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 Adult Social Care Survey (ASCS) showed Derbyshire consistently performed above or at the same level as the national average on indicators relating to keeping people well and preventing further need for support. For example, 66.15% people, said help and support helped them to think and feel better about themselves compared to the national average of 62.32%. 70.26% of people reported they spent their time doing what they valued or enjoyed, with the national average at 68.17%. 93.75% of people who received short term support, no longer required support, far higher than the national average of 77.5%. Survey of Adult Carers in England data showed 86.9% of carers found information and advice helpful with the national average of 84.47%.

We heard consistently from front line staff about many different projects supporting people in the community, and these were effective in supporting people's wellbeing. Direct payments were used to meet assistive technology needs and to overcome geographical barriers to care, for example one person lived on a boat and another person lived across a large field. Geographical factors meant rural areas did not receive the same level of wellbeing work, however we saw specific mental health work being undertaken in rural areas.

The Public Health teams and the Adult Social Care teams had been combined as one directorate. Leaders articulated the benefits of this in terms of preventing, reducing and delaying people from needing high levels of support through better integrated working. The prevention strategy was recently delayed to incorporate work with partners. We heard feedback that the local authority had a sense of ambition about early-help and prevention. There was a consistent message from leaders within the local authority and Integrated Care Board (ICB) system about pride in their current partnership provision and how they wanted to do more together in the future. The Community Transformation Partnership (Living Well) was a multi-disciplinary community mental health team involving social care and health professionals alongside VCSE workers. It offered short-term care packages of up to 12 weeks, to people who did not meet the threshold for community mental health (CMHT) intervention.

Provision and impact of intermediate care and reablement services

Reablement staff in localities supported people to regain their independence. Partners worked together to better understand people with higher frailty scores and people with multiple conditions. The local authority provided step-up and step-down beds to support admission avoidance, discharge and system flow. Mental health enablement was also available, which avoided longer-term support.

Intermediate care was governed and funded through the Better Care Fund (BCF). A consultancy had been engaged by the local authority and health partners to evaluate an optimum use of intermediate care resources. The system worked effectively together through hospital discharge 'hubs' and followed the different discharge pathways, with the VCSE as equal partners. In periods of high demand, discharge pathways 1 (low need and low intervention including reablement at home) and 2 (reablement and intermediate care in bed-based provision), could be overstretched leading to longer-term care packages.

Significantly more people over 65 years of age were re-admitted to acute-care and long-term care in Derbyshire, than the national average (65% of people aged 65+ were still at home 91 days after discharge, compared to 82.18% nationally - Adult Social Care Outcomes Framework ASCOF). Leaders and partners recognised and described how the intermediate care system was being improved. Although work was underway, this was yet to be reflected in the data.

Access to equipment and home adaptations

Long-term home adaptations work had been successfully separated from short-term work. The Short-Term Assessment and Reablement Teams (START) and Adult Care Assessment and Triage Teams (ACATT) had reduced waiting lists through a 'Simple Service', which offered direct assessment without the need for a professional assessment. There was a 'waiting well' system which involved staff calling people who were waiting, to reassess their needs in case their situation became more urgent. The occupational therapy (OT) service during the day and the out-of-hours service, sourced equipment and provided moving and handling plans, reducing unnecessary care placements. People reported very high satisfaction with this service and told us the equipment provided made their lives better. The local authority exceeded its 95% target for the provision of equipment on time, at 99%.

Mediequip, the integrated community equipment service, worked well and utilised approval panels for specialist items, although market-availability of products could be an issue. This was a dual-funded contract between the local authority and the NHS through the Better Care Fund (BCF). We saw many examples of specialist teams using assistive technology to support people to maintain their independence and meet sensory needs, and examples of direct payments for assistive technology. A new technology contract for equipment and alarms supported people to remain in their own home and provided a risk-flag to services if there was a change in activity. There was often a very long wait for home adaptations. Minor adaptations, such as a level access shower, had an average wait of 9 months and major adaptations at 18 months.

Provision of accessible information and advice

In Derbyshire more people (67.73%) found it easy to source information about support than the national average (66.26%). 62.76% of carers found it easier to access information and advice, compared with 57.83% nationally (SACE). People and partners told us that increasingly information was only available online, which could be a barrier. We heard positive examples from people that they felt supported with advice and information. Other people said the range of support on offer to unpaid carers had not been fully explained.

Information was available about people's rights under the Care Act, including in easy-read format, braille and languages other than English. 'Care choices' was a 100-page digital guide with accessible information, in a recite-me compatible format. There was also a guide to adult social care containing the whole range of required information. The easy-read version of the equality and diversity policy also provided an explanation of fairness in the process and staff confirmed these were successfully used.

The local authority had funded a VCSE service for an information and advice roadshow, particularly in rural communities. Public health also provided funding for organisations to reach into farming communities to address the digital divide. Sensory services had provided low-level advocacy information and advice to communities. There were also Derbyshire Gypsy Liaison Group (DGLG) workers in relevant areas.

Direct payments

Data showed a very strong practise of using direct payments. There was a mean-average wait of 18 days and a median wait of 14 days for direct payments to begin. Significantly more people accessed direct payments in Derbyshire than the national average. 47.9% of service users aged 18-64 accessed long-term support (national average 38.06%) through a direct payment and 19.14% aged over 65 (national average 14.8%). The proportion of all service users using direct payments was 31.4%, above the national average of 26.22%. (ASCOF/SALT).

Staff reported very positive uses of direct payments within the whole range of service functions. People told us direct payments had enabled them to have care that helped them to live their lives. Examples included, people and carers using direct payments to go away for the weekend and for support with cleaning. Short-term direct payments had been used to bridge gaps during waits for long-term direct payments. There was an example of a short-term direct payment being used to support hospital discharge, before a care package could start. The Direct Payments team worked with social work staff, providing information and myth-busting, to encourage the use of direct payments. We heard from staff and people using direct payments about difficulties in recruiting personal assistants due to levels of pay and availability of the workforce.

Recent closures of in-house day service provision led to some feedback from staff and people using services, about care being organised differently. We heard some people found it difficult to maintain the friendships they had built and there was concern about the level of meaningful daily activities available. However, we heard one example of a friendship group being maintained through a joint Personal Assistant (PA) arrangement, enabling them to access football. Direct payments had been used to meet individuals' choice preferences, for example in mental health services when individuals had fluctuating needs or specific preferences about providers. Direct payments had been used to support care for people living on a boat, where their home was across a field or where it had been difficult to organise care sustainably through traditional measures. We heard positive stories from people and staff about direct payments enabling people to live the lives they wanted and remain in their own home for longer.
