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 needed to do more proactive work 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. While there were examples of individual projects there was not an overarching strategic approach to this work. In the ASCS data, 60% of people said the help and support helped them feel better about themselves which was in line with the England average and 69% of people reported they spent time doing things they value or enjoy which was slightly above the England average of 67%.

Examples of some of the projects the local authority was doing included, looking to put in place technology enabled care as a way of reducing long term care needs. There was currently a delay in implementation of this because of delays in the setup of the digital system. The local authority had plans in place to progress this, but timescales were not clear. The local authority told us they hoped the system would have impact for the future. The local authority was working with public health on several initiatives within their health and wellbeing strategy such as physical activity and health management, mental health and wellbeing, smoking cessation and falls prevention. They were developing work to look at the best locations in communities for delivery and had started using leisure centres for example. They had been working with the voluntary sector, through a voluntary sector outcomes-based prospectus to support delivery. In addition, they were working with partners through the Better Care Fund to set up preventative services including a social prescribing project across GP practices, supported by the voluntary sector and an urgent community response service to reduce admissions to hospital.

Overall, more work was needed to use the population data. Work had been done to create a digital resource from the Joint Strategic Needs Assessment to inform the Health and Wellbeing Strategy and address health inequalities. This approach focussed on the current situation but did not include a proactive approach to projecting into the future to understand trends over the next 5 or 10 years to prevent, reduce and delay care needs on this time scale. There was a lack of data beneath the general population data to help the local authority understand needs in smaller communities and particularly isolated groups and their current and long-term care needs that may be missed by the wider data. We heard from front line teams about their awareness of certain groups, such as recent migrant communities, and travellers but did not always see this reflected in data and this did not enable future demographic pressures of an aging population to be predicted and addressed.

We heard from partners in the voluntary sector who told us they had the knowledge and contact with some of the more isolated groups that could support the local authority in developing this work and understanding and meeting the needs of those seldom heard groups. At the time of our assessment this was not in place, although the local authority told us it was an area where they felt they could do more. This work could help them identify seldom heard groups and those at greatest risk of a decline in their independence and wellbeing.

There was specific consideration given to the support for unpaid carers. The local authority worked with voluntary organisations through the Reading and West Berkshire Carers Partnership to provide this support. The local authority had a carers section on their website, with a separate section for young carers to identify the support available. In a Survey of Adult Carers in England (SACE) of those carers that had accessed information and advice, 85% of carers said that they found the information and advice they received helpful. Partners confirmed the support the local authority gave to carers helped people to stay out of long-term care.

According to the ASCS data 64% of people who had received short term care no longer required support. This is much lower than the England average of 77% and the local authority needed to do more in the area of preventative services supporting people's independence. The local authority was aware of this and there were some good examples in specific areas. For porting people to return to independence. The local authority had identified that there was more work needed to reduce the number of people discharged to care homes, which was impacting on the number of people whose short-term care did not extend to longer term care. Pathways had changed in the month before the assessment and the local authority was hoping this would start to show impact later in the year. There was also further work needed across the population and particularly in areas of deprivation to gather data to identify people with needs for care and support that were not being met, and also to address the issue of a high number of people of working age requiring long term care. Despite there being a relatively affluent and healthy population in West Berkshire, the working age population had a high number of people with long term care needs; the 9th highest in the region out of 20.

There were some good examples of support that was effectively reducing the need for long term support. The Sensory team were able to give positive examples of the provision of equipment to support people's sensory needs which prevented, reduced, and delayed the need for care. For example, smoke alarms and doorbells adapted for deaf people in their homes. The Mental Health team were also able to give positive examples of where they had supported people to rebuild their lives and go on to live independently.

Provision and impact of intermediate care and reablement services

The reablement service focused on people's reablement goals. They carried out regular surveys to obtain feedback from people and received positive feedback. A local authority survey of people who had accessed reablement reported 77% of people said they felt more independent as a result of the service. The local authority monitored how much they saved financially by maximising people's independence and reducing care. The pathways for discharge from hospitals had recently been reviewed to focus reablement for those that would most benefit, which resulted in more positive outcomes for people on that pathway. There was a focus on setting reablement goals from day 1 to support people to return to independence. Care plans considered people's wellbeing and quality of life with meaningful activities. For people with no new health or care needs on discharge, pathway 0 could be used to support people with social needs through the voluntary sector. For example, supporting someone to continue to attend church, or making sure pets were also cared for. The National Adult Social Care Outcomes Framework data (ASCOF) found that 5% of people over 65 received reablement/ rehabilitation services after discharge from hospital and 89% of people over 65 were still at home 91 days after discharge from hospital into reablement or rehabilitation. Both were above the England average of 3% and 82% respectively.

Access to equipment and home adaptations

There was good access to equipment and minor home adaptations to help people maintain their independence and continue living in their own homes. There was no wait for equipment. Locality teams also had access, with appropriate training to provide basic equipment to increase independence. One person told us that while they had been worried about falls, the provision of basic equipment in their home such as handrails, a walker and lifeline which had enabled them to stay independent. Where people had more complex needs in a small number of cases there was a wait for an assessment by an Occupational Therapist. In 93% of these cases the wait was less than 3 months. The local authority had a strategy to address the waiting list and had an ambition to have an Occupational Therapist in a leadership role in each team, they were also looking to introduce a Principal Occupational Therapist role to have oversight in this area.

Provision of accessible information and advice

There was information and advice available for people on their rights under the Care Act 2014 and ways to meet their care and support needs, on the council website. This included information for unpaid carers and people who fund or arrange their own care and support. Information on the website was only accessible to people who had a computer which created a digital barrier to access. The local authority had a digital infrastructure group that was supporting digitally excluded communities such as older people, refugees, and the Gypsy, Roma and Traveller community. This group was working with a third sector organisation to improve accessibility. However, we also had feedback that the website itself was not always easy to access. For example, people told us the number of tabs on the website could present a barrier for people with autism and it was difficult to access the information in other formats or languages. People who fund their own care also told us it was difficult to find the information they needed. Despite this, in the ASCS survey 72% of people who use services said they find it easy to find information about support, which is higher than the England average of 63%. This data would not account for those people that had been unable to access services due to barriers. The ability of carers to access support was in line with England averages at 56% (SACE), however as noted above carers were positive about support once they had been able to access it.

Direct payments

The local authority had a low uptake of direct payments. Only 16% of people received direct payments which is low compared to the England average of 27%. There was also a backlog in the waiting time for reviews of direct payments. Frontline teams told us the process was over complicated to implement and difficult to use effectively to give people choice. Staff felt it was easier to use a commissioned service. This was because of the time required to complete referrals as well as the resource availability within the direct payments team that meant they could not always be immediately responsive to requests. This was compounded by the fact that local wages were high, so if someone wanted to employ their own personal assistant using a direct payment, this would be more expensive and fall outside of the indicative budget. We had some feedback from carers we spoke with that they were not aware of direct payments or where they received a direct payment, they did not feel it supported their independence effectively.

However, there were examples of direct payments being used well alongside reablement to support independence on discharge from hospital. The team gave a positive example of where direct payments had been used to support cultural needs. Direct payments were also used well in transition to support young people's independence.

The local authority was aware of the low uptake of direct payments and was undertaking a review with ADASS including the initial assessment, communication with people, the recruitment of personal assistance (PA's) and staffing levels in the team, to make improvements and give people better choice and control over their care.