

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

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 collaborated 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 local authority worked with health, the HCRG group and voluntary organisations to create a Community Wellbeing Hub. The Community Wellbeing Hub was jointly funded by the Better Care Fund to create a multi-agency, single point of access for wellbeing services. It offered a range of advice services for people who needed help and support with employment, housing and social security benefits; community-based health and wellbeing services, physical and mental health needs; and access to essential supplies, such as food and medication. It was accessible to people via a phone call, text or email. People could contact the Community Wellbeing Hub themselves, and staff told us they would refer people to the hub for advice on voluntary sector services. The hub was created to respond to the Covid-19 pandemic and has continued to support people in the community to prevent, reduce and delay people's care and support needs. Data provided by the local authority showed an increase in partnership working over the past 18 months, increasing the number of partners involved with the Community Wellbeing Hub from 6 to 26. Data also showed an increase in referrals to the Community Wellbeing Hub in the same timeframe.

Feedback from unpaid carers was mixed about the resources available to them. We heard positive feedback regarding the information the carers centre could offer with 90.12% of unpaid carers in B&NES finding information and advice helpful, this was compared to the England average of 85.22%. However, support groups were not always accessible due to the unpaid carers caring responsibilities, and some felt support was not always flexible to meet their needs. Unpaid carers told us they found it difficult to access emergency respite when needed and found it difficult at times to contact their named worker for advice and support to prevent carer breakdown.

Prevention was a core component of the local authority's vision for the future. The local authority identified there were some improvements to be made and embedded to support people to lead healthier lives. Health partners felt their relationship and communication with adult social care had improved, and they had a shared vision for prevention. Key priorities in the area included smoking cessation due to 23% of the population smoking and continuing to work with sustainable communities. There was a joint health and wellbeing strategy and the local authority, alongside partners, focused on health inequalities. We heard how voluntary organisations worked with hospitals to safely discharge people with low level needs back home to promote independence.

A community support approach began with the First Response Team, the front door service to the local authority, with the aim of supporting people to connect with local services to reduce the need for care and support. However, there was a lack of data or recording from the first response team to evidence whether this was conducted effectively and how this impacted the outcomes for people.

Provision and impact of intermediate care and reablement services

There were clear and accessible pathways to short-term reablement and rehabilitation, however, should people require long-term support following reablement there were waiting lists for people to receive a Care Act assessment and long-term support, this meant people's needs could increase and independence lost due to delay in care and support.

The local authority used the 'home is best' model to hospital discharge and worked alongside providers to access intermediate care pathways. Whilst the reablement service appeared effective and stable, staff felt the hospital discharge process itself was not so strong. The Social Care Assessment Team worked collaboratively with health colleagues and attended regular multi-disciplinary team meetings to discuss people ready for discharge however, staff told us it was not as easy to work as collaboratively as they used to with the hospital team regarding patient discharge as they were no longer co-located. Staff told us they felt this impacted on the person's transition between services and could delay discharge. Health partners also told us they felt this had an impact and delayed people's discharge. The Integrated Care Board had recently de-commissioned their discharge to assess bedded unit, this unit was implemented to support with winter pressures and was decommissioned once risk and demand had reduced. Staff told us they were now using any home care provider and care home who had a vacancy to support with discharge and rehabilitation. Providers told us they did not always get a full picture of people's needs prior to discharge, this meant there was an increased risk of providers being unable to meet people's needs. The current interim care process was that people using this service would be placed where a care home had a vacancy, and the appropriate staff would visit the person in the care home for example, occupational therapist, physiotherapist and social worker. This meant people could be placed in care homes that did not fully meet their needs or promote their independence. The local authority also commissioned 6 'step up' beds allocated in extra care facilities to prevent hospital admission.

The Adult Social Care Outcomes Framework (ASCOF) data showed 88.57% of people 65+ were still at home 91 days after discharge from hospital into reablement or rehabilitation support, this was tending towards a positive variation from the England average of 83.70%.

Access to equipment and home adaptations

The local authority employed Occupational Therapists (OTs) and OT aides (unregistered staff) to assess people for equipment and adaptations to support people to remain as independent as possible. A clear pathway was in place for processing requests for assessments for equipment and adaptations. Requests for assessments were triaged by an OT duty team and prioritised, before being placed on a waiting list. A letter was sent to people advising them of options available whilst on the waiting list, and details of how to contact the team should their needs change. As part of the triage process minor pieces of equipment were assessed for and provided.

We were told that staff vacancies in the team had an impact on staff workloads and the waiting list, as well as the increase in referrals and increase in complexity. Staff told us there was a waiting list of approximately 12 months for an Occupational Therapy assessment dependent on the priority and need of the person. Data provided by the local authority showed a waiting list of 204 people waiting for an OT assessment with the median waiting time of 10 weeks and the maximum waiting time being 14 months. Where a person presented with less complex needs the case was assigned to an occupational therapy aide who would be able to schedule assessments in a shorter timeframe. The OT aide median wait was 14 weeks, with a maximum wait of 8 months. Following an assessment for a major adaptation and a Disabled Facility Grant (DFG) being approved, there were further waits of approximately 8 months before completion of work. Staff told us once equipment was prescribed the equipment was fitted in a timely manner.

Staff told us there was a lack of access to equipment to trial or demonstrate for people with a hearing or vision impairment, which meant that referrals were made to external organisations which led to delays for people.

There was a specific OT team within reablement whose sole focus was to visit and provide therapies to people in the community-based interim care beds, to return them to their optimum health and ability as quick as possible, this team prescribed and provided equipment in a timely manner, supporting people to gain their independence and build on skills already gained.

Plans were in place to improve the use of technology enabled care (TEC) to prevent, reduce and delay people's needs, however this was still in its infancy at the time of assessment.

Provision of accessible information and advice

The local authority provided information and advice to people in accessible formats but recognised the need to improve the accessibility of resources for example, for people for whom English was not their first language. Feedback about information was mainly positive with people telling us they knew how to contact the local authority should they need to. However, some unpaid carers told us they found it difficult to know who to contact for advice and guidance, we also heard the local authority's website could be difficult to navigate, particularly for older people who may face digital exclusion. Despite this feedback, the Adult Social Care Survey data showed 67.62% of people who used services found it easy to find information about support, this was similar to the England average of 67.12%. 69.05% of carers found it easy to access information this was a positive variation compared to the England average of 59.06%.

The local authority contracted a translator service however, staff told us, this was not always easily accessible and could delay information, advice, and assessments. Due to difficulties in getting an interpreter staff told us they would use a family member or friend to support the person which was not best practice.

The first response team did not complete home visits, this therefore limited people's opportunity to access information and guidance in a more accessible way. There were limited opportunities to provide information verbally to people who did not speak English. Leaders told us teams such as the Social Care Assessment team and the emergency duty team would make home visits in emergency situations.

Direct payments

Direct payment uptake was low, the local authority told us, this was an area where they recognised a need to improve. ASCOF data showed 21.8% of service users received direct payments this was tending to a negative variation compared to the England average of 26.22%. 28.61% of service users aged 18-64 received direct payments, England average of 38.06%. 11.43% of service users aged 65 and over received direct payments, England average of 14.80%.

Staff and leaders told us they felt the lack of uptake for direct payments was due to the large choice of commissioned services they had which meant people had choice without having to use a direct payment. Staff told us, they gave people the option of direct payment whilst conducting the Care Act assessment and supported people to complete the initial direct payment form, this was then passed on to the direct payments team to complete. Staff gave a positive example of dual funded care in which a person received a part commissioned and part direct payment service to support their individual care needs.