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 services and other measures to promote independence, and to prevent, delay or reduce the need for care and support. Feedback overall was that some services were available in this area for people, but more could be done to improve this.

Local authority leaders confirmed that a number of initiatives were available to support people in Brent including a community well-being project which supported up to 400 families per year, and a Resident and Household Support Fund providing support to people experiencing difficulties due to cost of living pressures.

A positive experience was reported by one person in relation to the strengths-based assessment and support they received from their social worker which enabled them to move from a care home into a more independent supported living environment. Another person was positive about the support given to enable them to be involved in activities, aimed at helping them live a healthier life.

Some preventative services were having a positive impact on well-being outcomes for people. Staff told us they had clear pathways to support individuals to return to the community from hospital and care homes and a focus on reducing people's needs was a priority. For example, they were able to get free adaptations to a person's home to prevent early care home admissions. Feedback from care providers was the local authority positively worked with them to promote people's independence.

Housing was one of the biggest issues in Brent. In particular, for single homeless people and people with mental health needs and physical disabilities. The housing team told us they received around 140 homelessness applications each week. A large number of private tenants were living in poor accommodation and the local authority had a focus on increasing social housing and maximising housing stock. Partners also told us this was the biggest challenge and that the local authority was trying hard to address this.

The housing team had been moved into a different area to adult social care staff, however relationships remained with teams working within the same environment. The local authority Homelessness and Rough Sleeping Strategy 2020-2025 documents the vision for 'Building a Better Brent' with specific housing aims designed to work alongside other strategies across the housing service. It aims to maximise the prevention of homelessness and to minimise the negative impacts of homelessness upon families and individuals where prevention is not possible. A housing surgery had been set up within the Brent Hubs to try to reduce the number of people who were homeless with provision of advice, support and information.

Senior staff were proud of work to date around prevention however they told us there was more to do. Brent Health Matters was a local preventative initiative funding social prescribers and care co-ordinators providing health outreach and community engagement, focusing on advocacy, advice and well-being of people. The local authority were trying to increase implementation of this model across local communities.

The local authority's focus in terms of prevention so far had been the acute sector (hospitals) where they felt there was positive joint working. There had been good primary care work around diabetes, and they recognised improvements were needed in the areas of mental health and sexual health. There was a focus on trying to empower people and maximise their independence and control.

National data in Brent was lower than the England average in several related areas indicating improvements were needed, including 66.91% of people who have received short term support who no longer require support, which is lower than the England average of 77.55% (ASCS, 2023). In addition, 58.39% of people say help and support helps them think and feel better about themselves, which is lower than the England average of 62.30 %, and 57.76% of people who reported that they spend their time doing things they value or enjoy is also lower than the England average of 68.17% (ASCS, 2023). Feedback from the local authority was that the data had now improved in terms of people who say help and support helps them think and feel better about themselves to 66.70%, which is higher than the London average.

Data and information was used by the local authority to identify required actions to improve the health and well-being of individuals and communities across Brent. For example, the local authority Joint Strategic Needs Assessment 2023 stated the rate of diabetes was higher than both London and England. The prevalence of mental health disorders for people 16 and over, and 65 and over, remained higher than London and England as well as inpatient stays in secondary mental health. Brent reported a higher rate of hospital admission due to falls in those age 65 and over, and rates of dementia were estimated around 4.1%, with hospital admissions higher than those for London and England.

The draft Adult Social Care Prevention Strategy (February 2024) focused on supporting people to live healthier lives, promoting independence and choice. This strategy had been developed through wider system discussions with key staff across adult social care and public health. It stated Brent has a growing and aging population with a growing care need for the elderly, people with long-term conditions and an increase in mental health needs. The strategy evidenced a strength's-based approach with the ethos "Home First" wherever possible. The strategy also discussed use of adaptations and equipment for people to promote independence including the importance of carers.

The strategy stated that the local authority was aware of the need to improve in a number of areas, including better co-production with communities, enabling equality in experience and outcomes, improving the 'front door' and case management, and enhancing their overall offer to people. Data analysis and engagement had started to indicate key areas for prioritisation going forward, these were ongoing including work to incorporate social prescribing when people first made contact with the local authority, to connect them to activities, groups and services in the community.

National data in relation to carers in Brent supported this need with 57.76% of carers able to spend time doing things they value or enjoy against the England average of 68.17%. Additionally, 76.47% of carers found information and advice helpful against the England average of 84.47% (SACE, 2022).

Partners told us there was a high level of need in Brent for services but not enough provision currently. There was a lack of community services, and funding cuts in the community such as day centres and specific support groups, for example domestic violence support in the community. Access to holistic support had reduced and partners were not able to meet broader needs. Feedback from the local authority leaders was that some financial funding was made available for housing related support which included 200 hours per week across four women's refuges in Brent and a women's service.

The local authority had been expanding their engagement services over the last 2 years with some funding to community services. One preventative service supported people's needs from escalating by giving advice, prompting people to claim benefits or go to the GP. Providers told us they felt local authority staff were passionate, friendly and willing to improve, but that there could be some mistrust towards staff from communities still based on more traditional views about the role of social workers.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver reablement services that enabled people to return to their optimal independence. We received positive feedback from people in relation to reablement. The local authority commissioned three care providers to carry out their reablement services. This was an integrated rehabilitation and reablement function, with health and social care working together to support earlier hospital discharges into the community and faster response times. The reablement team was a multi-disciplinary team including social workers, OTs, physios and community health partners. Funding had been provided from the 'Better Care Fund' to increase staffing such as for reablement OTs.

National data was slightly lower than the national average, for people over 65 with 78.95% of people in Brent still at home 91 days after discharge from hospital into reablement/rehab against the England average of 82.18%. (SALT, 2023). However, in terms of people not requiring support following reablement Brent were significantly better than the London average.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes. The local authority commissioned community equipment services jointly with the North West London Integrated Care Partnership. In August 2023 the local authority joined the London Community Equipment Consortium which consisted of 21 London Boroughs which meant there was a joined up and consistent approach taken with accessing equipment for people across these local authorities.

There were concerns in relation to the provision of community equipment which affected the processing of equipment orders, so action had been taken to employ a liaison person to support communications with a daily report on equipment needs. This specialist community OT was employed providing clinical leadership to frontline staff to support with equipment and adaptations. The local authority had also increased their stores to enable easy access to smaller or regularly used items. For special orders, staff were advised to go directly to the suppliers and this had been successful.

There was a high demand for community equipment provision and a scarcity of qualified OTs, so the local authority operated a model where staff who had trained as 'trusted assessors' were able to order or arrange for repair of more low-level pieces of equipment without referring to OTs.

Some partners told us the community equipment contract continued to be an issue and it impacted on people. For example, people having to go to a different place rather than home on discharge at times. However, other feedback was positive and that following one person's discharge from hospital, the equipment needed to support mobility was put in place in a timely manner, to ensure this safe transition took place.

There was a waiting list for OT services, however staff were generally positive about the OT weekly surgery which had been introduced to assist with this. Staff told us risks arising from the waiting list were well managed by managers. For example, they prioritised people who were at risk of falling. The OT team told us their waiting lists had reduced from 100 last year to about 20, due to increase in OT staffing.

Staff confirmed there were issues with providing equipment in a timely manner. Staff gave us some examples of impact from this. People were in bed for longer waiting for a stand or a sling. There was a pressure on families to transfer people without equipment at times and staff needing to send in continuous emails and complaints. They explained it was doubly challenging when you had to tie in equipment visits with British Sign Language (BSL) interpreters as both were a scarce resource. Supply did not always keep up with new developments. For example, some analogue rather than digital equipment was still supplied, and available equipment did not always include up-to-date sensory equipment. Feedback from senior staff was that their digital strategy was supporting the transfer of equipment from analogue to digital.

Staff told us the local authority gave them freedom to order bespoke equipment and did not question their professional judgement. They felt the provider equipment web site had improved and gave positive feedback about managers support around this and the new specialist community OT who communicated regular updates to them.

Senior OT leaders explained that adaptations made to people’s properties were not means tested which meant these were carried out more quickly for people. They recognised the digital and technology offer to people was limited and were in the early stages of this development as part of their prevention strategy.

Partners told us the lack of OTs meant a delay in areas such as housing teams assessing people's needs against available properties, so properties were remaining void. The local authorities housing department had trained surveyors to become trusted assessors as they identified OTs were a finite resource, so this enabled some adaptations to get done within private housing without needing OT input. Feedback from the local authority leaders was they prioritised these cases, understanding the need to act quickly.

Provision of accessible information and advice

People could not always easily access information and advice on their rights under the Care Act and ways to meet their care and support needs. This included unpaid carers and people who funded or arranged their own care and support. One person told us it was not easy to contact the local authority for information and advice. This was because there was not a single point of contact as social care workers were often agency staff workers and changed frequently. The person found it frustrating and so tried to avoid contacting social care, which placed them at risk of not receiving necessary support. One unpaid carer told us information had not been made available to the family so they were unaware of what support they could access such as opportunities for respite care. Carers told us they heard about what services were available in a variety of ways, for example supermarkets, charities and word of mouth, but were not sure who to speak with in the local authority if they needed something. Feedback from local authority leaders was that people were able to contact the local authority through a number of channels which included the website, face to face through Brent Hubs and via allocated workers. Part of the 'Brent Customer Promise' was to ensure people were responded to within one working day.

National data supports this negative feedback with 60.73% of people in Brent who use services finding it easy to find information about support which is lower than the England average of 66.26% (ASCS, 2023). Similarly, data for carers shows 45.71 % of carers in Brent who find it easy to access information and advice against the England average of 57.83% (SACE, 2022).

There were 5 Brent Hubs across the local authority that offered face to face access to universal services and advice including social care, housing and benefits and debt advice. Staff were positive about these hubs and felt it made it easier to support people who could be difficult to contact, such as homeless people or people with mental health needs, by signposting them to services.

Information was available to people such as a carers booklet to promote awareness of carers, including young carers, and who to contact for advice and support. The local authority was working with staff and partners to improve the IT system in co-production with Brent Carers Centre to develop a portal for self-assessments by carers.

Brent Council Digital Strategy 2022-26 set the local authority's ambition and aims of becoming a digital place and council. The local authority had worked with people, businesses and partners to deliver a themed programme of digital activity to improve digital access, access to public wi-fi and a focus on digital inclusion to enable people to participate.

Staff in teams were passionate to work effectively but said their time was taken up by trying to find out about services available to support people. Staff felt there could be more agencies and voluntary groups that they should be signposting and referring people to, as services that were previously in place, such as befriending, had dwindled and they found alternative, or replacement services were not being commissioned to replace those that had been lost.

Feedback from partners about accessibility to information and advice was mixed. One community group told us they had developed a directory of information and had been shocked how little some of the community knew about services available. Another told us information was not always easily accessible for people with learning disabilities or who were neurodiverse. However, another community group told us they worked well with the Brent Hubs, whilst an organisation supporting people with mental health needs worked positively with and received referrals through local authority staff.

Direct payments

There was good uptake of direct payments, and they were being used to improve people's control over how their care and support needs were met. The local authority Market Sustainability Plan (2023-25) documented that since 2019 direct payments have increased, rising from 661 packages in 2021 to 1,490 in 2023.

National data supports this evidence particularly for older people, with 34% of service users aged 65 and over in Brent accessing long-term support receiving direct payments compared to the England average of 14.18% and 34.02% of total service users receiving direct payments compared to the England average of 26.22%.(Adult Social Care Outcomes Framework, 2023, ASCOF).

Feedback from one unpaid carer on behalf of a person using direct payments said they felt it gave them autonomy and flexibility. It empowered them to use their support how they wanted to. Another family had discussed direct payments in the past however not recently and felt they would like to consider this further now given more information. Some carers we spoke with had not heard of direct payments but could see the potential of using these.

The aim of direct payments was to provide the least restrictive option to people, enabling people to have choice and control, remain at home and support cultural needs. For example, a carer was struggling due to a change in the needs of the person being supported. A direct payment was put in place for the person and their family so they could arrange personalised activities in the community, which led to an improvement in the person's well-being whilst also benefiting the carer. Another person used this to get someone to live-in temporarily, to enable their carer to travel.

The local authority actively promoted direct payments; although people had a choice if they preferred a commissioned service. Staff gave us positive feedback about the use of direct payments explaining they were offered as a default to ensure people and their families had flexibility and control over the support provided. People were able to select care providers that understood their language and culture or use services outside of the area which were more appropriate to them. Some staff were direct payments 'champions' to promote this further to colleagues.

Guidance was provided to people about the use of direct payments with ongoing access to information, advice and support. A direct payment team provided advice and guidance and supported with areas like financial advice and monitoring.
