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, unpaid carers, 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 was overall positive.

We heard how the local authority supported the wellbeing of unpaid carers. Unpaid carers told us how the local authority assisted them, particularly with funding respite. One unpaid carer was supported to access therapy and treatment whilst another unpaid carer used their funding to access arts activities.

National data in relation to carers in Westminster showed that 86.96% of carers found information and advice helpful, which was in line with the England average of 85.22% (SACE, 2022). This data was supported by unpaid carers we spoke with. One carer told us the support they had received made them feel empowered, and much happier in their role as an unpaid carer. Another unpaid carer shared the support they had received allowed them to make new friends and improved their social life, and this was something they would not have been able to do previously.

Some staff told us that they had a steady flowing workload due to the high homelessness population in the Borough. Some staff had found the specialist support from the Mental Health Outreach Worker and a Joint Homelessness Team particularly useful. Frontline teams highlighted that being homeless was not a barrier to receiving support from the local authority and that prevention measures and consideration of the Care Act was paramount. Local authority leaders told us supporting homeless people was an area they invested in to prevent and reduce care and support needs. Through collaboration with partners, local authority had secured grants to support people experiencing homelessness and substance misuse.

The local authority staff worked closely with the GP Liaison Workers, who completed an early intervention referral and looked at what could be provided from a prevention perspective. Staff told us they practised the social model of disability and focused on positive risk taking, whereby they provided a proportionate and relationship-based approach when they supported people. An example provided was when staff supported a person who was active in the community but posed risks as they were confused and at times needed to be assisted at home. Using a less intrusive approach, the person's care plan included the support of a carer to shadow the person to places of interest in the community.

Staff shared an example of contingency planning, where they worked with care home managers to assess people in hospital and develop rehabilitation, with the view that if risks became unmanageable after discharge home, they could move directly into the care home rather than return to the hospital. Throughout the home access visit the rehabilitation bed remained open and available for the person to return to, should risks be too high to manage at home. Staff shared that an area of improvement could be the introduction of integrated IT systems with health colleagues, to promote better information sharing. Staff showed acknowledgment of some integrated systems which had already improved relationships between health and the local authority.

Local authority leaders explained they had a highly responsive Information and Advice Team which delivered a strength-based focus with good management oversight. The team covered early help and prevention, home first, reablement and occupational therapy which focused on promoting people's independence. The team completed assessments, provided equipment and signposted to internal and external services. The team had formed good working relationships with the Home First Team who provided a responsive service from health colleagues.

The Joint Health and Wellbeing Strategy 2023-33 was co-produced with people, voluntary sector organisations and partners. The strategy set out the framework for local authority and its partners to tackle health inequalities and prevent people's health and care needs from escalating, and where possible reduce future needs for care and support.

Senior leaders acknowledged they are not complacent, they continuously strived to improve in this area by listening to communities' voices and VCS partners who work closely with residents. Examples of this include the Carers Found and Staying Safe Project, and the corporate work on the Community Equity Strategy.

Provision and impact of intermediate care and reablement services

The reablement service was an integrated rehabilitation and reablement function, with health and social care working together to support earlier hospital discharges into the community and working towards faster response times. The reablement team was a multi-disciplinary team which comprised of social workers, occupational therapists, physiotherapists, and independent living assessors. The service provided up to six weeks of reablement support.

The local authority worked with partners to deliver reablement services that enabled people to live independently. Feedback was mostly positive. We heard staff were allocated immediately after hospital discharge and through frequent contact people had felt supported. Frontline teams confirmed they had no waiting lists for people to access the reablement service and all the referrals were responded to within 48 hours, and same day contact was made if the referral was urgent. Although people using services had a single named allocated worker, we also heard that people felt uncomfortable due to the number of different caring staff who supported them. Local authority leaders acknowledged that this is a sector-wide challenge. They also noted they are actively addressing this with its partners.

The local authority's Five-year Reablement Strategy highlighted positive outcomes from reablement; 84% of adults who had completed reablement did not require long-term care. This was also evidenced in the National data in Westminster which showed 90.90% of people who have received short term support no longer require support, which is higher than the England average of 77.55% (ASCS, 2023). Also, 89.47% of people over 65 were still at home 91 days after discharge from hospital into reablement/rehab, which was higher than the England average of 82.18% (SALT, 2023).

In order to improve outcomes for people discharged from hospital, the hospital discharge single integrated pathways had been designed and streamlined to provide an improved discharge model for all people with new or increased needs. This had informed the development of Pathway 1 and Pathway 3. Pathway 1 had an integrated approach which supported early recognition of discharge and safe transfer for people who were medically stable and no longer required acute hospital care. Following discharge home, people were further assessed in the community. Staff told us the discharge pathways were clear and they carried out a functional assessment at the hospital and the person was seen within 24 hours at home. Pathway 3 had been setup to provide more efficient responses to supporting people who were unable to return home from hospital and required 24-hour care and supervision in an interim setting whilst an assessment of their long-term care needs took place. The aim was to allow for an accurate assessment of longer-term care needs once the person had reached their maximum level of independence in a placement setting. Staff shared they had access to nursing beds for 28 days stay to allow for further assessments and determine if the person was able to return home. There was also access to a residential home for people to stay for 6 weeks. The pathways were jointly funded across health and social care which provided multi-agency support.

The rehabilitation team supported positive outcomes alongside reablement pathways. They carried out home access visits with the person and tested out the equipment and assessed risks. The team only discharged the person if they felt confident that the risks could be managed. Throughout the home access visit the rehabilitation bed remained open and available for the person to return to, should risks be too high to manage at home.

The Approved Mental Health Professional (AMHP) service for Westminster operated as a multidisciplinary team and employed staff full-time. The team had also been supported by staff from the wider community teams. Staff expressed pride in the way the service worked with diverse cultures in promoting people's wellbeing through using a person-centred approach. Other frontline teams told us the AMHP service had been a helpful resource to discuss dilemmas when supporting people with mental health needs. The local authority shared 8 health-based places of safety with the neighbouring local authority as Westminster did not have a psychiatric admission hospital. Teams told us most people detained under the Mental Health Act had been admitted to A&E and were assessed at that point. To manage risks when arranging community assessments, the local authority had an established arrangement with the bed management service who supported them to reserve a place for a community assessment booked for the following day. Staff felt this was working well as communication around this more established practice had improved.

Frontline teams were continuing to look at what support could be given to all people being discharged from hospital with the current strain on the system and lack of beds. They gave examples of attending ward rounds, looking at discharge planning and working collaboratively with health and housing providers.

Access to equipment and home adaptations

People were able to access equipment and minor home adaptations to maintain their independence and continue living in their own homes. Waiting times for equipment or home adaptations were risk assessed and where care needs had been identified, interim arrangements were put in place, this was to manage risks until the equipment, or adaptations were in place. The local authority had a commissioned community equipment service provider.

A Professional Lead Occupational Therapist was employed in February 2023 to model service improvements, and this was further developed into a Principal Occupational Therapist role. The new post holder started in May 2024. The local authority had also identified a high demand for the community equipment provision and had therefore commissioned an external provider to manage the complex OT work which was referred to the Information and Advice Team. Complex OT work included manual handling and major home adaptations.

Reablement Occupational Therapists and Independent Living Assistants responded to functional assessment within a 48-hour period. Local authority leaders told us the OT provider had no waiting lists for people to be screened pending an assessment. There had been a 28-day timeframe set by the local authority for staff to carry out an assessment, so the maximum wait would be 4 weeks, and if an urgent need was identified they were assessed in 24 hours. The management of wait times for assessment and provision of equipment was supported by the training of some non-OT staff to order less complex items. The Standard Operations Procedures included the risk factors and timescales for OT processes, including signposting and referring to other departments, which included housing and the OT provider.

Local authority leaders told us there had been good quality assurance arrangements with the external OT provider. For example, where major home adaptations had been recommended the local authority's senior OT manager provided authorisation and transferred people to the housing team for completion of the works. The expectation was for this process to be completed within 6 weeks. Local authority leaders told us they had clear processes in place for reviewing OT adaptations to ensure the persons identified needs and outcomes had been met. The local authority had a shared recording system with the external OT provider which helped with transparency in communication.

Senior leaders told us there were challenges surrounding waiting times for home adaptations, particularly when permission from private landlords is required. However, the local authority had implemented measures to reduce waiting times for aids and adaptations by streamlining processes and increasing coordination with external partners. In examples where delays occurred due to external factors, such as landlord approval, they worked closely with all involved parties to expedite the process and explore alternative solutions where feasible to mitigate risk.

Local authority leaders acknowledged the challenges people faced around waiting for major home adaptations, in particularly waiting for permission from private landlords. Local authority leaders told us there had been a positive working relationship between the OT's and the housing department. For example, the teams jointly attended face-to-face assessments which delivered a person-centred approach. The assessments were booked within 2 weeks to meet the 28 days assessment target. Leaders shared they had good oversight of people referred for occupational therapy and due an assessment. While people were waiting for major adaptations, people were provided with equipment to reduce risks. We received positive feedback about this from people.

Self-neglect and hoarding had been identified as one of the biggest housing issues in Westminster. There was some preventative work between adult social care and mental health services to prevent people from risk of eviction. Staff told us about the benefits of the Handypersons service which was free of charge and supported people with low level housing repairs. Additionally, there had been a good use of a grant provision for maintaining safe standards within homes, which covered heating, damp-proofing and major home adaptations to promote accessibility and independence. There was evidence of effective use of assistive technology in place to prevent, delay and reduce need for care and support. Staff provided examples of issuing digital key safes and providing a bespoke home security system for people experiencing domestic abuse.

The local authority's housing and adult social care teams had implemented multi-disciplinary processes to support people who hoard. They had strengthened multi-agency prevention work, such as hoarding and self-neglect case reviews and provided advice. Both services shared information effectively to ensure there was no duplication of case work. A contract with psychological services was in place for people who were in hostels and hoard, and the Public Health team had recently commissioned a specialist hoarding support worker role.

Provision of accessible information and advice

Some people we spoke to told us that they 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 fund or arrange their own care and support. We received positive feedback from people who told us that they were provided with relevant information and advice and were referred to appropriate services. People told us the information and advice provided was clear and concise, which helped them to understand the process as well as the support that was arranged for them. National data supported this feedback with 66.68% of people who use services who find it easy to find information about support, which was similar to the England average of 66.26%, and higher than the regional average of 62.35% (ASCS, 2023). Similarly, data for carers shows 59.49% of carers in Westminster who find it easy to access information and advice, which was higher than the England average of 59.06% (SACE, 2022).

Staff told us the online 'People First website' was helpful, however noted there was ongoing work to make it more visible and accessible, particularly for autistic people. The local authority has evidenced that people had multiple ways they could get information in an accessible way, through the website's easy read guides and the use of translators. Senior leaders told us the local authority needed to be mindful of digital exclusion as they moved more into a digital led world. As part of the local authority's improvement plans, they have introduced Adult Social Care Digital Plan 2024-2027, where they aim to promote choice and obtain feedback from people on the effectiveness of digital solutions.

Direct payments

The local authority acknowledged there was a gap in people using direct payments and had plans to increase the numbers. Some people we spoke to had ongoing access to information, advice and support to use direct payments. Most carers we spoke to had been made aware of direct payments but had chosen not to accept this, however we also heard some carers had not heard of direct payments before. We heard from partners that there had been issues with the direct payments and felt there had been a lack of choice and control for people to use the service. This was due to system challenges and complexities with management of the direct payments.

Some frontline teams explained the uptake of direct payments in their teams had been low and they were actively having discussions during their interactions with people to determine if it could be appropriate. This was evidenced in the National data, which showed 21.58% of total service users receive direct payments, which was comparatively lower to the England average of 26.22% (SALT 2023). The local authority provided further information which demonstrated some improvement in the uptake."

Furthermore, the digital 'virtual wallet' was introduced following a successful pilot with over 100 people, which allowed people to manage their care budgets and purchase services online. Staff told us direct payments took time to be set up and having a direct payment team brought improvements, including giving the team the ability to refer people for specialist support when required. Staff explained direct payments had been beneficial for people for whom English was not their first language as they were able to employ personal assistants to meet both care needs and language needs.

We had feedback from people that direct payments enabled them to employ personal assistants to help with managing the life and social activities as well as making contingency provision for emergencies. This was a good example where the local authority had considered contingency planning.

In early 2023 the local authority undertook a review of their approach to direct payments. This involved engagement with people, staff and partners. As a result, some of the developments the local authority made had been to produce clear and easy read documents as well as an online video explaining direct payments and its effectiveness. A new dedicated direct payments team was set up who responded to the needs of people receiving direct payments. We had feedback from one partner that where unpaid carers needed additional support managing direct payments the local authority was proactive in providing support such as factsheets and guidance.
