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

Early intervention and prevention was a very clear strategic and operational intention. Senior leaders were clear that the new operating model supported people with complex needs, to remain in the community with an effective multi-disciplinary approach. In addition, the long-term impact of the new operating model reduced hospital admission and offered a wraparound support for individuals.

The local authority worked with people, partners, and the local community to make a range of services, facilities, resources, and other measures available to promote independence, and to prevent, delay or reduce the need for care and support.

Staff in the Hub considered whether access to the Early Intervention and Prevention (EIP) team for reablement and rehabilitation would be beneficial, for each person requesting an assessment and/or service unless the circumstances suggested it was inappropriate. The EIP also received referrals from hospital teams and intermediate care (where people are supported in a care home setting whilst receiving ongoing rehabilitation) to support discharge home. The Adult Community Service Manager and senior social worker (SW)/ Occupational Therapist (OT)/ Physiotherapist (PT) oversaw daily huddle meetings in the Early Intervention and Prevention team (EIP) to review concerns, risk, urgent work and allocations for that day. Reablement support was embedded in this team's approach.

National data from ASCS demonstrated 81.88% of people in Bracknell Forest who received short term support no longer required support.

The local authority's own data showed they have made a 19.3% reduction in permanent care home placements in the year 2023/24 as compared to 2022/23, which suggests that this model was effective in early intervention and prevention.

Staff told us the focus was to support people and prevent any further issues occurring, preventing hospital admissions and promoting health and well-being. The EIP team worked closely with reablement to ensure people received the least restrictive care available promoting independence and choice, with the aim of providing the right support at the right time. Their offer included a responder service, as well as a range of short-term and intensive services for up to 6 weeks.

There was a cross-sector model involving voluntary organisations, primary care networks (PCNs), and early intervention and prevention teams which aimed to identify people early and address quick deterioration in health, such as falls. PCNs helped identify people early through projects like Aging Well. Isolated individuals who may not be in contact were supported proactively, under the NHS Core 20 Plus 5 framework, which addresses health inequalities through focusing on the those most at risk of poorer health outcomes due to deprivation or protected characteristics. In Bracknell Forest, the partnership had identified people with learning disabilities and autistic people as priorities for this work.

Part of the early intervention and prevention offer was an Autism drop-in service held weekly. This offered support and advice to those with a diagnosis of Autism with anything from reading a letter to applying for a job. The focus was light touch and had promoted and encouraged independence which, for some people, had reduced the need for on-going commissioned services.

The EIP team had access to an assessment suite which offered clinic appointments with no waiting list. These clinics were run by trusted assessors and enabled people to explore equipment, home adaptations, telecare including for emergency response, and digital assistive technology solutions. These solutions enabled people to remain independent at home for longer. Not everyone we spoke with was provided appropriate information at assessment. For example, one person reported a lack of information shared about alternative falls detectors available such as a watch option and they were only offered a pendant alarm. Staff also reported that accessibility for people with learning disabilities or living with dementia needed to be improved.

National data from Survey of Adult Carers in England (SACE June 2022) showed that 89.29% of carers found information and advice helpful which was slightly above the England average of 84.47%. Other survey data from the same source which showed that 18.6% of carers were able to spend time doing things they value or enjoy, was not statistically different to the England average.

The ASCS (Oct 22) showed 57.43 % of people surveyed in Bracknell Forest stated help and support helped them think and feel better about themselves. According to same survey 29.70% people from Bracknell Forest reported they had as much social contact as desired (significant negative variance from England average of 44.38%). It is notable that in the local authority's Joint Strategic Needs Assessment (JSNA) loneliness is noted as a significant risk factor for people in Bracknell Forest.

Leaders told us a community map had been created. This identified over 500 social activities available within the local area. Working with the voluntary sector and community groups an officer from Public Health ensured the map remained up to date and reflective of the current offer. Working closely with 'Involve', a community service; friendship tables were implemented in the community in places including churches, shops and care homes. This was an initiative to combat loneliness and improve mental health and well-being.

Most other national data of surveyed people in Bracknell who used services (ASCS Oct 22) were comparable to or better than the England average. This included people who reported that they spent their time doing things they valued or enjoyed.

The local authority had recently coproduced an Integrated All Age Carers Strategy which included recognition of adult carers, young carers and carers of young people and children. At the time of our assessment, this had not been published. They recognised they needed to do more to support young carers and that young carers' needs were different to those of young adult carers aged 18-25. The Census 2021 suggested there were 133 young carers aged under 15 in Bracknell Forest. There was no reference in the draft Carers strategy to the No Wrong Doors memorandum of understanding to ensure that young carers were easily able to access information and support. It did however reference a range of services, including a weekly youth group and a 10-week rolling art programme commissioned by the local authority to provide support.

We heard variable feedback about whether sufficient specific consideration was given to unpaid carers. Most of the national data about carers in Bracknell Forest as taken from the Survey of Adult Carers in England (SACE October 2022) and based on experiences in 2021-22, were not statistically different to average experience of carers across England. The only exception was that 6.98 % of carers in Bracknell Forest were accessing training for carers as compared to the England average of 4.11%.

Many carers were offered one off payments for recreation or respite however, this was not always suitable or achievable. We heard from carers who felt unable to leave the person they cared for, or that the person they cared for would just contact them and become distressed meaning these options were not beneficial. Many carers we spoke with told us there was a lack of respite/short break provision and support available and did not feel they had access to short breaks, especially in an emergency.

A few carers we spoke with felt that there had been a positive impact on their health outcomes because of their assessment and any support provided to them as a carer. We heard from carers who felt restricted by their caring role, and how this had impacted on their physical and mental health and their personal relationships.

Carers were complimentary about the carers support organisations available locally. A partner organisation however noted that unpaid carers had good access to local support provisions from the local authority and via a statutory funded voluntary organisation.

We heard from many staff and leaders about the Bracknell Forest Community Network (BFCN) which ran public sessions such as the Happiness Hub and the Over 35's social group. These met several times a month in different venues. Whilst membership of the network required a referral, people could freely attend the public sessions, where a collaboration of support services was available to offer mental health and wellbeing advice to adults, or simply a space to talk or have company. The BFCN worked collaboratively with clinical and non-clinical partners in mental health and wider health and care systems and offered a person-centred approach to mental health. We heard about one person whom the Community Network team had built a relationship with, enabling them to attend sessions which improved their mental wellbeing and reduced their social isolation.

Other people told us co-production groups made a positive impact to their wellbeing. One person had previously used services themselves and now worked in the team that previously supported them. Another told us that they had previously been reluctant to leave their home but now had friends and a social life because their social worker encouraged them to join a co-production group.

Staff told us about collaborative work towards measures which could keep people safe and reduce a decline of mental health and wellbeing. For example, one staff member worked closely with the highways team to have pavements outside a property lowered, so the person could access the community independently which reduced their risk of social isolation.

We heard that Public Health officers worked closely with the Business Improvement Team to explore gaps and employment opportunities within the local area. Discussions were ongoing to support people to remain in work and encourage businesses to participate in work programmes.

The local authority used free to access public meetings such as the Happiness Hub, as well as the Hub to identify people with needs for care and support that were not being met.

Provision and impact of intermediate care and reablement services

Provision of intermediate care and support, and reablement services were a key part of Bracknell Forest's strategic approach, which were developed in close collaboration with health colleagues and other partners. These services enabled people to return to their optimal independence.

Senior workers reviewed referrals from wards to identify the correct pathway for each person on discharge from hospital. Pathway 1 was going home with a reablement package, Pathway 2 was step down to intermediate care, or pathway 3 would be a longer-term placement. Workers were allocated cases very quickly and information was sent using a secure email address and all staff had General Data Protection Regulation training. Discharge plans were discussed by a multi-disciplinary team to ensure clarity and consent was gained from the person.

The time taken from "discharge ready" to "discharge" from hospital varied according to the pathway required. Data for January to March 2024 showed people going home with a package of care on average waited 2.62 days as compared to 4.14 days on average across the Frimley Integrated Care System (ICS) as a whole. Over the same period, people being discharged with an interim package or short-term care home placement under discharge to assess, where care was provided pending a full assessment of needs, waited on average of 2.2 days as compared to 8.27 days across the ICS. People who required a new long-term care home placement waited on average 6.5 days as compared to 14.84 across the ICS.

The Adult Social Care Discharge Fund which is part of the Better Care Fund (BCF), was being used to recruit and retain homecare staff to support hospital discharge, assistive technologies, home preparation and to facilitate accelerated discharge. Evaluation of outcomes had shown that most schemes had demonstrated their intended impact, to keep more people out of hospital, and to promote independence. This was evidenced by a reduction in the long-term residential placements. One programme involved the provision of assistive technology grab bags including the provision of falls pendants. There were 13 different schemes, which in general had improved patient flow from discharge. Where trials were not successful, this was due to either too much or too little demand, or staff recruitment challenges. Learning was taken from this to inform future planning.

Senior leaders told us the local authority had stopped considering bed-based discharge to assess services as the default option, preferring to support people in their own homes first if possible, even to the extent of 24-hour live-in care if that was required.

National data from the Adult Social Care Outcomes Framework (ASCOF)/SALT (Dec 23) showed that at 10.21%, 3.5 times more people aged 65+ in Bracknell Forest received reablement/rehabilitation services after discharge from hospital than the England average of 2.91%. Of these 85.71% aged 65+ were still at home 91 days after discharge from hospital into reablement/rehab which was comparable to the national 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. One person told us they felt the range of aids and adaptations provided after assessment meant they were able to continue to care for their family member within their own home as per both of their wishes.

Previously, assessment referrals for equipment/adaptation were directed to the equipment provider, leading to delays of up to 300 days due to a lack of trusted assessors. To reduce people's delays, the local authority had diverted assessment referrals in house, and trained social workers to be trusted assessors. The longest waits experienced were for adaptations/ equipment such as ramps which required building to an individual specification.

The number of people waiting for occupational therapy assessments, and the provision of equipment was relatively small. At the time of our assessment 9 people were waiting for a Disabled Facilities Grant (DFG) assessment which might lead to a contribution towards the cost of adapting a home. The average wait was 52 days, but the longest wait was 126 days.

There were 9 other people awaiting assessments for smaller pieces of equipment, with an average of 36 days wait, and a maximum of 64 days. We heard from one carer who told us they had been waiting since Feb 2024 for an assessment for equipment/adaptation for a family member. Once assessed, over 90% of people received their equipment within three days, or sooner if urgent.

People experiencing sensory loss were supported by the specialist sensory team and worked closely with local charities such as the Degenerative Macular charity to provide information and advice as well as equipment and additional support.

Bracknell Forest Council were part of a Berkshire-wide health and care partnership which commissions the Berkshire Community Equipment Service. This was done through a Section 75 partnership agreement. This is an agreement between local authorities and NHS bodies which can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partners.

The agreement allowed West Berkshire to be the lead commissioner and contract with the service provider. By commissioning as part of a partnership, the local authority achieved better value and a wider range of equipment, than might have been affordable as a lone commissioner.

Provision of accessible information and advice

Most people could 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. The ASCS (Oct 22) found 67.74% of people surveyed in Bracknell Forest who used services found it easy to find information about support which was above the England average of 63.45%. The SACE national data showed 62.96 % of carers surveyed in Bracknell Forest found it easy to access information and advice which was not statistically different from the England average.

Not everyone we spoke with felt they had been provided information regarding support, resources, and other measures to promote independence or reduce needs for care available from the local authority. One person told us, "I really am struggling and unaware of what is or is not available from the local authority".

Some people told us that the local authority had not provided timely information about grants or benefits available to meet the cost of care, or adaptations to the home. One gave feedback to the local authority who apologised to them and the person believed they had since made changes to address this oversight.

A carers organisation felt there was a lack of accessible information for unpaid carers for example, on how to apply for housing and information on transitions, and that information was not always available in multiple languages.

One carer told us they were aware where to get help and advice should they need it and how to make contact. They found the local authority was very responsive when they needed to contact them. Another told us there was “a lot of support out there, but carers don’t even know if it is for them”, because they don’t see themselves as carers. Other carers reported people were not always made aware of what was available to them, especially for deaf people who struggled to communicate.

A Dementia Advisory Service provided information and support, including a young onset dementia advisor. to people with dementia and their families and carers, connecting them with community and health resources and supporting self-management. Waiting times for the service were 1-2 weeks. There was a face-to-face weekly peer support group which was well attended and highly valued. A Dementia Forum co-produced with people with dementia and their carers took place every 6 months which was also well attended. A co-production group supported the development of resources. The service distributed a newsletter to over 800 people and a Dementia Directory, available in GP surgeries and libraries was updated in 2023 which was also available in various languages.

Direct payments

Direct payments (DP) were being used to improve people’s control about how their care and support needs are met. The local authority provided a lot of information and support to direct payments recipients, especially in relation to safe recruitment, selection and being a good employer, including payroll and insurance. The local authority was supportive of requests for people to employ a family member, in circumstances where it was legal, and particularly where it facilitated quicker. There was a “support with confidence” personal assistants register which meant that people had some assurance in recruiting and selecting someone.

The local authority had a distinct Direct Payments team who supported recipients and provided information and advice, as well as training to social workers. A process was in place to support people receiving direct payment to pay for provisions. The team had the confidence around the usage of direct payments and provided a consistent approach for colleagues and people using the service. Many people told us direct payments for care worked well. They valued the local authority support with setting up, and their ongoing, advice, support, and monitoring.

The local authority told us there were no lengthy delays in a person accessing their direct payment after their individual budget was agreed. They provided support to ensure the person understood the paperwork and open a bank account which could take a few days, but then the DP would be made. The local authority provided access and funding for training for people using direct payments.

Direct payments were used extensively in Bracknell Forest as a means of enabling people to meet their needs in ways which reflected their preferences. This was reflected in the views of one carer who said the DP helped them do things for themselves.

The national (SALT) data showed that 100% of carers received direct payments, and 21.01% of service users aged 65 and over accessing long-term support who were receiving direct payments which was above the England average of 14.8%. This doesn't wholly correlate with more mixed feedback we received from some carers. One carer said, "there is always enough money to pay the carers and it works well", whilst another told us that they had stopped using direct payments because the direct payment amount was insufficient to recruit and retain personal assistants. The direct payments rate was limited to the standard homecare rate, which people were expected to top up from their own funds if they wished to pay more.

By contrast national (SALT) data showed that 25.81% of service users aged 18 - 64 accessing long-term support received direct payments as compared to the England average of 38.06%. Overall, an average of 23.61% of service users received direct payments which was not statistically different to the England average.