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 was moving toward a prevention and early intervention model. It was a key pillar within their adult social care strategy (2024-2025), which highlighted promoting people's wellbeing, resilience, and independence. This was focused on being both cost-efficient and giving empowerment to people to lead healthy and fulfilling lives.

Adult social care was embedded into wider local authority plans and strategies to support prevention. The new Health and Wellbeing Strategy, which was due to be published, outlined prevention approaches with partnership between adult social care, public health and housing. Senior leaders also told us adult social care, housing and public health all broadly aligned in their prevention vision. The adult social care prevention strategy (2024-2026) was clear and concise but was not recorded as being coproduced.

Senior leaders recognised the key challenges people faced which impacted on their health and wellbeing, with availability and quality of housing being a significant issue. The most recent housing strategy acknowledged the potential impact of these issues on people's physical and mental health and targeted improved access to housing and repair services to support prevention of needs.

The Haringey State of the Borough report (2023) outlined Haringey had the 8th highest rate of statutory homelessness (living in temporary accommodation) in London, compared to being 5th the previous year. There had been a 71% reduction in rough sleeping since July 2018. The current housing strategy, a coproduced Rough Sleeping Strategy (2023-2027), and plans for a new coproduced homelessness strategy, were targeting prevention of homelessness and supported people to reduce risks to their health and wellbeing.

Mental health was also recognised as a key risk by leaders and partners. Prevention strategies were aligned on the need to improve mental health early intervention. The local authority worked with partners to fund prevention activity, such as the mental health wellbeing network. There were also plans for a refurbished mental health centre which would support people before they reached crisis point, but this project had experienced significant delays.

The local authority had prevention services which had a positive impact on well-being outcomes for people. The Multi-Agency Care and Co-ordination Team (MACCT) was an integrated service which supported adults living with frailty and/or multi-morbidity concerns to maintain or improve their health, independence and well-being. For example, supporting people with falls prevention was an area of focus and had supported people to be more confident and stable with their mobility which helped to reduce accident and emergency visits.

The Connected Communities team also supported a prevent, reduce, delay approach. The team was spread across the borough to be closer to the communities it supported and provided a proactive approach to prevention. The team worked closely with partners, for example, being part of a local hospital advice hub which supported people with accessing universal services such as housing and finance. Partners fed back they were grateful to the local authority for supporting this. However, the Connected Communities team had reduced its staffing numbers, and this put a strain on the service.

The local authority's website had a range of resources which supported prevention. For example, information was available for ageing well, including an ageing well guide for people which was produced with partners. The guide covered topics for maintaining health and independence and was a positive example of collaborative working between the local authority and health partners to support prevention.

National data showed where people were able to access services, they had positive outcomes. For example, 69.57% of people said help and support helps them think and feel better about themselves which was statistically better than the England average of 62.48% (ASCS 2023-2024). This highlighted the positive outcomes achieved by the prevention approach in the area.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services which enabled people to return to their optimal independence. There had been an ongoing transformation of reablement services, with senior leaders telling us this was one of the local authority's strengths.

Local authority data showed, following phase 1 of their transformation, reablement pathways had become more efficient, with the service completing 99.2% assessments within 28 days (Information provided June 2024).

Haringey's reablement provision was made up of 2 teams, a community reablement service of carers and a reablement therapy team, whose input supported people to regain function. Approximately 85% of referrals came from hospital discharge, with 15% coming from the community to support reduction of hospital admissions. In an example given by the local authority, a person was referred from their GP following a serious injury and was put on the reablement pathway to reduce the risk of a hospital admission. Structures were in place to help prevent unnecessary admissions and promote independence.

Domiciliary homecare providers also supported with reablement care if required. A care partner told us reablement pathways were working well and they were able to work closely with occupational therapists to reduce people's care needs. They also told us the local authority had improved their reablement review timescales, so assessments were completed within 6 weeks. This supported people to plan next steps in a timely manner.

People had good access to reablement and rehabilitation services. A person told us they had accessed rehabilitation following a short time in hospital, this supported them to access additional support to eventually return home. National data showed 6.50% of people aged 65+ received reablement/rehabilitation services after discharge from hospital, which was statistically significantly better than the England average of 2.91% (Adult Social Care Outcomes Framework 2022-2023).

National data also showed 66.67% of people 65+ were still at home 91 days after discharge from hospital into reablement/rehab which was a negative variation as compared to the England average of 83.70% (SALT 2023-2024). However, the local authority told us these figures were not accurate due to an internal data recording issue. The local authority's data for between 01 October 2023 and 01 January 2024 showed this to be 91.07%, which demonstrated the local authority performing strongly.

Access to equipment and home adaptations

There was a significant waiting list for people accessing occupational therapy (OT) assessments and this impacted on people getting timely access to equipment. As of 15 October 2024, data provided by the local authority showed the waiting list was 420 people. However, the local authority had also outsourced 600 assessments to a third-party provider shortly before the data was provided. These 600 assessments had not been included in the waiting list data and therefore people waiting for an assessment was significantly more than 420. The median average wait time for people over the previous 12 months was 172 days and the maximum wait time was 465 days. The OT team also supported Children's services and health services in their roles.

Partners told us about the impact the waiting lists was having on people, for example, they were concerned for people's welfare as there were delays in assessment and completion of home adaptations.

The local authority had increased resource to reduce the waiting list and mitigate risk. The local authority had expanded staffing within the OT team through recruitment. The team used screening and prioritisation to triage referrals based on risk. For example, the team told us they could make urgent visits for people such as those requiring palliative care, so equipment was in place to make them comfortable. Contact was also being made with people on the waiting list to check if there had been a change in need or if any low-level aids could support people in the interim.

Following the move to a locality model, systems supported joint working between the OT team and frontline teams. A frontline team told us OTs on duty worked closely with them to review referrals and where there was urgent need, assessments were completed within 48 hours. They also told us members of frontline teams were trusted assessors which supported people to access low-level aids and equipment in a timelier manner and reduced workload on OTs.

Frontline teams told us equipment deliveries were generally not an issue, with set timescales for urgent and non-urgent deliveries. Local authority data showed, in the 12 months prior to September 2024, 328 out of 424 deliveries were completed on time, this equated to approximately 77%. In September 2024, 61 out of 77 delivery orders were completed within a month, which was a rate of 80%. The target delivery timescale was 2-3 weeks. A care partner told us provision of equipment for people had recently improved and people were getting access to aids and equipment in a timelier manner.

The local authority also had an assistive technology offer to support people to remain independent. They supported people with a range of technology, with approximately 2500 people supported with an emergency lifeline. The team received referrals from frontline teams and partners. For example, the team told us they received referrals from a hospital where a person was at risk of falls and required technology for discharge, such as falls sensors or alarms. People's assessment records showed the local authority utilised assistive technology, as they were supported to have a key safe and lifeline pendent.

There was a waiting list of approximately 100 people for assistive technology as of 8 October 2024, but the team told us they prioritised urgent referrals, such as hospital discharges, safeguarding and readmission prevention. The team told us these referrals were completed within 2 days.

Frontline staff teams were passionate about supporting people with their independence using aids and equipment. For example, a frontline team told us how a person was supported to access an unconventional adaptation to allow them to leave their home and take part in social activities. The team also told us they were proud to reduce the waiting time for people and support people to access equipment as soon as possible.

The local authority incorporated adaptations and equipment into their future planning. A staff team told us OTs were working with housing to support a new house building programme, so people's homes were more 'future-proof' and adaptable to support people's needs. A senior leader also told us bespoke homes were being built for people with future additional needs and they had received positive feedback around this.

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. Partners told us information and advice was difficult to access. A key issue highlighted was people not being able to get through to speak with the local authority, with contact attempted by people several times. Another partner raised concerns about the local authority not responding to people. They told us this created a great deal of frustration for people and was across several areas of the local authority.

Recent local authority survey data (Haringey Survey of Adult Clients 2023-2024) showed 25% of people finding it fairly or very difficult to find information and advice about support, services or benefits (a 2.5% increase compared to the previous year). 17% of people found it very easy to find this information, which was 7% less than the year before. However, National data reflected the local authority was performing in line with other areas. The ASCS 2023-2024 showed 63.35% of people who use services found it easy to find information about support which was in line with England average of 67.12%.

Accessibility to information and advice was a priority area of the local authority's Adult Social Care Prevention Strategy (2024-2026). This included enhancing the website to provide clear and accessible information, launching a public awareness campaign to ensure people know how to access the right information and development of locality hubs. A staff team told us the move to localities allowed people to access information or support all in one place and this would be especially beneficial for people with disabilities who would be able to be supported with multiple services at once.

The local authority had a range of information on their website which outlined their duties under the Care Act 2014 to meet care and support needs. This included 'Haricare' which was a directory for adults who needed care and support. The website had useful tools for people such as an eligibility checker which informed people where a Care Act assessment may be required. Despite this offer, some partners told us the local authority website was difficult to navigate and understand for people which prevented them accessing information easily.

The Connected Communities team supported access to information and advice. For example, the team told us an area of community concern was social isolation. The team had recently produced a leaflet signposting people to organisations who could help. The team also facilitated weekly community-based drop-ins which were advertised across the borough. The team told us they felt like a truly front-door team, based in the community and visible to people. This was a positive example of proactively supporting people to access information.

The local authority had specific roles to support provision of information and advice. For example, there was a dementia co-ordinator who supported people with dementia and their relatives with accessing information. A partner told us this role had a positive impact for the community as the role supported knowledge of services and they also held events to promote understanding and dementia awareness across the borough.

Provision of accessible information and advice for unpaid carers was an area for development. National data showed 42.65% of carers found it easy to access information and advice, which was statistically significantly worse than the England average of 59.06% (SACE 2023-2024). Other data also showed 71.43% of carers found information and advice helpful, which was significantly worse than the England average of 85.22% (Survey of Adult Carers in England 2023-2024). There was mixed feedback from carers on available information and advice**.** Some carers told us they had received relevant information from their social workers and partners. However, some other carers felt it was difficult to get information and advice directly from the local authority.

The local authority had increased their support services for unpaid carers, with a further commissioned digital offer which included social connection and foundational support for people in their caring roles**.** However, carers and partners told us unpaid carers were not consistently signposted to commissioned information services and would have to source information themselves. While provision of information was available, supporting carers to understand what was available to them was an area for development.

Direct payments

The local authority was supporting people to access direct payments, which were used to improve people's control of how their care and support needs were met. National data showed 24.56% of people using services received direct payments and this was in line with the England average of 26.22% (Adult Social Care Outcomes Framework 2022-2023). Uptake of direct payments for people aged 18-64 and over 65 was also in line with the England average for each age group.

There was no waiting list for direct payments. The local authority told us they implemented robust, real-time monitoring to ensure direct payment referrals were progressed promptly. The local authority was planning to retrospectively report on the time from the agreement of an individual budget to the start of a direct payment, but this was not yet possible.

Unpaid carers gave us mixed feedback on direct payments. Some carers had heard of direct payments but felt they would not have anyone to support them with it. However, carers who did access direct payments were positive about their experience. They told us the direct payment was manageable and allowed them to take their relatives into the community and take part in activities. They also told us the local authority was involved with the monitoring of the direct payment use.

There was a designated Direct Payment team who supported people and staff to know how direct payments worked and if they were suitable. The team offered support and practical assistance to people, including with administrative tasks related to the direct payment. The team told us they undertook financial monitoring and regular audits of direct payment use. There was also a commissioned partner to give people support with direct payments. This included a personalised service which empowered people and gave choice in their care and support. The service also helped people to source Personal Assistants (PAs) if this was required. There were 2 direct payment advisors within the borough. A frontline team told us they would usually refer people to this service if they wanted a direct payment, so they fully understood the responsibilities of this. This was reflective of staff having knowledge of resources around direct payments.

Frontline staff told us they supported people to access direct payments. A team told us they supported a person to access a gender specific provision as this was appropriate for their needs. The local authority understood barriers to accessing direct payments and was taking steps to remove them. There was monitoring of direct payment uptake, including around equitable uptake across the population and a quarterly monitoring report. Information indicated direct payment uptake was broadly reflective of the population accessing adult social care services across demographics and location.