London Borough of Haringey: local authority assessment

How we assess local authorities

Assessment published: 7 February 2025

About London Borough of Haringey

Demographics

The London Borough of Haringey is home to over 260,000 residents. The borough's population has grown by 3.6% since the last census in 2011. Although Haringey has a younger age profile compared to England and Wales, Haringey is ageing faster compared to other London Boroughs. The number of residents who are aged 65+ has seen an increase of around 24% since the Census carried out in 2011.

The majority of Haringey's population identifies themselves as White, making up 56.99%. The local authority identifies as a diverse borough; 17.58% are from Black, Black British, Caribbean or African, 8.73% are from Asian, Asian British and 9.67% identified themselves under 'other' category.

The population has an Index of Multiple Deprivation score of 9 (1 is the least deprived, 10 is the most deprived) meaning it is one of the most deprived local authorities in England. Highest levels of deprivation were in the east of the borough.

Haringey is in the North Central London Integrated Care System together with 4 other London boroughs. The London Borough of Haringey is a Labour-led council, with a large majority.

Financial facts

- The local authority estimated in 2022-2023, its total budget would be **£499,480,000**. Its actual spend for the year was **£536,936,000**, which was **£37,456,000** more than estimated.
- The local authority estimated it would spend **£100,567,000** of its total budget on Adult Social Care in 2022-2023. Its actual spend was **£113,681,000**, which was **£13,114,000** more than estimated.
- In 2022-2023, **21%** of the budget was spent on Adult Social Care.
- The Local Authority has raised the full Adult Social Care precept for 2023-2024, with a value of **2%.** Please note the amount raised through Adult Social Care precept varies from Local Authority to Local Authority.
- Approximately **3,625** people were accessing long-term Adult Social Care support, and approximately **700** people were accessing short-term Adult Social Care support in 2022-2023. Local authorities spend money on a range of Adult Social Care services, including supporting individuals. No 2 care packages are the same and vary significantly in their intensity, duration, and cost.

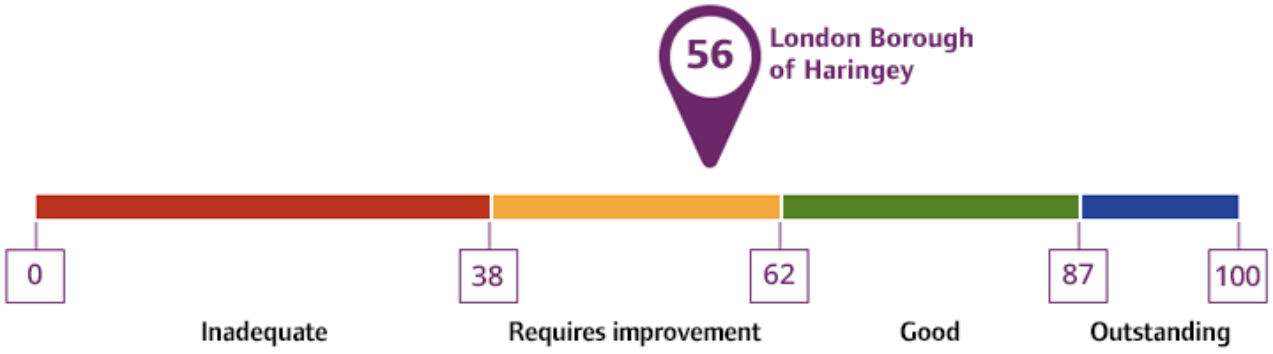
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

London Borough of Haringey

Requires improvement



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 2

Partnerships and communities

Score: 3

Safe pathways, systems and transitions

Score: 2

Safeguarding

Score: 3

Governance, management and sustainability

Score: 2

Learning, improvement and innovation

Score: 2

Summary of people's experiences

People’s experience of the local authority’s services, care and support was mixed, with examples of both positive and negative outcomes.

Most feedback from unpaid carers was negative. This was related to the availability, quality and outcomes of assessments. Some carers told us support was not easily accessible or suitable and they did not feel supported in their caring roles. Carers who had access to an allocated worker told us their workers were responsive and supported them. Some carers told us getting a break was difficult. This was detrimental to their wellbeing and left carers at risk of breakdown.

People’s experiences of assessment, care planning and reviews was mixed. Assessments were broadly person-centred, strength-based and reviewed people’s needs holistically. However, timeliness of assessments and reviews were a barrier for people, with people facing long waits to be assessed or access support. Where people had accessed support, there were examples of positive outcomes for them. Contacting the local authority was also a barrier, with information not always being accessible. Communication needs were not always considered for people.

People had positive experiences of being supported by multi-agency integrated teams which enabled people to access services and stay independent. People were supported to access care provision within the local Integrated Care System (ICS) where in-borough provision was not available, but access to some provision was limited. This included day services and respite. There were mixed experiences of transitions between services such as Children's to Adult's services. Most people who used services felt safe but contact with people and partners following safeguarding referrals was not always consistent. People were receiving increased engagement through coproduction activities such as carers and coproduction groups.

Summary of strengths, areas for development and next steps

The local authority was undergoing a transformation to a locality-based model to improve their processes and better support communities. Senior leaders told us they recognised their areas for development and the transformation was in response to this. Impact of this transformation was not yet clear, but staff and partners told us this was a positive change.

Carers' support was a key area for development, and this was reflected in data which showed significantly worse performance than national averages in several areas. The local authority had taken steps to improve their unpaid carers offer including a further commissioned carer support partner. A coproduced carers strategy was being developed but the current strategy was out of date.

Waiting lists delayed people accessing support. The local authority had reduced their waiting lists, including by outsourcing backlogs. Staffing had been increased across social care significantly to help manage workloads, which included frontline teams, but some staff told us capacity was still an issue.

Information was not always accessible. This included supporting people with reasonable adjustments, so information was available in a suitable format. Support for people with sensory impairments was limited, although the local authority was taking steps to increase this. The front-door of adult social care had moved to localities to streamline contact processes and there were plans for physical hubs to support people to access information.

There was a strength-based and outcome focused model. Staff feedback and assessments broadly reflected this approach. Access to care provision was limited and this had some impact on people's choice over services. The local authority had strong working relationships with neighbouring local authorities to access out-of-borough services.

Coproduction to influence change was recognised as an area for improvement. Partners told us support and investment for coproduction had been limited and there was mistrust from communities following, for example, a cancelled coproduced project. The local authority was taking steps to address this, and this was reflected in strategies and processes such as specific coproduction groups.

Safeguarding processes reduced the risk of abuse and/or neglect to people. Communication with people and partners was inconsistent following referrals but staff understood the need to make safeguarding personal. Transitions pathways from Children's to Adult services were being transformed to support earlier contact with young people and more robust processes.

The local authority's integrated teams performed strongly. The Multi-Agency Care and Coordination Team (MACCT) offered people a coordinated service which reduced hospital admissions and supported independence. Similarly, reablement services were performing well and reduced readmission to hospital.

Senior leadership was visible, supportive of staff, and worked together to support a positive culture. There was a positive workforce development offer with opportunity for progression. Quality assurance systems supported the local authority to improve their systems and processes.

Theme 1: How London Borough of Haringey works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

The local authority was undergoing a transformation of their pathways for people accessing assessments, care and support. There had been a recent transition to a locality-based model, which meant some frontline teams were specific to areas of the borough. This transformation was ongoing and new teams were being embedded.

Access to assessments and reviews was limited due to challenges contacting the local authority. People and partners told us contacting the local authority over the phone to request assessments or support was time consuming as it was difficult to get through to speak with staff. Conversely, people who already had an allocated worker told us their workers were contactable and responsive to them.

As part of their new localities model, the local authority's front-door for social care was also being transformed. Locality front door teams received and screened referrals for assessment and services. This replaced the previous borough-wide 'first response' team. There were plans for the new front door system to include walk-in services at hubs across the borough as well as access to services through telephone and email. Leaders and staff felt this would improve the local authority's responsiveness to those requiring support from adult social care services.

Most people and relatives we spoke with who had received assessments told us their views, needs and wishes were respected and they were happy with their commissioned support. However, some relatives felt their loved one's needs had not been holistically assessed, and long-term goals and support for independence had not been considered. A person-centred approach was not always consistent, and this was reflected by data. The local authority's own Haringey 'Survey of Adult Clients (2023-2024)' found only 54% of clients felt they had enough choice over the support they received. This was 8.3% less than the previous year. Data from national sources showed 55.06% of people were satisfied with care and support which was a negative variation as compared to the England average of 62.72% (Adult Social Care Survey – ASCS 2023-2024).

The local authority had adopted their own model of strengths-based practice to support person-centred assessments and deliver outcome focused support for people. For example, staff undertaking assessments asked people to score themselves out of 5 in key areas (independence, connection to community, social interaction, safety and contentedness) and this was used as a wellbeing benchmark and was re-scored when completing subsequent reviews to measure improvement.

Staff teams told us they used a person-centred and strength-based approach. For example, frontline teams told us people were supported to access their choice of moving to a different area to be closer with their family where possible. Frontline teams also adopted an approach to promoting independence, supporting people to stay at home where this was their preference. While staff teams understood people's right to choice, national data showed 66.96% of people felt they had control over their daily life. This was a negative variation as compared to the England average of 77.62% (ASCS 2023-2024).

Referral pathway arrangements supported co-ordinated approaches across different agencies and services. For example, the learning disability service had multi-disciplinary pathways to support co-ordination, including a complex physical health needs pathway and a dementia pathway.

Assessment teams were competent in carrying out assessments. Teams were supported by their managers, who considered complexity and current workload when allocating cases to staff. Staff were also supported to access training to support them in specialist assessments. An example being the learning disability team who accessed training to support people with communication needs.

Timeliness of assessments, care planning and reviews

Assessments and care planning arrangements were not always completed in a timely manner and there was a risk this would impact on people negatively. For example, a person told us they did not access day service support for 12 months due to delays in assessment processes. Partners also fed back people were waiting for prolonged periods, with a partner telling us people were waiting too long to be assessed.

The significant waits for assessments and reviews were reflected in the data provided by the local authority. As of 15 October 2024, 248 people were waiting for an assessment and 1600 had been waiting for a review. The median wait time for assessments was 55 days and the maximum waiting time was 523 days. The median waiting time for a review was 190 days and the maximum waiting time was 882 days. National data showed the local authority had reviewed (planned or unplanned) 37.22% of long-term support clients which was tending towards a negative variation as compared to the England average of 57.14% (Short and Long-Term Collection - SALT 2023-2024).

The local authority recognised waiting lists as an area for improvement and there had been a reduction in people waiting since June 2024. The local authority had outsourced 600 assessments and reviews to reduce their backlog to coincide with their move to a locality model. A senior leader told us there was a wider approach to increasing team capacity following the move into localities which would support the completion of more assessments. A frontline team told us their waiting lists had reduced following a move to a locality model. Initial indication was the locality model was having a positive impact on timeliness of assessments, but it was not yet clear if this was a sustainable long-term model.

The local authority had systems to mitigate risk across their waiting lists. Referrals were being screening and prioritised to ensure people with the most urgent needs were contacted more quickly. Managers also had ongoing oversight of the review waiting list, with prioritisation given where there was a change in need. The local authority had also carried out checks on people receiving support to mitigate risk. In the last 12 months out of 3800 people who had received care and support, 3600 had been contacted for a '360 review', which acted as a non-statutory review of needs. Where it was identified increased or reduced care was required, this was referred to assessment teams for appropriate action. This reduced risks to people but there remained a risk to people not able to access services.

Once assessments were allocated, front line teams told us they met set timeframes, except for more complex cases. A frontline team told us they had an assessment completion target of 28 days from allocation, but there was flexibility where more time was required to complete the assessment.

Care providers gave mixed feedback about their involvement in reviews. Some providers told us they were consulted when reviews were taking place, but others felt they were not involved with the process. This inconsistency risked relevant information from care providers about people's care and support not being included within people's reviews and impacting on their outcomes.

Assessment and care planning for unpaid carers, child's carers and child carers

The local authority told us they recognised the needs of unpaid carers as distinct from the needs of the people they supported. Despite this, carers consistently gave negative feedback about how they were assessed and supported. This was also reflected in national data, with Survey of Adult Carers in England (SACE) metrics (2023-2024) showing 23.29% of carers satisfied with social services, which was worse than the England average of 36.83%.

Some carers told us support for their wellbeing could be improved. These carers reflected support had not had a positive impact on their lives and their health and wellbeing was declining. A carer told us the inaction of the local authority had a profound impact on them, with others telling us their caring role was detrimental to their physical and mental health. Carers' wellbeing not being supported effectively increased the risk of carer breakdown.

Accessibility of information, assessments, reviews and services were a barrier for some carers. Partners told us it was time consuming for carers to contact the local authority, and prolonged waits for assessments contributed to carer stress. Another partner told us as carers often found it difficult to make continuous plans, such as respite, when there was not an allocated worker involved. Some carers told us they were waiting prolonged periods to access assessments, reviews and decisions on commissioned support.

Despite concerns in delays in assessment and support, the local authority had reduced its carers assessment waiting list. As of 15 October 2024, there were 17 carers waiting for an assessment, with a median waiting time of 32 days and a maximum waiting time of 309 days in the last 12 months. However, the local authority had a target of completing assessments within 28 days and average wait times still fell outside of this timescale. Senior leaders told us there was an identified data issue in relation to the transfer of carers information across their systems that resulted in some delays. This issue was said to be now addressed.

When assessments were accessed, carers felt their needs were not adequately identified and met. Unpaid carers told us assessing staff were nice and listened, but there was a lack of understanding and recognition of their needs. Carers told us of being given support, which was not appropriate for them, without other options being considered. Carers told us their needs were not identified when the cared for person was being assessed. This was in line with feedback from partners who told us the local authority could improve consistency in offering joint assessments for both the unpaid carer and cared for person. National data showed 48.15% of unpaid carers felt involved or consulted as much as they wanted to be in discussions, which was statistically significantly worse than the England average of 66.56% (SACE 2023-2024).

The local authority completed carers assessments in-house but also had a commissioned partner to provide information, advice, emotional support and guidance for carers. They delivered this in several ways depending on need. This included online, face to face, over the telephone or via a home visit. Some carers told us access to this commissioned partner had allowed them to access support groups and connect with other unpaid carers.

Staff teams gave examples of systems to support carers. A frontline team told us they worked with a partner organisation to identify carers, and any support needed in their caring role. For example, carers were supported to access technology which allowed them to leave home for short periods and this supported them to manage risks to the cared for person.

Senior leaders told us they had acted to make improvements to their unpaid carers offer, which included an improvement plan. This included improved systems to support staff with completing carers' assessments; drop-in services for carers to access assessments and support; a further commissioned partner who supported with information and advice, and the creation of a carers coproduction group. While these were positive developments, the impact of these actions was not yet clear. A partner, however, shared there had been some recent improvements to the carers offer since a move to localities.

There was a commissioned partner who supported young carers. The partner provided information, advice and youth groups support. The frontline transitions team told us they made referrals to the partner where they identified young carers. A senior leader told us they recognised young carer outreach could be improved. The newly commissioned carers service also supported with identifying young carers.

Help for people to meet their non-eligible care and support needs

The local authority had services to support people with non-eligible needs. Staff told us how the locality front door teams supported signposting to teams and services following the start of the transformation. The transitions team also told us they supported young people to access information on housing and employment.

A team consistently referred to by other staff teams was the Connected Communities team. This team provided bespoke support for people until they had access to the services they needed, with no limits on the time spent supporting people. The team supported people to access a range of services, such as housing and community groups.

Other services within the borough which supported people with non-eligible needs included the autism hub, which supported over 500 autistic people. A relative of a person accessing this service told us they loved going there and accessing the available activities. A further example was the Haynes dementia hub, which was a local authority run service providing dementia support and awareness to the wider community.

Eligibility decisions for care and support

The local authority used national eligibility criteria to decide whether people and unpaid carers were eligible for care and support. The framework for these eligibility decisions was clear. The local authority had systems to provide outcomes of assessments, including written decisions on eligibility.

The local authority used their wider complaints process for appeals of eligibility decisions and did not currently have a separate process for appeals. In the 12 months preceding June 2024, there had been no appeals against the outcome of assessments.

Financial assessment and charging policy for care and support

The local authority had a significant backlog of financial assessments. As of 11 October 2024, 553 financial assessments had been awaiting assessment/completion for over 28 days. The median waiting time for financial assessments to be completed was 174 days and the maximum waiting time was 464 days. Senior leaders told us this was due to an increase in demand which had now been outsourced and all outstanding financial assessments were planned to be completed by February 2025.

Delayed financial assessment and billing were raised as a concern within a recently published Safeguarding Adult Review (SAR) in 2024. In their response the local authority referred to bringing financial assessment processes under a single leadership team with other social care functions to improve internal working.

The local authority had contributions for community care services and fairer contributions policies available on their website. There was also further information available on the website about charging, including for people who accessed residential services.

There had been a process outlined for appealing the outcomes of financial assessments. This included an initial review, followed by an appeal reviewed by a panel if required. The local authority told us there were no recorded appeals in the 12 months prior to June 2024.

Provision of independent advocacy

An advocate can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations. The local authority had a commissioned advocacy provider in place who supported people to access statutory advocacy.

People did not always have timely access to advocacy. Some frontline teams told us delays in accessing advocacy could lead to delays in processes such as assessments and reviews. Teams told us waiting times varied, with the longest wait being over 6 weeks. However, the wait was usually 1-3 weeks depending on priority. Delays in advocacy put people at risk of not accessing timely support. Senior leaders told us the local authority worked closely with the commissioned advocacy provider to improve recruitment and retention of their staff, prioritise risk and to reduce waiting times for advocacy.

Frontline staff gave examples of when advocacy was used to support people. There was an advocacy decision support tool which supported staff with referrals for advocacy services. A partner told us staff understanding of advocacy had improved over time. Staff also accessed support from the commissioned advocacy provider to develop understanding and support referral decision making.

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.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority understood its local population profile and demographics but recognised reducing inequalities in experience and improving outcomes was a continued area for development. This was recognised as a priority of the 'Haringey Deal' which sought to reduce inequalities in Haringey, supporting people to live a secure, healthy, and fulfilling life. Senior leaders understood the impact of inequalities across the borough, with identifying and listening to seldom-heard groups a priority for the local authority.

Haringey is the 4th most deprived borough in London with deprivation concentrated in the east, as compared to the west (Index of Multiple Deprivation 2019). The local authority told us high levels of deprivation contributed to lower healthy life expectancy. This was as low as 55 years of age in some wards. This meant people were starting to experience poor health and wellbeing much younger than the national average of 63 for men and 64 for women.

The borough was ethnically diverse. 65.1% of the population identified as from black and minority ethnic groups (BME) or other white ethnic groups (Office of National Statistics Census 2021). The local authority had also identified health inequalities across ethnic groups. For example, disparities in health outcomes were particularly stark for eastern Europeans and black African Caribbean, as compared to white British people.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act 2014 functions. However, strategies to reduce inequalities and improve outcomes for people were an area for development. For example, we were not assured strategies in this area had been coproduced and therefore fully represented people's needs. Equality strategies, objectives, and action plans did acknowledge and include plans to improve coproduction in this area.

The local authority used equality impact assessments (EIAs) to support decision making. However, a senior leader told us they felt the quality of equality information and data in EIAs could be improved to better inform decision making. The adult social care commissioning peer review (2022) also identified updates being needed to Equality Impact Assessments.

The local authority worked closely with key partners to better understand and reduce local health inequalities. For example, a senior leader told us they worked closely with public health and had developed an anti-racism coordination partnership group to support a reduction in inequalities.

The local authority commissioned research to better understand its communities and their needs. For example, 'Community Voices' used researchers who represented their own community groups to speak with a range of people from different ethnic backgrounds to understand their experiences of the cost-of-living crisis. The research informed opportunities and actions for the local authority to improve their relationships and support for communities.

The local authority had established links to community partners to support understanding of their communities and tackle inequalities. This included the use of the Borough Partnership Board and the more recently established Equality, Diversity and Inclusion (EDI) working group to support people to have a voice and reduce inequalities. Impact of the EDI working group was not yet clear. Some community partners highlighted there was still work to be done to understand and support seldom heard communities.

Haringey commissioned a range of health inequalities projects, with 17 projects overseen by a Neighbourhoods & Inequalities Board. For example, there was a specific project to support Somali mental health, which was an area identified for development by a partner. The local authority monitored projects and received positive feedback which supported their continued funding in most cases. The local authority recognised involvement of the voluntary and community sector in projects led to better outcomes for people, and it was recognised some projects would benefit from reaching out to these partners.

The local authority had also supported the introduction of community health champions and proactively approached to engage communities such as the Gypsy, Roma and Traveller community.

The local authority's move to a locality-based model was an opportunity to be closer to, and better understand communities. The Adult Social Care Strategy Action Plan (2024-2025) outlined plans to develop outreach into communities at a locality level for better engagement. This was also in line with an identified action from the Community Voices research project, which highlighted improvement to contact points for people. This work was still under development and there remained scope for increasing outreach at a frontline level for adult social care.

Support for unpaid carers from ethnic minority communities was an area for development. Partners told us there was a need for more work with these communities to support people in their caring role. The local authority had begun to reach out to unpaid carers from different backgrounds through, for example, their carers co-production group. The newly commissioned carers online service was also supporting with identifying 'hidden carers' which included those from minority backgrounds.

People and staff gave examples of staff having a good understanding of cultural diversity. For example, a frontline team told us they took steps to meet people's diverse needs, such as support for people to access places of worship. A person told us how they were able to have culturally appropriate meals from their commissioned support and this was very important to them, having a positive impact on their life.

Inclusion and accessibility arrangements

People's experience of accessibility arrangements was not always positive, and this created barriers when accessing support. The Office of National Statistics Census (2021) highlighted the importance of translation provision in Haringey with 30% of Haringey residents not speaking English as their first language and approximately 1 in 4 of this group identifying as not speaking English well or not at all.

Partners told us there was a lack of information available in other accessible formats and said the local authority's website did not include information in different languages for people whose first language was not English. The local authority's website had a translation function for multiple languages, but the local authority recognised this function was not always easy to find for people using the website. This created a barrier to people accessing information in a language they understood, especially for those not digitally competent.

Provision of accessible information for people was variable. For example, a frontline team told us they would use online tools to translate documents rather than access local authority translation services. Another frontline team told us they had internally requested translated versions of documents, such as assessments, for people. This highlighted an inconsistent approach being taken by frontline teams.

The local authority had commissioned interpretation services to support people. Staff were positive about access to these services when speaking with people. A staff team told us over the phone and in person interpreters could be booked and in place in a timely manner. This included access to British Sign Language (BSL) interpretation.

The local authority's use of easy-read information to support people with learning disabilities and/or neurodivergence was inconsistent. A person's relative told us communication needs were not considered before the person's assessment, such as easy-read information, to prepare them for the process. A partner also told us they felt there was a lack of easy-read information available for people.

Staff teams, however, told us how they adjusted processes to improve accessibility for people. A frontline team told us they could link in with the learning disability team to access easy-read material to support them in their role.

The local authority supported staff to access training to support people with diverse needs. Frontline teams told us how they received training to support communication with people with learning disabilities, autism, neurodivergence and hearing impairments. This supported staff to make conversations more accessible for people.

The local authority had a rehabilitation officer who supported people with sensory needs, such as those who had a sight and/or hearing loss. They supported people with sensory assessments and to use services, such as transport. There was only one staff member in this role, and this increased wait times to access services. A partner also told us there was a lack of commissioned services for people with sight loss. A staff team told us the local authority planned to increase the number of rehabilitation officers.

The local authority had provision to provide documents in formats accessible for people with sensory impairments. For example, large print, braille and audio tape was available for people with sight impairment.

Partners felt digital exclusion was a barrier for people in accessing services. The local authority recognised this, and digital inclusion was a priority area within the Adult Social Care Prevention Strategy (2024-2026). This included expanding digital training programmes to help residents use online services; providing access to digital tools and equipment through community hubs; developing online platforms to facilitate virtual support and social connections.

The local authority held events for people which were accessible and inclusive of communities. For example, the local authority's dementia co-ordinator held dementia friendly events for people. These events allowed people and unpaid carers to connect to a range of community groups and services who supported people to access information in appropriate languages. Groups and services at these events supported the borough to be more dementia-friendly and inclusive.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with stakeholders to understand local needs for care and support but also recognised the need to work more closely with local people and communities and this was reflected in the Commissioning Strategy for Adult Social Care (2024-2029). Leaders also told us the local authority's move to a localities model would support a better understanding of people's needs.

Haringey had launched a commissioning coproduction board as a mechanism for providers and people to support commissioning design and implementation. Due to its infancy, the impact of this approach was unclear, but there was some evidence the board had begun to influence processes such as quality assurance of services.

The adult social care commissioning strategy identified a range of key service needs which included: day opportunities, digital inclusion and technology, more and enhanced respite, developed and expanded support for unpaid carers, support for people with complex needs and behaviours that challenge, more move-on accommodation for people with mental health needs, dementia-friendly services and strengthening of transition services. These areas were in line with feedback we received from people, partners, staff and leaders and showed an understanding of local need.

There were positive outcomes where the local authority had worked with people to respond to local care needs. For example, partners were positive about the provision of the local Autism Hub, which was coproduced and described as an exemplar service.

The local authority worked with local stakeholders to utilise data to understand care and support needs of the community. Data was available on their systems, such as within their Joint Strategic Needs Assessment (JSNA) and market position statement, which helped to inform commissioning practices. A senior leader told us the JSNA and other relevant reports, informed decision making on the best use of resources. There was a focus on the local authority becoming data-led in their decision making and this included commissioning.

Market shaping and commissioning to meet local needs

People's access to a diverse range of local support options which were effective, affordable, and high-quality was inconsistent. Care provision within the borough was limited, but the local authority worked closely with other North Central London (NCL) boroughs to provide support for people.

Staff and partners told us about gaps in service provision in the area. This included care homes, dementia-friendly services, specialist accommodation for autistic people, complex placements and mental health provision. These areas were outlined within the local authority's Market Position Statement (2024) as service needs, except for specialist autism services. There was, however, a separate Haringey All Age Autism Strategy (2021-2031) which did refer to improved autism provision for young people and adults.

The local authority's Adult Social Care Commissioning Strategy (2024-2029) and Market Position Statement (2024) outlined the need for an outcome-based and person-centred commissioning model. Available provision within the borough made a person-centred model more limited. For example, staff told us there was a lack of available placements for people at a higher risk of falls or needing 1:1 support. They gave an example of a person being ready for discharge from hospital for 10 days as there were no available local placements for them.

The local authority's commissioned homecare was focused on outcome-based support and was delivered by a small number of domiciliary-care providers which were locality-based. People told us they were supported to access homecare support, which was flexible, person centred and of good quality.

People and partners were not always included in market shaping activity. The Adult Social Care Commissioning Strategy was not recorded to be coproduced, although it was said to be informed by the voices of people and other stakeholders. Some care providers felt they were not given an opportunity to voice their views on local needs and engagement was limited. Despite this, the local authority held monthly care provider forums to understand provider perspectives and gather feedback. A care provider told us the forums were useful and they were also used for external agencies to provide input for local providers.

The local authority's commissioning approach aligned with internal and external stakeholders. This included the objectives of housing, public health and the ICB. The commissioning strategy, alongside other relevant partner strategies were reviewed by the Health and Wellbeing Board, supporting joined up approaches. Staff, leaders and partners in each of these areas also told us about joined up working at a strategic level. For example, a senior leader and a staff team told us about reduced capacity of accommodation for people with a learning disability, especially for those who required wheelchair accessible housing. Support in this area was reflected in the Housing Strategy (2024-2029) which was committed to supporting accessibility in a set proportion of homes.

Haringey told us there was a range of market shaping activity taking place to improve their carers offer. This included plans to have a carers 'representative' at each locality site at least once a week; improved outreach to the hard-to-reach carers; improved identification of carers; strengthened review and assessment arrangements and better contingency care arrangements. The local authority had also introduced a second commissioned provider for carers support. This organisation supported with online information and advice as well as identifying 'hidden' carers who did not access support.

Ensuring sufficient capacity in local services to meet demand

Capacity for care and support within the borough was limited and as a result, a large proportion of care and support was commissioned out of the borough.

Data provided by the local authority in June 2024 showed 45.8% of people's placements were outside of the borough. 45.2% of placements in the last 12 months were also out of the borough. The local authority told us most of these placements were within the NCL sub-region, with which the local authority had a close working relationship. The most recent Market Sustainability Plan outlined a significant proportion of placements outside of the NCL region (approximately 30%). Reasons cited by the local authority for the large proportion of out-of-borough placements included limited suitable accommodation or services; client and family choice and specialist care provision not being available.

The local authority had outlined strategic plans to reduce out-of-borough placements. Staff told us there was a recent project to understand how people could be returned to the borough to reduce out-of-borough placements. This included considerations such as placements in supported living accommodation or other development opportunities such as units to support older people with more complex needs such as dementia.

There was a recognition of the need to ensure sufficient capacity in care provision to meet increasing need within the borough and this was reflected in the Commissioning Strategy for Adult Social Care. For example, it was recognised there was an ageing population, and this would increase demand for services such as homecare, residential care and day services. There was acknowledgement this would require investment in capacity, workforce development, and infrastructure to meet growing demand.

The local authority worked closely with the NCL system to retain oversight of residential and nursing care provision across the system. There was shared consideration of block bed arrangements where there was capacity, which supported consistent capacity for the local authority. This approach helped to mitigate risk to people who required care home placements.

Access to some specialist accommodation was limited, particularly for people with complex needs. While a partner told us a large majority of people's accommodation needs can be met within the NCL, another frontline team said this was a challenge. Immediate placements for people with complex mental health needs were difficult to source. Another partner told us there was a risk to people residing in institutions, such as long-stay hospitals, facing lengthy waits for placements. Despite these concerns, the local authority had effectively managed waiting times for supported housing. As of June 2024, in the preceding 3 months, 3 people waited for supported housing for over 7 days from the date of their support plan agreement, with an average of a 19 day wait for these people.

Data provided by the local authority in June 2024 showed people could experience delays in accessing care and support where there was reduced care provision capacity. For example, the longest average waits in the 3 months preceding June 2024 were for nursing care provision and supported living services. Waits for these services averaged 27 days from support plan agreement. The local authority cited the likely cause of delays to accessing service provision was a lack of capacity in the market to meet the specific needs of individuals.

The local authority had sufficient capacity in their homecare market to meet demand. A frontline team told us they did not encounter delays with homecare being sourced for people. People were also said to usually have more than one option with language and religious needs considered where applicable.

Lack of local provision had some impact on people accessing personalised services such as day services. A person's relative told us how a lack of day service provision had meant the service the person attended did not offer access to the type of activities they wanted. National data showed 63.16% of people who use services felt they have choice over services which tended towards a negative variation from the England average of 70.28% (ASCS 2023-2024). This reflected reduced choice over services in the local area.

National data showed unpaid carers accessing breaks from their caring roles was in line with or slightly above national averages. For example, 23.16% of carers reported accessing support or services allowing them to take a break from caring for more than 24hrs which was slightly better than the England average of 16.14%. 16.84% of carers accessed support or services allowing them to take a break from caring for 1-24hrs was in line with the England average of 21.73% (SACE 2023-2024). While this was at least in line with national averages, a large proportion of carers did not feel they were accessing services to allow them to have a break. A staff team told us there were difficulties in sourcing respite for carers. A partner also told us respite was not in place quickly enough and they were aware of carers waiting over 6 months to hear about respite support.

A partner told us a specialist provision which offered high quality services and advice was the Dementia Hub. The Dementia Hub offered information and advice for people as well as day service provision. A senior leader was positive about this provision but felt it was more accessible to people in the West of the borough, where it was located. A staff member also felt dementia services in the East could be more developed. However, the local authority had invested in dementia services in the East, which included, for example, an older person's day service which was coproduced and met dementia-friendly design standards. Access to support across the borough was also being actioned as part of a NCL dementia working group which were looking at transport and provisions to support people access support in the East. Dementia-friendly services were identified as a key service need by the local authority.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed. Quality of services data was positive. For example, 87.50% of residential care homes were rated good by CQC rating and the only nursing care home in the borough was also rated good. 66.67% of Homecare services were rated good, and 12.96% rated requires improvement. 42.86% of Supported Living rated good by CQC rating, the remaining services were not yet rated. The local authority had also had no commissioning embargoes related to quality concerns in the last 12 months.

The local authority had a Quality Assurance and Contract Monitoring (QACM) framework which set out the approach they took to ensure local care and support services provide what individual service users needed. The Quality Assurance and Contract Monitoring Board met monthly to oversee and ensure the integrity and effectiveness of service delivery by contracted providers, located within the borough and local NCL system. The local authority worked with partners, such as the ICB, to assess performance data assess compliance with quality standards, and address any issues or concerns.

There were processes to apply suspensions on providers where concerns were raised. The quality assurance team told us they worked closely with other agencies and the provider to analyse any issues and support the provider to create an improvement plan. A staff team told us they worked with the Quality Assurance team and the Safeguarding team to create an action plan and monitor progress where a concern was raised about a provider. There were also processes in place to ensure urgent reviews of people's care were prioritised when concerns were present about services they used.

There was not a clear process for reviewing the quality of people's placements outside of the NCL system. While the local authority sourced feedback about placements from people and their representatives during '360' non-statutory reviews, this was a light touch process and did not fully review the quality of the services people received. There were clear processes where concerns could be raised about providers, however, the backlog and delays of people's statutory Care Act annual reviews highlighted a potential risk of concerns about people's care services not being known to the local authority which may have been identified during this process.

As part of their contracting arrangements, the local authority did not commission new care with registered services which were rated requires improvement or inadequate. This approach mitigated risk when placing people.

Quality assurance arrangements were in place to support quality of local services. The quality assurance team told us they tried to ensure they visited service providers at least once a year to complete mock inspections and identify potential areas for improvement. They also told us they regularly checked CQC ratings for changes and where ratings had reduced, they requested service improvement plans from providers.

Commissioned partners in the voluntary and community sector were monitored for the quality of their performance. For example, a commissioned partner told us they completed quarterly reports for their commissioner with themes. This supported people to receive better quality services and outcomes.

Care providers told us quality assurance processes supported them to improve their systems and practices. They told us staff were available to speak with them and were part of regular meetings which supported.

The local authority was focused on improving people's voice in improving quality of services. For example, the Commissioning Coproduction Board had developed a methodology to support people's voice in contract management and quality reviews of services. This was still being developed but would support people's voice within this process.

Ensuring local services are sustainable

Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruption or provider failure; contingency plans were in place to ensure that people had continuity of care provision in this event.

The local authority had developed a shared commitment to paying a sustainable market rate for accommodation with the NCL system, underpinned by sub-regional market analysis of costs and transparent relationships with providers. The system used this evidence base to support market sustainability and where appropriate efficiencies in negotiations with individual providers, including through inflationary uplifts, agreeing common spot rates, agreeing access to each other's block contract arrangements and agreeing some joint block arrangements.

The local authority had adopted commissioning approaches to support a sustainable market. For example, for homecare, most care was supported by regular contracted homecare providers who had 'bundled hours' arrangements (approximately 70%). The remaining proportion of homecare were spot purchases which were sourced through a dynamic purchasing system. This was a system which involved home care providers registering their ability to pick up people's care without tied contract arrangements. This approach allowed smaller and medium sized providers to stay in the market as they still accessed local authority commissioned care.

Some care providers told us they were concerned about sustainability. A care provider told us they used zero hours contracts and at times where there was a lack people to support, it was more difficult to keep staff and put pressure on their sustainability. The local authority engaged with providers to understand workforce challenges and needs. Provider forums were used as a platform for the local authority to listen to providers.

In the 12 months preceding June 2024, 2 homecare. 3 supported living, 3 residential care homes and a nursing care home handed back contracts early. This impacted the care of 34 people, with 16 of these people in a residential care home. The local authority told us this was due to financial viability of individual packages of care or the business model of the providers. All people's care was reallocated to ensure continuation of services.

The local authority actively promoted the use of Skills for Care training for care providers. They told us they encouraged and supported them to access these resources during visits, provider forums, and through Proud to Care North London. National data showed 61.45% of adult social care staff with the care certificate in progress or partially completed or completed, in line with the England average of 55.53% (Adult Social Care Workforce Estimates ASC-WE 2023-2024). The local authority told us providers could access training and support to enhance their skills through the NCL Market Programme.

The local authority had identified the need to increase personal care services for people using direct payments and commissioned a partner to promote the role of becoming a personal assistant to support people's choice in services. Data showed a positive impact of investment in these services, with an increase of 117 people (20%) using direct payments in December 2024 as compared to April 2024.

Providers gave mixed feedback on the level of support they received for recruitment and retention. They told us some recruitment information was shared with them, but this was not always beneficial. Despite this, national data showed the local authority to be performing better than national averages in this area. For example, 8.44% of adult social care jobs were vacancies which was slightly better than the England average of 9.74%. There was also a statistically significantly better rate of turnover of adult social care employees, 0.12, as compared to the England national average of 0.25. (ASC-WE 2023-2024).

The local authority had a market sustainability plan which assessed the sustainability of local care markets. The plan outlined how the local authority supported the fair cost of care. For example, the agreed cost of care with residential providers was said to not require further subsidy from self-funding users of residential services. The plan recognised the risks posed to local services.

The local authority facilitated fair pay for adult social care staff. As part of contract arrangements, homecare providers were required to pay the London Living wage. There were also arrangements for homecare providers being required to pay for travel and waiting times for staff.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority was developing strong partnerships and worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area. Since service restructures following the establishment of the North Central London Integrated Care Board, the local authority told us they were resetting partnership arrangements to ensure a positive and productive approach moving forward.

The local authority came together with the ICB and other local health and care partners in the Haringey Borough Partnership (HBP). The HBP reported to the Health and Wellbeing Board alongside the NCL Care Partnership. The partnership was used to support shared ambitions, strategy and priority actions for the health and wellbeing of people. The partnership also input from communities through membership from the Voluntary, Community and Social Enterprise sector (VCSE) representatives.

A senior leader told us the HBP helped strengthen internal and external relationships with Children's services, Public Health, Housing and senior health partners. The local authority had shared objectives and alignment at a strategic level with partners, for example through the Health and Wellbeing Strategy. A senior leader told us strong partnership working with VCSE and health partners was reflected in the HBP's thematic delivery areas 'start well', 'live well' and 'age well' which aligned with the strategy.

There were local authority teams who worked with partners to achieve national and local objectives. For example, the Integrated Reablement team were undergoing a transformation and had seen improvements in its performance. The integrated service provided support through OTs and physiotherapists who worked closely alongside local authority care staff. This supported people to achieve reablement goals. The team also worked closely with a health Rapid Response team, who referred individuals from the community who were at risk of admission. The team would support these people for short periods to reduce risk of admission.

A senior leader told us there was still scope for improvement of integration of adult social care and health services. However, opportunities for further integration had been recognised and joint working was said to be improving. They gave a positive working example of a multi-agency drugs and alcohol team who supported people to achieve better outcomes. A safeguarding adult thematic review also highlighted there had been significant improvement in multi-agency communication because of the introduction of the localities model, for example for hospital discharge.

Arrangements to support effective partnership working

There were clear governance, accountability and monitoring arrangements for the HBP, with clear roles and responsibilities. The HBP had a clear structure with defined roles and set priorities. The partnership was co-chaired by a senior leader of the local authority and a local health trust. Structures within the partnership were built around the HBPs thematic areas of focus, with a board for each area with set roles and priorities.

The local authority had both formal and informal partnership working arrangements to support delivery. For example. the local authority had a Section 75 (NHS Act 2005) agreement with the ICB to facilitate partnership working but this was currently being jointly reviewed.

People benefited from a joined-up approach from the local authority and partners where there were integrated services. For example, people were supported by learning disability services to access both social care support and healthcare to reduce risks and identify positive outcomes.

Where Section 75 agreements were not in place, such as with the Mental Health Trust, teams worked with health partners to support people, but approaches could be inconsistent. There was mixed feedback from staff on how well these processes worked.

Partnership working to facilitate agreement of funding splits was an area for development. A senior leader told us data showed the local authority had a disproportionate level of health funding for complex care packages as compared to other areas and this impacted on the local authority financially. A staff team also told us funding splits were being reviewed for people with mental health needs to ensure these were reflective of people's social care and health needs. Staff told us they had received support and training to take part in joint funding discussions with health colleagues. Staff understood the level of evidence required to support joint funding decisions.

The local authority used pooled resources, such as the Better Care Fund, to deliver positive outcomes for people through integrated services. This included the reablement pathway and the MACCT.

The MACCT was a positive example of proactive integrated working. The team worked to reduce and prevent inappropriate hospital admissions. For example, the team told us they were able to support a person who was at high risk of falls. Following a referral, they supported them to receive a physical and functional assessment, a Care Act assessment, a medicines review, an OT assessment for a wheelchair and eventually an agreed package of care. The team did not have a time limit on input and continued their support until the person was safely discharged from the service.

People's experience of the MACCT was mostly positive with 94.4% of 53 responders to a patient survey responding they felt the service was very good or good. A person fed back on the service, stating they had provided strong support for their relative who had complex needs. They said the team offered a broad range of services but managed to execute their role as a team effectively.

Internal partnership working arrangements also supported people to achieve positive outcomes. People told us adult social care and housing had worked closely together to support them to get support. A frontline staff team also told how they had close working relationships with the housing team, and they had supported a person to remain in their home while relevant assessments were taking place at their newly allocated property.

Impact of partnership working

The local authority and its partners monitored their partnership working and the impact it had on outcomes for people. Effective use of pooled resources was also monitored. An outcome monitoring framework for the HBP monitored performance across their priorities and objectives. A performance dashboard monitored performance across several local health and care indicators. For example, there was a measure of care home admissions for people aged over 65 over a quarterly period and this was compared to regional and national averages.. As of October 2023, this approach was being developed with a focus on linking specific outcomes to more holistic wider population health outcomes. Monitoring frameworks were planned for projects to measure efficacy and outcomes for people. For example, the local authority was working with partners to improve the local dementia offer for people and as part of this work were part of a dementia working group. This included development of monitoring framework to show how outcomes were being improved.

Better Care Funding projects were also monitored to measure effectiveness. For example, for people referred to the MACCT there had been a 40% decrease in hospital emergency department attendance in the year following MACCT intervention, as opposed to the year before. Monitoring information which showed efficacy was used to support future funding decision making such as continuation and potential expansion of the MACCT.

Working with voluntary and charity sector groups

The local authority's structures were being developed to support collaborative working with voluntary and charity organisations to understand and meet local social care.

The local authority supported the contribution of voluntary, community and social enterprise sector at a strategic level. For example, the VCSE sector was represented at the Joint Partnership Board (JPB) and the Health and Wellbeing Board, to help inform decision making at a strategic and executive level. There was mixed feedback from partners on whether they felt listened to or had opportunities to inform strategies and projects. A commissioned partner told us they had worked closely with the local authority to coproduce strategies and gave examples of where they had supported regeneration projects within the borough. However, some non-commissioned VCSE partners told us they felt ignored, did not inform strategy or the local authority was not responsive to them.

The local authority recognised they needed to develop and build capacity in the VCSE sector. The local authority had formed the 'Haringey Community Collaborative' as a platform to support this. The aim of this collaborative was to support grassroots organisations and underserved groups to strengthen governance, grow fundraising channels, build capacity, and increase impact. It also aimed for the VCSE sector to have a stronger voice in council decision making and strategy development.

The VCSE sector were being supported to have more input into local authority processes. For example, the VCSE sector was invited to be part of the commissioning coproduction board. A commissioned VCSE partner was also part of the carer's coproduction group, and a staff member told us links with this partner were strong. The partner told us they were hopeful their membership of the group would support outreach to new carers.

The local authority understood the unique contribution of the VCSE sector and commissioned well placed partners to support communities. For example, partners were commissioned to provide direct payment support, befriending services, wellbeing network and a home from hospital service.

The local authority also worked with the ICB to fund VCSE-led projects. For example, a senior leader told us about 'Tottenham Talking'. This project involved VCSE support for peer led group activities and therapy support for people with long standing mental illness. This supported the sector to access funding to support their communities effectively.

The local authority had staff roles which facilitated the work of VCSE groups. For example, a partner told us they worked closely with the dementia coordinator who was supporting them by advertising their services to people who may not know about them.

Staff told us they referred people to VCSE sector when required. A staff team told us they used 'Haricare' to search for services to support people, but the team told us they also had to keep their own list of services to make sure they had the most up to date information to support people.

Theme 3: How London Borough of Haringey ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 2

2 - Evidence shows some shortfalls

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

The local authority understood the importance of safety and the risks people faced across their care journey. They identified and mitigated risks to safely manage peoples' care. The Safeguarding Adults Board (SAB) provided measurement and monitoring of safety processes on a regular basis. The views of people who used services, partners and staff were listened to and considered by the local authority.

The local authority had systems and planning in place to respond to seasonal pressures, such as winter. The local authority, in partnership with the ICB, used investment to support safe management of care and support. For example, extra funding was used to support block bed capacity in residential services.

Senior leaders told us they managed safety in the care system by ensuring that all local authority staff were properly supported and equipped with the tools they needed to safely manage care. Support was provided through supervisions and learning and development opportunities, such as a Multi-Agency Solutions Panel (MASP). The MASP provided multi-agency support to staff in managing high levels of risk and complexity. Advocacy services were accessed by staff where required, but assignment of advocates was not always timely.

The local authority understood their processes for the safe movement of people between services. Staff spoke about cohesive partnerships within the local authority which supported safe, secure, and timely sharing of information to enable people to move safely between services. The move to the localities model also supported a more integrated approach across teams. Staff told us teams could work more closely together to support people and mitigate risk, such as supporting people to access urgent OT assessments and Care Act assessments.

Safety during transitions

The local authority was developing its approach to support people with transitions. There were some inconsistencies with how care and support was planned and organised with people, together with partners and communities to support safe transitions.

There was mixed feedback on experiences of hospital discharge from people and partners. Although reablement processes were performing well, partners told us the local authority could improve communication and timeliness of hospital discharges. This included people detained under the Mental Health Act 2005 who required Care Act assessments to support their discharge.

Care providers told us there had been recent improvements to hospital discharge but there had been some examples of people being discharged without appropriate support or provisions in place, with a care provider telling us they had to mitigate this risk. Some partners felt communication concerns and delays to discharge were due to a high workload and a lack of availability of local authority workforce.

The hospital discharge team told us they were now at full staffing capacity but recognised there could be delays to hospital discharges. They told us there were sometimes disagreements on the level of support required for people on discharge between staff and health partners. The team told us there was a pilot project underway to improve multi-agency discharge planning and processes to support strength-based practice.

There were clear, person-centred pathways and protocols to help prevent risk to people's continuity of care. The hospital discharge team told us their Home First and early-intervention approach supported safe transition for people from hospital to home. For example, a staff team told us a deep-clean of a person's home was organised in advance of their hospital discharge to minimise delays.

A SAR thematic analysis in September 2024 identified there was scope to improve hospital discharge processes, including discharge planning for people with complex needs and multi-agency working. The analysis recommended the Haringey Safeguarding Adults Board (HSAB) audited the effectiveness of practices supporting people leaving hospital where they had complex needs. The hospital discharge team told us due to now having a fully staffed teams, social workers could spend more time and focus on people with complex needs awaiting discharge from hospital.

Senior leaders told us there was ongoing improvement to discharge pathways, including an increase in discharging people home rather than to care settings. They told us following a move to multi-disciplinary working, communication and timeliness of decision making around discharge had improved. This supported the local authority to move towards meeting discharge targets.

Leaders, staff, and people identified safe, effective transitions from Children's to Adult services was an area for development. A new cross-directorate and multi-agency Integrated Transition Service had been in development since April 2023. The service aimed to build on Haringey's Preparation for Adulthood Action Plan (2022-2024) and drew on learning from a recent external regulator's report to improve support for vulnerable young people (14-25) transitions to adulthood. Staff told us the new strengths-based approach, which was in a pilot stage, aimed to engage young people earlier. This would allow sufficient planning time to prepare people for adulthood, employment and potential housing options.

The local authority understood the importance of maximising people's independence whilst mitigating risks. For instance, we heard young people's records were consistently updated on digital systems to ensure care continuity and safe transition to Adult services.

Pathways for identifying, assessing, and allocating complex and non-complex cases for people moving between Children and Adult services were well-understood by the local authority. Partnership working improved outcomes for young people who would not otherwise have achieved these results. Additionally, staff were aware young people undergoing this transition often had dual needs or diagnoses such as learning disability or mental health needs and worked with them and their families to provide holistic support. For example, a young person was supported to move to Adult services whilst remaining with the same provider service; this service received training from the local authority to enable them to continue to support the person as they reached adulthood.

People's and carers' experiences of transitions between Children's and Adult services were mixed. An unpaid carer told us they felt well-informed throughout their child's transition to Adult services and had a clear sight of next steps. Conversely, some young people experienced lengthy waits and struggled to access resources. Another person's relative also told us they had to chase the transitions team for the outcomes of the young person's assessment.

A carer's coproduction group facilitated by the local authority said there was work being done to improve transitions between children's and adult's services, but this was in its infancy.

Systems and processes to support people moving out-of-borough were in place. People's safety and wellbeing was supported when people transitioned to a new local authority area. The local authority funded ongoing care for 6 weeks once a person had moved to another area. The local authority ensured the receiving local authority were informed of any moves. The local authority also funded incoming people's care and support indefinitely where there were disputes over funding with other authorities until an outcome was reached.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. Some processes of contingency planning required development.

The local authority had clear processes to respond to interruptions to people's care and support such as in the event of provider failure, unplanned events, emergencies and cross-border service interruptions. This involved pre-set arrangements with local providers and agencies, as well as other local authority partners, to ensure services could be rapidly stood up and to secure care continuity if the need arose. Similarly, systems were in place to provide immediate care to keep people safe out of hours.

Quality assurance processes were in place to help monitor provider effectiveness and any concerns were discussed in a multi-disciplinary forum. There was a clear process to inform all relevant internal and external parties of business failure (including other local authorities using the provider) to minimise risk to those receiving care and support, and the circumstances that would lead the suspension or decommissioning of a service. Learning was fed back into the commissioning cycle, including feedback from people who used the service and their families.

Frontline staff told us proactive contingency planning was an integral part of their work. For instance, they worked closely with emergency services as part of their contingency planning to keep highly vulnerable people safe. An Emergency Duty team worked across Children's and Adult services to support care continuity 'out-of-hours', with daily handovers to the day team. Staff said they involved families to support contingency planning for those with learning disabilities in the first instance; thereafter, they would engage day services and homecare providers to mitigate risks.

We were told contingency planning for unpaid carers was important to the local authority. However, details around how they planned with carers to minimise risk when they could not fulfil their caring duties were vague. Additionally, some carers told us they did not feel the local authority had considered their future caring responsibility. A carer told us they were worried about how they will manage their caring role in the future, and another told us that future plans and respite care were not discussed as part of their carers assessment. However, some carers felt that plans for care and support were clearly explained to them and their wishes for the future were considered in their assessments.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

The local authority had transformed its safeguarding referral pathway following the introduction of its localities model. A central safeguarding team screened and triaged referrals based on eligibility and urgency. As pathways were still developing, referrals reached the local authority via different routes, including directly to the safeguarding team, through the first response team, and through the locality front door team. There were target timescales for dealing with safeguarding referrals. For example, it was expected referrals were screened or triaged within 24 hours and cases were allocated to staff members by a manager within 48 hours. Data provided by the local authority in June 2024 stated the median processing time for a safeguarding concern was 13 days from start to finish.

While there were processes to support staff to raise safeguarding concerns, these were not always followed. For example, a person was recorded to have raised an allegation of abuse in their assessment, but this had not been formally raised as a safeguarding concern. Despite this, risk to the person was mitigated immediately and a personalised approach was taken to support them to stay safe. The local authority acknowledged this reporting error but told us staff were now supported with training and workshops to ensure understanding of processes. Staff also told us the safeguarding systems and processes were person-centred and reflected peoples' wishes to support them to remain safe.

The local authority worked closely with the Safeguarding Adults Board (SAB) which met quarterly. For example, the SAB Quality Assurance Subgroup reviewed the local authorities processes around managing provider failure and service interruptions and refreshed their Joint Section 42 (s.42) Enquiry Framework. We heard the local authority's data team shared safeguarding data with the HSAB when requested, including information relating to timeliness of actioning safeguarding concerns.

The local authority acknowledged the importance of joint training and multi-agency collaboration to ensure the safe sharing of confidential information relating to vulnerable children, families, and adults. For example, there was a clear procedure for triaging urgent police referrals and the actions leading to a protection measure being implemented. The local authority used a regional multi-agency adult safeguarding to support their procedures.

The local authority monitored their safeguarding processes and strived to improve them where possible. Following an internal audit of safeguarding processes, the organisation had made several operational changes, for example, to how staff recorded people's information. They continued to monitor the consistency of this documentation. Other areas of action included the need for more proactive planning and professional meetings so clear actions could be agreed within set timeframes with responsible parties outlined. This included care providers and other agencies such as housing.

Safeguarding concerns which did not meet the statutory referral criteria were processed in appropriate ways which informed internal colleagues and community health partners of the risks to people. This approach helped identify the support people needed and prevented an escalation of needs.

The Safeguarding Adults Board told us that the local authority made use of Safeguarding data themes and trends to better understand risks to people. This enabled shared learning and drove improvement.

68.12% of people who used services felt safe in Haringey, which was in line with the national average of 71.06% (ASCS 2023-2024). 81.16% of people said the services they used made them feel safe and secure which was tending towards negative variation from the national average of 87.82% (ASCS 2023-2024). 78.35% of carers felt safe which was in line with the national average of 80.93% (Survey of Adults Carers in England 2023-2024).

Responding to local safeguarding risks and issues

There was a clear understanding of local safeguarding risks and issues. A senior leader told us there was a focus on homelessness and transitional safeguarding. For example, they told us there were risks for young people who did not meet statutory criteria for support, but work was being undertaken to safeguard young people. A Transitions Board supported processes to support the young people. The SAB chair told us there had been successes in transitional safeguarding and stronger partnership working had supported young people to the right outcomes.

SAB structures supported the reduction of risk and prevention of abuse and neglect. Sub-groups were structured around key risk areas and supported improvement. For example, there was also a sub-group which was focused on prevention and engagement to gather people's voice around key issues.

There had been 2 commissioned SARs since 2023. These reviews identified a range of recommendations and learning for the local authority and relevant partners. SARs included action plans with relevant recommendations, actions required, set timescales and lead officers identified. This supported implementation of improvements and partners being held to account by the SAB. For example, a recommendation had identified improvements to the Mental Capacity Practitioner Manual for adult social care staff. This had been actioned accordingly and was marked as completed.

Local authority staff were supported to access training and learning from SARs. A staff team told us issues and learning from SARs gave them an opportunity to reflect on and discuss practice, including at safeguarding learning forums.

Partners were supported to improve practices to keep people safe following SARs. For example, following a concern raised in a SAR around pressure ulcers, providers told us they had been supported to access training around pressure ulcers which enabled them to keep people safe. However, care providers were not always supported to learn from safeguarding investigations. While some providers told us the local authority shared learning with them, others told us this was inconsistent or did not happen.

There was a multi-agency information sharing agreement which supported local agencies to share information appropriately and quickly. For example, there was a system in place for the police to share safeguarding concerns, where they were rated on urgency. This supported the safeguarding team to triage referrals and plan appropriate responses.

Effective processes were in place to respond to Deprivation of Liberty Safeguards (DoLS) referrals. The majority of DoLS applications were outsourced. However, an internal DoLS team monitored the progress of applications and provided supervisory approval of applications, while supporting external partners such as care homes to navigate the process. There was a clear process in place for triaging DoLS applications and the Chair of the SAB was assured the local authority was actioning DoLS assessments effectively.

The median processing time for DoLS applications was 14 days, with a maximum processing time 50 days. There was no DoLS waiting list and the majority of DoLS referrals were outsourced.

Responding to concerns and undertaking Section 42 enquiries

Partners told us they did not always receive updates, outcomes and responses when making safeguarding referrals. This included both care providers and partners from the VCSE sector. Some partners told us they had raised concerns to the local authority about this but had not observed any improvement. However, another partner told us they had built a positive relationship with the local authority around safeguarding, and they felt able to challenge the local authority where necessary.

An internal audit completed by the local authority identified 71% of referrers were informed of the outcome of s.42 enquiries. The local authority felt this proportion demonstrated good practice around communication as it was not always appropriate or possible to respond to referrals. However, feedback we received indicated communication around safeguarding remained an issue.

Staff told us they worked with partners to safeguard people. For example, residential care homes were asked to complete investigations and take steps to safeguard people where appropriate following referrals. Staff told us they challenged partners where protection plans did not mitigate risk to people. The local authority retained oversight of this process. This supported people to be protected from the risk of abuse or neglect.

Local authority data showed, as of June 2024, the median processing time of a safeguarding concern was 13 days, the longest processing time was 302 days. The median processing time of a s.42 enquiry was 21 days, with the longest processing time 51 days. There was no waiting list for concerns or s.42 enquiries.

Partners gave us mixed responses on the timeliness of responses to referrals. Some partners felt concerns were dealt with quickly, whereas others did not.

The local authority had created a multi-agency s.42 enquiry framework and guidance, which was to be used by all staff managing or undertaking a Statutory Safeguarding Adult Enquiry under Section 42 of the Care Act 2014. The guidance included a process flowchart showing the different stages of the process including alternative responses if s.42 safeguarding enquiry criteria had not been met. The guidance emphasised the importance of involving the person at risk of abuse or neglect from the beginning and gaining their views on what they would like as the outcome. There was clarity on what constituted a s.42 safeguarding concern and when s.42 safeguarding enquiries were required, and this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a s.42 enquiry.

The local authority also used London ADASS (Association of Directors of Adult Social Services) s.42 guidance to support consistent decision making. Support was available to staff to undertake their safeguarding duties effectively and this was reflected in national data. 69.31% of independent/ local authority staff had completed safeguarding adults training, which was significantly better than the England average of 48.70% (ASC-WE 2023-2024). Partners also gave mixed responses about the knowledge of staff around safeguarding with some partners feeling staff were knowledgeable but others not.

Making safeguarding personal

Staff told us they contacted people, or their representative, once safeguarding concerns were received to gather more information and check their desired outcomes. A frontline team told us some people found it important for a face-to-face approach and in line with learning from SARs, this approach was adopted where possible. The team gave an example where an appointment had been made with a person at risk at a place where they felt safe to speak with staff about safeguarding concerns. However, a person's relative told us neither they, nor their loved one, was contacted by the local authority following raising an allegation of abuse. While feedback from people was limited, a partner also told us people were not always kept up to date on ongoing investigations or outcomes.

Systems supported a making safeguarding personal (MSP) approach. For example, referrals which met s.42 criteria, had clear processes in place regarding the division of responsibility for further enquiry. Where there was an allocated staff member who already worked with the individual, further enquiries would be allocated to this staff member. This supported continuity and support from a staff member the person knew. However, if there was not an allocated staff member, the person was safeguarded by the central safeguarding team.

Staff we spoke with demonstrated a strong understanding of a personalised approach to safeguarding and this was reflected in examples they gave. For example, a frontline team told us about concerns raised about an individual with care and support needs. The referral was due to concerns about neglect and the caregivers' approach to supporting the person. A staff member visited the person and took the time to build rapport, understand their needs and recognise there were no concerns around neglect and supported them to remain where they chose to be.

Staff told us people's rights were respected and staff followed relevant legislation such as the Mental Capacity Act 2005 and the Equality Act (2010) to support people to make choices that balanced risks with positive choice and control in their lives. For example, a frontline team told us how they supported a person at risk to make their own choices following a mental capacity assessment which showed them to have capacity to make their own decisions.

Staff understood the need for advocacy and upholding the rights of those they supported However, staff told us statutory advocacy was not always readily accessible and it took up to 6 weeks to get an advocate for people. National data showed 14.29% of individuals lacking capacity were supported by advocate, family or friend which was significantly lower than the England national average of 83.38% (Safeguarding Adults Collection 2023-2024). It was not clear if this again was due to a recording issue within the local authority's safeguarding systems.

The local authority's data showed, in 2022-2023, the proportion of people asked about their desired outcomes from safeguarding enquiries was 86% which was 4% less than their target of 90%. They also found 94% of people's outcomes met or partially met. The local authority told us the most recent data indicated 95% of people felt they had their outcomes met or partial met, which was a positive performance indicator.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

It was clear the leaders recognised the need to improve people's experiences, and this was supported by the local authority's strategies and action plans. However, systems and processes had not always supported people to have positive outcomes. This was particularly evident in the experiences of unpaid carers and people awaiting assessments. There was evidence of some improvement in outcomes, and this coincided with ongoing transformations, but the impact of these changes was not clear and some concerns remained.

There was a stable adult social care leadership team with clear roles, responsibilities and accountabilities. Leaders were visible, capable and compassionate. Leaders are experienced adult social care professionals which allowed them to support staff effectively in their roles. Staff told us local authority leaders made them feel valued in their roles. The local authority's political and executive leaders were broadly well informed about the potential risks facing adult social care.

Adult social care structures were undergoing a large transformation as the local authority had adopted a new localities model. Senior leaders told us the local authority's new structure reflected the communities they supported, was based on improving strength-based practice, and would help the local authority improve their delivery of Care Act 2014 functions. Structures were still being embedded and concerns the new structures sought to address remained, but initial feedback from staff and partners was positive.

Governance structures supported internal working relationships. For example, public health and housing demand functions sat under the Adults, Health and Communities Directorate which meant these areas, alongside adult social care, reported to the Director of Adult Social Services (DASS). This supported an aligned delivery of functions and a co-ordinated, preventative approach.

There was an adult social care risk register which documented the main risks to delivery performance. This included relevant actions to improve performance, and a risk rating system based on level and risk. Escalation processes were also incorporated into the register.

There was mechanism for challenge at a member level despite there being a large political majority. The local authority had an Adults and Health Scrutiny Panel, which scrutinised a range of functions related to Care Act 2014 duties. Roles in this panel were cross-party. This panel supported counsellors being held to account.

The local authority undertook quality assurance activities to inform its approach. The Quality Assurance Board met quarterly to provide an overview of the quality and safety of practice, process and systems. Internal and external audits, performance data, people's and staff's feedback all fed into the Board to inform service delivery, strategic planning and commissioning. Senior leaders told us they undertook, along with managers and senior practitioners, a range of audits and supervisions including monthly case file audits and thematic audits. They told us how this fed into senior leadership meetings and supported improvement of practice. Externally completed work, such as DoLS authorisations were subject to review and sign off from an internal manager to ensure quality and consistency of approach.

Strategic planning

Senior leaders acknowledged current challenges which impacted on delivery of Care Act 2014 duties, but allocation of resources was focused on supporting improved performance. Leaders understood the key areas for development and the investment in the locality model reflected this.

Most strategies were up-to-date and highlighted relevant key areas of development for the local authority. There was not an up-to-date Carers Strategy however, with the previous strategy running between 2020-2023. A lack of an up-to-date strategy for carers was significant due to the negative experiences of unpaid carers reflected in this assessment report. However, a new coproduced Carers Strategy was being developed and senior leaders told us they were focused on bringing tangible improvements to services and support for carers.

Workforce and recruitment challenges put pressure on frontline services. A partner told us assessment delays were due to the lack of availability of staff. Some staff teams also told us they were understaffed which increased their workload. There was a reliance on agency/locum staff to fill these gaps. Use of agency/locum staff was significant, making up 26% of the adult social care workforce (full time equivalents) as of July 2024. They told us there was ongoing work to reduce this, including through converting agency/locum staff to permanent staff where possible.

Turnover of staff also impacted people receiving services. A partner told us people wanted more consistency in staff they were speaking to as they built trust with an allocated staff member only to find they had left soon after.

Despite the concerns of some staff teams, the local authority told us they had increased staffing to support the implementation of the locality model by 25% and these posts were built into the budget for 2025-2026. Staffing had also been weighted in line with need, with increased staffing in the East of the borough where people's needs were generally higher. Staff told us since the move to a locality model, recruitment, retention and caseloads had improved. Senior leaders told us increased levels of agency/locum staff were in part due to this increased staffing to support the new locality model and allowed testing of staffing levels and roles required to respond to demand.

The local authority's use of data and insight to inform on risks, performance and strategy was continually being developed. A staff team told us senior leaders had recently brought influential changes to data collection and presentation. Data was being used to monitor risk areas, such as waiting lists, but some data presentations were still being refined to provide more granular details for leaders and managers. The team told us there had been major improvements since the change to a new data system and they were able to support data reporting for leaders to inform decision making and performance review. Systems to support leaders accessing data were not always consistent. While there were data reports and dashboards for leaders, a senior leader also told us they did not always receive regular performance information about adult social care. Despite this, they told us they did regularly meet other leaders, and they were proactive in seeking information which supported them in their role.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems. There was a data protection policy which supported staff to keep people's personal information safe. There was also a data protection officer and senior information risk owner who supported governance of data sharing.

The local authority used a secure data management system to store people's information related to adult social care.

Staff told us there were clear arrangements for when they shared information with external organisations. For example, a staff team told us they used encryption of emails where necessary when sharing information over email. A staff team also told us they knew to consult the Caldicott Guardian where needed. A Caldicott Guardian is a senior staff member responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

There were clear processes for data breaches. Where there was a data breach, staff and leaders reported this to the Information Commissioner's Office as required by the Data Protection Act (2018).

Learning, improvement and innovation

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

Partners told us coproduction was not well embedded and this was recognised by the local authority. For example, a partner told us it was not clear how coproduction was influencing change. Other concerns included the local authority not investing in supporting people to take part in coproduction which created barriers for people. We were told when there was effective coproduction, the local authority did not always follow through with projects. A senior leader told us the local authority had not communicated effectively with people to explain decisions when coproduced projects had been stopped. This all contributed to mistrust of the local authority from communities.

Despite concerns in this area, the local authority was committed to developing coproduction. Corporate local authority priorities included 'The Haringey Deal', which acknowledged they needed to do better to gather people's voice. The local authority had committed to improving relationships with communities and to work with people to support them to have a say in decision making. This approach was beginning to embed, with new strategies taking a coproduced approach. Senior leaders also told us the local authority supported people to access coproduction opportunities through reasonable adjustments, such as pre-meetings, easy read documents and accessible building and times of day in which sessions were held.

New processes reflected people's voice supporting decision making. The local authority had introduced carers and commissioning coproduction groups. These processes were still being developed but a partner told us people felt more listened to with this approach and it was more representative of communities. People told us they would benefit from more coproduction training to contribute effectively, and the local authority told us coproduction training was ongoing for these groups. A partner told us while previous coproduction had felt more tokenistic, a coproduction group demonstrated a positive approach.

The localities model was responsive to local communities and was an opportunity to improve coproduction and relationships. A senior leader told us the localities model supported coproduction of a newly developed journey through adult social care for people, and an external partner was supporting to map this journey so improvements could be made. The approach was still being embedded, with plans for physical hubs so people could receive a face-to-face service. Data was being collected on people's experience of the locality model and there were plans for this to develop services further.

The local authority worked closely with peers to support and improve their practice. For example, senior leaders met with local counterparts to share best practice. A senior leader told us the local authority had benefitted from a Local Government Association (LGA) peer review and this had highlighted the need for more coproduction in commissioning practices. This had triggered the implementation of the commissioning coproduction group.

The local authority also worked with external partners to learn and continuously improve. For example, following an external review in May 2023, the local authority took over the line management of mental health staff and commissioned services from the mental health trust. The review identified staff were undertaking Care Act 2014 statutory responsibilities 31% of the time. Senior leaders told us this transition had been managed well, without a drop in performance. A staff team told us the restructure had supported the adoption of a recovery model, rather than a medical model, which was in line with the Care Act 2014. They told us they now felt more represented at a strategic level and could be more flexible in presenting funding decisions. However, staff told us they were still embedding into their new roles as new structures continued to develop.

A senior leader told us the local authority had not previously been an early adopter of technological tools and strategies. However, this was beginning to change, with an example being the 'Technology for our Ageing Population: Panel for Innovation' (TAPPI) project. The local authority had been awarded funding to take part in a coproduced project, along with 5 other local authorities, to improve the way technology was used in housing and care. This project was also supported by University of Cambridge researchers, to study the benefits of the project and share learning to the wider care and housing sectors.

Staff told us of a positive working culture which supported continuous learning and improvement. Staff were supported with their continuous professional development, with a range of training and progression opportunities which were driven by leaders. There was a staff learning and development plan in place which outlined the training staff were supported to access in their roles. A staff team told us they could request specific training if they felt it would be beneficial to them and they would be supported to take part in it. Staff also accessed frequent case discussions with senior staff and leaders to aid their learning and support people to better outcomes.

The local authority had a strong learning and development offer. Leaders in senior roles, were an example to staff of the local authority investing in development. Both the Principal Social Worker (PSW) and DASS had progressed from a practitioner level to senior leader roles. The local authority supported apprenticeships and Assessed and Supported Year in Employment (ASYE) for newly qualified social workers. Staff gave several examples of opportunities for progression, but some staff teams shared staff moving to more senior roles put pressure on services on the frontline as they were not replaced with permanent staff.

Learning from feedback

The local authority had systems to receive feedback from staff, partners and people but recognised this needed continuing development. People and partners did not always feel listened to at a strategic level. For example, the local authority commissioned a Joint Partnership Board (JPB) with reference groups as a mechanism for people's voice to be heard on aspects of health and social care. While there were previous examples of positive impact from the JPB, attendees of the Board had raised concerns about the governance and effectiveness of the JPB in supporting a diverse range of people to give feedback and be listened to. A partner also told us the JPB initially worked well and supported input from people with lived experience, but input had gradually decreased, and funding was not present to support the Board sufficiently as it was labour intensive. Senior leaders told us a review of the JPB had taken place in response to feedback and an action plan was being developed with a third party to improve JPB processes.

Despite these concerns, other partners told us the local authority listened to feedback at an operational level. For example, a partner told us the local authority listened to and responded to concerns they had, which improved staff practices.

The local authority sought feedback on experiences from people, unpaid carers, and staff. For example, the local authority supported the establishment of third-party organisation Disability Action Haringey (DAH). The local authority commissioned DAH as a representative of disabled people to support their voice to be heard and provide more inclusive and effective services and was a positive example of sourcing feedback from people. The local authority also completed their own carers survey and adult social care survey. The local authority stated areas for development from surveys were being addressed through their new localities model, through better access to services, and through better communication. There was also provision given to support assessments/ reviews to be undertaken earlier. The local authority was part of a Department of Health and Social Care project to design and test a prototype for a standard assessment toolkit for local authorities. As part of this work, people were being contacted for feedback on assessment processes to inform future improvements to national processes.

The local authority gathered feedback from people as part of their quality assurance reviews as well as asking people if they wanted to take part in future co-production activity. Themes from this feedback were being used to inform training, continued professional development and were part of known challenges the local authority was working to address such as communication, waiting times and commissioned care. This feedback was also used as part of the service re-design for the move to a locality model.

The local authority sought feedback from staff to support practice improvements. For example, through the LGA annual health check survey (2024). The local authority scored consistently highly in areas of feedback from social workers, including for effective workforce planning systems, wellbeing, and safe workloads and allocations. Haringey ranked 15th nationally based on average responses to all standards measured within the survey, for local authorities which took part.

A leader told us reflective practice was an important part of the working culture and was embedded with staff supervisions. This was also shown in the LGA annual health check survey (2024), where social workers scored highly for supervision helping to critically reflect on work and supervisions helping to reflect on how regulatory standards were met.

There were 13 detailed investigations completed by the LGSCO related to the local authority. The local authority was late with remedies 50% of the time, as compared to the average of 25.34%. This meant the LGSCO agreed with over 9 out of 10 complaints made to them about the local authority and in half of the complaints, the local authority was slow to respond to recommendations.

The local authority received 223 complaints about adult social care in the 12 months prior to 1 June 2024, with an average 29-day response time. Complaints were analysed and relevant actions were taken to support improved performance with findings and actions discussed at quarterly monitoring boards. Managers and leaders received reports on complaints to keep oversight of concerns. The local authority had started recording compliments in 2024 and as of 1 June 2024 had received 15. The local authority told us they were shared with staff to help boost morale and support motivation for high standards.

Learning was evident when things went wrong. Staff were supported to access 7-minute briefings and access training and reports following SARs. The Safeguarding Adult Board and a relevant sub-group oversaw actions to improve processes following SARs.
