Supporting people to lead healthier lives

Indicative score:

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

Public health was integrated within adult social care in Suffolk and senior staff talked passionately about this. Their focus was particularly in relation to people's wellbeing. Staff told us their approach was that they wanted to walk alongside people – not be doing 'to' them. This linked to their approach of working to people's strengths and capabilities.

'Feel Good Suffolk' was one initiative the local authority had developed alongside district councils. It focused on better health behaviours for people, for example support to stop smoking, manage a healthy weight and to be more active. The aim was to try to reach people who were not currently accessing services, promoting their health and wellbeing, and delaying or preventing the need for formal services in the future.

Staff had focused on the use of data from SODA (Suffolk Office of Data Analytics) to enable them to do more targeted preventative work alongside the district councils, police, and other agencies. Staff told us their positive relationships with district councils meant they were able to have more detailed information at 'place' level about community needs. Then, by sharing this with the locality teams, this helped them understand their communities better. One partner agency spoke positively about working with the local authority and explained they were working on how to connect better with data sharing to inform this work more.

Personalised care was a current focus for the local authority as the use of direct payments was identified as being low. The local authority's ambition was to increase this to enable people to have further choice and control in relation to their care and support. A project team had been set up to increase staff confidence and practice in promoting direct payments.

Preventative services closely linked to occupational therapy in Suffolk where they were using more creative, preventative measures, for example digital equipment to reduce care and increase independence and wellbeing. The integration of occupational therapists (OTs) into areas meant it was easier to get assessments completed, and get advice and equipment to support people to retain their independence. One example given was in relation to a piece of equipment provided for a carer to use when supporting their relative in the bath. This had reduced the time it took for them to get ready in the morning by about an hour, making this a far less stressful experience for them both.

A homecare reablement short-term service, 'Home First,' worked using 'strength-based' practice to promote people's independence by focusing on their own qualities and resources. Senior staff told us 80% of people did not require ongoing care following this service.

The local authority was developing some new reablement and short-term services in conjunction with health partners, to prevent admission to hospital. These were for people with a learning disability and autistic people, and people with mental health needs. This was a result of some people being discharged from hospital without adequate support in the past. One service was delivered in the community with the aim of helping to prevent, reduce, and delay the need for care and support, also providing emergency support if needed. Alongside this was an accommodation service that could offer support for up to 4 people who were at risk of their care and support breaking down in a crisis, which could result in a hospital admission.

A number of community-based early intervention services supported people at home and helped avoid people being admitted into hospital unnecessarily. These used a multi-agency approach with health and social care staff working together. One REACT service covered Ipswich and East Suffolk and a similar early intervention service was based in West Suffolk. The 'West Suffolk Anticipatory Care Project' sat within the local authority locality teams and aimed to support people who had been identified as very high risk of hospital admission. For example, some people aged over 65 with long-term conditions who lived in some more deprived areas.

Advocacy partners were working to increase awareness for local authority staff of when to make referrals for advocacy support. They told us they felt communication between themselves and the local authority could be better at times, for example with some discharges from hospital, and they could not always get to speak with staff in a timely way. However, another partner agency told us they had a good relationship with the local authority and felt the local authority had a good sense of what wellbeing meant and of the infrastructure needed to support the wellbeing of people in communities.