas 63.9 years is the national average.
	34.8% of Slough's population is estimated to be inactive - participating in fewer than 30 minutes sport or physical activity per week - significantly higher than the regional average of 22.7%.
	Slough has a higher estimated prevalence of diabetes among the adult population at 10.2%, compared to the 8.1% regional and 8.5% national average.
	Slough has a preventable cardiovascular mortality rate of 69.3 deaths per 100,000 of the under 75 population, compared to a rate of 46.7 across England and a regional average of 38.4.

For more information, visit: **www.slough.gov.uk/council/joint-strategic-needs-assessment/**

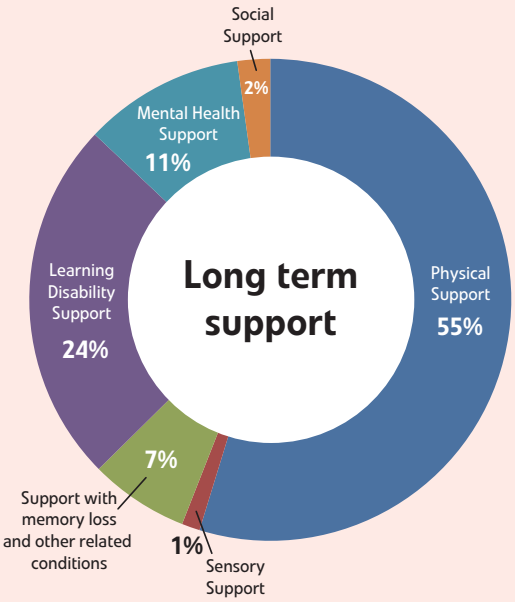
Adult social care: How are we doing?

People

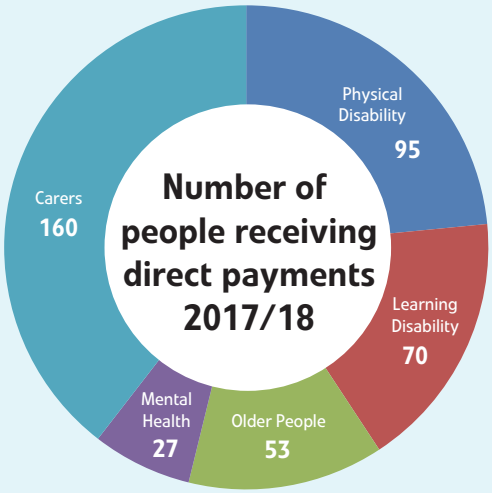
2,245 people used adult social care services in 2017/18

1,012 people received short term support, including reablement and rehabilitation following discharge from hospital

1,233 people were receiving long term support at the end of the year; this includes nursing care, residential care and direct payments



Direct Payments



Budget

We spent approximately £32m on adult social care in 2017/18. This includes:

	£12.2m	Care Homes
	£4.8m	Supported Living
	£5.7m	Care at Home
	£1.4m	Day Opportunities
	£4.2m	Direct Payments

The remaining budget was spent on staffing costs, the voluntary sector, replacement care (respite) and other preventative services.

What you have told us

The Adult Social Care Outcomes Framework (ASCOF) set priorities for care and support and is used to measure progress and strengthens accountability.

Highlights of the 2017/18 results.

However, only 62.3% are satisfied with the care and support they receive. This is a marked improvement from the 57.2% last year, but we still have work to do.

In the Local Account 2016/17 we highlighted a number of priorities. Here is a summary of how we got on.

We said	We did
Target key groups and individuals most at risk of poor health and wellbeing to take up health checks.	In 2017/18, 18.9% (6,759) of eligible adults aged 40-74 were offered an NHS Health Check and 7.3% (2,598) received an NHS Health Check. This is an increase from the previous year.
Continue to support more people to manage their care and support needs through direct payments.	The number of service users choosing a direct payment instead of a commissioned service increased from 52% to 59% in 2017/18.
Promote preventative activity, including social prescribing.	A wellbeing prescriber pilot took place in 2017, co-ordinated by SPACE.
Roll out the single point of access integrated hub.	The single point of access (Berkshire Integrated Hub) went live in September 2017.
Relaunch the Safe Place Scheme.	The Safe Place scheme was relaunched in Slough in November 2017.
Work with the NHS to develop our Frimley Health and Care Sustainability and Transformation Partnership (STP).	Now known as the Frimley Health and Care Integrated Care System (ICS), we are working closely with the NHS to support the health and wellbeing of Slough residents.

Highlights

Our achievements

- 90.1% of older people (65+) who receive reablement or rehabilitation services after being discharged from hospital are still at home 91 days following discharge. Slough consistently performs well in this area, supporting our older population to remain at home for longer.
- More people quit smoking in Slough (71%) than the local (51%) and national (51%) average after help from our smoking cessation service.
- More of our residents are benefitting from assistive technology to support their health and care needs. This includes a project that used technology to support people with learning disabilities to improve their health, activity levels and social connections.
- The successful introduction of the Responder Service prevented 687 unnecessary ambulance call outs.
- Of the DoLS (Deprivation of Liberty Safeguards) applications received, 100% of individuals who lacked capacity were supported by an advocate, compared to 88% last year.
- 540 people and their families were supported through the Slough Memory Clinic to access local services, including information and advice.
- We had 8,017 contacts of which 2,146 progressed further.
- 405 people including carers received a direct payment, which is an increase of 45 over the last year.

Our challenges

- An increasing number of people who use adult social care services are telling us that they have as much social contact as they would like. However it is still only 43.8%, so we have more to do with our partners to reduce loneliness and social isolation in Slough.
- 69.6% of Slough adults aged over 65 received the flu jab and 47.5% of people that are at risk received the jab. This is lower than the local and national average.
- Although the number of people who feel satisfied overall with the care and support they receive has increased, at 62.3% we still need to improve their experiences.
- Slough residents are less active compared to the regional and national average. We need to do more to encourage our residents to live more active lifestyles.

Supporting people to live safely

Safeguarding

Ensuring the most vulnerable adults in our community are supported to feel and live safely remains a high priority. This year:

- 118 individuals were subject to safeguarding enquiries
- 225 DoLS (Deprivation of Liberty Safeguards) applications were received:
  - 51% relate to individuals with dementia
  - 24% with learning disabilities
  - 70% were granted
  - 24% were not granted.
  - 6% were withdrawn

Safe Place Scheme

In 2017 the Safe Place Scheme was relaunched in Slough. This works by asking local businesses and services, who have signed up to the initiative, to place a 'Safe Place' sticker in their window. This helps identify businesses and services as a place where vulnerable people can seek help should they feel uncomfortable or unsafe when out and about.

This usually means making a telephone call on the person's behalf; to the police, a parent, carer or support worker and providing a temporary safe haven until support arrives or it could be as simple as offering someone a place to sit and a glass of water.

Further information about the national scheme can be found at: **widgit.com/safeplacescheme**

Prevent

"A young male with learning disabilities was referred to Prevent (the Government's strategy to stop people becoming terrorists or supporting terrorism) with concerns about possible extremist attitudes and radicalised behaviour. He was assessed as isolated and vulnerable after leaving education. A multi-agency approach resulted in appropriate support being put in place to ensure he is no longer isolated or vulnerable to radicalisation. One to one support through the local authority has resulted in him learning new skills, meeting new people and gaining help with finding employment."

Supporting people to feel socially connected

GoodGym

The GoodGym has a three tier offering:

1) A weekly running and volunteering group that helps around the borough with local tasks
2) Small groups of volunteers who run to an older isolated adult and help with a one off task
3) Individuals that run to an older isolated adult to relieve the burden of loneliness through befriending.

> “Jenni and Manjit arrived and met the lovely Mr A, who needed a sofa moving to the garden, to make a bit more space for when his wife came out of hospital. The duo quickly set to work lifting the cushions then moving the sofa out to the garden, ready for the council to collect later. Mr A also gave them some chocolates to share with the rest of the GoodGym Slough group as a thank you.”

SPACE

We continued to invest in the voluntary sector through SPACE (Slough Prevention Alliance Community Engagement). Highlights for 2017/18 are detailed below.

- The Slough Advice Centre held a showcase event to demonstrate the wide range of services provided from the centre and through partners.
- Strengths based conversation training was delivered to SPACE associates, as well as training around deaf awareness and learning disability awareness to ensure that SPACE associates are skilled at working with the whole community.
- Community events have been led by SPACE associates e.g. the International Older Peoples' day event run by Slough Seniors.
- 66% of people who responded to the health and wellbeing questions improved their score after a SPACE intervention.
- A new group called 'Men's Matters' was launched in Langley to connect socially isolated and lonely men together. It has a growing membership and offers regular lunches, social outings and health related advice sessions such as diabetes awareness. It also signposts members to organisations to get more targeted support as required.

Wellbeing Prescribing

The Wellbeing Prescribing pilot incorporated all aspects of a person's health and wellbeing, which included their social, practical, physical and emotional needs.

People were referred by adult social care and GPs to the Wellbeing Prescribing Service for an assessment. Individuals were then connected to the relevant voluntary organisations, to help meet their identified needs.

"Miss W. is a 55-year-old lady who is registered blind, partially deaf, had recently experienced two bereavements in her life and as a result, felt incredibly lonely and isolated.

Through conversations and relationship building with the Wellbeing Prescriber, it was identified that Miss W would like to attend a recently developed 'Living with a long term condition' workshop. It was also agreed that she may benefit from counselling services to address her recent bereavements.

The main goal for Miss W. was to get involved with volunteering. Following the support she received through the Wellbeing Prescriber Services, she now feels empowered to start volunteering, and is supporting other residents of Slough."

Support for carers

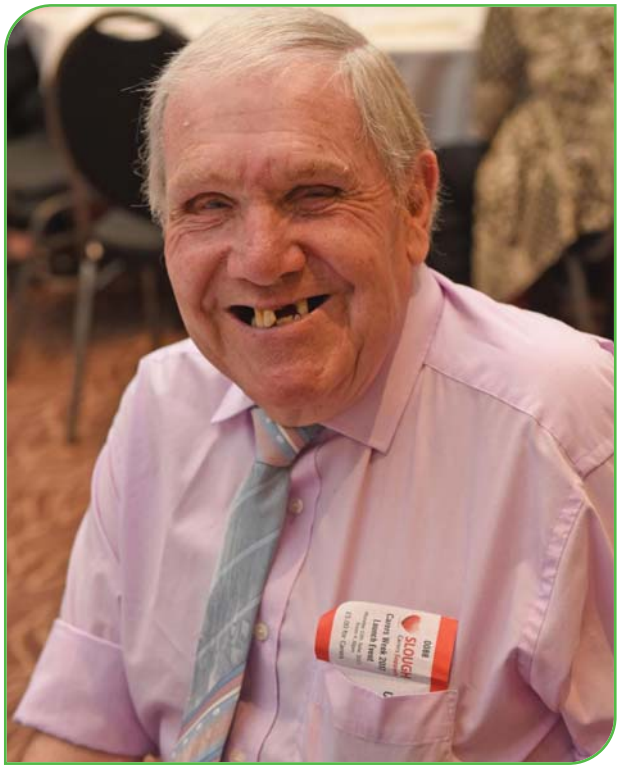
Carers Strategy

The Slough Carers Partnership Board has continued to oversee the joint five year Carers Strategy, developed by Slough Borough Council, The Slough Children's Services Trust and Slough CCG. For more information visit **www.slough.gov.uk/council/strategies-plans-and-policies/slough-carers-partnership-board.aspx**

Berkshire Healthcare Foundation Trust

A new carers lead is working across both Slough Community Mental Health Team and Slough Older People's Mental Health Team services. They undertake:

- assessments of carers supporting people with mental health problems and dementia,
- facilitate Carer support groups - including monthly café,
- offer regular carers training, information sessions and forums.



Slough Carers Support

Highlights from the year:

- Slough Carers Support relaunched the Carers Discount Card, which offers discount at a number of local businesses. For more information visit: www.sloughcarerssupport.co.uk/carers-card-benefits
- 510 carers registered
- 356 carers are receiving the monthly newsletter
- 3 new peer support carers groups in place as well as quarterly carers forums
- hosted a successful carers week 2017 - 114 carers were part of the activity.

Working with Carers UK

A digital resource is available to all Slough carers offering a range of e-learning tools, information and sign-posting. It also includes free access to the Jointly app, which supports carers to co-ordinate their caring responsibilities. 206 carers accessed this resource last year.

To find out more, visit: www.slough.gov.uk/health-and-social-care/digital-tools-to-support-carers.aspx

Slough Borough Council is a member of Employers for Carers, which provides information and support to organisations to enable them to be a more carer-friendly employer. SBC has an umbrella membership; this means small or medium employers in Slough (with fewer than 250 staff) can access the resources through our membership, free of charge. To date, seven local businesses have subscribed.

For more information, visit: **www.slough.gov.uk/health-and-social-care/employers-for-carers-.aspx**

Regional developments to support carers

Slough Borough Council led a Berkshire wide engagement event looking at the integrated approach to supporting carers in both health and social care settings. The outcome was to raise awareness of carers and young carers, and was attended by approximately 70 people. This will help inform future developments to support the needs of carers.

Supporting people to live independently in their own homes

Responder Service

This council run 24 hour service is operated through Careline. It offers additional help for vulnerable or elderly people with no other support. The service aims to:

- support residents to maintain independence and remain in their own homes,
- reduce the need for ambulance services,
- reduce the number of presentations to Accident and Emergency departments,
- reduce the number of avoidable hospital admissions.

The service is delivered following individuals triggering their alarm for assistance, using their assistive technology system.

> Mrs H wears a wristband activator which can alert Careline using her phone line.
>
> *I've got MS (multiple sclerosis) and once I fall over I can't get up without help. Over the years I have had them out a few times. It used to be the paramedics who came out and all they had to do was just get me up. It is a very good service, they are really nice. It is a great reassurance and my daughter feels happier as well. I never take the wristband off; I have even been known to take it on holiday!*

In 2017/18 there were:

- 702 responder service attendances to such alarms
- 393 confirmed falls
- 15 required an emergency ambulance service attendance
- 687 ambulance call outs prevented.

For more information, visit **www.slough.gov.uk/health-and-social-care/telecare-and-assistive-technology.aspx**

FallsFree4Life

As one in three people aged 60 and over fall each year, Slough Borough Council has commissioned this innovative free service. FallsFree4Life is aimed at preventing falls entirely in those aged 60 and over in the Slough area. This is achieved by reaching out into the community to identify those that may be at a medium risk of falling often without knowing it.

In 2017/18 the service carried out 636 assessments and won the Royal Society of Public Health Technology & Health Innovation Award.

> *The well balance exercise class is very good. I feel more confident to go and do my daily activities. Before the classes I felt reluctant to leave the house and I felt really depressed most of the time. These classes have been a lifeline for me.* Mr A.

Slough Memory Clinic (as part of Older People's Mental Health Service)

The Memory Clinic now offers an evidenced based Cognitive Stimulation Therapy in English and Punjabi to patients. The aim is to stimulate cognition through discussion, activities and orientation. Each session has a different theme and in addition to maintaining and supporting cognitive functioning, it has also shown in some cases to contribute to reduced stress and anxiety. We use a range of resources for each session, including food, music and sensory activities.

> *"Before attending these sessions I would stay in one place, I did not know what will happen and how life will go. I used to worry about how I will manage. But coming to the group and seeing other people, I know I'm not alone. There was a time I would buy things for the house and could buy 10-15 items without a shopping list. Now even with a list, I will forget things from that list.*
>
> *Now I've come back to that same situation, I'm not 100%, but I feel 80%, I'm alright. Someone who keeps thinking and thinking will ruin themselves. If I did not join the group, it is possible that I would be in a home now. There was so much stress building up, but now I ignore the worries."*
>
> Mr A, who attended the sessions.

Working closely with our partners and the NHS

Frimley Health and Care Integrated Care System (ICS)

Last year we provided an update about the Frimley Health and Care Sustainability and Transformation Partnership (STP) which brings together more than 30 statutory health and social care organisations to improve services and support residents to live healthy, happy and independent lives. This has now been re-modelled to Frimley Health and Care Integrated Care System (ICS).

The ICS has set five priorities which include: improving prevention and self-care, improving outcomes for people with long term conditions, managing people living with frailty or complex conditions, urgent and emergency care, and reducing variation and health inequalities.

In the last year the ICS has achieved a number of successes, highlighted below.

- Improved patient experience with more joined up care being provided in people's homes
- Patients have better access to GP and primary care teams (8-8, Mon-Fri, and enhanced urgent care access 7 days a week).
- There are fewer people with mental health problems having to travel out of the area for treatment.
- Employment support services are available for people experiencing serious mental health problems.
- Improved Access to Psychological Therapies (IAPT) services for people with long-term conditions.
- Improved quality of care and support provided in care homes which means that people are less likely to attend A&E, be admitted to hospital or have prolonged lengths of stay in hospital.
- Our shared care record allows our community workers to access information immediately, reducing the number of times people have to tell their story and improving care decisions.

"James is a 50 year old man with Asperger's syndrome. He has had a difficult life, moving around the country, struggling with his mental health and finding it difficult to look after his own health and wellbeing.

After living in Slough for a few years, James reached a crisis point in his life. His flat was no longer safe to live in and he was refusing all the support he was offered. He became violent towards his neighbours and family.

His social worker worked very closely with health professionals, the police, the CCG and James's family to get James a placement in a special recovery unit. Here he was finally able to get the help, support and medication he needed to start to live a more stable, independent life.

James now lives in a supported living flat. He is happy to engage with support staff to develop his skills; he accepts support from health professionals and has a positive relationship with his family."

Single Point of Access

The Single Point of Access (known as Berkshire Integrated Hub) provides a single referral route for professionals through to all our social care and community health services. Referral co-ordinators, supported by a multi-disciplinary team, triage calls and co-ordinate any on-going action required. This approach is aligned to our adult social care three tier asset based conversation approach and uses the wellbeing prescribing service as part of the onward referral route.

> Miss S was referred by her GP. Following an accident she was having physiotherapy, and had a discussion about how her condition had changed her ability to care for herself but also for her elderly parents, with whom she lived.
>
> Miss S was happy to have an assessment to determine both her care needs and her caring responsibilities. She was able to benefit from Slough's wellbeing prescribing service, which provided information about carer support services.

Stroke Recovery Service

This brings together a number of disparate contracting arrangements that existed for stroke support within the East of Berkshire. A joint commissioning process with neighbouring east Berkshire health and social care partners resulted in a new co-ordinated service supporting stroke survivors out from hospital to continue their recovery at home in the community.

> Following a stroke, Mrs R was unable to drive and could no longer work, which left her feeling very isolated, lonely and anxious. Her daughter was caring for her as much as she was able, but had her own childcare responsibilities. She felt very anxious about leaving her Mum alone. The stroke recovery service was able to help by referring Mrs R to a number of local support organisations. A support co-ordinator was able to help her access information in her own language. Her daughter was also referred for a carer's assessment. Mrs R is now supported through the support network she has created, and her daughter feels a lot happier leaving her Mum alone.

Supporting people to live healthier and more active lives

Public Health

Cardiowellness4Slough (CW4S)

Our integrated lifestyle service means that residents can either refer themselves or be referred by their GP. The service provides people with a direct route into a range of preventative services such as weight management, falls prevention and smoking cessation. In 2017/18 there were:

- 1,949 referrals, including 75% from BAME groups
- 1,147 assessments
- 1,600 referrals to behaviour change programmes.

Annual Health Checks

In 2017/18 18.9% (6,759) of eligible adults aged 40-74 were offered an NHS Health Check and 7.3% (2,598) received an NHS Health Check. This is an increase from 2016/17.

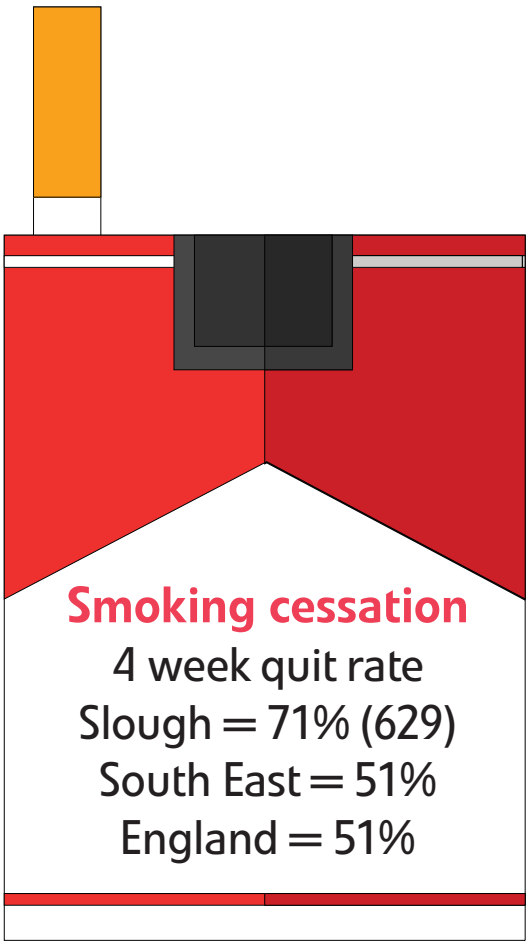
Flu jabs

In 2017/18 69.6% (8,871) of Slough adults aged over 65 received the flu jab and 47.5% (8,969) of people that are at risk received the jab. The uptake of both is lower than the South East (72.8% and 48.8%) and England (72.6% and 48.9%).

Eat4Health

"The Eat4Health initiative was great for me. I learnt so much about food intake and have adjusted my lifestyle accordingly. The course really helps people of all ages to achieve good weight loss even when you're in your seventies. I would never have thought it possible but thanks to the Eat4Health programme it is."

Tomas, 71, lost weight through the Eat4Health programme.



Active Slough

Get Active continues to facilitate a huge range of activities for Slough residents. Participants are encouraged to try out new activities and socialise with others. Programmes have been devised following local consultations with the voluntary sector and community groups. The programme is regularly updated to ensure the community can access a wide variety of sport and physical activity.

In 2017/18, 3,675 people attended Get Active sessions, which included 358 people with disabilities.

> Sue, an 83 year old from Cippenham, shared her experience of the seated exercise classes:
>
> *I could not have been more impressed with these classes. They are perfect for anyone, like me, who wants to do a bit more exercise without it being too hard. I'm always anxious about doing new things, especially sport/activity; however the instructor has given me real confidence in taking part. Each week the classes seem to get a little harder, but I'm keeping up! These classes have been magnificent for me, my confidence has improved massively, I can cycle further and I've made new friends.*

Drug and alcohol service

Turning Point delivers a recovery focused service in Slough, supporting individuals to become more resilient. The service also provides online support via their wellbeing cloud, which enables people to digitally (and anonymously) access information, advice, online screening and interventions. Feedback shows that 90% of service users found the service to be helpful.

For more information visit **wellbeing.turning-point.co.uk/slough/**

Co-production

Co-production is about having equal working partnerships between carers, people who use adult social care services and professionals. It is about working together to ensure diverse views and ideas are represented, so they can be used to make positive changes in the community.

Slough Mental Health Services

Slough Mental Health Services continue to embed co-production as a guiding principle through creating an 'enabling environment'. It has a range of health and educational programmes in place, including the continually developing Peer Mentor programme. This has introduced social prescribers, working across health, social care and community partner organisations. It aims to promote independence and self advocacy, building social cohesion, resilience and wellbeing in line with the community asset based approach.

World Mental Health Day

Slough Mental Health Services co-designed and hosted, with people that use services, an event in Slough which was attended by 180 people. The aim of the day was to raise awareness about mental health through drama, music and poetry. This was then followed by an open session with information about local mental health services. It was attended by 500 people.

Working together toolkit

The toolkit was co-designed with people who have experiences of using health and social care services. It is aimed at professionals and highlights some of the barriers, tips for effective communication and the different types of engagement to consider, aiming towards a more co-productive approach.

> Bernadette and Shahnaz were part of the group who developed the toolkit:
>
> *We feel it's nice that our thoughts are valued. It was good to meet the other people involved who are in the same boat as you, as well as the professionals who understand our situations and meet us on the same level. We could be open and honest, and didn't feel embarrassed talking about our difficulties in the room. In the past we haven't had the chance to have an input, but now we've had the opportunity to be heard. There wasn't a hierarchy. We were always told what was happening and what to expect.*

Developing a co-production network

To support our approach, we have reviewed our current partnership board arrangements and have co-designed a new and innovative way of working with our community. We will be creating a new co-production network which will bring people together with a broad range of experience of health and social care services with representatives from adult social care, health and Healthwatch. Together they will work as equal partners to come up with ideas and solutions to help positively influence how the council and other providers deliver services.

For more information about co-production in Slough, visit: **slough.gov.uk/health-and-social-care/co-production.aspx**

Our future priorities

- To continue to develop our close relationship with the NHS in a range of work streams, including the roll out of Integrated Care Decision Making Teams.
- To develop our preventative approach including the wellbeing prescribing service, reviewing our housing related support and support for older people.
- To increase the number of eligible residents attending their annual health checks.
- To continue to develop our approach to co-production by establishing a strategic co-production network.
- To locate our adult social care teams in the communities they serve in order to strengthen our relationships and be more responsive.
- To continue to identify and strengthen local community assets and support the 'Make Every Contact Count' model in the community and voluntary sector.
- To develop our approach to supporting adults with learning disabilities into paid employment.
- To roll out the use of technology to support people with their health, activity and social connections.
- To work with our partners and local carers to co-produce a local Memorandum of Understanding to help improve the identification and support of carers.
- To continue to work with partners, including The Slough Children's Services Trust, to ensure we meet the needs of young people transitioning to adult social care.
- To continue to promote the use of direct payments to support residents choosing how their care and support needs are met.

Contact details

For more information about the **Local Account** contact:

Tel: 01753 875538
Email: beinvolved@slough.gov.uk

Useful numbers

- **Adult Social Care**
  Tel: 01753 475111 (option 1)
- **Mental health services**
  Tel: 0300 365 0300
- **Slough Carers Support**
  Tel: 01753 303428
  Email: sloughcarers@gmail.com
  Website: https://sloughcarerssupport.co.uk

Out of hours contact

- For out of hours social care issues, including child protection call: 01344 786543.
- Adults with mental health needs, or their carers, should contact the Community Mental Health Team on: 0300 365 0300 (for new referrals) or 01753 690950 (for existing referrals)

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 2017/18

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 475111.

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 475111 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 475111 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 475111.

Haddii aad doonayso caawinaad ah in lagu turjibaano warbixinta dukumeentigaan ku qoran, fadlan weydiiso in qof ku hadla Inriis uu ku Waco 01753 475111 si uu kugu codsado.

اگر آپ کو اس دستاویز میں دی گئی معلومات کے ترجمے کے سلسلے میں مدد چاہئے تو، براہ کرم ایک انگریزی بولنے والے شخص سے 01753 475111 پر کال کرکے اس کی درخواست کرنے کے لئے کہیں۔

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