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 had an Adult Services Prevention Strategy 2023-2024 and as a local authority with an ageing population recognised the importance of the role that preventative services would have in not only reducing, delaying, and preventing the need for future care and support, but also in ensuring people would have a good life and achieving the corporate ambition to tackle health inequalities.

The strategy was up-to-date, clear and detailed, referencing the Care Act 2014, the NHS Long-Term Plan 2019, and outlined its scope in terms of defining prevention in the local authority's approach. The approach was aligned with Northumberland's Joint Health and Wellbeing Strategy and set out a whole system approach, looking at the public sector to maximise the health and wellbeing of the workforce and the people they supported. The local authority recognised it was critical they made every contact count, and worked with internal and external partners, such as Fire, Housing, the Prison service, and through Northumberland Communities Together and the wider VCS sector.

One Call was the main "front door" to services in the local authority and played a key role in identifying those who had unmet needs and or would benefit from prevention. The local authority looked at every contact as an opportunity to provide early help using a strengths-based approach in line with its practice framework. As such One Call was a key feature of the pathway people could use to access preventative services. On average One call received 1,200-1,300 calls a day, helping to keep vulnerable people safe and well 24/7 by providing advice and support at the earliest opportunity. The Joint Equipment Loans Service delivered more than 1,000 pieces of equipment each week.

The local authority had a range of well-established services in Northumberland focused on helping people to stay heathy and independent, including reablement services, supported living and extra care services, occupational therapy, home improvements and adaptations, assistive technology, equipment and support for unpaid carers. More than 20,000 people each year received information, advice, support and services from adult social care services in Northumberland.91.84% of older people were still living independently 90 days after being discharged from hospital into reablement service (SALT 23/24) and 93.51% of people who had received short-term support no longer required support, a significantly higher proportion than the England average at 77.55% according to the Adult Social Care Outcomes Framework (2022/23) (ASCOF). As such it could be seen preventative services, and work done to reduce and delay the need for more costly care were effective.

According to the SACE, 27.48% of carers were able to spend time doing things they value or enjoy and although this was higher than the rest of England average (15.97%).Most of carers spoken to as part of our assessment stated they did not feel they had time to carry out their own lives and interests, reflecting the fact more than 70% of carers in Northumberland were not able to spend time doing the things they enjoyed beyond caring.

Although the prevention strategy worked across partners, opportunities for co-production with people who had lived experience were not always fully utilised. Carers felt that assumptions were made about their lives, and they want the Council to ask them what services they needed, because when they did not, it made them feel like they were not a priority.

The preventative model had been further developed through a pilot based in Cramlington as a single hub. The triage hub pilot, known as 'Communities First' had brought together key professionals and services such as social workers, occupational therapists, housing, Short Term Support Service (STSS), and the VCS to form a prevention hub. Immediate needs were met for those who required an immediate and or short-term response to have those needs met. There would be ongoing goal focused support provided by the prevention teams which may identify the need for long term support after a period of monitoring and review, with preventative options explored. The result of this was fewer people were being considered for long-term needs where an immediate response was available and those with long-term needs had the focus needed for ongoing support. In the first 3 weeks following the start of the pilot, 80 people were seen at the hub with only 1 person who needed to be transferred to long-term care.

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. According to SALT, 91.84 % of people aged 65+ were still at home 91 days after discharge from hospital into reablement/rehabilitation which was higher than the England average of 83.70%. Staff described how the Intermediate Care Unit and the STSS worked to provide a long-term care package to facilitate home discharge. Support had been co-ordinated across different services through multidisciplinary team working that included Occupational Therapists (OT) and Physiotherapists. People were invited to be part of the process, and the relative of a person using services reported their relative had choices once discharged from hospital to return home with a good homecare provider and excellent day care provision to support them as a family. Staff in Northumberland were person-centred and sought to be creative and responsive in meeting people's needs on discharge to keep them safe until they were able to access additional services. This included using the STSS service to provide immediate support at home.

The approach to discharge reflected the practice framework principle of strength-based, person-centred care across physical and mental health. Cumbria, Northumberland, Tyne Wear NHS Foundation Trust Interview (CNTW) highlighted the local authority, held people at the heart of what they did. One of the targets outlined was the 72-hour follow-up for people discharged from inpatient wards, which was linked, and involved close working with, the local authority social care teams to prevent re-admissions to hospitals and provide reablement.

Access to equipment and home adaptations

Northumberland equipment service, the Joint Equipment Loans Service (JELS) was operated inhouse by the local authority but was jointly and equally funded with the Integrated Care Board (ICB). The Principal Occupational Therapist (POT) demonstrated a robust service and clear process for JELS. The service delivered 1000 pieces of standard equipment each week to enable people to live healthier lives, independently. People were able to access independent advice about what may be useful for them, and there was a handyperson service available for people that fitted equipment and offered telecare to prevent, reduce and delay the need for more costly care. The JELS did not have a waiting list for the provision of equipment, however, they did operate a delivery timescale, which was monitored monthly through the JELS dashboard.

Target timescales for the delivery of standard stock were, for emergency deliveries, 48 hours, urgent deliveries, 5 days, and standard deliveries, 10 days. The maximum waiting time for delivery of standard stock items was set at 10 working days. The target was 95% of deliveries within this timescale, and over the previous 12 months JELS had achieved 97%. Requests for non-standard equipment were submitted to the JELS Specials panel which met 3 times each week, or more regularly if there was an immediate request. The process was set out for practitioners and outlined in a clear and useful process of JELS timescale triangle.

The local authority collected and recycled equipment and ensured cost savings for the local authority. 83% of equipment such as beds and hoists were checked and reused. The Principal Occupational Therapist (POT) highlighted the local authority and OT team were working together to increase drop-off points for equipment in the county.

Working with multi-disciplinary teams, including the hospital discharge teams and the community short-term care team, occupational therapists provided urgent equipment within 24 hours for people. The team also supported and assisted people to arrange GP appointments to reduce hospital readmissions. This resulted in better long-term outcomes for people, reducing the need for long-term care and increasing independence.

Northumberland sensory services/BID told us Specialist Interest Workers (Social Workers with additional qualifications in Sensory Social Work) carried equipment such as sensory doorbells and vibrating smoke alarms in their cars when visiting people so that equipment could directly and quickly be given to people. This had made people feel safe and allowed the local authority to respond to emerging unmet or safeguarding needs.

Access to adaptations presented frustrations for those who needed major adaptations made to their homes. The Motor Neurone Disease (MND) association highlighted people's experiences, around the DFG disabled facilities grant (DFG) process in Northumberland, citing the length of time taken for adaptations to be made to homes.

Provision of accessible information and advice

According to the ASCS 72% of people who used services in Northumberland found it easy to find information about support, higher than the rest of England where 66.26% of people found it easy to access information from adult social care services. Northumberland County Council used a single point of access for all social care services in the area. Early access to information to prevent, reduce and delay the need for care was a key feature of the local authority's prevention strategy.

According to the SACE, 66.41% of carers found it easy to access information and advice higher than the rest of England where 59.06% of carers accessed information easily. Partners from the VCS stated that the local authority were good at making language simple and easy to understand. Some people found the local authority web site was easy to navigate and locate appropriate advice and information where required. However, it was suggested the easy read documents required further development to ensure they were available for those with multiple or intersectional needs. For example, those who may have a sight impairment and a learning disability.

People shared with us that accessing information about sensory services was difficult because there was not a lot of cohesion between services, but once the information was received in the way it was needed to make informed decisions, the impact was immeasurable. Some carers supporting people with mental health needs felt that information was not always clear and could be difficult, with links on the local authority's website needing to be updated leading some groups to develop their own directory of services for their members.

Direct payments

The uptake of direct payments in Northumberland had been driven by its strategic prioritisation and the way in which care and support was made available to people in the local authority. We were told by staff and people the uptake had been limited by a process which was difficult to access. People had found it easier to manage care and support when homecare was delivered directly by the local authority and no longer needed to be managed through a direct payment. Carers said they knew what direct payments were, and although the process was not always clear, they knew it existed. Some people with learning disabilities did not know what direct payments were. Healthwatch found people in Northumberland preferred to access directly commissioned services rather than direct payments.

However, direct payments had come to be seen by the local authority, as an opportunity to not only offer choice and control to people in accessing care and support, but also an opportunity to offer creative response to need, build on community engagement, and enable people who lived in more rural areas to have their care needs met. Further, the process for accessing direct payments had been improved with staff receiving additional training and support and dedicated direct payment advisors.
