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 worked with people, partners and the local community to make available a range of resources and other measures to promote independence, and to prevent delay or reduce the need for care and support. National data from the Adult Social Care Survey (ASCS) for 2023/24 said 60.51% of people said help and support helped them think and feel better about themselves. This was a not statistically different from the England average (62.48%).

The local authority's Adult Services Support and Engagement Team (ASSET) worked closely with people who did not have eligible need and staff described multiple examples of times they had worked with people to prevent, delay or reduce people's needs. Staff spoke about the work of ASSET as being very individualistic, staff used their time with the person to identify what their goals were, and working to meet these and encourage the person to engage with the relevant services.

Staff, leaders and partners described recent initiatives to prevent, reduce or delay need, such as work with community, housing and health partners around falls prevention which had been used to inform a new model for Occupational Therapy (OT), including the use of trusted assessors to reach people sooner. Community partners described how they had worked alongside the local authority to encourage physical activity and reduce loneliness and isolation. They said they would often combine regular activity clubs like dance or yoga with a social element to enable people to build and sustain social networks, in line with the local authority's priorities.

The local authority's public health function had undertaken extensive work to understand population risks and health inequalities. We heard about multiple initiatives that were implemented to keep the population healthy to prevent and delay the likelihood of people developing needs in the future. These covered areas such as smoking cessation, alcohol reduction and promoting healthy diets.

The local authority worked closely with partners through its health and wellbeing partnership board to respond to risks to population health. For example, we heard about recent work to improve diets and nutrition as well as initiatives that had encouraged people at risk of falls to do more physical activity, which would have benefits for the health of Gateshead's population.

Tackling deprivation and health inequalities was a strategic priority. Demographic data showed people in the borough lived in some of the most deprived areas in the country. Staff and leaders described how poverty was often a driver of poor health, and we saw how the corporate 'Thrive' agenda was closely linked to the integrated adult's and health strategy, which aimed to use partnership working to reduce poverty through improving areas like access to employment, housing or support services for young families. The National Development team for Inclusion (NDTi) had been recently commissioned to carry out a three year project with the local authority around Community Led Support. This work was anticipated to help the local authority to enhance its prevention offer and benefit all aspects of its pathways.

Whilst there was a lot of strategic focus in this area, staff described how there were longer-standing systems or services in adult social care that helped people overcome these challenges. The front door team frequently mapped people to community resources, such as food banks or social clubs. The GATES service regularly enabled people to enter employment where an illness or disability had previously prevented them from doing so. We saw an example of a person who was in employment when their care needs increased. Through ongoing support from GATES they improved their confidence and were able to stay in paid employment.

Staff said they took a 'make every contact count' approach to interventions and often used contacts as an opportunity to speak to people about healthy diets, smoking cessation or income maximisation. This was an area of focus across the health and wellbeing partnership which staff and partners described had helped them all contribute to the local authority's approach to prevention.

People had access to technology to keep them at home for longer. We saw examples where the provision of telecare technology had reduced the need for more restrictive or intrusive interventions. The local authority told us they had worked to improve access to technology such as Lifeline alarm or housing scheme connections, which had seen a 22% increase in the use of equipment between January and December 2023. Staff and leaders told us this was an area of focus and there had been work to identify new assistive technology offers to further enhance this.

We heard feedback from staff and partners that there were sometimes gaps in community provision for low-level support for people with mental health needs. The local authority was aware of this and was working with partners to expand its prevention offer. Despite this gap, the examples we heard about the work of ASSET showed how intensive preventative work with a social worker often enabled people to find the right services or interventions to delay future need.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that supported people to return to their optimal level of independence and this had been a recent focus of improvement. National data from the ASCOF for 2023/24 said 63.33% of people aged over 65 were still at home 91 days after discharge from hospital with reablement or intermediate care, which was a negative statistical variation from the England average (83.7%). The national data showed there was opportunity to improve outcomes for people who had received reablement. Staff and partners said they felt recent changes had started to improve the effectiveness of reablement.

There was an Enablement and Independence Service Team that provided reablement to people in the community. Staff spoke positively about the availability and timeliness of this service for both hospital discharge and to avoid admission to hospital. We saw examples of people being discharged from hospital with reablement. People had clear goals based on their needs and interventions were strengths-based. People and unpaid carers spoke positively about the reablement service, telling us it was reliable, and the staff were friendly and supportive.

The local authority had recently used Better Care Funding (BCF) to increase capacity in reablement and 'discharge to assess'. The Better Care Fund (BCF) is a funding stream from central government which is intended for use for integrated projects that achieved shared outcomes around avoiding admission to hospital or hospital discharge. The local authority told us how they had been able to increase the numbers of referrals accepted by these services by '231%' over a 5-month period. National data from the ASCOF for 2023/24 said 2.75% of people aged over 65 received reablement or rehabilitation services after discharge from hospital, which was not statistically different from the England average (2.91%).

The local authority also had a reablement team who automatically contacted any person discharged from hospital to check they were managing well and identify any further need for reablement support. The team also delivered a rapid response service designed to avoid hospital admission or keep people safe at home where the alternative option might be a more restrictive intervention such as a care home. We heard how the team proactively became involved in cases where someone could be at risk of crisis, increase in need or hospital admission. Staff spoke very positively about the impact this team had on people they worked with.

The local authority had an Enablement and Independence Service which was attached to the Achieving Change Together (ACT) team. This team often worked with people in the community to maximise their independence. Staff told us about a person with a learning disability who worked with the team to develop their confidence and independence in the community which prevented them from needing to move to a more restrictive setting. In another example, the team worked with a person who had experienced trauma and related substance misuse and the team became involved in the case to build trust and enabled the person to access treatment and services which improved their independence.

The local authority and health partners had also set up a rapid response service which was designed to support people immediately to respond to non-medical urgent situations. Staff spoke positively about the interventions of this team, which would often keep people safe, avoid hospital admission and reduce or delay need.

Where people required more intensive rehabilitation following discharge, or to avoid admission to hospital, there was jointly funded residential rehabilitation available. The local authority and health partners had used Better Care funding to develop a residential intermediate care centre, which staff and partners told us provided sufficient residential reablement capacity across the borough and was effective in providing a place for people to rehabilitate after hospital discharge as part of the 'discharge to assess' pathways, or to prevent them being admitted to hospital in the first place.

Access to equipment and home adaptations

People were able to access equipment and minor adaptations easily and waiting times for OT assessment and major home adaptations had improved. Staff were trained to assess people for minor equipment and adaptations and local authority data showed these were installed promptly. The local authority had a commissioned provider for equipment and we saw how this was available to people at an early stage, to reduce or delay needs.

Staff described how OT cases were allocated in a risk-based way and people who were waiting for adaptations would usually have other interventions in place to keep them safe whilst they awaited a full assessment and adaptation works. Staff were trained to provide low level adaptations or equipment before referring a person for a full OT assessment

People said they received equipment or minor adaptations promptly and local authority data supported this. The local authority used trusted assessors who were staff specially trained to assess people for minor equipment and adaptations without a full OT assessment. Records we looked at showed equipment was put in place promptly and was coordinated with reablement or homecare interventions. Local authority data showed that for equipment and minor adaptations nearly every order was responded to within 7 days.

Provision of accessible information and advice

Feedback we received about access to information and advice was mostly positive. Partners told us people were able to access advice easily, but we did hear it was sometimes harder to access information outside of office hours. We also heard that sometimes people did not know where to go for information about what was available to them. National data from the ASCS for 2023/24 said 74.44% of people said they found it easy to find information and advice which was a positive statistical variation from the England average (67.12%).

People could contact the local authority by telephone or online to seek information. The local authority had worked with the voluntary and community sector and partners to establish and maintain a directory of community services, and we heard how the voluntary and community sector was also used to deliver information and advice to people. The local authority had been undertaking work to improve their information and advice offer. For example, the local authority, alongside health partners, had recently introduced autism hubs to provide specialised advice to autistic people and their families. We also heard about work underway with housing and health partners to create better pathways to information and advice through them.

The local authority told us about additional accessibility tools and processes they used for online information to improve its accessibility. These included a service to translate website information into a variety of languages and an editing service who reviewed all material before it was published online to check it was accessible.

There had also been work to overcome risks around digital exclusion. The local authority identified poverty as a risk to digital inclusion so had provided grant funding to an organisation to coordinate a multi agency programme of work on Digital Inclusion, which included work to redistribute reconditioned laptops, tablets and phones to people in deprived communities. The local authority also told us how the ongoing strategic work with NDTi was designed to review pathways and improve people's access to information and advice.

Direct payments

National data from the Adult Social Care Outcomes Framework (ASCOF) said 19.67% of people use direct payments, which was a negative statistical variation from the England average (26.22%). Local authority data for February 2024 showed this had increased to 20.4%, which brought them closer to the England average.

Staff told us about using direct payments to meet people's needs in a personalised way. We heard about direct payments being used to enable people to pursue important hobbies or interests as well as to provide personal assistants that had enabled people to enter education or employment. Staff said they used direct payments to support unpaid carers, such as providing them for support with gardening, housework or cleaning to enable them to sustain their caring roles. However, staff also said they sometimes found the information about direct payments hard to understand and so did the people they supported. The local authority was aware of this and was in the process of improving their direct payment offer. They were recruiting to the direct payment team to increase the size to enable them to better support staff and people in setting up a direct payment. They also told us they planned to simplify the process with the aim to increase the numbers of people who took on a direct payment.