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 worked with people, partners, and the local community to make available a range of services, facilities, resources, and other measures to promote independence, and to prevent, delay or reduce the need for care and support.

The Medway Council Adult Social Care Strategy 2021 – 2025 gave a vision for adult social Care in Medway, based on a strategic approach to prevent, reduce, delay need and meet care and support needs. Prevention services to promote independence included a contract with a voluntary and community service who offered residents of Medway free impartial advice, support, and guidance to enable people to access appropriate support services in the community. The service had 'Care Navigators' to assist people to better navigate through health, social care, and voluntary sector support services to find the right service to meet their needs.

Senior leaders were aware of significant inequalities in Medway. For example, there were low rates of cancer treatment in some deprived areas and high rates of mortality from cancer. The local authority was using a Health Determinants Research Collaboration (HDRC) research project to measure the impact of inequalities. Senior leaders told us there was a 2-year programme to identify and put into place new ways of working to make Medway a 'Marmot Place.' A Marmot Place recognises health and health inequalities are mostly shaped by the social determinants of health, such as the conditions in which people were born, grew, lived, worked, and aged. An action plan is then developed to improve health and reduce health inequalities.

The local authority had an online service called 'A Better Medway' which provided specialist support, advice, programmes, and resources to help people living or working in Medway improve their health and well-being.

Preventative services were having a positive impact on well-being outcomes for people. Public Health initiatives had been launched to support people in Medway including a falls prevention programme to reduce demand on adult social care. This was based on evidence showing strength and balance improvements, helped to prevent falls. The local authority also provided a holistic health checks, which was a full assessment of health. People's blood pressure was checked, and their health monitored. Nordic walking and healthy weights were additional services available. A smoking cessation shop opened in Chatham in 2015, where people could also undertake health checks there. In 2011, 25% of people smoked in Medway and the most recent evidenced 9% of people smoked. Public Health leaders had asked people in Medway what their priorities were, which were identified as the cost-of-living crisis and poor quality of sleep. Leaders told us they were considering what their next health promotions would be to address these and demonstrate to the community they had listened to their concerns. The local authority were aware improvements were needed to support staff to better understand the public health offer, so this could be promoted to people during assessments.

There was a focus on using occupational therapy as a preventative measure, to offer early intervention services to people to reduce their care needs. Occupational therapy waiting lists were increasing and the local authority told us this meant more people were accessing the right support, at the right time to be as independent as possible and to be re-abled. The occupational therapy team assessed new and existing double handed packages to determine their suitability for 'a single-handed care package as opposed to a double care package. A double-handed care package was where more than 1 paid carer was provided on each visit to someone to deliver personal care to the person in their home. The project was determining where 1 paid carer could undertake these tasks instead. A healthcare partner said since staff had received this training they had grown in confidence and people's needs had reduced service wide due to these techniques.

Staff told us they had a good relationship with all care agencies and gave an example of how they worked with a provider who had asked for a review of a care package for a person using their service. Staff visited the person and realised the person was able to do more than first realised. Staff encouraged the person to move more to increase their movements which would aid their muscle movement. This had a positive outcome as the person became more independent with the same care package. National data showed 74.50% of people who received short term support in Medway no longer required support. This was below the England average of 77.55% (ASCOF/SALT).

The Lead Member for Adult Social Care, Health and Well-being told us the use of assistive technology was a priority in Medway in relation to the local authority's prevention offer. They told us the local authority was working collaboratively with the local university to use assistive technologies more effectively.

Medway's Better Care Fund recognised the importance of housing, adaptations and the Disabilities Facilities Grant (DFG) in supporting people to remain living in the community. The local authority planned to make the DFG more flexible and discretionary to make it more accessible to people.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services which enabled people to return to their optimal independence. The local authority commissioned a care provider through the Better Care Fund (BCF) to carry out their reablement services. Daily meetings were held with the local authority within a multi-disciplinary team, which included the Integrated Discharge team, to share information on cases, consider options for long term care, and eligibility for therapy. NHS leaders described the relationship with Medway as a good example of partnership working for the benefit of people living in Medway.

The care provider offered a reablement bed service for people who required intensive enablement to support them to go home. They operated a Home First service, where they saw people within 2 hours of hospital discharge. The Home First service aimed to support people back to independence, reduce dependence on the reablement service, and prevent any long-term care needs. This support was provided for up to 6 weeks, with a conversation with the local authority midway through to discuss if the person would need long term care. Step down and reablement beds were available locally, however an increase in specialist beds was needed.

A 'Transfer of Care Hub' had recently been introduced for multi-disciplinary organisations to make collective decisions on people's discharge pathways. Health leaders positively viewed this as supporting decision making and allowing a more shared, informed process. This was still in its early days and the impact had not yet had a measurable effect.

The local authority received mostly positive feedback from people about the community support outreach team, and we saw examples of people being supported to enable them to continue living independently, including how a person was supported to apply for welfare benefits and attend health appointments.

The frontline First Response team promoted independence through available technology in care packages. For example, telecare sensors were able to detect the front door was open and fall sensors measured the impact of a fall. The local authority also had a community team which provided support through preventative, reablement, intermediate or longer-term support to people with mental health needs, learning disabilities and autism. The team worked in partnership with other teams and had a multi-disciplinary approach.

National data showed 6.51% of people aged 65+ received reablement/rehabilitation services after discharge from hospital, which was significantly above the England average of 2.91% - Adult Social Care Outcomes Framework (ASCOF)/SALT. The data for people aged 65+ who were still at home 91 days after discharge from hospital into reablement/ rehab, was 72.00% which was below the England average of 83.70% (ASCOF)/SALT). Health leaders recognised this disparity and were looking at quantitative data for readmissions to ensure people had been discharged under the appropriate pathways.

Access to equipment and home adaptations

The local authority and NHS Medway Integrated Care Partnership, jointly commissioned community equipment and minor adaptations from an external provider. Standard core equipment was delivered to people within 5 days of the order being placed and orders could be prioritised for earlier delivery if required according to need and risk. This was confirmed by data provided by the local authority which showed the average waiting times for provision of standard stock for the last 12 months was 5 days (maximum 38 days). The average waiting time for provision of specialist stock for the last 12 months was 20 days (maximum 98 days) as the wait times for specialist equipment was determined by the manufacturer. A voluntary partner told us people were waiting a long time for adaptations to properties and in 1 case the person was waiting 15 months, where an assessment had been completed but the work remained on a waiting list, which meant the person was unable to leave the property.

Local authority data also showed the median wait time for equipment assessment in the last 12 months was 42 days. The maximum wait time for equipment assessment in the last 12 months was 356 days. The target time was 28 days from referral to start of assessment. Whilst people were seen within 2 months of the referral, delays in the last 12 months were due to increased demand following new front door processes where cases were considered for prevention and enablement prior to social work assessment, and the lack of staffing resources to meet demand. This was being addressed through the 'right size' exercise with a significant investment into the occupational therapy service, including an additional 2 occupation therapist and 3 trusted assessors to manage demand. In the interim, extra funding had been secured, supported by the Department of Health and Social Care Workforce Grant, to reduce the backlogs.

Staff told us they had regular meetings to identify ways and initiatives to improve services. One example was they identified a rubber foot for walking aids could help reduce falls. They had also introduced an auto-telephony service to encourage the return of equipment, spoken to charity shops, placed adverts and called people to discuss whether their equipment was still required. All of which had improved equipment return rates.

The team working with integrated discharge gave us examples of how assistive technologies were considered as part of care packages, and staff who worked with assistive technology undertook joint assessments and were able to recommend its use where appropriate.

Provision of accessible information and advice

People could not easily access information and advice on their rights under the Care Act and ways to meet their care and support needs. This included unpaid carers and people who fund or arrange their own care and support. Staff told us the local authority did not always provide information according to the Accessible Information Standard, which is a rule for health and social care services saying they must communicate with people in a way they can understand. Staff used creative measures such as printing pictures to help them with communication. The local authority had plans to make address this with the Medway DDaT Strategy. The strategy acknowledged more could be done to improve digital access and inclusion and other services and processes could be designed around people who were unable to use digital services.

Whilst people were on the waiting list for adult social care service's they were sent a 'Waiting Well' letter, however the letter was not available in accessible formats or non-English options and was not available electronically. Senior leaders had identified accessibility to information and services required improvements to ensure people could easily access and understand advice and support available to them, for example, ensuring their website was available in alternative languages, although to a 24-hour translation service was available to staff.

The local authority had received complaints from unpaid carers who said they did not have internet access, so they required written information to ensure they had access to information as required. A voluntary organisation told us the majority of information and advice was now on the local authority website, there were no leaflets available to people and there were no 'hubs' in the community people could use to get information and advice.

A voluntary and community group told us the local authority needed to take more action to address digital exclusion as some of the population did not have access to technology which made accessing information and advice, health appointments or employment difficult. Another group told us they had been involved in a digital project with the local authority a few years ago to understand the community's challenges with digitisation but had received no feedback or outcomes from this. A senior leader told us they had advised the group to apply for funding to run digital awareness classes to help people use digital platforms including raising awareness of online fraud, improving understanding of online banking/shopping, and reducing isolation. It was unclear if these classes had taken place.

Representatives from the local authority attended regular meetings as guest speakers for a voluntary organisation which assisted the local authority to gain a better understanding of the local communities and the barriers people faced. People were advised of services available in the council and how to access these. For example, adult education services and six months later there had been an increase in people attending adult education services. This had led to people being empowered to access employment, housing and reduced isolation.

National data showed 62.73% of people who use services in Medway found it easy to find information about support. This was below the England average of 67.12% - Adult Social Care Survey, 2023 (ASCS). For unpaid carers, 55.37% found it easy to access information and advice and the England average was 59.06% - Survey of Adult Carers in England (SACE).

Direct payments

People told us they used direct payments to control how their care and support needs were met and mostly described positive outcomes from using them. For example, people were able to employ personal assistants directly and take breaks away as a family.

National data showed 13.14% of service users aged 65 and over in Medway who accessed long-term support, received direct payments. The England average was 14.18%. 28.67% of total service users received direct payments compared to the England average of 26.22% (ASCOF/SALT).

People had ongoing access to information, advice, and support to use direct payments. We received mixed feedback about the process. We were told some unpaid carers found the process easy and supportive, however in contrast, partners told us there were delays in setting direct payments up. People who were considering direct payments had an initial visit from local authority staff to ensure they had enough time to understand what they were agreeing to and if required, a further visit would take place.

The local authority had a Self-Directed Support team who supported people who chose direct payments including support with accounting and payroll. The team promoted direct payments with the locality teams and recognised there were areas for improvement relating to reduced waiting times for direct payments and continuing to build on the personal assistant (PA) database. Processes were in place for monitoring direct payments, such annual audits and ad hoc audits if required. Unpaid contributions, unauthorised expenditure, and expenditure in excess of their budget were also monitored.

Data from the local authority showed the average waiting time to set up a direct payment from receipt of referral was 73 days. In the interim, people waiting were offered a commissioned package of support. Since April 2023, 208 people had stopped using direct payments. Analysis of data by the local authority showed a change in people's circumstances (passed away/moved to alternative accommodation). Over 10% of people chose to opt out but reasons were not outlined, other people were recorded as ending direct payment as it was unsuitable. It was not clear if further analysis had taken place around any other contributing factors, however staff told us in some areas there was a shortage of Personal Assistants.