Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

The local authority had arrangements in place to prevent, delay or reduce needs for care and support. The adult social care outcomes framework (ASCOF) short- and long-term support (SALT, 2023-2024) data, showed a very high proportion of people (90.10%) who received short-term support no longer required support, which was better than the national average (79.39%). Additionally, data showed a similar-to or better-than national average performance on metrics from the adult social care survey (ASCS, 2023-2024). For example, 65.29% of people said help and support helped them think and feel better about themselves (national average 62.48%); 70.25% of people reported they spent their time doing things they valued or enjoyed (national average 69.09%); 98.35% of people who used services described their home as clean and comfortable (national average 94.05%); 93.39% of people who used services felt clean and presentable (national average 93.28%) and 92.56% of people who used services received adequate food and drink (national average 93.71%).

The survey of adult carers (SACE, 2023-2024) showed 94.12% of carers in the local authority area found information and advice helpful, which was better than the national average (85.22%). The number of carers able to spend time doing things they valued or enjoyed (12.00%), was similar to the national average (15.97%).

Partners told us the strength-based framework was working well and the local authority engaged well with people with lived-experience. People said they were supported by various multidisciplinary teams (MDTs), including referrals to district nursing teams and physiotherapists, allowing them to maintain independence in their own home. There was a ‘hub’ in the town centre available to people in the community, intended for people with mental health difficulties to support their wider determinants of health (the wider factors at play that can affect a person’s health, such as housing, employment or social connections).

We saw the Adult Social Care Prevention Strategy 2024 to 2028 which set out how they intended to prevent people's needs arising and build resilience. This reflected nationally recognised best practice.

We found the Responsive Integrated Assessment Care Team (RIACT) and the front door (ACT) arrangements, worked well to support people in the early stages of their care relationship with the local authority. The effectiveness of these was central to the local authority's performance in achieving high levels of people receiving short-term care no longer needing care. The ACT team worked with people for up to 16 weeks following referral and only referred onto longer-term social worker teams following this period if long term support was found to be necessary. We were told the RIACT team used 'just checking' assistive technology, which helped analyse the needs of a person when there was conflicting information about them. For example, data around a person's overnight activities could be gathered through remote monitoring together with information gathered from family. The person was then able to be assessed as to whether they needed further support.

Staff said they focused on a 'least restrictive' option of care. Prevention measures were considered as part of the front-door 16-week service such as minor household works or equipment, as well as referrals to other services such as carers and advocacy services. RIACT offered food and toiletries to some people when they were being discharged from hospital which supported them to go home. We also heard about a community grocery which supported people on low incomes to access cheaper food. We heard public health had a role in supporting adult social care embedding 'making every contact count' (MECC).

There were drop-in sessions available for people with drug and alcohol difficulties and activities on offer. There was a food bank, and people could also access clothing and a 'care and share' group, a citizens advice bureau and emergency accommodation. Some partners said there was a lack of social support groups and affordable day services for people with dementia. Although there was a memory cafe and singing groups for people with dementia. Partners and leaders said there were good operational links between primary care and the learning disability team and national targets on health checks for people with learning disabilities had been achieved. A falls collaborative had grown from the local health and care partnership arrangements. Public health funding had supported physical activity programmes in two leisure facilities. Social prescribing and health coaching were available through a primary care alliance which supported people with their physical and mental health and gave support to make positive lifestyle changes. Joint work with housing had led to utilising local housing stock to avoid residential care placements for older adults and people with long-term conditions. This work was also involving people currently residing in residential care homes exploring options of them returning home with support. Leaders said the 'Accommodation with Care and Support Strategy' encouraged joint working with housing. There was a voluntary, community and social enterprise (VCSE) organisation funded to support people with issues around homelessness and rough sleeping. We heard about a flexible use of extra-care housing such as a person moving into supported living but during a delay was housed temporarily in an extra-care facility, there were also step-up and step-down beds available for assessment.

People said there were plans to further develop the prevention offer and the local authority clearly had plans to further embed public health within adult social care. We found staff were creative and supported people to remain independent in a person-centred and strength-based way. There was a consistent use of residential care homes as a last resort and we heard about social prescribers being used by frontline staff to promote independence at home and reduce care needs. For example, following a period in hospital a person with substance misuse and self-neglect difficulties was placed in a care home. After receiving support from the alcohol access team, they were supported to engage in woodwork and restoring furniture. They were supported to move from a care home to an extra-care housing setting with occupational therapy support and lived independently. We heard the range of services and activities such as exercise groups and coffee mornings in sheltered and extra-care housing were accessible to the wider community.

Technology was also used to reduce long-term care needs. 'Lifeline' and 'Just Checking' equipment allowed people to be assessed in their own homes, which supported their independence.

Provision and impact of intermediate care and reablement services

The local authority provided effective intermediate care and reablement services and enabled people to return to or gain optimal independence. ASCOF/SALT data 2023-2024 showed a similar proportion of people (3.38%) over 65 years of age, received reablement or rehabilitation services after discharge from hospital to the national average (3.00%). In addition, 81.48% of people aged 65 and over who had reablement or rehabilitation services after discharge from hospital, were still at home after 91 days, which was similar to the national average of 83.70%.

There was a clear focus in the local authority on providing short-term support to prevent longer-term care. Leaders and partners agreed there was a strong relationship around hospital discharge and the local authority's work in reablement and short-term interventions was well regarded and effective. They had a consistently low number of discharge delays with high performance in reablement delivery and outcomes. There was a clear process map for reablement for staff handling referrals.

We heard about an example where the RIACT team worked with people in bed-based intermediate care alongside physiotherapists to maintain/regain skills such as kitchen assessments and home assessments to reduce care and support needs. One person initially required two-person care in the intermediate care setting but after working with the team was able to live in supported living with one-person care.

Access to equipment and home adaptations

People could generally access equipment and minor home adaptations to maintain their independence and continue living in their own homes. The local authority had improved access to the DFG with low eligibility criteria, however after increased demand for DFG assessments they implemented a risk and impact assessment which prioritised need.

There were arrangements and guidance for staff on how to access aids and equipment. A 'community equipment service' guide set out the equipment available and the process for ordering. We saw an occupational therapy 'first point of contact' guide to support staff in assessing the need for occupational therapy involvement. There were, however, waits for occupational therapy assessments. The median waiting for time for occupational therapy was 129 days and a maximum of 320 days. Consistent with other waits in the local authority, risk prioritisation by the duty team was completed and urgent referrals could be made. There was also risk prioritisation guidance for managing referrals for equipment. At the point of contact, people were given information and guidance with any preventive equipment that could be provided while they waited for assessment.

Some actions had been taken to reduce waiting times since June 2024. The team of contractors had expanded to address demand, which had reduced the time from order to start date falling from 143 to 84 days. This had improved the existing cases awaiting a start date with the original contractors from 40 days to 13 days.

The local authority had a contract with an external equipment provider to provide assistive technology equipment and there were 84 assisted technology installations between July 2023 and July 2024. It had a seven day target response time and a process for urgent requests. 75% to 80% of referrals were installed within 48-72 hours and the seven day target was achieved fully within the 12 month reporting period.

There was an effective contract arrangement with a general equipment provider. For standard stock equipment the contract was achieving 98% completions against a six-day working target and there was no waiting list for equipment in the local authority as of July 2024. The RIACT team provided support around discharge and maximising independence, and we heard examples of people having an opportunity to try out equipment and advice at home. The local authority maintained a small supply of equipment such as shower chairs, stools, commodes and toilet frames for example, which enabled staff to provide equipment urgently.

Provision of accessible information and advice

People could access information and advice and ways to meet their care and support needs. The ASCS (2023-2024) data showed somewhat more people (71.64%) who used services found it easy to find information about support than the national average (67.12%). The SACE (2023-2024) showed a similar number of carers (61.11%) found it easy to access information and advice as the national average (59.06%).

There was a jointly funded 'hub' central to the local authority, where residents could access advice and support on a range of issues such as debt. There was a 'living-well' directory which provided information about the local area including availability of VCSE services. There was a 'Duty to Provide Information and Advice' guide for staff on the duty to provide information about people's rights under the Care Act 2014. There was a range of sources of information on the website of the local authority and they had evaluated the accessibility of the information as appropriate for people with varying needs. There were resources available to tailor information to meet people specific needs. For example, if required they could print information on yellow paper and there were Braille writers. Information was also available face to face and verbally if someone could not access on-line information. There was signposting information on mental health support, drug and alcohol services and for people experiencing domestic abuse.

Partners agreed information was accessible and was available in other languages. We heard about a steering group involving partners looking at how to improve information on the website. Partners said they received funding to provide out of hours advice and information. People gave mixed feedback on information availability, some people had difficulty identifying who to contact for information and others said the local authority had provided information in a format that suited them and was tailored to their specific needs. We saw an example of a person with a severe and enduring mental health condition having information tailored specifically to them and their carer.

Direct payments

We heard examples of direct payments being used to support people in a strength-based way such as helping a person with gardening and another person finding it simple to access a personal assistant. A person who was a carer said they had accessed a bus pass as part of a direct payment and felt supported. One person had used a direct payment to access education opportunities. Another example demonstrated how a direct payment was used for a person where their first language was not English. They had care and support from a personal assistant that spoke their first language, arranged and funded through a direct payment. Staff told us about a further example of an autistic person with communication difficulties using a direct payment for singing lessons, and one of their outcomes from support was workplace employment.

Use of direct payments had been historically high in the local authority and had recently reduced, however uptake of direct payments was still higher than the national average. ASCOF/SALT 2023-2024 data showed 89.29% of carers received direct payments, with no national average to compare it to. 51.57% of people aged 18 to 64 who accessed long-term support, were receiving direct payments. This was better than the national average of 37.12%. Although people aged 65 and over accessing long-term support and receiving direct payments (9.71%) was somewhat worse than national average (14.32%). Overall, 32.37% of people accessing long-term support received direct payments which was somewhat better than the national average (25.48%).

Staff and leaders described efforts to improve communication internally within the local authority and develop easy-read documentation about direct payments for people in order to maintain or improve their direct payments, noting that uptake had decreased over the last few years. An organisation was commissioned to provide support and source personal assistants and staff said this worked well. Staff and leaders also said an increase in choice among home care providers had led to fewer people accessing a direct payment.