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 worked 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.

Feedback from unpaid carers about the resources available to them was positive and we heard feedback about the different types of support people had received from voluntary partners. Unpaid carers told us they wanted more emotional wellbeing support and because of this the local authority commissioned a bespoke counselling service for carers. The feedback we received about the counselling service was positive.

Some carers told us they found it difficult to attend services and support groups on offer for unpaid carers due to their caring role. Data from the Survey of Adult Carers in England 2023-2024(SACE) showed 84.09% of carers found information and advice helpful this was similar to the England average of 85.22%. The SACE data also showed 29.11% of carers were able to spend time doing the things they enjoy; this was significantly better than the England average 15.97%.

Prevention was a core component of Islington's vision for people to live healthier, longer and more independent lives. The local authority's ambition was that by working in a multi-disciplinary way they would achieve better outcomes for people and provide them with the right care and support at the right time in the right place. The local authority had recently implemented a new integrated front door approach (Access Team) to serve as a single point of access for all adult social care, hospital discharges and community health referrals from residents, clinicians and other professionals. This reduced the number of times people had to tell their story and meant staff could seek professional advice and guidance from other professionals who were co-located in the multi-disciplinary team, providing holistic support and advice at the first point of contact. Leaders identified this was a new approach and that improvements could still be made to the process once it was given time to embed. Staff told us the transformation had a positive impact on both staff and people using services. People told us they previously found it difficult to get through on the telephone to adult social care prior to the implementation of the new front door.

The previous Access Team was part of the council-wide Islington Contact Centre and the new model was solely for adult health and social care. Staff told us this meant they were able to provide a more person centred approach to people needing advice and support. The single point of access held contact details for over 2000 voluntary and community services which meant people were able to easily access help and support that appropriately met their needs. Voluntary and community groups included groups for people living with dementia, with mental ill health, groups for asylum seekers, refugees and migrants, and faith groups.

There were 3 Access Islington Hubs that provided holistic wraparound support to prevent, reduce and delay the need for statutory support. The hubs were multi-disciplinary hubs supported by health, adult social care and the voluntary and community sector. Community connectors supported people in the community to access advice and support in the community. The local authority told us feedback from people using this service was positive and promoted strengths-based practice and independence.

Preventative services were having a positive impact on people's well-being. Staff spoke positively about how joint working has improved outcomes for people. National data from the Adult Social Care Outcomes Framework (ASCOF) for 2023/24 showed 78.32% of people who received short term support no longer required support, this was similar to the England average 79.39%. National data from the Adult Social Care Survey 2023-2024 showed 62.59% of people said help and support helped them think and feel better about themselves. This was the similar to the England average 62.48%.

Staff worked closely with housing and occupational therapy to support people to maintain their independence and live in their own home for longer. Examples of how equipment such as a bath seat or perching stool reduced the need for statutory care services and allowed the person to maintain their independence were shared. Staff worked with housing to ensure people were living in properties that supported their needs. Staff and leaders were working with housing on the Draft Housing Strategy 2024-2034 to look at how the local authority could maximise existing and develop new capacity. Staff were aware of plans to increase capacity through the development of extra care housing to support people to live independently for longer. Data provided by the local authority showed the number of people going into residential care last year had decreased to 194 people being placed in care homes in 2024 from 225 people being placed in care homes the previous year.

The local authority and partners used funding through the Proactive Care Fund to pilot the Lilli solution, supporting residents to remain independent for longer living in the community with the use of assistive technology. The Proactive Care Fund offers funding to local authorities and Integrated Care Boards to implement home care monitoring solutions. Data provided by the local authority showed the outcomes achieved from the use of assistive technology, this included support and reassurance to the person 22.33%, reduced impact of falls 21.02% and reduced hospital admission 15.5% with many instances of multiple outcomes being achieved.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that enabled people to return to their optimal independence. The local authority introduced the 'Take Home and Settle' offer, allowing people to be discharged home with 7 days free support to allow them to return home and determine how they manage at home before receiving a full Care Act Assessment. The Take Home and Settle offer was available 24 hours a day every day of the week to support hospital discharge. This meant people would not have to wait until the next working day to return home with care and support, reducing delays in discharge and reducing the risk of deterioration of people's physical ability from being in hospital. Records reviewed evidenced this working effectively. The Adult Social Care Outcomes Framework 2023-2024 also showed 2.88% of people 65+ received reablement/rehabilitation services after discharge from hospital, this was similar to the England Average of 3%. National data from Short and Long Term Support for 2023/24 showed 76.19% of people aged 65+ were still at home 91 days after discharge from hospital into reablement/rehabilitation. This was slightly worse than the England average 83.70%.

The reablement service is a multi-disciplinary service giving holistic support to people who have recently been discharged from hospital and require some short term care and support to allow people to return to their optimum health and ability. The reablement service supported all adults over the age of 18 who required short term care and support including specialist support for people with mental health needs and people with a learning disability and autistic people. Staff took a strengths-based approach to assessment at hospital discharge and worked across disciplines to triage referrals and ensure people received short term care where required.

Access to equipment and home adaptations

The local authority used a variety of roles to assess people for equipment and adaptations to support people to remain as independent as possible. The local authority employed Occupational Therapists (OTs) and OT assistants, who were not qualified OTs but were trained to assess people for standard equipment and minor adaptations. A clear pathway was in place for processing requests for assessments for equipment and adaptations. Requests for assessments were triaged by an OT duty team and prioritised, before being placed on a waiting list. Low level equipment requests would be dealt with via an assessment from an OT assistant, this meant that OTs could then concentrate on referrals for people with more complex needs such as housing adaptations through the Disabled Facilities Grant. People told us they received an OT assessment and equipment in a timely manner and felt the equipment provided supported them to be more independent as per their wishes.

Staff told us the OT duty system was a new approach and had supported with identifying urgent cases and the screening process of referrals, which meant people's needs were identified quicker and risk was monitored more effectively.

The waiting list for OTs meant the median waiting time for people to receive an OT assessment was 3 months with the longest wait being 1 year 8 months. Leaders told us an OT improvement project was in place and improvements had already started to take place such as duty, training trusted assessors and the provision of smaller equipment and minor adaptations carried out by OTAs. However, leaders identified improvements were not fully embedded and further improvements were yet to be made.

The local authority had recently recruited a Principal Occupational Therapist (POT) to implement and support with the improvement project and oversight and training of the OT team. Staff recognised the POT had been supportive, approachable and had created good working relationships with adult social care (ASC), raising awareness and understanding of the OT role.

The local authority had also invested in training staff across ASC to become Trusted Assessors; these were staff who were not qualified as OTs but were trained to be able to assess people for low level equipment and minor adaptations, this was a new role and had not yet embedded enough to fully determine the impact this had on OT referrals.

The local authority has a community assessment project to which people could be referred to receive an assessment for equipment such as a bath chair. This meant people who were able to provide some information such as the size of their bath, and were able to travel to the community site, would be able to receive an assessment quicker than if they waited for an OT to attend their home. This helped people to receive equipment quicker, preventing the need for statutory services.

Provision of accessible information and advice

The local authority provided information and advice to people in accessible formats but recognised the need to continue to improve their offer to ensure they reached everyone in the borough. People could access the new front door via email, online form or telephone. Staff told us the front door did not carry out home visits however, the First Point of Contact Team carried out face to face visits carrying out Care Act assessments, carers assessments and low level safeguarding.

People who used services sometimes found it hard to know who to contact when they needed advice and guidance about their care and at times felt the Islington webpage was difficult to navigate. Other people found it easy to access information and found information received useful. The Adult Social Care Survey 2023-2024 showed 66.87% of people who use services found it easy to find information and support, this was similar to the England average of 67.12%. The Survey of Adult Carers in England 2023-2024 also showed 60.42% of unpaid carers found it easy to access information and advice, this was similar to the England average 59.06%.

The local authority contracted a translator service and staff told us this was easy to use and quick to access. The local authority also provided information in several different languages and understood the languages spoken in Islington. The local authority also had a Sensory Team and a British Sign Language (BSL) Team who would support people who were hard of hearing or blind or Deafblind, staff within the sensory team were also trained in BSL. Staff told us how the sensory team would support with communication tools if needed and would often carry out joint visits to support with communication and understanding.

Direct payments

There was good uptake of direct payments, and they were being used to improve people's control about how their care and support needs were met. People told us how they used their direct payments to flexibly meet their needs using services they chose rather than commissioned services. People had ongoing access to information, advice and support to use direct payments. ASCOF data 2023-2024 showed 28.97% of people received direct payments this was better than the England average 25.48%.

The local authority had clear processes and guidance in place to support staff and people who use services to set up direct payments. The local authority had a direct payment employment team and had direct payment support workers to ensure a smooth process for people wanting to use direct payments. Direct payments are money that a local authority pays to people regularly (or someone acting on their behalf) so they can arrange their own support, instead of receiving social care services arranged by the local authority.

Data provided by the local authority showed 339 people decided to no longer use direct payments between June 2023 and May 2024, 46 of which were direct payments for carers. Reasons for this included care and support no longer being required or a change in the service provided. ASCOF data showed 98.01% of unpaid carers received a direct payment. All unpaid carers we spoke with said they were aware of direct payments, feedback from unpaid carers regarding direct payments was positive, unpaid carers told us they used the money to enable them to have some recreational time of their own to maintain their wellbeing.
