Haringey LONDON

Adult Social Care Services

The Local Account 2017/18

'We will support people to live healthy, long and fulfilling lives with control over what is important to them'

http://www.haringey.gov.uk

Contents Page

The Local Account is an annual publication that provides residents of the London Borough of Haringey with a summary of the adult social care activities that have been delivered by the council and its partners in the past year. This edition looks at March 2017 to April 2018.

Foreword

I am pleased to introduce Haringey's Local Account 2017/18 for adult social care services, which gives an update on the progress we have made in the year as well as what we plan to do in 2018/19 and beyond.

This account aims to help local residents, service users, carers, care providers and commissioners understand more about the social care services that the Council and its partners provide to adults in Haringey. The account sets out how we have been performing in providing these services and the difference these services have made to the lives of the people that we support.

Adult Social Care Services continues to face many challenges such as continual budgetary reductions, increasing demands and pressures deriving from an ageing local population who are living longer, which is good, but with increasingly complex needs. We are also seeing an increase in the needs of younger adults, as well as experiencing some difficulties with attracting and retaining a social care workforce. This means Haringey Council has to think in new ways to meet the diverse care needs of our population.

Our vision for Adult Social Care in Haringey is to promote independence and wellbeing, maximize improved physical and mental health, and enable choice and control, by ensuring all adults in Haringey have access to the right support, at the right time, in the right place, if and when they need it. In this way, we can ensure that all adults in Haringey are able to live healthy and fulfilling lives, with dignity, staying active and connected to their communities.

In the past year, Adult Social Care and Public Health have been brought together to create a new directorate called Adults and Health. This reflects on our focus to empower individuals to take control of their own lives and to stay as healthy and independent for as long as possible. Making the move to a system that primarily promotes independence and the resilience of individuals and communities is not an easy task. It will take time and relies on building on years of good practice, as well as a shared vision with our staff, service users, carers and families, community organisations, health providers and neighbouring local authorities.

That is why we have in place an adult social care transformation programme, which responds to the pressures on the system and personalises the way people receive the support they need. In delivering this new model of care, we are working in partnership with all stakeholders to shift resources towards a preventive approach that helps and promotes independence and supports communities to become strong, resourceful and resilient.

We are delivering innovative, local system changes that are improving support for every resident who accesses our health and social care services. We are also working with our partners to drive positive change for residents across the wider region. Our work towards Social Care and Health Integration has not gone unrecognised; in 2018, the Local Government Chronicle (LGC) announced the shortlist for the LGC Awards 2018, with Haringey making the list of finalists for our Design Framework for Integrated Care in the Health and Social Care Category.

We are keen to get your views on how we can improve the report in future and include the information that you want to read. If you have any comments or ideas for next year's Local Account, please let us know by completing the feedback form at the end of this document.

We remain ambitious and passionate about improving the health and wellbeing for all our residents and will use your views from any current and upcoming consultations to help shape services for the future ahead.

Beverley Tarka
Director of Adults & Health

Local Borough Profile

Haringey is ranked **30** out of the **326** local authorities in England with respect to deprivation, and is the 6th most deprived in London

Around **15%** of residents in Haringey are from Black ethnic groups and just under one in ten are Asian **(9%).**

The total resident population in Haringey is

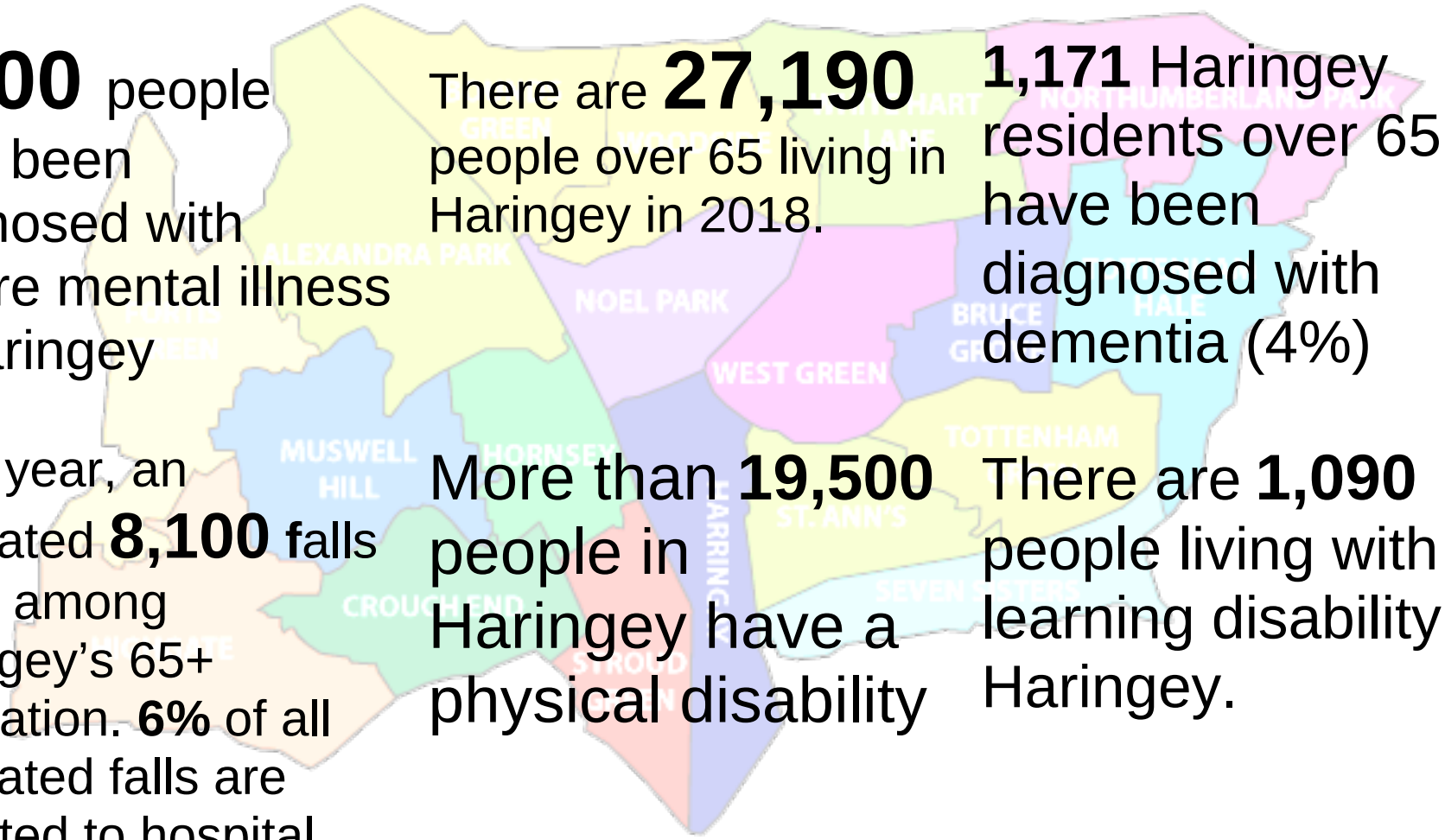
282,904

Haringey's population is expected to increase by 4% by 2028, to **294,829**, with the largest percentage growth in older age groups (65+)

63% of the Haringey population are from a BME group or Other White ethnic groups

Haringey has similar rates of depression **(6.5%)** compared to London but higher rates of serious mental illness **(1.3%)**.

Local Borough Profile



4,000 people have been diagnosed with severe mental illness in Haringey

There are **27,190** people over 65 living in Haringey in 2018.

1,171 Haringey residents over 65 have been diagnosed with dementia (4%)

Each year, an estimated **8,100** falls occur among Haringey's 65+ population. **6%** of all estimated falls are admitted to hospital.

More than **19,500** people in Haringey have a physical disability

There are **1,090** people living with a learning disability in Haringey.

The data above has been put together using the state of the Borough Profile. You can view the full document http://www.haringey.gov.uk/state-of-the-borough

Adults Data – How we performed in 2017/18

- We received 4,025 requests for support compared to 3347 in 2016/17

4,025

- 1065 people received one-off support compared to 1013 in 2016/17

1,065

- 806 People received Short Term Reablement services to help them regain independence compared to 574 in 2016/17

806

- 658 People started to receive an ongoing support service including community activities compared to 668 in 2016/17

658

- 1702 People did not go on to receive a service for a variety of reasons. (pay themselves, not eligible etc)

1,702

- Service users receiving community based social care services through self-directed support

80%

- 405 People were directed to other types of help and support including community activities compared to 1417 in 2016/17

405

- A total of 2824 service users received services through a direct payment or personal budget compared to 2624 in 2016/17

2,824

- 1870 safeguarding concerns were raised. This represents a 14% decrease in the safeguarding concerns raised from 2179 in 2015/16.

1,870

- 4884 Adults used our services last year. 2003 users of ASC are aged between 18-64. 2880 users of ASC are aged 65+

4,884

- 1548 people received home care support to enable them to stay in their own home compared to 1804 in 2016/17.

1,548

- 826 people were in permanent residential placements during 2017/18 compared to 779 in 2016/17

826

- There are 1595 carers known to services in Haringey. We assessed and reviewed 1017 carers during 2017/18. 165 carers received Direct Payments

1,595

- 428 number of people with mental health issues supported by services compared to 443 in 2016/17.

428

- Number of working age (18-64) people with learning disabilities living in residential or nursing accommodation compared to 142 in 2016/17

141

Adult Social Services Priorities

Adult Social Services plays a crucial part in helping residents to remain healthy and independent, whether this is through the provision of information and advice, access to universal or prevention services or more intensive support to those with very significant needs. Some of these services are directly delivered and others commissioned from independent providers, including the voluntary sector.

The objective is to help people to live as independent a life as is possible for them and have access to services that support and encourage that independence. Our starting point is to consider what people can do for themselves and build upon this. To take forward key aspects of this work, we have established a set of work streams that will help us to meet our transformation goals and focus on the core functions of:

- Maximising the independence, health and wellbeing of residents in communities
- Preventing health deterioration by promoting healthier choices
- Managing down the demand for more complex and costly services
- Improving services & reducing costs by working differently and together with partners
- Safeguarding all adults from abuse

We are committed to being open and transparent about our progress so that residents and others can easily track our performance and hold us to account. We publish regular updates to show how the council and partners are achieving against specific targets and you can our track progress including where improvements have been made and where performance is not up to scratch by going to our Priority 2 webpage: **https://www.haringey.gov.uk/p2**

Haringey Corporate Plan

Outcomes for adults are a priority in the council's Corporate Plan for 2015-18[1]. This is a recognition of the importance that is placed in Haringey on the work of Adult Social Care and its partners, and we all have a role to play in helping to achieve them. The objectives for Outstanding for all are:

1. All residents will be as healthy as possible for as long as possible.
2. All residents will feel more supported by the community to be healthier and to live independently for longer.
3. Support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing.
4. Residents assessed as needing formal care and / or health support will receive responsive, safe and high quality services.
5. All vulnerable adults will be safeguarded from abuse.

Our Priorities going forward

The Adult Social Care offer in Haringey applies to all adults in the Borough and applies equally to people who pay for their own care as well as those whose care costs are met by us.

Our Vision: Our vision for Adult Social Care in Haringey is to promote independence and wellbeing, maximize improved physical and mental

[1] https://www.haringey.gov.uk/local-democracy/policies-and-strategies/corporate-plan-2015-18

health, and enable choice and control, by ensuring all adults in Haringey have access to the right support, at the right time, in the right place, if and when they need it.

Our Principles: Our principles to delivering our vision help us shift away from institutional care towards move to more community, home based solutions forced on the individual. **We will:**

1. Prevent: Take every opportunity to support healthy and fulfilling lives by preventing the emergence or escalation of health and care needs and reduce the long-term need for services.
2. Connect: Work with residents, families, the voluntary sector and providers to ensure that more needs can be met in a community setting that reflect the personal networks and relationships of residents in Haringey.
3. Inform: Help those who require support, and their Carers, find ways to maintain control of their lives and health by providing information, advice, signposting, and support that is proportionate to their changing needs.
4. Work in Partnership: Design and commission services jointly with our health partners so that resources are allocated in the most effective way and residents' experience of maintaining or regaining their health and independence are joined-up and supportive.
5. Reduce Inequalities: Recognise the diversity of our communities and how different groups experience risk and vulnerability so that we can reduce inequalities in health and wellbeing within Haringey.
6. Safeguard: Work with partners to ensure that all vulnerable adults are safeguarded from abuse.
7. Co-Produce: Ensure that we actively engage and work with all stakeholders, in particular those who use services, Carers and their representatives to develop support options for the future.

Borough Plan 2019-2023 – Consultation

We are currently consulting on our draft Borough Plan. The draft Borough Plan sets out our proposed priorities for Haringey. These priorities have been developed following significant engagement with residents and partners, including; a large Residents' Survey of 1900 local people; two Borough Partners events, each bringing together over 100 local community organisations, businesses and public sector partners; a staff conference reaching 1600 staff; and a wide range of smaller workshops and discussions.

The priorities set out are underpinned by evidence, a summary of which is published in the 'State of the Borough'[2] evidence pack. The Plan sets out a proposed set of outcomes and objectives - and an illustration of the actions that the Council will undertake to achieve them. It also talks about some of the ways we want the Council to work in order to support these objectives through having good customer services and a focus on value for money.

The Borough Plan's key priorities include:

- **Housing** - a safe, secure and affordable home for everyone, whatever their circumstances
- **People** - strong families, strong networks and strong communities nurture all residents to live well and achieve their potential
- **Place** - stronger, connected communities where together we improve our environment by making it safer, cleaner and greener
- **Economy** - a growing economy which provides opportunities for all our residents and supports our businesses to thrive
- **Your Council** - the way the council works

The Borough Plan consultation will run until 11 December 2018. Use the link below to have your say:
https://www.haringey.gov.uk/borough-plan-2019-2023-consultation

[2] http://www.haringey.gov.uk/state-of-the-borough

Our Progress and Service Priorities Going Forward

Objective 1: A Borough where the Healthier Choice is the Easier Choice

"We are supporting people to make positive, informed choices about their health and wellbeing"

The Haynes Dementia Hub

The Haynes Centre is a specialist dementia hub, which provides different levels of support to those diagnosed with dementia. **The day service provision** is offered via social worker referrals to adults with a moderate or severe dementia diagnosis.

The Day Opportunities Hub is open to everyone with a dementia diagnosis, including those who can support themselves and those who need to bring support with them (i.e. personal assistant, family member), with the aim of offering preventative and delaying activities. This can be accessed by self, family, GP or social worker referral. This is offered on a pay as you go basis.

The Information Hub is open to everyone in Haringey seeking a support network, information and guidance around dementia, and the offers available across the borough.

The centre also supports the Haynes Relatives Support Group (HRSG) monthly meeting (the carers at the Haynes), and hosts monthly Tom's Club which aims to provide a supportive and social environment for carers of people with dementia who are not accessing the Haynes Centre as well as current users.

To date, we have:

- Developed links with and promoted use of Hub space to dementia-related organisations/services, including but not limited to: The Memory Clinic, Dementia Navigators, Dementia Steering Group, Hornsey's Neighbourhood Health Centre, Alzheimer's UK[3], Dementia Action Alliance[4] and the Bridge Renewal Trust (BRT)[5];
- Promoted the Haynes to other day opportunity providers as a touch-point for residents with dementia accessing day opportunities in the community;
- Sign-post residents with a dementia diagnosis, their families and carers to dementia-friendly day opportunities in the community using Haricare, Dementia Connect and up-to-date local knowledge;
- Deliver day activities and promote Hub space to a mix of services/ providers/ volunteers who can meet needs of residents with a dementia diagnosis;
- We have proactively linked with the day opportunities market and network and are influential in the development of dementia-friendly day opportunities in the community;
- Created regular open spots for special events, guests and themed sessions. We have enjoyed, circus skills classes, adapted yoga, musicians and theatre groups;

[3] https://www.alzheimers.org.uk/
[4] https://www.dementiaaction.org.uk/
[5] http://www.bridgerenewaltrust.org.uk/

Objective 1: A Borough where the Healthier Choice is the Easier Choice
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- We have a daily exercise programme which is adapted to meet each client's needs, sitting, standing stretching etc.;
- The regular bible study and religious study groups we hold help spiritual wellbeing;
- We offer balanced meals every day along with healthy snacks and drinks;
- Skills based workshops also run on a regular basis to enable muscle memory and cognitive strength to remain such as: baking, cleaning, kitchen safety, hand washing and personal care;
- All residents of Haringey with a diagnosis are enabled to use our fully accessible bathroom, shower, bath when required; and
- We work closely with clinicians and the memory clinic to report our observations and any changes in physicality/mentality or cognitive ability; this enables the medical teams to adapt medications to suit the client's needs.

Our priorities for next year:

- To continue to provide different levels of support to those diagnosed with dementia;
- Re-design partnership with 'Spare Tyre'[6] (a leading UK participatory theatre company, engaging those least involved in arts and cultural activity). We will work alongside Jacksons Lane, the theatre leading the partnership, and Homes for Haringey. Spare Tyre is a leader in the field of dementia arts, bringing a wealth of experience of engaging with people living with dementias and their carers. The project is all about bringing people from different sectors together, putting wellbeing at the heart of everything we do, and working at a very local level. This project began October 2017 and continues until 2019;
- Deliver dementia friendly coaching sessions to staff;
- Continue growing student placement growth; and
- To run day placements at over 90% at all times.

Ermine Community Hub

The Ermine Community Hub provides a day service provision for adults with Learning Disabilities, Complex needs and Autism. The Hub provides a sociable environment in which service users can meet other service users and join in different activities. We offer a variety of activities and drop in sessions such as drumming, yoga, cycling, singing, art sessions and we have a well-equipped sensory room.

An area within the Ermine Community Hub has been specifically redesigned to provide a specialist Autistic Service to meet the needs of adults diagnosed with autism.

[6] https://www.sparetyre.org/

Objective 1: A Borough where the Healthier Choice is the Easier Choice

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The day service provision is offered via social worker referrals to Haringey Learning Disabilities Partnership (HLDP). **The drop in hub** is open to all with a Learning Disability, Complex Needs and Autism diagnosis who can either support themselves or they can bring support with them. People will have the opportunity to socialise with friends, make new friends, access the cafe and computers and participate in a variety of pay as you go activities such as drumming, yoga or sensory. **The Information Hub** is open to everyone in Haringey seeking a support network, information and guidance around the offers available for people with Learning Disabilities, Complex Needs and Autism across the borough. We have:

- Continued to promote the Hub to the wider community and have seen an increase in Adults with Learning Disabilities accessing the hub to partake in activities or information and advice.
- Signposted Adults who contact us querying about services available by using Haricare (social care directory), local knowledge or referring them to the local coordinators
- Regular coffee mornings with family carers that helps build relationships with our carers and gives carers an opportunity to discuss the running of the Hub and any concerns. The feedback received in our coffee carer morning meetings has also been positive, with many parent carers informing us of the significant impact on the overall health of service users, which was observed in general behaviour at home (or place of stay) and art work.

- The Hub runs a variety of activities for people, which are outcome focused either at the Hubs or in the community such as trips to places of interest, drumming, yoga.

- We conduct surveys twice a year to measure satisfaction and collate feedback from both service users and parent/carers. The result from the surveys was highly positive with some valuable feedback. The results indicated a high rating for well-being and health, where service users were 'learning how to manage their health and what was unhealthy for them'. Other results also indicated that Ermine Community Hub scored highly on the 'range and quality of social relationships' and 'service satisfaction.
- As an outcome from the surveys and using the feedback productively, a new fitness group session was created. The fitness group focused on allowing service users to experience a positive session surrounding well-being, combined with a community outing to the local leisure centre (Tottenham Green). In addition, the group also personalised their own fitness t- shirts and switched to 'portion plates' which were also available to parent/carers to buy.
- At the Hub, we now provide postural sessions, which offer 'Acheeva Beds' as part of physiotherapy for service users. The postural sessions are an integral part of having a person centred approach, which include service users who may have mobility issues, or are wheelchair users.
- We also support a number of adults who access the hub to attend regular swimming sessions.
- We have the fitness and health group, which promotes healthy eating and fitness.

Objective 1: A Borough where the Healthier Choice is the Easier Choice

"We are supporting people to make positive, informed choices about their health and wellbeing"

Our priorities for next year:

- Increasing the variety of sessions and engaging a higher rate of external users by promoting our services
- Extending our information hub and the services we offer within our centre (display screen of our activities with dates and times)
- Creating a brochure for Ermine Community Hub promoting our services and activities
- Visiting other community hubs to work in collaboration and exchange ideas
- Set up a service user forum to ensure there is an even representation of views and opinions on the running of our day to day services and how to improve them
- Recruit volunteers for the service, tying in with universities and colleges, local voluntary and charity services such as BRT
- Work with Haringey Council internal services such as Speech and Language Therapy, Physio, Social Services and Local Area Coordinators
- Creating work experience/volunteer opportunities for service users to empower them with skills as a part of their personal development (kitchen/reception/dining hall)
- Promote a centre run largely by service users, increasing sustainability and independence

First Response Team

The First Response Team (FRT), act as the front door to Haringey's Adult Social Care. The FRT aim to meet client's needs at the first point of contact by providing advice and information otherwise known as sign posting.

The FRT work closely with the Reablement Team to support people to regain their strength and confidence; as well as working closely with health professions (G.P's, District Nurses, Mental Health Services) to promote health and wellbeing.

People with Personal Budgets

Every person eligible for support from the council's Adults' Services is offered a personal budget so they can control how their needs are met. This year the number of people receiving self-directed support through direct payment and personal budgets was **2824**. Work continues to encourage the use of personal budgets.

Winkfield Community Hub

A new Community Hub has been created at the Winkfield Centre, providing health and social care for people with learning disabilities. People are now able to access a range of community clinical interventions, including psychiatry, psychology and social care, from one location. Services are delivered in an accessible and modernised setting.

The centre offers a range of services and facilities including:

- A full range of activities and classes including Art, Craft, Ceramic, Mixed Media, Textiles, Collage and a choir!
- Comfortable waiting and dining areas with internet access
- A fully equipped new assessment centre for the Occupational Therapy Service to complete a thorough assessment of people needs

Objective 1: A Borough where the Healthier Choice is the Easier Choice

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- An assessment and training centre for people with visual impairments as well as other support enabling residents with disabilities and/or sensory impairment to manage their disability, maintain their independence and take control of their lives
- A fully equipped training kitchen
- Bathing facility fully equipped with hoists
- A relaxing garden area with pond and seating; the perfect place for lunch in the spring and summer months
- Tottenham Hotspur Football Club run weekly Chair based Exercises and Massage/Physiotherapy classes in the Centre through its Foundation programme

Our priorities for next year:

- Further enhance clinical delivery from both Winkfield and Ermine Road.
- Integrate community services more robustly to provide better support and intervention around prevention and health care.

Haringey's Annual Public Health Report 2017/18

This year's annual public health report is on stroke. While recent reductions in the number of people dying early from stroke in Haringey are to be welcomed, there are still higher numbers of people having strokes and higher death rates from stroke in Haringey than the London and England average. The good news is that many strokes can be prevented from happening in the first place and the Annual Public Health Report demonstrates the wide variety of work currently taking place in Haringey to prevent future strokes.

We are working with local voluntary and community sector organisations to train them to carry out over 5,000 blood pressure checks in community based locations over the next 2 years. We are also working with partners such as businesses and schools to make Haringey a healthier place to live, study and work, so that it is easier for people to be physically active and eat a healthy diet in order to help stay free from cardiovascular diseases like stroke. For those people who have suffered a stroke we will continue to focus on providing high quality rehabilitation and support to help them stay as independent as possible.

We will continue to work together to support people living with stroke and their carers to be as independent as possible.

For more information, go to: http://www.haringey.gov.uk/annual-public-health-reports

Objective 2: Strong Communities, where Residents are Healthier & Live Independent, Fulfilling Lives

"We are working with our communities and the voluntary sector so they can support wellbeing"

Where people need our help we make it as easy to access as possible to ensure that they get the right support, at the right time and in the right place. This means working closely with local people, families, Carers, community groups, the voluntary sector and other statutory partners such as health and housing to provide support. A stronger sector will be better placed to use its grass roots expertise to provide quality services that meet the needs of all residents in Haringey.

We are improving our digital information offer which will enable us to positively build on prevention initiatives. Improved our online information offer supporting residents, staff and partners to access relevant information whenever needed. We now have a website that supports an improved customer journey.

We continue to update and make improvements to our comprehensive directory of services on Haricare[7] that supports the workforce with support planning and signposting, as well as giving residents access to information on the services available in their area. We worked with BRT to compile the Haringey VCS directory (http://bridges.force.com/directory/). Helping people choose the right care and support as well as reducing the number of unnecessary contacts to the FRT.

Community First

It has been recognised that the current ways of delivering public services are unsustainable and that we need to consider a different approach to encouraging positive outcomes rather than dealing with negative ones.

'Community First' aims to develop services so that they are better able to support people to address problems at the earliest opportunity and prevent those problems from escalating. The overarching aim is to challenge the existing culture, norms and behaviours within the council to support a new way of working that not only builds community networks, but also looks imaginatively at how and where residents want to receive support that improves or maintains their independence. We have:

- Developed design principles of a new prevention and early intervention offer;
- Commissioned BRT to undertake consultant and engagement with residents to ensure that they play a meaningful role in the discussions, decisions and implementation of services that affect them;
- Engaged with key services and created a 'Community First' Design panel to help shape the programme; and
- Identified service areas where we can undertake 'trials' to understand better what the current offer is and what is required.

Carers

Carers have the rights to an assessment of their needs, separate to those of the cared for person and regardless of eligibility for social care. Carers are supported to recognise their own needs and access appropriate support. Our vision is to have a coherent and effective carers' offer that supports carers to maintain their health and wellbeing, continue to care and promotes independence.

[7] http://haricare.haringey.gov.uk/

Objective 2: Strong Communities, where Residents are Healthier & Live Independent, Fulfilling Lives

"We are working with our communities and the voluntary sector so they can support wellbeing"

We recognise the significant contribution carers make to the community and to the people they care for and we believe carers should receive the appropriate help and support as and when it is needed.

As a result, over the past few years, we have been talking to, and working with carers to identify what improvements could be made to the service we provide. We have:

- engaged with carers to help us plan and design services that gives carers the help and support they need to continue caring;
- Developed clearer policies and procedures concerning carer's assessments;
- Developed a respite policy to help us improve the way we assign and deliver respite;
- Made it easier for people to access a carer's assessment;
- Simplified our internal processes to provide you with a better service; and
- Introduced an interactive online carer's eligibility checker that signposts residents to the appropriate service or support.

Our priorities for next year:

- Working with Social Care staff to improve people's experience of respite care in Haringey and to ensure the process better meets the needs of individuals;
- Working with the community to make it easier for people to find respite and working with providers to increase the range of options available for respite;
- Deploy trials and work alongside services to identify challenges and opportunities;
- Develop customer journeys, personas and profiles;
- Develop a Target Operation Model which defines the future vision, scale of ambition and scope of a new prevention and early intervention model;
- Improving the quality of community services and ensuring they are providing the right support to local populations; and
- We will ensure that services for carers within the borough meet their needs, helps them to continue with their caring role and balance this with having a life of their own.

New Carers Service for Haringey: What you need to know

A new service called Carers FIRST is now the lead service provider for adult carers in Haringey. The Haringey Council commissioned Carers FIRST to provide information, advice and support to adults who provide unpaid care for a relative or friend due to ill health, physical or mental illness, disability, frailty, or addiction.

Who are Carers FIRST?

Carers FIRST are a charity that have been delivering services to carers for 27 years and currently supports over 20,000 carers across West Kent, Medway, Lincolnshire and neighbouring borough Waltham Forest.

Objective 2: Strong Communities, where Residents are Healthier & Live Independent, Fulfilling Lives

"We are working with our communities and the voluntary sector so they can support wellbeing"

What are the benefits of the new contract?
In addition to a range of support services, information and advice, Carers FIRST also manage the Carers' Register in order to ensure people receive accurate and up-to date information about services in the Borough.

They will be the single point of contact for the initial request for information, advice and guidance, offering:

- emotional support;
- advice and assistance;
- peer support groups providing mutual support;
- face to face, drop in and telephone appointments;
- training courses;
- workshops; and
- newsletter.

How to contact Carers FIRST
Carers FIRST provides a dedicated telephone support service through their Carers Hub. Someone is available to take your call from 9am-5pm Monday to Thursday and 9am-4.30pm on Fridays. Carers can call the hub to register at any time or ask questions about their caring role.

You can contact Carers FIRST on **0300 303 1555**.

Multi-Disciplinary Team

As part of a quality improvement project, the Multi-Disciplinary Team (MDT) have developed and run a fortnightly positive behaviour support clinic, attended by families and paid carers to consider ways to best support individuals with challenging behaviours. This project has been successful in bringing together the expertise of the MDT and those that know the individuals well to achieve positive outcomes for people with learning disabilities, including a reduction of medication, reduction in the frequency of behaviour that challenges and an improvement in quality of life. It has allowed people to access MDT support promptly without the need for long waiting times and widened access to shared learning about positive behaviour support approaches.

Our priorities for next year:

- Continue to run the Positive Behaviour Support (PBS) Clinic as part of the challenging behaviour pathway to enable access to further intervention from the community team or intensive support team where needed.

Objective 3: Support at an Earlier Stage for Residents who have Difficulty in Maintaining their Health and Wellbeing

"We are joining up health and care to provide services that keep people at home and independent"

We are working with our partners to develop and improve our services to offer care and support, which is person-centred and coordinated to improve outcomes and deliver a better experience for service users, their families and carers.

Assistive Technology

Assistive Technology is used to describe a wide range of equipment and services such as pendant alarms to monitoring sensors for long-term health that can help people with disabilities with their functional capabilities. It is extremely important to understand how assistive technology can be used by people with chronic disabilities to maintain a good quality of life and remain independece in their own homes.

In a bid to maximise independence and the ability of individuals to function as part of the community, the council is looking at the role assistive technology can play in improving outcomes for local people. We have:

- Involved residents in a six week pilot study with support from Alcove - a provider of modern Assistive technologies – to assess how technology could help improve the lives of potentially vulnerable or physically less able people; and
- Worked with and provided information to residents about the benefits of technology and the ways it can improve the lives of adult social care service users.

Our priorities for next year

- Employ results from the pilot study and feedback from residents to inform our wider Assistive technology offer and how we can best utilise devices to prevent dependence in ageing adults;
- Work with industry experts to help us develop an innovative Assistive Technology offer to help our residents achieve the outcomes they deserve; and
- Extending the availability of assistive technologies as part of a care package in order to maximise independence.

Reablement

The most usual way of helping adults and older people to promote living independently, is by arranging a care worker to help the person with tasks like getting up and going to bed, keeping clean and tidy, eating and drinking properly and managing household bills. Whenever possible this support will be provided in a way that develops independence and is strengths based, this means that we' will work with an individual to build on their existing strengths rather than focus on things they have difficulty achieving. In 2017/18 we helped **806** adults through our Reablement Service.

Objective 3: Support at an Earlier Stage for Residents who have Difficulty in Maintaining their Health and Wellbeing

"We are joining up health and care to provide services that keep people at home and independent"

The service aims to offer a period of intensive Reablement for up to six weeks to help people regain their independence after a period of ill health or hospital stay. The service gives people the peace of mind that they or their loved ones are safe through solutions such as Telecare - a 24-hour home safety and personal security alarm that automatically summons help when a person needs assistance. Reablement assists individuals to identify their aims and goals to be achieved in daily living by working with reablement staff to build levels of confidence. We have:

- On average 75-80% of clients who have participated in Reablement services require little or no ongoing support at the end of their intervention;
- Clients who have participated in reablement describe the service to be "immensely impressive", "excellent", "reliable";
- The service has reduced waiting times from receipt of referral to assessment by a therapist to less than 2 weeks;
- Occupational Therapists within the team have been upskilled to be able to recommend and process major adaptation requests thus ensuring clients have their needs addressed in a timely way and reducing their need for ongoing support in the longer term;
- The introduction of the "daily huddle" with all staff, giving them the opportunity to share successes, opportunities and problems and ensuring full transparency throughout the management structure in resolving issues;
- Introduced a "Buddy" System where each enabler is paired with a therapist to develop their skills further around the Trusted Assessor role and to provide further supervision where needed. This is also being rolled out to social workers to further improve response times for fitting of simple aids and adaptations; and
- Continued regular meetings with Health Leads to ensure a fully integrated approach to service provision and proactive problem solving at the earliest opportunity.

Haringey and Islington Wellbeing Partnership

The Wellbeing Partnership has been established to enable local organisations to deliver better health and care services, to reduce inequalities and improve the health and wellbeing outcomes for the people of Haringey and Islington. It is working towards the integration of health and social care services in the boroughs in order to deliver these improvements. As a result, the Partnership will be better able to deliver, at a local level, the necessary service transformation to achieve a sustainable health and social care system.

Single Point of Access

The Single Point of Access (SPA) Team works across health and social care to ensure the residents of Haringey receive a service that is preventative, responsive and proactive in meeting both short and long-term health and social care needs.

The SPA is recognised as a gold standard service, which supports the discharge of Haringey residents from various hospitals to home with existing care; home with reablement support; bed based intermediate care; step-down facilities; and longer-term health funded placements.

Objective 3: Support at an Earlier Stage for Residents who have Difficulty in Maintaining their Health and Wellbeing

"We are joining up health and care to provide services that keep people at home and independent"

Referral to SPA ensures a timely, appropriate and collaborative decision is made around a patient's discharge needs. An informed and positive approach is taken to risk management to facilitate more complex discharges and ensure appropriate use of resources. SPA arrange discharge to assess home visits. These are carried out within 2 hours of a patient arriving home and aim to ensure that any risk of readmission to hospital is minimised and the individuals needs are met appropriately.

We have made great strides with redesigning our discharge processes from hospital for people that require extra support on discharge. We have had commitment from all agencies and have adopted a test and learn approach so that we can try small changes and incrementally scale them up. We have been seeing good impacts on reducing delayed discharges at North Middlesex Hospital and the challenge is to sustain this.

Our priorities for next year:

- Single point of access for out of hospital services to improve crisis management and prevent unnecessary admissions, including enhanced rapid response and use of 'virtual wards' to enable more clients to be supported to remain at home;
- Improving the guidance and support for patients to identify and manage long-term health conditions, including new secondary prevention services for diabetes, kidney disease and mental health to be commissioned over 2018/19; and
- Working across Haringey and Islington to identify older people with frailty and test interventions to support and prevent a health and care crisis.

Objective 4: Those who Need Care and /or Health Support Will Receive Responsive & High Quality Services

"We are focusing services on maximising independence, with flexible choice and control"

In Haringey, we have developed a range of provision for vulnerable older people that has a greater emphasis on helping people to continue to live independently at home, maximising their independence and reducing social isolation.

Currently, too many older or vulnerable people are admitted to hospital, when with appropriate out of hospital care, they could be treated in the community and looked after in their own home. In response, we are investing in out of hospital care which will ensure people who are in hospital but do not need to be, have access to community alternatives.

We are developing new approaches and improving the skills mix in hospital discharge teams to reduce unnecessary referrals to social care from hospitals.

Direct Payments

Over the past year, the council has embarked on a strategy to improve its Direct Payments Service. The project aims to improve the service and increase the take-up of Direct Payments which is the Department for Health's (DH) preferred method for delivering social care.

Increasing the use of Direct Payments supports objectives within the council's Adult Social Care Strategy, which is to promote independence and develop individual and community resources that prevent, delay and reduce the need for care and support.

In delivering the strategy, the council is in the process of reviewing all aspects of the direct payment process in partnership with service users.

We have:

- Run workshops with residents to review the direct payment service;
- Run workshops with staff to review and update direct payment processes and procedures ;
- implemented benchmarking exercises to assess best practice and ensure we are offering the best service to residents; and
- Undertaken a service user questionnaire to identify areas of improvement.

Our Priorities for next year:

- Improve the internal processes and procedures to make them more efficient and clearer for service users;
- Develop training and guidance for practitioners to better support service users;
- Procure new providers to better support direct payment users;
- Improve financial monitoring and measuring service user outcomes; and
- Update the councils Direct Payment Policy.

Objective 4: Those who Need Care and /or Health Support Will Receive Responsive & High Quality Services

"We are focusing services on maximising independence, with flexible choice and control"

Transitions

Since September 2017 we have been working to develop a seamless service between Children's and Adult pathways so that young people receive support before reaching adulthood that maximises their opportunities for independent living. We have:

- Set up a monthly co-production group with service users and their families. Among the achievements are development of a Moving On Tool for young people to find disability wellbeing information more easily;
- Developed enhanced web pages on apps for social care to promote independence;
- Developed a clearer continuing health care pathways process for professionals to ensure continuity of services for people with social care needs;
- Enhanced information and signposting via the Local Offer and Haringey web pages on community services;
- Strengthened the process for referrals from Child and Adult Mental Health Services (CAMHS) to adult social care; and
- Developed access for Care leavers to a new low-level mental health support service.

Our Priorities for next year:

- Undertake a review of all information and guidance, updating policy documents and communications with service users;
- Review the Transition procedures;
- Explore partnership working with the community to develop employment opportunities for people with disabilities and low level needs;
- Enhance internal Transition processes to minimise delays in the assessment process;
- Recruit a dedicated person to oversee Care Leavers and Special Educational Needs and Disability (SEND) information and advice; and
- Ensure that young people in transition are assessed by their 18th birthday, and engage with Children's Services and Education at earliest stage to improve planning and outcomes, including accessing the local offer for education.

Provider Market

Our commissioning model now focuses on providers who provide added value on top of the commissioned care package particularly in homecare market. Robust commissioning and procurement process under Dynamic Purchasing System (DPS) has resulted in no new placements with providers who do not have 'Good' or 'outstanding' Care Quality Commission (CQC) rating.

One of our major provider trains staff to carry out blood pressure checks to service users and family members. Family members are being offered training in personal care and manual handling by one such provider to empower family members with the right skills and, as a consequence, reducing reliance on carers in the long term.

Objective 4: Those who Need Care and /or Health Support Will Receive Responsive & High Quality Services

"We are focusing services on maximising independence, with flexible choice and control"

The commissioning team works very closely with the CCG and Haringey workforce development team manager, to encourage providers to access free or subsidised training to improve the quality of care in the borough.

Our Priorities for next year:

- Increase the percentage of commissioned providers rated 'Good' or 'outstanding' by CQC;
- Work with the homecare market to ensure staff have contracts that offer guaranteed hours as opposed to zero hour contracts and ensure staff are being paid travel time;
- Implementation of DPS which creates a fair and competitive market for providers as a consequence providing service users with varied choice of provisions and services; and
- Collaborative work with the North Central London (NCL) CCG, local authorities and NHS providers to jointly negotiate and manage rates in provider market.

In other areas, we have:

- Improved our processes for reviews for care packages and adjusted packages where they were not well targeted to promote independence for the individual based on changing needs;
- Provided extensive training for staff and partners of the new notification process; and
- We continue to work collaboratively with colleagues across health and community services to avoid duplication and provide an assessment of residents' needs that addresses their health and social care problems.

Other priorities for next year:

- Increase availability of supported living placements as an alternative to residential;
- MDT for those with long-run social care needs to ensure health conditions are also managed;
- Developing our workforce to embed the principles of 'maximising independence' through our assessments, reviews and care planning to ensure all clients are helped to progress towards identified goals; and
- Use of an integrated digital record across health and care to improve the ability of health and care practitioners to join-up.

We will continue to work with all our staff, to ensure they understand our vision and commitment to maximise independence and quality of life. We continue to work with staff to develop methods of sharing good practice, ensuring seamless, joined up services which empower services users.

Objective 4: Those who Need Care and /or Health Support Will Receive Responsive & High Quality Services

"We are focusing services on maximising independence, with flexible choice and control"

Supporting People with Mental Health and Complex Health Needs

The HLDP have reviewed their health and social care resources to support people with mental health and complex health needs. This ensures that we get the right support to the right people. The review has also improved our pathways into specialist services. We are better able to provide holistic assessment of health and social care needs to ensure people access the right services dependent on their needs. Where we are not the appropriate team to support them, we ensure that they are signposted to other services or voluntary agencies to meet their identified needs.

Our priorities for next year:

- Reintroduction of a Nurse Led Mental Health Clinic. People are referred to the Nurse Led Clinic when they are felt by Psychiatrists to be stable in their mental state, but not felt ready for discharge. This is a positive way of ensuring people receiving regular monitoring of their mental health, and any concerns can be flagged immediately. Person centred interventions can then be put in place in order to support the person and avoid the risk of mental state deterioration, placement breakdown, and/or potential hospital admissions.

'Purple Folders'

Our Purple Folders promote health and independence, and contains important information that supports effective health care for people with learning disabilities. They are used when the team see our service users, GPs and dentists also contribute by writing in them. The independence is achieved by it being a person (patient) hand-held record they bring with them when they have contact with NHS services. It provides them and their carers a degree of ownership over managing their health.

Objective 5: Safeguarding vulnerable adults from abuse

"We are making safeguarding everyone's business to reduce the risk for vulnerable people"

The Care Act (2014) creates a legal framework so key organisations and individuals with responsibilities for adult safeguarding can agree on how they must work together and what roles they must play to keep adults at risk safe from abuse or neglect.

The provisions of the Care Act are intended to promote and secure wellbeing. Under the definition of wellbeing, it is made clear that protection from abuse and neglect is a fundamental part of that. Identification and management of risk is an essential part of the assessment process; the risk to an adult of abuse or neglect should be considered at this point.

Adult Social Services Lead Agency

Adult Social Services is the responsible lead agency for providing care services for people in need, including those at risk of abuse. We investigate allegations of abuse as well as:

- Liaise with advocacy services;
- Complete needs assessments for vulnerable people and their carers;
- Contribute to Strategy Meetings; and
- Use intelligence to identify key themes, raise awareness of abuse, and neglect with staff, partners and the public through improved communications and campaigns to include those that organise their own care via personal budgets.

Haringey Safeguarding Adult Review

Following the death of a Haringey resident in 2016, the Haringey Safeguarding Adults Board (SAB) commissioned an independent author to lead the process of a Safeguarding Adult Review (SAR) on reviewing the work of all agencies and seeking to identify learning. Adult Services and other agencies have engaged fully in the review, and have worked hard to agree on areas of learning. The SAR was completed and published last year. We will also work with other key partnerships to share learning arising from all statutory review processes. This work is led by the Haringey SAB's SAR subgroup.

Adult Safeguarding Practice

The Chair of the Haringey SAB and the Assistant Director of Adult Social Services carried out an internal review in 2017, on safeguarding adult practice in Adult Social Services. The purpose was to provide a constructively critical eye on all areas of practice, process, quality and performance.

The review provided insights into the adult safeguarding practice in Haringey, utilising a range of evidence sources. In terms of the stated objectives, the reviewers concluded that the services are broadly compliant with the Care Act (2014) although there were some areas for improvement clearly identified.

Objective 5: Safeguarding vulnerable adults from abuse

"We are making safeguarding everyone's business to reduce the risk for vulnerable people"

A Safeguarding Adults Improvement Plan has been developed to address the issues identified. The plan explicitly addresses the needs of vulnerable adults who are at risk of abuse and neglect. This informed service improvement and development throughout the period of investigation, as well as workforce development planning and training needs.

Good progress has been made to implement improvements; and there is ongoing monitoring of the Safeguarding Adults Improvement Plan through the Adults Services Redesign Steering Group and Safeguarding Adults Board.

The Adult Safeguarding Prevention Strategy 2017-2020

The 2017-2020 Haringey Adult Safeguarding Prevention Strategy[8] continues the work of the previous strategy showing the ongoing commitment of different agencies and partners involved with adults: to promote safety, prevent abuse and protect vulnerable adults, whilst promoting an approach to enable adults to protect themselves, living their own lives and make their own decisions.

The Strategy sets the strategic direction for prevention in adult safeguarding and the main priority areas of work for the different agencies and partners that care and support vulnerable adults in our community. It represents an ongoing collaboration between these partners using the Strategy as a framework for the partnership work in safeguarding adults at risk from abuse.

Training

Training, of adults at risk and staff, is a key part of the Prevention Strategy. We have a staff programme of regular safeguarding adults training that includes online training. There is a wide range of awareness information to keep our wider workforce, partners and service providers aware of adult safeguarding issues. Safeguarding referral data is used to identify adults most at risk and to target prevention work such as awareness and support information.

During 2017, **478** people received training through short briefing sessions, full-day and half-day training sessions, as well as twilight sessions delivered over a number of evenings and a recovery college course over 6 weeks. We have also organised courses for staff and partners on Financial and Material Abuse and Self Neglect and Hoarding. Special briefings were also organised to help **99** staff understand domestic fires involving vulnerable adults. The London Fire Brigade (LFB) ran these sessions.

In other areas, we have:

- Embedded the principles of Making Safeguarding Personal[9] (MSP) to enhance involvement, choice and control for the individual subject to a safeguarding concern;

[8] https://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/safeguarding-adults-policies-and-procedures

[9] https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp

Objective 5: Safeguarding vulnerable adults from abuse

"We are making safeguarding everyone's business to reduce the risk for vulnerable people"

- Recruitment of permanent staff, including Team Manager, Business Support and Social Work staff;
- Improved the proportion of people subject to a safeguarding intervention who say that outcomes partly or fully met;
- Introduced rotation of social work staff across the service into the safeguarding team in order to improve knowledge and practice across the organization in regards to safeguarding;
- Reduced the number of Section 42 enquiries from 452 in 2016/17 to 266 in 2017/18 in Haringey to closer to our comparator boroughs by screening cases only requiring advice, information and signposting;
- An introductory level e-learning course has been placed on the council's website for easy access, providing accessible information and advice to small community groups and the wider public;
- Improved the proportion of service users who report feeling safe and secure in those services to above the London average;
- Safeguarding campaign launched in June 2017. Poster and information giving useful community contacts for help and organisations circulated to the Voluntary Community Sector (VCS) and schools;
- Changes to client information work flow system that supports the accurate recording and reporting of data to the Haringey SAB;
- Agreed a streamlined process for reporting of safeguarding concerns from the Mental Health Trust's (MHT) into the Local Authority;
- Flow chart and safeguarding process map for Mental Health developed in conjunction with the Trust Adult Safeguarding Lead;
- Improved joint working with MHT in regards to identification of cases and ensuring that MSP has been included at the start of the process and evaluated at the end; and
- Dedicated Duty Officer to address all safeguarding queries Monday to Friday

Our priorities for next year:

- Review process of referrals into the service to improve direct access to the safeguarding team for incoming alerts;
- Work with Children's Services around learning, to improve recording and reporting of safeguarding adults concerns;
- Improve targeting and prevention by monitoring and identification of poor quality safeguarding practice, increased risks and vulnerabilities to abuse, safeguarding themes, trends and locations and ensure engagement of service users, carers and community and voluntary sector to current concerns and trends are captured;
- Use intelligence to identify key themes and raise awareness of abuse and neglect with staff, partners and the public through improved communications and campaigns;
- Improve multi-agency knowledge and awareness of mental health including Mental Capacity and the use of Advocates in safeguarding work;
- Continue to ensure that safeguarding practice is person centred, outcome focused and unnecessary deprivation of liberty of vulnerable adults by regular auditing;

Objective 5: Safeguarding vulnerable adults from abuse

"We are making safeguarding everyone's business to reduce the risk for vulnerable people"

- Continue to ensure that timely, proportionate responses when abuse or neglect has occurred and vulnerable adults are not being unnecessarily deprived of their liberties via response time and prompt allocation of cases /applications;
- Continue to ensure that vulnerable adults are not deprived of their liberties unnecessarily, safeguarding practices continue to improve and enhance the quality of life of adults in Haringey;
- Focus on improving the quality of our directly delivered and commissioned services to put in place a preventative approach to safeguarding risk;
- Increase the coordination and impact of our work with partners through the Haringey SAB to ensure it is a shared agenda locally;
- Raise awareness of safeguarding among our residents and improve the information and advice available beyond those receiving formal services;
- Further develop the awareness and skills of clinical staff across Haringey's health providers to ensure issues are raised and dealt with; and
- Develop links with the Local Safeguarding Children's Board (LSCB) in regards to joint areas of concern around those young people transitioning to adults, such as modern slavery and Child Sexual Exploitation (CSE).

About the Haringey SAB

The Haringey SAB is a statutory body that works to make sure that all agencies are working together to help keep adults in Haringey safe from harm and to protect the rights of citizens to be safeguarded.

For more information on what we did in 2017/18, you can visit the Haringey website to view the Haringey Safeguarding Adults Annual Report 2017/18 (http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab#sabannual_report).

How safe and secure do residents feel?

Haringey's performance has continued to improve with **89%** saying that services have made them feel safe and secure. This is above both the London average and its Comparator borough averages for 2017-18, and is actually within London's Top Quartile

How we know we are making a difference

Compliments

Your views and experiences of ASC services in Haringey are important to us because we want to give you the best services we can. By listening to you, we can find out how well we are doing and learn how to continue to improve the services we offer.

To make a comment, compliment about Haringey Council ASC, please visit our website and navigate to 'How to make a complaint'. You can provide us with ideas or suggestions on how we may improve our Adult Social Care services and letting us know when our staff or services have done a good job and we get things right.

What some of our service users said to us…

Case 1

A 59-year old women with Downs Syndrome, probable dementia and moderate to severe learning disabilities spent the last 8 years confined to the second story of her home due to an irrational fear of stairs, and complex behavioural issues.

As a result of an intensive piece of work by HLDP, culminating in a three-hour hands on session, supported by London Ambulance Service (LAS), Speech and Language Therapist and Occupational Therapist the team coaxed her, step by step, down the stairs, into transport and into her new home. Since then her lexicon has expanded significantly. She is actively engaging with other people, clearly is very proud of her new home and generally has started to live a more meaningful life, e.g. She sat in the garden on Tuesday, enjoying the sunshine and eating chocolate cake in a local restaurant.

Case 2

An allegation of physical abuse of AH by a paid carer was received. Investigating officer visited the person twice at home as part of the safeguarding process to gather more information and arrange a safeguarding meeting, which was attended by wife, daughter, care provider and commissioners.

Concern was wholly substantiated which led to training for all carers, part of measures implemented from safeguarding point of view was for provider to also review their policy around out of hours and reporting incidents. Both AH and his family expressed appreciation and the manner in which the whole safeguarding enquiry and meeting was carried out and the efforts the local authority made to safeguard the vulnerable people.

Both concerns was dealt with in a timely manner, with protection plans promptly and involvement of the vulnerable person and their families.

Case 3

Mrs P is a 65-year old woman who was living with dementia. She was originally from Wales and she moved to London in the 70's to work. She had no family or friends in London.

When she started to struggle with meeting her everyday needs a support package was put in her home to support to her remain at home for as long as possible.

As her dementia progressed, she needed more support. Her needs were discussed with the MDT, which included our colleagues at the Community Mental Health Team, and she had a care coordinator that visited her on a regular basis. Mrs P also received an Occupational Therapist Assessment and was provided with equipment for Manuel handling. She was also provide with assistive technology equipment so that she could remain at home and be as independent as possible.

When Mrs P was no longer able to care for herself at home a meeting was held with her social worker. Mrs P had always stated that she wanted to return to her homeland, which she considered to be Wales.

In the best interests' meeting, it was agreed to support Mrs P to move into supported living in Wales so that she could be closer to her family who wanted to be involved in her life. The Social Worker worked with the Local Authority in Wales as well as liaising closely with her family.

Her family contacted The Assessment Team Support Manager to thank the Social Worker who she said listened to the views of their Aunt and family and that when she moved back to Wales she was very happy. The family felt that this was going to be an impossible task and the outcome for the client was very positive.

Case 4

A concern was raised from the safeguarding lead of the church and by the Mental Health Team regarding alleged neglect. Mr M's advanced dementia was impacting negatively on him leading to both verbal and physical assault on Mrs M. As part of the protection plan, he was initially offered a carers' assessment. However, Mr M's condition further deteriorated and became unbearable for Mrs M who also had her health problems to deal with and needed to be safeguarded. The safeguarding team continued to provide support and an action plan was put in place to mitigate further risks. The safeguarding outcome was for Mr M to be placed in a dementia care home for respite with the view of making it permanent. Mr M is now under Deprivation of Liberty Safeguards (DoLS) in a care home in his best interest receiving support with all activities of daily living and medicine administration. Mrs M expressed her gratitude for the enormous support she received from the safeguarding team for both of them during the safeguarding process.

Case 5

FRT received a call from where the caller reported he was unable to walk and access his bath. A series of questions were asked to establish whether this is a new situation and whether the person had seen their GP.

The caller explained that his inability to walk had just occurred and that he had not yet seen his doctor. The caller confirmed that the symptoms had not been diagnosed and was unsure of why he was unable to walk.

The caller was asked in the first instance to contact his doctor who could diagnose what is occurring and then the GP could make a subsequent referral to Adult Social Care if necessary.

It was identified by the FRT worker that in this instance the first point of contact should be with the doctor as a medical need had been identified. The FRT worker sent out a booklet of aids and adaptations, which the client could look through and purchase equipment privately. In addition, the client was also directed to 'Ask Sara' an online interactive website, which provides advice and products that makes daily living easier.

Typically, (before FRT completed a problem solving session about sign posting), this telephone contact would have led to a referral and then a subsequent assessment. This client may have had to wait for an assessment, only to be sign posted at that stage. In this instance, the FRT worker established that a medical professional was required and even though FRT did not take a referral in the first instance, the client was informed of the right steps to ensure that his health and social care needs were met.

FRT workers are increasingly sign posting callers appropriately at the first point of contact, providing clients with useful information that they can access independently.

We take customer feedback very seriously and always try to learn from what people tell us. We support managers to engage with people who are not satisfied to try and resolve as many issues as possible so that people do not feel they need to submit a formal complaint.

You can complain to the London Borough of Haringey in the following ways: http://www.haringey.gov.uk/complaints and use the online feedback form. If you are unable to use the form, please contact us by phone on 020 8489 1988.

What we will do with your complaint?
The law says what we must do with adult social care complaints. When we receive your complaint, we will try to sort out the problem straight away. If we cannot we will:

- write to you within three working days with the contact details of the person who will deal with your complaint
- offer to discuss your complaint with you so that we can clarify the issues and how the complaint will be investigated
- respond to your complaint within 10 working days, or agree a new deadline with you before then if we cannot.

The First Response Team is your single point of contact, and will be able to assist you with your enquiry. Here is all the information you need if you want to get in touch with us.

Write to: **First Response Team** 2nd Floor, River Park House 225 High Road London, N22 8HQ	Telephone 020 8489 1400 Opening Hours: Monday to Friday, 9am to 5pm E mail: Firstresponse@haringey.gov.uk (charged at standard rate depending on provider and subscribers package)

One of our dedicated team of Community Care Officers will be pleased to assist you with your enquiry.

Haringey Haricare

Haricare is our Adult social care directory. It contains information about products and services for adults who need care and support, and their carers. Information in this directory is provided by service providers themselves and overseen by Haringey Council.

You can visit Haricare by going to the following link:
http://haricare.haringey.gov.uk/

Feedback Form

Thank you for taking the time to read Haringey's 2017-18 Adult Social Care Local Account. We welcome your feedback on this Local Account. Please send completed forms to: **Governance & Improvement Service, 2nd Floor, River Park House, 225 High Road, Wood Green, London, N22 8HQ.**

You can also email your feedback at asclafeedback@haringey.gov.uk

1. **How did you find out about the Local Account?**

2. **Did you find the Local Account report informative?**

   ☐ Fully ☐ Partly ☐ Not at all

3. **Was the Local Account interesting to read?**

   ☐ Fully ☐ Partly ☐ Not at all

4. **Was the Local Account laid out in a way that was easy to read?**

   ☐ Fully ☐ Partly ☐ Not at all

5. **Was the Local Account easy to understand?**

   ☐ Fully ☐ Partly ☐ Not at all

6. **If you said partly or not at all for questions 2-5, please explain why:**

7. **Do you have any further comments, or how the Local Account could be improved next year?**