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 commissioned preventative services, ranging from information and advice, peer group support, carer breaks, and worked with community groups to deliver services locally. Services were available and sensitive to people's differing needs, such as carers and people with dementia.

Public Health initiatives were in place that focused on key challenges and priorities identified through the Joint Strategic Needs Assessment (JSNA) and health and wellbeing board. There was a clear link between the identified challenges of the area and the services available. These priorities and actions were well understood, and impact was monitored through the health and wellbeing board.

The Social Care Direct service was able to effectively direct people to a range of preventative services in the community that catered to people's early and more specialist needs. Staff across teams used Durham Locate which provided information about the services available across the county and knew about services in their communities. As a response to mental health needs in the county, the Durham Mental Wellbeing Alliance implemented a single point of access for referrals, so people did not have to repeat their story. The arrangements were in place to support earlier prevention. Most carers we spoke with said the support they have received from the local authority had helped them with their own mental wellbeing. They were signposted to appropriate services for their needs. National data indicated that 88.13% of carers found information and advice helpful, which was slightly better than the 84.47% England average (Survey of Adult Carers in England, published June 2022). However, several carers indicated they were aware of support, but they did not have enough time to attend support groups or felt that the support available did not suit their needs.

The local authority had recognised the increasing need and a gap in services to support people who hoarded and implemented the Breakthrough service. This was a practical, multi-agency service, with roots in trauma informed practice, which was still developing at the time of our assessment but was seen as having positive impact for people. There was a focus on exploring further on how services could better support people to remain independent in their own homes for longer.

While the public health strategic plan was clear, we did not see a comparable version for adult social care. We did not see how adult social care preventative activity was monitored, impact measured, or gaps identified. Activity within the local authority's register of services that prevent, reduce and delay need tended to focus on formal intervention and intermediate care and reablement, with fewer activities that delivered earlier prevention outside of public health. For example, some staff identified that there was a gap in earlier prevention services for older people and were unclear what was being done to resolve it.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver reablement and intermediate care services that supported people following a stay in hospital and to recover at home. The local authority recognised that there had been capacity issues and funding challenges that had affected their approach, and they were exploring the delivery of a new model at the time of our assessment. The local authority recognised that their offer focussed on supporting hospital discharge and missed opportunities to prevent, reduce, and delay the need for acute intervention. There was a recognised commitment within the local authority to innovate and improve in this area, taking a more preventative, therapy-led approach.

Three hospital discharge teams operated in the county, linked to each of the main acute hospitals and connected to the community hospitals. People were able to be discharged from hospital within 24 hours of being medically fit for discharge and the receipt of a referral. There were no waiting lists for hospital discharges at the time of our assessment. Homecare or care home beds were sourced quickly, and there were no delays to hospital discharge linked to lack of capacity in commissioned services.

The Transfer of Care Hub (TOCH) focussed on a person's needs to support speedier hospital discharge. This was a multi-disciplinary approach between the local authority and hospital teams, alongside housing and substance misuse teams where relevant. This was done in a person-centred way. For example, staff described support to an individual who was hoarding, and who would not allow therapists to enter their home. The TOCH worked with the individual and arranged to put support in place, funded by the local authority, to ensure the individual's priorities, alongside supporting their reablement and safety in their home.

Options were available to people as part of their reablement journey that reflected people's differing needs, including intermediate care beds, 'time to think' assessment beds with a maximum stay of 3 weeks, and short-term domiciliary intervention and reablement services for up to 6 weeks, and 'time to heal' beds for a maximum of 12 weeks. This linked into community rehabilitation services through Occupational Therapists and Physiotherapists as needed. Clear criteria were in place to ensure people received the right level of support. County Durham was in line with the England average for successful reablement with 84.27% of people aged 65 and over still at home 91 days after discharge from hospital into reablement or rehabilitation services, compared to the England average of 82.18% (Short and Long Term Support, published December 2023). However, national data indicated that 70.86% of people who received short term support no longer required further support, which was not as good as the 77.55% England average (Adult Social Care Outcomes Framework, published December 2023). The local authority had recognised that their reablement approach could be more preventative and they were exploring changes to their approach, particularly to increase capacity in their community reablement service, to improve this.

Access to equipment and home adaptations

People could access a range of equipment and home adaptations to maintain their independence and continue living in their own homes. People were supported by knowledgeable and conscientious staff across teams, integrated arrangements, and partnerships, via assessments of their needs and a responsive provision of equipment.

Occupational Therapists were integrated into teams and worked across social work and NHS teams. An equipment advisor worked within the county, providing independent information and advice for people who needed to purchase or hire equipment or make adaptations. An 'Independent Living House' was available for people to try equipment or technology before going through the process of buying or hiring this.

The local authority told us that they had very small waiting lists (less than 10) for the allocation of an Occupational Therapist to complete assessments. They told us that all assessments should be completed within 28 days and the median completion time for June 2023 to May 2024 was 26 days. Where waiting lists did arise, the local authority communicated well with people and used the risk threshold tool to allocate and triage effectively.

The local authority told us that 95% of their equipment was delivered on time, within a day or a week, for example equipment to support mobility like a Zimmer frame. Major installation of equipment, such as stairlifts, were in place within approximately 2 months. This was predominantly due to manufacturing time rather than delays in the local authority. Home adaptation such as accessible showers could take up to 6 months. New contracts to speed up people's waiting times for equipment and adaptations were ongoing at the time of our assessment. The Disabilities Facilities Grant was well utilised in the area to support home adaptations. There were delays in major home adaptations, when design and contractors were required and this was a lengthier process, due to availability of contractors within the wider market.

An online converted house was available to support staff to learn and understand equipment and adaptations available. This was mandatory learning for staff. Staff also told us that the local authority had an online portal to support people to check on the progress of their equipment provision enabling them to get updates independently.

Bariatric equipment was identified as a challenge by some local authority teams. This included how quickly equipment could be manufactured. There were close relationships with commissioning teams about challenges around contracts, sourcing appropriate suppliers, and managing best value for money so that issues could be addressed as quickly as possible.

The sensory team within the local authority worked with people with sight and/or hearing loss. They worked with wider teams, and were included in joint visits with social workers, housing colleagues, and home care agencies where packages of care were in place. The team advised and sourced equipment, and supported safety in the home and community. Examples were provided of the way the team effectively used equipment and technology to support people whose first language was not English or British Sign Language (BSL) to read braille.

Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs. In County Durham 70.64% of people who use services found it easy to find information about support, which was better than the England average of 66.26% (Adult Social Care Survey, published October 2023). This included unpaid carers where 67.68% of carers found it easy to access information and advice, which was better than the England average of 57.83% (Survey of Adult Carers in England, published June 2022). This was primarily through the local authority's Durham Locate website, or through their online policies and procedures portal, which had some accessibility features included. Social Care Direct was available over the phone to support people with information and advice and to find resources in the community to meet their needs. Some information was available in leaflets and through community-based locations such as libraries.

Specific needs were met through commissioned services. For example, a partner organisation was commissioned to provide information, advice and guidance services for people who are deaf, deafened, or deafblind. Another organisation provided information and advice to people with dementia and their carers and had specialist provision included for people with early onset dementia, people in the prison system, and veterans.

Some partners told us a lot of the local authority information was online, which disadvantaged people in rural areas who did not have access to robust internet connections. We received mixed feedback from partner organisations about how easy Durham's information was to navigate. Frontline staff told us they provided information in accessible formats. We heard examples of where information had been provided in over 30 different languages to support people seeking asylum and refugees.

Direct payments

There was a low uptake of direct payments in the local authority area as 15.02% of people who used services received direct payments. This was significantly lower than the England average of 26.22% (Adult Social Care Outcomes Framework, published October 2023). The local authority was aware of this, and several staff told us that there had been a drive to increase take up of direct payments. Teams had direct payments champions and training was provided to staff to understand and promote the use of direct payments.

The internal direct payments team offered support to people who accessed direct payments or their representatives. There was clear and robust local guidance on how to set up, support and audit direct payments. Support included facilitating recruitment of Personal Assistants. Individuals could access a service that worked alongside the council to support people with payroll services or to manage accounts. Personal Assistants were advertised on Durham Locate and with support through the local authority's commissioned recruitment tool. Personal Assistants were able to access support through the Care Academy.

Data from the local authority showed that 79 people who had ongoing care and support needs stopped receiving a direct payment in the 12 months preceding our assessment. Their analysis showed that people's needs changed, and they did not feel able to manage their direct payment, and often requested a commissioned service, or people moved into long term care. It was not clear if further analysis had taken place around other potential contributing factors, such as age, primary care reason, or what area of the county people lived in.

Transitions to direct payments were described as smooth and enabled independence, choice, and control. For example, one family where an individual had been supported to move into supported living. The person's parents were then employed as personal assistants through a direct payment, allowing the individual to settle into their new accommodation, while maintaining continuity of care. The local authority told us that they were exploring projects to support young people transitioning to adult services and people with a learning disability to use direct payments to support independent travel.

We heard from frontline staff that the availability of Personal Assistants was seen as a barrier to accessing direct payments. If an individual needed several Personal Assistants, recruiting could be a challenge and it could take time to get arrangements in place.

Information the local authority had about why the take up of direct payments was low, was anecdotal. Some staff felt that the strength of the domiciliary care market reduced people's need to explore alternatives that could be supported by direct payments. Others reflected that direct payments were complicated, people didn't want the stress, or they didn't have capacity to consider them at the time they were offered due to it being a difficult time, for example, as part of discharge from hospital. The local authority's commissioning intentions, for example through their market position statement, did not indicate how they intended to support the development of services that would help people to take up and use their direct payments.
