Dominic O'Brien,
Principal Scrutiny Officer

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12 February 2026

To: All Members of the Overview and Scrutiny Committee

Dear Member,

Overview and Scrutiny Committee - Thursday, 12th February, 2026

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

11. WORK PROGRAMME UPDATE (PAGES 1 - 38)

Scrutiny Review – Hospital Discharge

Yours sincerely

Dominic O'Brien,
Principal Scrutiny Officer

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Agenda Item 11

LATE BUSINESS SHEET

Report Title: Agenda item 11

Committee: Overview and Scrutiny Committee

Date:12 February 2026

Reason for lateness and reason for consideration

Under s100B(4)(b) of the Local Government Act 1972, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency by reason of special circumstances. These circumstances are that the report was being finalised by the Adults and Health Panel Members and there is a need for Overview and Scrutiny to consider the report to make a decision and put forward to the last Cabinet meeting of the municipal year on the 10th March 2026 to allow a response to the scrutiny recommendations.

The Committee are asked to approve the Adults and Health Scrutiny Panel review recommendations on Hospital Discharges and if required delegate any minor amendments to the report to the Democratic Services Scrutiny Manager in consultation with the Chair of Adults and Health Panel.

Haringey LONDON

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Scrutiny Review – Hospital discharge

A Review by the Adults & Health Scrutiny Panel – 2025/26	
Committee Membership	Cllr Pippa Connor (Chair)
	Cllr Cathy Brennan
	Cllr Dr Thayahlan Iyngkaran
	Cllr Mary Mason
	Cllr Sean O'Donovan
	Cllr Felicia Opoku
	Cllr Sheila Peacock
	Helena Kania (Co-opted Member)

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CONTENTS

1. **Chair's Foreword ……..** **Page 2**
2. **Recommendations ……** **Page 4**
3. **Context to the Review ……** **Page 7**
4. **Committee Membership and Terms of Reference ……** **Page 7**
5. **Background to Hospital Discharge ……** **Page 8**
6. **Evidence received – Hospital Discharge Teams ……..** **Page 10**
7. **Evidence received – Adult Social Care services ……..** **Page 14**
8. **Evidence received – Housing services ……..** **Page 19**
9. **Evidence received – Further issues relating to hospital discharge ……** **Page 23**

1. Chair's Foreword

I would firstly like to thank my panel members, council officers and external partners in giving their time and consideration to the hospital discharge process, allowing robust and thoughtful scrutiny of this important area that affects so many of our residents.

I would particularly like to acknowledge the hard work from our Scrutiny Officers, which underpins this report, and allows our findings to be articulated to both cabinet and the wider public.

This report summarises the Panel's findings on hospital discharge, reablement, and integrated community support, with a focus on improving outcomes for residents following illness or significant life-changing events.

The Panel recognises the substantial progress being made across North Central London (NCL) to streamline discharge pathways and strengthen multi-agency working, while identifying further opportunities to enhance consistency, clarity and support for residents.

A central theme is the importance of **clear, accessible information** for residents, families, carers and advocates.

Prior to any assessment or checklist, individuals should receive written guidance explaining the process, the right to request a recording, the routes for challenging decisions, and the financial implications of care. Improved communication is essential to ensuring transparency, confidence and informed participation in decision-making.

The Panel also identified the need for a more robust and transparent funding framework for **Continuing Healthcare (CHC)**. A strengthened memorandum of understanding with the Integrated Care Board (ICB) would reduce disputes, improve efficiency, and ensure that public resources are used effectively.

To support safer, quicker discharges and prevent future hospital admissions, the Panel welcomed stronger **multi-agency community teams**, recommending the inclusion of housing officers and the expansion of trusted referrers such as sheltered housing providers. Closer co-location and alignment of local authority and ICB teams within shared hubs would further improve coordination and reduce duplication.

The Panel noted ongoing work to redesign **reablement services**, including the upcoming 31Ten report. Clarity is needed on how the new model will integrate with community partners and hospital teams. Close monitoring of hospital readmissions will be essential to ensure that changes in reablement duration do not negatively impact outcomes. Greater financial transparency is also required so that costs of community-based approaches are shared fairly across partners.

Improving post-discharge support remains a priority, and the Panel highlighted the need for services equivalent to "Homes from Hospital" to be available to all residents who require them.

Finally, the Panel welcomed the expansion of **Assertive Community Treatment (ACT)** but expressed concern that eligibility will be restricted to only the highest-need patients. Further clarity is required on how those below the ACT threshold will be supported by multi-agency teams, and the Panel recommended embedding the Assertive Outreach Team within those teams to ensure coordinated mental health support.

Overall, the Panel supports the direction of travel across NCL and Haringey but emphasises the need for clear communication, strong partnership arrangements, consistent and coordinated pathways, and transparent monitoring to ensure that all residents receive high-quality, timely and person-centred care following hospital discharge.

Cllr Pippa Connor

Chair – Adults & Health Scrutiny Panel

2. Recommendations

Community-based approach	
1	To make the report on the future model for reablement services from external consultancy 31Ten available to the Panel. In particular, clarity is needed on how the new model will develop a joined-up approach with locality teams, community partners and hospital staff.
2	Close monitoring of hospital readmission rates is required after the implementation of the new reablement model to ensure that any reduction to the length of reablement programmes is not having a detrimental effect on patients and leading to more expensive hospital readmissions. Clarity is required on how data related to the implementation of the new service provision will be monitored and compared to the current service.
3	That the Council ensures robust monitoring of the new reablement model through: • Close tracking of 30-day and 90-day hospital readmission rates to confirm that any reduction in programme length does not negatively affect patient outcomes or lead to increased readmissions; • Clear reporting on performance data, demonstrating how outcomes under the new model compare with the current service; and • Full financial transparency for the community-based approach, including evidence that the Council is not assuming a disproportionate share of system costs and a breakdown of Directorate contributions to joint-working arrangements.
Multi-agency community teams	
4	Housing officers to be included in multi-agency teams to assist with post-discharge support and prevention of hospital admission.
5	Expand types of trusted referrers to MACCT/multi agency-teams, for example sheltered housing providers.
6	Multi agency teams led by local authority and the ICB need to be linked together within the same hub to improve coordination and avoid duplication.
Housing – Step-down accommodation	
7	The Panel welcomed the progress in making vacant step-down units ready for people to be discharged to. The Panel highlighted the ongoing importance of maintaining quick turn-around times and ensuring that vacant step-down properties were, cleaned, furnished and ready to be occupied at short-notice in the future.
Continuing Healthcare (CHC)	

8	The Panel emphasised that clear written information should be provided to residents/families/carers/advocates prior to any assessment or checklist taking place so that they were clear about the process and the questions that would be asked. The information provided to residents should also: • Make clear that the recording of assessments can be requested. • Make clear how decisions could be challenged and explain the process for this. Provide details on financial assessment/eligibility and ensure that residents are clear about any financial contribution that may be required from them.
9	A clearer agreement / memorandum of understanding should be developed with the Integrated Care Board (ICB) to specify funding arrangements for CHC and to avoid the sticking points which are leading to the local authority and the ICB using public resources to dispute cases with each other.
Aids & Adaptations	
10	The Panel highlighted priorities for future monitoring including progress on previous recommendations and: • Improvements on contracts and commissioning, including through the Dynamic Purchasing System. • Monitoring and tracking of case progress, the use of the support plan as progress is made and how the resident is included in that process. • Accurately capturing the voice of residents in the discussions on their case.
Homelessness and People with No Recourse to Public Funds (NRPF)	
11	The Panel recommended that an assessment be made of whether the provision available at Osborne Grove is being fully utilised in circumstances where residents are unable to move on from step-down accommodation due to homelessness issues.
Assertive Community Treatment (ACT)	
12	The Panel welcomed the forthcoming extension of Assertive Community Treatment (ACT) but was concerned that the threshold for this support to be provided post-discharge would only be for patients with the highest needs. The Panel recommended that further clarity was provided on how patients who fall below the threshold for ACT will be supported in the community by the multi-agency teams after discharge from hospital.
13	The Assertive Outreach team should be embedded with the multi-agency community teams to ensure that mental health patients receive co-ordinated support post-discharge.

Post-discharge support	
14	The 'Home from Hospital Service', or similar support services, should be guaranteed to all post-discharge patients who require it: • The Council and NHS Trusts should ensure that all patients being discharged from hospital are made aware of the service in the information that they receive prior to discharge. • Information about the service should be provided to all Councillors in terms of the advice about support organisations that they can signpost their constituents to. • Consideration should also be given to whether information about the Service should be prominently advertised in the Council's communications channels.

3. Context to the Review

3.1 The Panel had previously conducted a Scrutiny Review on access to health and social care services for residents of sheltered housing[1] which had made a number of recommendations, including on the provision of specialised targeted support for clients with high needs and improved access to GPs, district nurses, mental health staff and voluntary/community organisations.

3.2 The Panel was subsequently made aware of a rolling Adult Social Services programme of service improvement and extra capacity into services in addition to work with health colleagues around hospital discharge and improving integrated care services and intermediate care to help ensure that residents get the best outcomes they can following an illness/life changing event. Given the ongoing relevance of these issues, the Panel felt that it would be important to consider the wider barriers to discharge from hospital.

3.3 The Council's Corporate Delivery Plan 2024-26 includes the following Outcome Areas and commitments which are relevant to this Review[2]:

- Residents connected with the right support at the right time in the neighbourhood
    - Implement the Localities Programme, including projects that support the integration of health and social care, to deliver the right support at the right time to targeted residents and reduce the impact of health inequalities.
- Secure and resilient lives
    - Implement the Carer and Hospital Discharge Toolkit
    - Review and update the Carers' Strategy
- Vulnerable adults are supported and thriving
    - Services will be redesigned to deliver localities model to improve connections and understanding with the local community, designed with resident participation and incorporating Assistive Technology.
    - Implementation of a strength-based approach to assessments and review, which recognises residents' and carers' unique qualities throughout services.

4. Committee membership and Terms of Reference

4.1 The membership of the Adults & Health Scrutiny Panel that conducted this Review were:

Councillors: Pippa Connor (Chair), Cathy Brennan, Thayahlan Iyngkaran, Mary Mason, Sean O'Donovan, Felicia Opoku, Sheila Peacock.

Co-opted members: Helena Kania.

4.2 The terms of reference for the Review were:

[1] Scrutiny Review, Sheltered Housing – Access to Health & Social Care Services 2021/22 https://www.minutes.haringey.gov.uk/documents/s131424/Sheltered%20Housing%20Review%20-%20final%20draft.pdf
[2] p.25 Haringey Corporate Delivery Plan 2024-26 https://www.haringey.gov.uk/sites/default/files/2024-08/haringey_corporate_delivery_plan_2024-2026.pdf

The aims of this project were to review the current arrangements for discharge from hospital including:

- Issues that cause delays to discharge from hospital.
- Communications with the Council and other services about the requirements of patients post-discharge.
- Issues around care packages and any aids and adaptations requirements that may arise.
- Delays to Care Act assessments.
- Links/communications between mental health services and social care teams.
- Care for higher needs service users, including those in supported housing schemes

5. Background to hospital discharge

5.1 The issue of delays to hospital discharge is summarised by NHS England as follows: *"once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience."*[3]

5.2 The health policy think-tank, The King's Fund, analysed NHS data which showed that the number of patients remaining in hospital overnight who no longer met the criteria to stay averaged 13,771 in February 2023. This equated to a monthly total number of bed days lost to delays of over 385,000 in a single month. The King's Fund estimated the total direct costs of these delays (including staff time and hospital overheads) to be £1.89bn in 2022/23 but noted that there would also be additional indirect costs such as cancelled operations or staff time spent arranging care packages[4].

5.3 More recent statistics indicate little change since the 2023 King's Fund analysis. Figures from January 2025 show the number of delayed discharge patients had slightly increased to 13,866. Of these patients, 6,483 (46.75%) were experiencing a delay of 21 days or more and, for this cohort of patients, the reasons for the delays were[5]:

- 31% - Further assessment needed and/or agreement required on what further care may be required.
- 18% - Awaiting a short-term bed
- 17% - Awaiting home or community care
- 17% - Awaiting a bed in a nursing or care home
- 16% - Other

5.4 In addition to the pressures caused to the NHS, delays to hospital discharge can also have a detrimental impact on the health of patients. Up to 65% of older patients experience decline in function during hospitalisation[6] according to the British Geriatrics Society which adds that

[3] https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/
[4] The hidden problems behind delayed discharges and their costs, King's Fund (March 2023) https://www.kingsfund.org.uk/blog/2023/03/hidden-problems-behind-delayed-discharges
[5] Delayed discharges from hospital, Nuffield Trust (May 2025) https://www.nuffieldtrust.org.uk/resource/delayed-discharges-from-hospital
[6] Deconditioning awareness, British Geriatrics Society https://www.bgs.org.uk/resources/deconditioning-awareness

many of these patients could prematurely end up in a care home as a consequence of their 'deconditioning' in hospital.

5.5 The Department for Health and Social Care (DHSC) stated in a policy document in January 2023 that *"both delays in discharge processes and shortages of capacity in social care and community care are making it more challenging to discharge patients"*[7]. The DHSC's approach to improving discharge from hospital is based on three main strands[8]:

- **Improving joint discharge processes** – including through systematic discharge planning between health and social care, starting from the point of admission by identifying patients with complex discharge needs, setting an expected date of discharge and working with families and carers to plan discharges.
- **Scaling up intermediate care** – including the expansion of 'step-down' care, designed to help people move from hospital into more appropriate settings for their needs, with wrap-around support for their rehabilitation/reablement.
- **Scaling up social care services** – including improved access to social care with a particular focus on domiciliary care.

5.6 DHSC guidance published in 2022 set out the approach that the NHS and local authorities should take together to plan and implement hospital discharge, recovery and reablement in the community. This placed particular emphasis on the "Discharge to Assess, Home First" model[9] where most people are expected to return home or to a community setting as soon as they are medically fit for discharge. The assessment for their longer-term care and support needs then takes place at a later time when they have reached a point of recovery.

5.7 Discharge pathways from hospital are categorised according to the needs of the patient and the definitions of the main discharge pathways from hospital (which are used nationally) are as follows:

- **Pathway 0** – Simple discharge to usual place of residence (which could include a care home) with no Health / Social Care input (either fully independent or restart of existing services).
- **Pathway 1** – Discharge to recover at usual place of residence, with support from Health and/or Social Care and other relevant services.
- **Pathway 2** - Rehabilitation in a temporary bedded setting until able to safely return to usual place of residence.
- **Pathway 3** - Life changing event, home is not an option at point of discharge (require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs).

5.8 Pathways 1, 2 and 3 now involve co-ordination from integrated 'care transfer hubs' in hospitals which are staffed by multidisciplinary teams, including health, social care, housing

[7] p.24, *Delivery Plan for recovering urgent and emergency care services*, DHSC/NHS England (Jan 2023) https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf
[8] p.25, *Delivery Plan for recovering urgent and emergency care services*, DHSC/NHS England (Jan 2023) https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf
[9] Hospital Discharge and Community Support guidance, DHSC (Mar 2022, updated Jan 2024) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1087354/Hospital-Discharge-and-Community-Support-Guidance-2022-v2.pdf

and the voluntary & community sector. According to Department of Health & Social Care guidance the care transfer hubs work *"in an integrated way providing autonomous clinical, professional decision-making to support the planning of complex discharges, and to broker the required support through adult social care, intermediate and community health services."*[10]

6. Evidence received - Hospital Discharge Teams

6.1 The Panel spoke to the Discharge Team at the Whittington Health NHS Trust and to staff including the Chief Nurse and Deputy Chief Operating Officer at the North Middlesex University Hospital (NMUH) about their discharge processes.

6.2 The Discharge Team Manager (Whittington) explained that the team comprised of five or six members from different backgrounds including nursing, therapy and community services. Referrals were received from the hospital therapy team explaining the current needs of the patient and flagging any safeguarding, housing, social services or care home issues. After receiving a referral, the team then screened the referral to make decisions about next steps which could include a referral to social services, a package of care and the most appropriate accommodation (including temporary accommodation or a permanent care home placement if required).

Delays

6.3 The Discharge Team Manager (Whittington) explained that statistics on delays were recorded and reported at NCL (North Central London) level. There was also a weekly report compiled by the team which included details of every patient considered fit for discharge but remained in hospital for whatever reason. The current rate was around 63-67% (i.e. of patients who were ready to leave hospital but could not leave) which could be around 30-40 patients per day.

6.4 The Panel was provided with the data from one of these weekly reports for a period in late July 2023. The report included details of the 25 patients that were experiencing a delay to their discharge at this point with a combined total of 349 delay days (an average of 14 delay days per patient). The majority of patients (19 out of 25) were over the age of 70. The reasons for the delays were as follows:

- 8 patients (32%) had a Pathway 1 delay – this involved awaiting the availability of resource for assessment and start of care at home. The longest delay at this point was 31 days and the average delay was 11 days.
- 5 patients (20%) had a Pathway 2 delay – this involved awaiting the availability of a rehabilitation bed in a community hospital or other bedded setting. The longest delay at this point was 24 days and the average delay was 12 days.

[10] Hospital Discharge and Community Support guidance, DHSC (Mar 2022, updated Jan 2024) https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance#structure-roles-and-responsibilities

- 10 patients (40%) had a Pathway 3 delay – this involved awaiting the availability of a bed in a residential/nursing home that is likely to be a permanent placement. The longest delay at this point was 38 days and the average delay was 20 days.
- 1 patient was awaiting a therapy decision to discharge.
- 1 patient was categorised as 'homeless/no right of recourse to public funds/no place to discharge to'.

6.5 The Deputy Chief Operating Officer (North Middlesex) reported that, on average, there were 75 patients at the NMUH awaiting discharge into a pathway and that this was a higher number than seen in many London hospitals. The majority of patients were managed by either Enfield or Haringey. As of 14th August 2023, there were:

- 25 Enfield Pathway 1 patients waiting with a combined 'bed day loss' of 187 days.
- 38 Haringey Pathway 1 patients waiting with a combined 'bed day loss' of 447 days.

While these rates did vary, the waits tended to be a little longer on the Haringey side.

6.6 The Discharge Team Manager (Whittington) explained that some people would only be waiting for 1-2 days but other may be waiting for 1-3 months. Those waiting longer would typically be in the higher age groups and with high needs, perhaps waiting for a care home place.

6.7 Other reasons for delays could include an issue with the patient's accommodation that meant that it was not safe and it was therefore necessary to find temporary accommodation or a 'step down' in the meantime. It may then be necessary to wait for temporary accommodation where the property needed further preparation such as cleaning, new furniture or adaptations. There could also be minor delays with rehabilitation services, depending on how complex the patient's needs were.

6.8 It was established that delays could sometimes be caused by the need to wait for certain things to be ready. Any discharge should be planned 48 hours before the discharge, including medication, letters/information and equipment. However, if all of this was not completed then a discharge may need to be delayed until the next day.

6.9 There could be a "snowball effect" in factors which cause delays. For example, if the documentation was not ready then the medication would not be ready and this could then have a knock-on impact on the transportation which may have been arranged for a certain time.

6.10 Asked about the operating hours of the hospital pharmacy due to the impact on the ability to facilitate discharge, the Discharge Team Manager (Whittington) said that the inpatient pharmacy service at the Whittington Hospital was open between 9.00am and 4.30pm on weekdays and 10.00am and 1.30pm on weekends. At weekends there was also an out of hours pharmacist on call for emergencies. She understood that there had previously been conversations about extending these hours to help facilitate discharge, but this would involve additional staffing/resource. She added that pharmacy issues would typically only cause a one-day delay and that this was a low proportion of the overall number of delays.

6.11 The Deputy Chief Operating Officer (North Middlesex) explained that issues causing delays across boroughs included:

- Family disputes (including property-related issues, or disagreements about provision of support/modifications);
- Access to equipment;
- Access to the patient's home (e.g. loss of keys);
- Homelessness (social deprivation issues are particularly relevant in NMUH catchment area);
- Patients with no recourse to public funds;
- Patients being rejected by multiple residential care providers (e.g. due to behavioural issues, difficulties with families, etc.);
- Insufficient care provider capacity (including provision of care packages in Pathway 1 or Pathway 3).

6.12 Asked about dealing with non-medical issues such as family disputes or loss of keys, the Chief Nurse (North Middlesex) said that in some cases in was necessary to move a Pathway 0 patient to a bed on a nurse-led ward on the main site while these issues were being resolved in order to free up a bed elsewhere.

6.13 Asked for clarification on who was in overall charge of coordination of the various different elements required for discharge, the Deputy Chief Operating Officer (North Middlesex) said that this could vary depending on the complexity of the case and so sometimes this would be directed by social services whereas others may be managed more directly by the discharge team. He explained that the discharge team had a daily discussion on current cases and the list of patients would include details of who was responsible for leading on each case. The Chief Nurse (North Middlesex) added that, if everything was led by the discharge team, then that could make engagement with other teams more different. The palliative care team would have an important role with patients at the end of life, for example, so there was a balance in identifying responsibility, particularly in complex cases, depending on the needs of the patient. Information could be shared at daily MDT (multi-disciplinary team) meetings.

6.14 When referring to social services, the Discharge Team Manager (Whittington) said that the form itself was completed by therapists who would describe the function of the patient. She explained that the therapist would not recommend care specifically but would set out details of, for example, whether the patient needed assistance to wash, dress, prepare meals or if they needed to use a walking frame. The discharge team would then read this information and make a recommendation about whether it was safe for a person to go home or whether other pathways were necessary such as 24-hour care. Supporting information may also be recorded to support the recommendation, such as through a behaviour chart to illustrate what the patient was doing during the day and during the night. The patient, and family members where appropriate, would be involved in the conversations prior to the recommendations being finalised.

6.15 When referring to social services, the Discharge Team Manager (Whittington) explained that the form itself was completed by therapists who would describe the function of the patient.

She explained that the therapist would not recommend care specifically but would set out details of, for example, whether the patient needed assistance to wash, dress, prepare meals or if they needed to use a walking frame. The discharge team would then read this information and make a recommendation about whether it was safe for a person to go home or whether other pathways were necessary such as 24-hour care. Supporting information may also be recorded to support the recommendation, such as through a behaviour chart to illustrate what the patient was doing during the day and during the night. The patient, and family members where appropriate, would be involved in the conversations prior to the recommendations being finalised.

Impact of discharge delays

6.16 The Deputy Chief Operating Officer (North Middlesex) explained that discharge delays had an adverse impact on patients in the following ways:

- Specialty bed not always available;
- Patients' loss of muscle mass and tone;
- Psychological impact of being away from family;
- Loss of independence;
- Loss of confidence;
- Risk of falls due to unfamiliar environment;
- Risk of infection.

6.17 He added that discharge delays also had an adverse impact on hospital flow in the following ways:

- Delays in patients being allocated bed;
- Difficulty in timely off-loading of ambulances;
- Reduction in flow through the Emergency Department;
- Risks to routine surgery (though cancellation of surgery for this reason is relatively rare as the use of additional beds would usually be the response);
- Cost of opening additional 'escalation' beds (ambulances must now off-load within 45 minutes which reduces pressure on the ambulance service but can increase pressure on hospitals).

Care home placements

6.18 In relation to care home placements (Pathway 3), the Discharge Team Manager (Whittington) explained that there could be various reasons for delays, including because there were no vacancies or because a patient was considered to be challenging due to their behaviour. In some cases it may be necessary to consider placements outside of the London area but there could sometimes be issues as relatives may not be happy to travel further.

6.19 The Discharge Team Manager (Whittington) said that there was little they could do about care home capacity, but it would be helpful if social work colleagues could help to manage expectations from patients and families. It could sometimes be very difficult to find a care home place in the geographical area that the patient/family wanted so this conversation was needed to make clear that they were unlikely to get a place in their chosen area but also to

understand the likely timescales. For example, they may be placed in a care home for six weeks after which they would be assessed again.

6.20 Asked if the Whittington NHS Trust ran care homes or step down beds (as some other Trusts did this), the Discharge Team Manager (Whittington) confirmed that they did not and that all contact for these were through social services.

7. Evidence received – Adult Social Care services

Haringey Council service delivery – team structure (Reablement Service and Hospital Team)

7.1 In evidence to the Panel, the Head of Integrated Care (Adult Social Services), explained that there had been very high levels of demand since the Covid-19 pandemic and so the service delivery had been reviewed with the team split into two sections:

- the **Reablement Service**, which had a set service specification with criteria on eligibility for up to six weeks of reablement with the aim of enabling people to stay in their homes without the need for ongoing long-term care.
- the **Hospital Team** to manage more complex cases where people could no longer manage at home and required a permanent placement, a long-term package of care or rehabilitation. This included social workers going onto the wards to undertake a Care Act assessment and put in place a support plan to meet that person's needs upon discharge.

7.2 Reablement is a support intervention to help people regain their independence after a period of illness, particularly following discharge from hospital. This takes place in the home with the help of reablement carers who are trained to support people to regain strength and become more confident with day-to-day activities, including new strategies and techniques to perform tasks. In Haringey, reablement services last for a maximum of six weeks. The service was described as operating a 'home first' model and was supported by funding from the Better Care Fund (BCF).

7.3 A good practice reablement case study was provided to the Panel, involving a resident who was allocated 12.25 hours of care per week following a knee replacement. They required assistance with housework, meals, strip washing and dressing. On an initial assessment after 18 days of the care package starting, the resident was able to independently perform a strip wash and dress and prepare basic meals. The resident was able to use the main stairs and steps leading to the bathroom but with some fear and, although able to get into the bath with the use of a bath board, did not have the confidence to do this alone. It was therefore agreed that these tasks would only be carried out with a carer present until they became more confident. On a follow up assessment 9 days later, the resident was able to use the stairs and bath board independently. The client agreed that the overall care package would come to an end after another 5 days.

7.4 A second good practice reablement case study involved a bed-bound resident who required 4 double-handed (involving two care workers) calls a day following hospital discharge. The resident was receiving physiotherapy input from the Integrated Community Therapy Team

(ICTT) at Whittington Health. After review from the occupational therapist and carers it was agreed to reduce the double-handed care to single-handed care, thereby reducing the number of care hours per week from 42 to 22.

7.5 In terms of ongoing care, the Panel heard that residents received an annual review to assess their care needs but, if there were particular concerns, then a 3-month or 6-month review could be triggered. This would be specified in the records following transfer from the Reablement service. Care agencies could also raise concerns at any time which could lead to a review. All providers had direct access back to the brokerage service or they could contact the first response team which would feed the concerns to the relevant team

7.6 In September 2025, the Panel was informed that a 'health check review' of Haringey's reablement service had recently been carried out by the external consultancy 31Ten. The review outlined the strengths of the service and the areas for development, starting the exploration of the options for reablement in the future. Panel members expressed concerns that, given the financial circumstances of the Council, savings might be obtained through cuts to reablement services, such as by shortening the numbers of weeks in the reablement package for example. The Director of Adult Social Care said that there were different models for reablement being considered through an options appraisal. She said that the Council wanted to ensure that the service reached residents being discharged from hospital and in the community with the best potential for good outcomes and also to ensure that it is good value for money. It was also noted that the BCF was in the process of being reviewed and may operate differently in the future.

7.7 The Panel made clear that it wished to see the full report from the external consultancy when available, a clear statement of the purposes and aims of the future reablement service and an analysis of the available options. The Panel also highlighted the importance of the new model being integrated into a joined-up approach with locality teams, community partners and hospital staff.

7.8 Asked by the Panel about the current performance of the reablement service, the Corporate Director of Adults, Housing & Health and the Director of Adult Social Care commented that:

- There had recently been a good audit outcome and there was a strong interface with the hospitals.
- There were some key challenges with the workforce in terms of difficulties with recruitment and an older overall age-profile.
- There was a perception in some quarters that the Council could deal with some of the most complex cases. However, the 6-week reablement package was a short-term intervention with planning for next steps that was best suited to less complex cases. This highlighted the importance of a good understanding and positive working relationship with NHS Trusts and the ICB on how best to jointly manage cases.
- The Council was currently performing well, partly because of the time invested in building local relationships. Where based in hospitals there was a multi-disciplinary team (MDT) approach with services and support around it.

- The Hospital Team was not currently integrated into the localities model and it was felt that this model currently worked well, based on site in hospitals, interfacing with community services and localities to ensure smooth pathways.
- The Localities Teams (in the West, Central & East of the Borough) were described as the engine rooms for Adult Social Care. The Hospital Team covered many of the same residents but had a physical presence in the hospitals which helped to get the best person-centred care and pathways out of hospital.
- It was important to be realistic about multi-disciplinary team (MDT) working in hospitals because social workers cannot be on the wards all the time and cannot attend all MDT meetings due to time constraints.

RECOMMENDATION 1:

To make the report on the future model for reablement services from external consultancy 31Ten available to the Panel. In particular, clarity is needed on how the new model will develop a joined-up approach with locality teams, community partners and hospital staff.

RECOMMENDATION 2:

Close monitoring of hospital readmission rates is required after the implementation of the new reablement model to ensure that any reduction to the length of reablement programmes is not having a detrimental effect on patients and leading to more expensive hospital readmissions. Clarity is required on how data related to the implementation of the new service provision will be monitored and compared to the current service.

RECOMMENDATION 3:

That the Council ensures robust monitoring of the new reablement model through:

- **Close tracking of 30-day and 90-day hospital readmission rates to confirm that any reduction in programme length does not negatively affect patient outcomes or lead to increased readmissions;**
- **Clear reporting on performance data, demonstrating how outcomes under the new model compare with the current service; and**
- **Full financial transparency for the community-based approach, including evidence that the Council is not assuming a disproportionate share of system costs and a breakdown of Directorate contributions to joint-working arrangements**

<u>Multi-Agency Care & Coordination Team (MACCT)</u>

7.9 The Panel spoke to the Multi-Agency Care & Coordination team (MACCT), the primary aim of which was to establish preventative measures to reduce the need for GP and hospital appointments. The service supports adults living with frailty and/or multi-morbidities to maintain or improve their health, independence and well-being. This was predominantly for older adults, but the service did work with some people under the age of 60. The proportion of patients under 50 was very low (2.9%) but did involve some cases that were not going to get this type of support anywhere else.

7.10 The MACCT was funded from various sources including the Better Care Fund with a budget of around £7.8m. It reported to the adult community service directors at Whittington Health, the Haringey GP Federation, the Age Well Steering Group and the Partnership Board.

7.11 The MACCT comprised of around 25 professionals from multiple agencies and disciplines as part of an integrated team. This included physios (3), occupational therapists (3), mental health workers (1), social workers (2), pharmacists (2), community matrons (3) and GPs (2). The MACCT had also made a recent bid to the ICB for further funding of around £100k to increase capacity, including a new social worker post (expanding from two posts to three posts) and more support staff to free up time for the clinicians.

7.12 It was also noted that there was not currently a housing officer which could potentially be useful in dealing with housing issues relevant to complex health and social needs.

7.13 It was noted by the Panel that that MACCT had started some years ago as a pilot project and were now building better links with localities teams and integrating the work more closely, including with social workers who carry out the Care Act assessments. This was why a third social worker in the MACCT team would be particularly useful.

7.14 The MACCT team had two sub-teams covering the West and East of the borough but if expanded could match the localities/neighbourhoods working with West, Central and East sub-teams. This would enable closer working relationships with the voluntary sector and the localities teams.

7.15 Results for the service included:

- a 40% fall in A&E attendances for residents who had been referred to the team;
- a 30% fall in inpatient admissions – though when people did go to hospital, their length of stay tended to be longer due to the acuity of their ill health.
- It was also believed that the number of GP appointments was reduced but figures were not available on this.

7.16 The referral criteria for the service were to establish that an individual had multiple long-term health conditions and social complex needs which meant that they could not be treated by a single service with a pathway.

7.17 The operating model included ‘General’ and ‘Static’ referral routes.

- The General route referrals were from trusted referrers such as GPs, perhaps because someone was presenting to them frequently or had not been seen for some time despite known health issues. The clinicians had two hours allocated for each assessment as this was required for a complex geriatric assessment. This was a holistic approach to assess the whole person to identify frailty and to listen to the person to put them at the centre of their own care. It also included financial issues and social history. A care plan was then generated with risks and priorities identified which would be shared with their GP.
- The Static route referrals involved proactive case finding. Stream 0 (zero) involved multidisciplinary teleconferences which were held 3 to 4 times per week and the aim was to build on this due to the locality model. The multidisciplinary teleconferences

involved discussion of cases in relevant localities and data from local hospitals, including the North Middlesex and the Whittington, and from the London Ambulance Service. Data included information about who was regularly presenting, their age and any existing action being taken by local agencies. This could then generate action from the multidisciplinary team. Stream 1 involved navigators working to target PCNs across the borough to generate lists of moderately frail patients from GP practices and then proactively contacting them to see if they would be willing to have an assessment. The assessment involved a checklist and patient reported outcome measures and was conducted over the phone or through a home visit.

7.18 The role of GPs in complex cases was queried by the Panel and it was estimated that around 90% of GP practices in Haringey engaged with the multidisciplinary teleconference system but it was acknowledged that it could cause barriers and slow things down when GP practices did not engage.

7.19 With regards to communications and the local community the Panel was informed that:

- A new project was in development to build relationships with sheltered accommodation so that clinics could be held there involving navigators and clinicians.
- Patient information forms were provided to clients and information was translated into five languages. Caregivers were also informed of services being provided.
- There had been patient events held involving other health partners including diabetes services, GP Federation outreach teams and Reach & Connect.
- There was outreach work through the navigators to food banks and to specific communities such as the Somali community.
- Over 40% of clients were from an area of high deprivation, highlighting the importance of outreach in these areas.

7.20 The Panel queried the outcomes for people who were not accepted by the service as they did not meet the criteria. It was explained that the clinical reason was sent to the referrer who would then need to consider the best next steps for the resident, which could include remaining on a waiting list for a specific service or referral to a different service. GPs also had access to social prescribers who could enable access to other services.

7.21 Panel Members highlighted the needs of people who were not able to access the MACCT service yet, firstly by recognising that they needed help and then knowing how to access or be referred to services. It was reiterated that the service currently relied on trusted referrers and this could potentially be expanded, for example to sheltered housing services. It may also be possible to improve communications in order to advise people on what to do if they are not accepted by the MACCT team. The MACCT team had contributed to the Age Well booklets which was a useful resource.

7.22 With regards support for people with dementia, it was noted that there were many residents with undiagnosed dementia or other cognitive impairments so it was necessary to support people to get a diagnosis where this may be required. There were also links with

dementia navigators and the memory service that could be used and it was also possible to flag up cases via the multidisciplinary teleconferences.

RECOMMENDATION 4:

Housing officers to be included in multi-agency teams to assist with post-discharge support and prevention of hospital admission.

RECOMMENDATION 5:

Expand types of trusted referrers to MACCT/multi agency-teams, for example sheltered housing providers.

RECOMMENDATION 6:

Multi agency teams led by local authority and the ICB need to be linked together within the same hub to improve coordination and avoid duplication.

8. Evidence received - Housing services

'Step-down' accommodation

8.1 The Panel spoke to the Head of Support and Wellbeing for Housing Services at Haringey Council who set out details of sheltered/supported housing across the Borough. This related to the element of the terms of reference (see paragraph 4.2) on care for higher needs service users, including those in supported housing schemes.

8.2 Haringey Council owns 20,500 properties (5,000 leasehold and 15,500 rented):

- Including 1,356 supported housing for older people properties;
- The properties are located in 23 sheltered housing schemes (including communal spaces for people with higher personal needs) and 29 Community Good Neighbour schemes (properties without communal spaces for people with lower support needs, including those from younger age groups, who nonetheless require some support to live independently) across Haringey;
- All properties are linked to the Haringey Council Community Alarm.

8.3 The service supported a diverse, multi-dependency group of residents ranging from aged 50+. Typically, those residents in the Sheltered Schemes had a higher support need than those of the Community Good Neighbour schemes. These schemes aim to promote independent living whilst having the assurance of support available when needed.

8.4 Intermediate care services were provided in step-down accommodation, mostly to older people, to help them avoid going into hospital unnecessarily, to help them be as independent as possible after discharge from hospital and to prevent them having to move into residential or nursing homes until they really need to. For step-down accommodation there were 21 Supported Housing step-down flats (9 of which were currently vacant). Of the 21 flats:

- 14 flats were for the use of people under the remit of Adult Services (mainly older people and people with physical disabilities);
- 2 flats were for the use of people under the remit of mental health services;
- 5 flats were for the use of the resettlement project working with hospital discharge teams.

In terms of accessibility, of the 21 flats:

- 10 properties were on the ground floor;
- 6 properties were on the first floor with no lift;
- 3 properties were on the first floor/third floor with lift;
- 2 bungalows.

Some properties had adaptations such as wet rooms and had disabled access.

8.5 The **eligibility criteria for step down accommodation** was:

- Aged 50 or over who are ordinarily resident in Haringey.
- People who do not have settled accommodation to facilitate a discharge from hospital or their existing property is unsuitable to return to.
- People who are likely to have care and support needs as set out under the Care act 2014 or who would benefit from a period of reablement before being assessed for care and support under the Care Act 2014.
- People whose care and support needs can be supported in a Supported Housing environment.
- People who have capacity (as determined under the Mental Capacity Act 2005) to understand the legal requirements of the Scheme's licence agreement.
- People who do not have capacity (as determined under the Mental Capacity Act 2005) to understand the legal requirements of the Scheme's licence agreement **and** The Court of Protection has made an Order authorising a particular person to sign a particular contract on behalf of an incapacitated adult.

8.6 **Hospital discharge for existing Council Tenants** – When staff received a discharge date from the hospital for the tenant, they would inform relatives and any support services such as home care that needed to restart. The following points were checked with the hospital or with adult social care in circumstances where they were involved:

- Have care services previously supplied been reactivated?
- Has there been a review of care needs?
- Are additional services to be supplied on discharge?
- Is the tenant sufficiently mobile to manage their flat, or reach the accommodation especially if stairs must be climbed?
- Has the tenant been given clear instructions about medication?
- Has an out-patient follow-up appointment been made?

If staff believed that adequate support would not be in place at the point of discharge, they would let their manager know, contact the Council's First Response service and notify any family members or carers.

8.7 **Hospital discharge for non-Council Tenants –** This related to residents not previously known to housing services but a referral had been made for discharge to a property because of a

'bed blocking' situation. When a referral for a non-resident hospital discharge was received by the team manager and Hub Coordinator, a discharge summary was required and checks made that the available accommodation met the needs of the resident. The length of stay would also be discussed – as part of the protocol the maximum is 12 weeks but there would later be further meetings to discuss the resident's needs and whether the length of stay needed to be adjusted. As with Council tenants, various checks would need to be made:

- Have care services previously supplied been reactivated?
- Has there been a review of care needs?
- Are additional service to be supplied on discharge?
- Has the tenant been given clear instructions about medication?
- Has an out-patient follow-up appointment been made?

8.8 Asked about the vacancy rate, including the fact that 9 out of the 21 step-down properties were currently vacant, the Head of Support and Wellbeing for Housing Services said that the likelihood of those 9 flats being filled quickly was low and that they only allocated properties based on referrals received from social services and did not allocate properties themselves. It was for adult social care and discharge teams to discuss and conclude whether they wanted to use these properties for which they would pay the rent and service charges. He also clarified that social services used step-down properties in relation to their clients for various different reasons and not just discharge from hospital.

8.9 On the typical length of stay at a step-down property, the Head of Support and Wellbeing for Housing Services explained that the 12-week maximum specified in the protocol was rarely enforced and that there were some residents who had been in a property for nearly a year. This was often because social services were working through their individual circumstances and trying to find permanent accommodation that it would be safe for them to go to. This could include the time needed to make adaptations to their main property. The Team Manager for Housing Services commented that when someone moved into step-down accommodation it then became about getting an assessment done and what support was needed in order to be able to move on to their permanent property or an alternative. This could include whether the care package or mental health support was sufficient, for example.

8.10 The Assistant Director for Housing Demand commented that practical barriers were also an issue when a resident's needs had changed so significantly, such as needing ground floor accommodation for example. It was also relevant how early they became aware of particular issues so that the right support could be put in place. The Head of Lettings & Rehousing, commented that there was a lot of demand for ground floor properties or possibly first floor properties with lifts. Detailed assessments were carried out for people requiring sheltered accommodation and this was where the pressure points were with plenty of people on the list for ground floor accommodation. Wet rooms and other adaptations were also in high demand.

8.11 The issue of wheelchair accessibility into and within properties was also raised as a relevant concern. The Assistant Director for Housing Demand flagged that, in addition to the issue of single people being discharged from hospital, for whom sheltered housing was often a good

solution, there were also cases where one person in a family might have increased needs, such as a wheelchair adaptive property. This meant that there was a particular challenge in finding larger properties suitable for such needs. It was suggested by the Panel that could be a requirement of all new social housing/housing association properties, particularly as demand for accessibility was likely to rise with projected increases in the age and medical needs of the population.

8.12 Asked how long it typically took after a property was vacated to make it fit for the next person to come into the property and how this time could be reduced. The Head of Support and Wellbeing for Housing Services said that this could vary and that, while adult social services paid the charges, Housing Services had staff on the ground that clear and clean the properties as quickly as possible and buy anything needed and charge this to adult social services. When a referral was received and an agreement made in relation to the funding, it would take up to 3-5 days to clean and equip properties (e.g. with furniture) according to the requirements. He explained that, when orders were made to suppliers for furniture, there was a lead-in time for this to be completed.

8.13 The Panel expressed concerns about possible delays to hospital discharge that this could cause and highlighted the importance of shortening the period of time in which a property could be made suitable to be occupied by a new resident. A Panel Member suggested that properties could be cleaned before a referral was received and that furniture/bedding could also be arranged in advance unless there was a specialised adaptation needed. The Head of Support and Wellbeing for Housing Services clarified that his team did not have the funding to refurbish flats in this way and so funding for this was secured for each case when a referral was made from social services.

8.14 At a later evidence session the Panel was informed that the issues around funding had been resolved with work ongoing to get the units cleaned and furnished so that they were ready for people to be discharged to. The Panel welcomed this development and highlighted the ongoing importance of maintaining quick turn-around times and ensuring that vacant properties were ready to be occupied at short-notice in the future.

8.15 The Assistant Director for Housing Demand, commented that the arrangements for the step-down properties had ended up being in place over a number of years with different parts of social care taking on, for example, two or three properties each. It may therefore be timely to review this and make sure that the best use of the housing units was being made. She added that some Better Care Funding had recently been allocated in relation to winter pressures for five units which had largely been well utilised. The funding had also supported a hospital discharge coordinator working between the Council and the hospital which had improved the planning. While this funding had initially been allocated for winter pressures, she was hopeful that this funding could be continued. But she added that there was a separate issue to consider whether a model could be applied to all 21 units rather than blocks of units.

8.16 In conversation with the team from NMUH, the Panel asked about the availability of step-down accommodation in cases where patients were ready for discharge but did not have

any permanent accommodation to be discharged to. The Deputy Chief Operating Officer (North Middlesex) confirmed that this did sometimes happen, with decisions made about suitability in conjunction with Adult Social Services. He added that they were all working towards a "home-first" approach as patients would often have better capacity in a home environment as opposed to a hospital setting. The Chief Nurse (North Middlesex) added that there was less availability of step-down in the north and east of the borough so there was room for improved provision. She also confirmed that there was greater step-down provision in Enfield borough, partly because of the greater number of residential/nursing homes in that area.

RECOMMENDATION 7:

The Panel welcomed the progress in making vacant step-down units ready for people to be discharged to. The Panel highlighted the ongoing importance of maintaining quick turn-around times and ensuring that vacant step-down properties were, cleaned, furnished and ready to be occupied at short-notice in the future.

9. Evidence received – Further issues related to hospital discharge

Continuing Healthcare

9.1 Continuing Healthcare (CHC) is a package of care provided and funded by the NHS for a relatively small number of patients with a high level of need. These packages of care can be of particular relevance to hospital patients on discharge pathway 3 which involves discharge to care homes. The Service Director for Adult Social Services explained that CHC was very beneficial to residents as they received fully funded 24-hour care that a local authority could not provide.

9.2 It was noted by the Panel that there were a relatively small number of CHC packages provided in Haringey when compared to national rates and other similar Boroughs and there were concerns that the Council had been taking on people with complex needs and funding support for them when it should have been the responsibility of the NHS.

9.3 In July 2024, the Panel spoke to the Director for Adult Community Services at Whittington Health NHS Trust who explained that the CHC Team worked alongside multi-disciplinary team (MDT) colleagues to screen and complete CHC checklists as all patients are entitled to be screened to ascertain if they require a CHC assessment. The CHC/MDT teams and hospital identified patients who had a rapidly deteriorating condition and were approaching end of life so that they could be fast tracked for CHC assessment automatically.

9.4 The main CHC assessments/tools were:

- **CHC Checklist:** a screening tool used in a variety of settings to help practitioners identify individuals who may need a referral for a full assessment of eligibility for CHC. This could be used in a variety of settings and the checklist scoring had 11 domains with the threshold set deliberately low to screen people in rather than out. Information for this could be gathered from families and patient notes.

- **Decision Support Tool (DST):** used by the MDT to assess whether individuals had a primary health need. The DST assesses the individual's need as low, medium or high under each of the 11 domains and determines what level of care and support they need.
- **Fast Track Tool:** a means for ensuring that a person's care is not delayed unnecessarily when an individual has a rapidly deteriorating condition, which may be in a terminal phase. This provides short-term authorisation until a full CHC assessment can take place.

9.5 In written information provided by the North Central London Integrated Care Board (NCL ICB) the spend per head of the population was shown to be lower in Haringey than the NCL average. This was explained by the outer Boroughs (Barnet and Enfield) having a higher proportion of over-65s.

9.6 The NCL ICB also acknowledged that nationally there were higher levels of CHC than the London region. This was explained by demographic factors and historic inequalities in health outcomes.

9.7 The Director for Adult Community Services at Whittington Health NHS Trust said that the low CHC figures in Haringey were an area for improvement, noting that most referrals came from local hospitals and so it was important to raise awareness of CHC for clinicians, particularly when there was a high turnover of staff in London. The ICB had recently established 'in-reach' nurse roles in each hospital to help identify those who may have increasing care needs and may reach the criteria for CHC.

9.8 The Service Director for Adult Social Services informed the Panel that the Adult Social Care team was working with the NCL ICB to renegotiate terms and their dispute policy. The dispute policy was being reviewed by an external lawyer with expertise in CHC to consider whether it was compliant with NHS England guidance and also to do some benchmarking work to compare Haringey CHC data for the past five years. This information would support further discussions with the ICB. The Service Director for Adult Social Services acknowledged that Haringey's figures were historically low and added that a new project team had recently been established in the Council to work on CHC.

9.9 Asked whether there was a way of knowing how many people were still being denied CHC, the Service Director for Adult Social Services explained that the new project team had a template and tracked every template that was submitted, chasing it in writing with the ICB after 28 days if the assessment had not taken place. This had strengthened the monitoring of this process. It may also be necessary to liaise with care homes in future to be able to monitor checklists that they had submitted and support them in this area as the Council may not otherwise be aware of their checklists.

9.10 Asked what residents could do to ensure that CHC assessments were recorded and that they had access to this information, the Service Director for Adult Social Services explained that the NHS England guidance for CHC made clear that when a checklist was completed, the receipt should be provided by the NHS. The resident and their family should receive a copy of this and then also receive the decision in writing. This had not always happened in practice but the new monitoring process that had recently been established was robust and aimed to ensure that this now happened.

9.11 Asked how it could be established that residents had fully understood their CHC assessment, including whether a recording of the assessment was kept as part of the record, the Service Director for Adult Social Services explained that the CHC assessment had a capacity tool within it and required the applicant to have capacity or for a family member to be present on their behalf. The DST was recorded line by line and signed off by the resident/family member/advocate, social worker and nurse as part of the multidisciplinary approach. A copy should then be provided to the resident.

9.12 With regards to the monitoring of the assessments themselves, the Service Director for Adult Social Services confirmed that her project team did participate and challenge any records that they did not feel was an accurate reflection and would also provide support for appeals. The team would be available to Members or others involved with the assessments as the aim was to be available to everyone and transform the way that residents accessed NHS care.

RECOMMENDATION 8:

The Panel emphasised that clear written information should be provided to residents/families/carers/advocates prior to any assessment or checklist taking place so that they were clear about the process and the questions that would be asked.

The information provided to residents should also:

- **Make clear that the recording of assessments can be requested.**
- **Make clear how decisions could be challenged and explain the process for this.**
- **Provide details on financial assessment/eligibility and ensure that residents are clear about any financial contribution that may be required from them.**

RECOMMENDATION 9:

A clearer agreement / memorandum of understanding should be developed with the Integrated Care Board (ICB) to specify funding arrangements for CHC and to avoid the sticking points which are leading to the local authority and the ICB using public resources to dispute cases with each other.

<u>Aids and adaptations</u>

9.13 The term ‘aids and adaptations’ refers to mobility equipment or adaptations to a person’s home that they may require to help with mobility issues. In circumstances where a person’s mobility needs have significantly increased following a stay in hospital, and there is a requirement for aids and adaptations to be put in place before they can be safely discharged from hospital, waiting times for providing the equipment or installing adaptations can be a significant cause of delays to hospital discharge. Issues around aids and adaptations requirements is included in the terms of reference for this Review.

9.14 There are a wide range of different aids and adaptations that can be provided including hoists or frames, stairlifts, ramps, grab rails, lowered kitchen worktops or wheelchair-

accessible showers. The main areas where accessibility can be an issue include getting through doors, moving around the home, accessing kitchen/bathroom facilities and getting in and out of bed. Local authorities have a statutory duty to help qualifying disabled people with home adaptations.

9.15 The process for this usually involves a needs assessment, conducted by an occupational therapist, to establish the aids and adaptations that may be required by the applicant. Funding to support this work is available through the mandatory Disability Facilities Grant (DFG) and various other discretionary grants but applications are subject to qualification criteria and means-testing. Works can only proceed if the proposed adaptations are both 'necessary and appropriate' and 'reasonably practicable' as defined by national legislation.

9.16 Where complex adaptations to a property are required, a referral is made to a surveyor who will conduct a site visit before a schedule of work is commissioned through a Dynamic Purchasing System. The completed works are inspected by the occupational therapist and surveyor before being signed off.

9.17 A shortage of capacity for occupational therapy services is acknowledged at national level and this contributes to delays to the provision of aids and adaptations across the country. As of 2023/24 there were 21,454 occupational therapists working in the NHS and 3,800 working in adult social care (3,200 of which were employed in the local authority sector).[11] A workforce survey report conducted by the Royal College of Occupational Therapists in November 2022[12] found that:

- 86% of occupational therapists reported an increased demand for their services within the past 12 months;
- 79% stated that people were presenting more complex needs due to delayed interventions;
- 78% said that their team wasn't large enough to meet demand.

9.18 In evidence to the Panel, the Service Director for Adult Social Services said that, even without workforce/supply issues, only something basic such as a handrail could be installed quite quickly but more complex adaptations would still take quite some time to complete. The Head of Integrated Care added that, in some cases, people may still be able to go home before the work had been carried out but if a person's home was not considered to be safe for them until the work had been completed, then they might need to be placed temporarily in a step-down facility.

9.19 Asked how aids and adaptations could best be used to prevent people from requiring readmission to hospital, the Service Director for Adult Social Services explained that the Disabled Facilities Grant enabled various innovative options for adaptations that an individual may need (e.g. moving the stairs or even an extension on a property when that was the only viable option). The Head of Integrated Care added that, while there was the

[11] Royal College of Occupational Therapists, Workforce Strategy Action Plan England 2024-27 https://www.rcot.co.uk/support-the-profession/workforce-strategy/2024-2027

[12] Royal College of Occupational Therapists, Workforce Survey Report 2023 https://www.rcot.co.uk/latest-news/workforce-survey-report-2023

issue of the person's immediate needs to be able to get them home safely, it was also necessary to consider their longer term need to enable them to continue to live in that property. Obviously, as this involved the use of public money, any adaptation needed to be necessary and appropriate to that person's assessed level of need. A big part of this work was around prevention and promoting independence.

9.20 The Panel has been tracking the issue of aids and adaptations for some time as part of its work programme, separately from this Review, due to concerns raised by residents about delays in installation of adaptations and difficulties in communications with the Council. In September 2022, the Panel made a series of recommendations for improvement including widening provider choices to provide alternative options when delays occur and to proactively improve communications with residents over delays and expected timescales for works to be carried out[13].

9.21 Measures to respond to these recommendations have been implemented and overseen by a project board with several updates provided to the Panel. Changes have included:

- Reducing waiting lists by commissioning an external team to provide additional support on assessments and support planning processes.
- Recruitment of an additional occupational therapist and occupational therapist assistant.
- Improved communications with residents through a 4-6 week contact pathway to update them about the status of their case, a new case management system and an initiative to proactively contact everyone on the waiting list.
- Use of resident feedback, complaints and Members' inquiries to improve monitoring of service satisfaction.

9.22 In March 2025, the Commissioning Project Manager with responsibility for the project report reported to the Panel[14] that:

- the overall waiting list had been reduced from over 1,000 in September 2024 to a current figure of 388.
- over the same time period, the average number of days on the waiting list had been reduced from close to 200 days down to 122 days.
- the number of assessments completed in a month had increased from 50 to 210.

9.23 However, the Service Director for Adult Social Services acknowledged that there was a long way to go in relation to cases where there were multiple layers of complexity. In some cases, there could be several different professionals working with someone and so the Council had made a commitment that there would be a lead professional on aids and adaptation cases so that there would be someone taking ownership for coordination. This would help to improve the tracking of cases and avoid unnecessary delays.

9.24 The Panel highlighted priorities for future monitoring including progress on previous recommendations and:

[13] Minutes, Adults & Health Scrutiny Panel, 15th September 2022 (includes full list of recommendations) https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=74001
[14] Minutes, Adults & Health Scrutiny Panel, 31st March 2025 https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=82097

- Improvements on contracts and commissioning, including through the Dynamic Purchasing System.
- Monitoring and tracking of case progress, the use of the support plan as progress is made and how the resident is included in that process.
- Accurately capturing the voice of residents in the discussions on their case.

9.25 In conversation with the Discharge Team at the Whittington Hospital, Councillors reported that they had received a lot of feedback from residents about the difficulties in getting aids and adaptations made to their home, such as a ramp for example, and that consequently they could not be discharged home from hospital until that work had been completed. The Discharge Team Manager (Whittington) agreed that this could cause a delay in some cases, but that they would look at any information available about the property (including photographs) and, with the therapists, look at what mitigations could be put in place. This could include putting in place equipment such as a specialised bed or a commode, for example or particular support from carers. It could involve situating a person on a different floor of their building if there were accessibility issues. The reason that a patient could be sent to a care home rather than their own home was if it would not be safe for them to return home. This could be a particular concern in cases of Alzheimer's or dementia where the person's condition was deteriorating and they could not be left alone.

9.26 On the process for housing adaptations, the Discharge Team Manager (Whittington) explained that this would typically involve a conversation with a therapist who may conduct an 'access visit' by visiting the patient's property to assess its suitability before they were discharged. Access visits could not always be carried out now due to limited resources so therapists may have to rely on photographs/measurements and only carry out access visits if this was not sufficient to make a decision on safety. The Urgent Response Service Manager (Whittington), added that there was a daily meeting with Council staff to discuss the patients and exchange information to support the discharges. These were helpful but there were some limitations on what they could do. For example, the provider of equipment in Haringey had recently been changed and this had not been easy as equipment that used to be delivered within a couple of days was now sometimes taking weeks.

9.27 Concerns were raised by the Panel about older people who didn't have families to rely on to help with assessments of properties (e.g. by sending in photographs). The Discharge Team Manager (Whittington) responded that they would have social workers liaising with them and, as previously mentioned, a therapist could conduct an 'access visit'. The Urgent Response Service Manager (Whittington), added that there was a multi-agency team in the community to provide wrap-around support and assessments for residents, including complex patients, to help them to be able to stay in their own home. The Discharge Coordinator Lead (Whittington) added that there used to be the Bridges (rehabilitation) Ward which would help people to move from the acute side of the hospital, but this was no longer funded.

9.28 The Deputy Chief Operating Officer (North Middlesex) acknowledged that delays could happen on the hospital side, for example by failing to assess the patient's aids/adaptations needs until they were medically fit and close to discharge when this could be done earlier in

some cases (though this would not necessarily be sensible in all cases as needs could change). There could also be delays caused in the ordering process for the equipment/adaptations with some back and forth over the specifications and matching this specifically to what was available to be supplied. There had also been issues in the supply chain causing delays for the ordered equipment to be provided. In Enfield, the nurses in the rehab wards could order equipment directly, whereas, in Haringey, the nurses would have to make these requests for equipment to another team which would usually cause a further delay.

RECOMMENDATION 10:

The Panel highlighted priorities for future monitoring including progress on previous recommendations and:

- **Improvements on contracts and commissioning, including through the Dynamic Purchasing System.**
- **Monitoring and tracking of case progress, the use of the support plan as progress is made and how the resident is included in that process.**
- **Accurately capturing the voice of residents in the discussions on their case.**

Homelessness and People with No Recourse to Public Funds (NRPF)

9.29 Panel Members requested further explanation about circumstances where a person awaiting discharge has no recourse to public funds as this could cause additional delays. The Deputy Chief Operating Officer (North Middlesex) explained that this involved a small minority of cases but that they could be very complex and could involve options such as repatriation to their country of origin when discussed with them. It could also involve a wide age-range of people. Asked by Cllr Connor about the UK-wide policy on such cases, the Deputy Chief Operating Officer (North Middlesex) explained that there could be specific guidelines in particular circumstances (such as in the case of the large number of Afghan migrants that arrived in the UK a few years previously) but, where there were unique circumstances, there were no specific guidelines, though there were some legal precedents from past cases. However, it was rare for cases to reach a court situation. It was clarified that, while there were not UK-wide guidelines, there was a clear process followed in the NCL area.

9.30 With regards to legal obligations to people experiencing homelessness, the Deputy Chief Operating Officer (North Middlesex) said that there was a process where a series of letters were sent to the patient/their family. There could be a variety of issues that cause the homelessness, including a family dispute which needs to be resolved or a deterioration of the property causing a problem between the patient and their landlord. He added that patients were not discharged to the street and a night in a hotel was sometimes funded in order to provide a discharge destination, after which the patient becomes responsible for their accommodation. Close communication would take place between the hospital and Adult Social Services about the appropriate overall package of interventions for that patient's needs. Services from the voluntary sector were also sometimes involved.

9.31 The Discharge Team Manager (Whittington) also confirmed that, where homeless referrals were flagged, they would liaise with the housing teams in the appropriate borough and provide support with documentation until there was an outcome.

9.32 The Team Manager for Housing Services at Haringey Council explained that homelessness referrals needed coordination, planning and probably an assessment as well, with an appropriate accommodation placement then determined. The Head of Lettings & Rehousing added that the unmet housing need would be a top priority whichever route they came through, whether that was coming out of hospital or coming out of step-down accommodation. The assessment would also examine what support they needed in terms of physical, medical and wellbeing areas. The challenge was in finding the right property that met the person's individual needs, such as the floor level and the facilities/adaptations.

9.33 The Service Director for Adult Social Services explained that the 21 step-down units sat within the Council's housing related support offer and may be utilised for a short period of time while an assessment and/or rehabilitation took place before permanent accommodation had been found. The Panel expressed concern that some residents were not able to move on from the step-down units and could be there for a number of months due to homelessness/NRPF issues. The Service Director for Adult Social Services said that those who were homeless/NRPF could access Osborne Grove as this was specifically funded by the Home Office and Department of Health for homeless people.

9.34 Asked about the number of people being discharged without a permanent residence to go to, the Service Director for Adult Social Services explained that the hospital Trusts experienced about three such cases per day, but these were not necessarily always an issue for adult social care services as many would be discharged to alternative options such as hotels, Osborne Grove, etc, depending on the circumstances. Finding a suitable option may sometimes lead to discharge delays.

9.35 The Panel noted that, while step-down accommodation was sometimes used for those who have nowhere else to go on discharge, there were also concerns around these residents not being able to move on from this accommodation. The Panel suggested that Housing Services should assess whether the provision available at Osborne Grove was being fully utilised in such circumstances.

RECOMMENDATION 11:

The Panel recommended that an assessment be made of whether the provision available at Osborne Grove is being fully utilised in circumstances where residents are unable to move on from step-down accommodation due to homelessness issues.

<u>Complex cases (including mental health issues)</u>

9.35 Councillors reported that they sometimes had casework examples of people with challenging behaviours (including mental health issues) being discharged into residential settings (such as sheltered housing) which they caused conflict with other residents, including elderly residents. She observed that there was the issue of whether a place was

available but then also whether it was an appropriate place. The Discharge Team Manager (Whittington) said that referrals to either residential settings or care/nursing homes settings would be based on the patient's needs, with high needs cases likely to require nursing care. If a patient was behaving in a certain way that was causing concern, then social services would assess that and decide if they were in the most appropriate setting and whether more support was required. If a patient had a mental health background then the mental health team in the community that was supporting them would be responsible for finding the placement for the patient. She acknowledged that finding a placement could sometimes be difficult, particularly if that patient had a tendency to be disruptive, so there could be mitigations such as additional monitoring of the patent during the day.

9.36 In conversation with the team from NMUH, the Panel noted that a reason given for discharge delays included patients being rejected by multiple residential care providers. The Deputy Chief Operating Officer (North Middlesex) said that this was an issue only in a minority of cases (perhaps 10-15%) but that this often meant that the number of patient days increased due to the delay. It was sometimes possible to obtain interim accommodation arrangements in conjunction with adult social care colleagues. He added that some providers may have already taken on residents with complex issues and therefore find it difficult to take another one. The Chief Nurse (North Middlesex) commented that this type of case had increased post-pandemic with more patients with mental health disorders.

9.37 When asked for the Adult Social Care team's perspective on this issue, the Service Director for Adult Social Services responded that these types of complex cases were likely to be the cohort of residents receiving support from secondary mental health services. If they did not meet the criteria for secondary mental health services, they would have the same opportunities for care and support as everyone else through a Care Act assessment as part of the discharge process. She added that someone who had been discharged from hospital following treatment for a mental health issue may be eligible for Section 117 aftercare services which provided a higher level of care and support than mainstream adult social care services. In terms of adult social care services, she felt that there may have been an oversubscription to service users discharging from acute mental health services and that this was reflected in the mental health budget. She added that younger cohorts should be supported more effectively to be more independent at home. She also noted that there were empty acute mental health beds in NCL which was unusual and reflected new processes including the timely processing of Care Act assessments.

9.38 In a later conversation with the Corporate Director of Adults, Housing & Health and the Director of Adult Social Care, the Panel was informed that there was significant pressure on reablement services for residents with mental health issues and this was a priority, not least because of the volume of casework arising from residents and from Councillors. It was also noted that Haringey's reablement team did not provide support for people with complex mental health needs. It was suggested that there could be a case for future invest-to-save work in this area in collaboration with the mental health trust, but this was difficult considering the Council's financial services.

9.39 Details were also received about forthcoming plans to expand access to Assertive Community Treatment (ACT) in Haringey. ACT is described by the Royal College of Psychiatrists (RCP) as a model of specialist intensive support for people with severe mental illnesses to help them live in the community and stay out of hospital[15]. This involves the use of a multidisciplinary team to help the patient to function as independently as possible and to meet basic needs such as housing, food and work. The RCP also notes that a keyworker from the team is *"responsible for providing and coordinating the care of each individual, helping the person to manage his or her symptoms on a day-to-day basis and overseeing medication"*. The aims of care plans are to reduce the severity of symptoms and improve social function. It is specifically noted that patients with *"poor adherence to medication regimens"* may benefit from ACT.

9.40 In November 2025, the Panel received information from the Chief Operating Officer of the North London Foundation Trust (NLFT) that additional funding had been secured to implement Assertive Outreach Teams in Barnet, Enfield and Haringey which did not yet have stand alone teams for ACT. The other two Boroughs in the North Central London (NCL) area, Camden and Islington already had established Assertive Outreach Teams.

9.41 It was anticipated that the new ACT service would provide support for around 90 people in Haringey Borough at any given time and would have the active involvement of community psychiatric nurses and social workers. The service would be working closely with the local authority. It was also noted that the case management system would enable the closer monitoring of patients judged to be at higher risk of experiencing symptoms.

9.42 It was also noted by the Panel that there would be improved crisis prevention facilities when the Canning Crescent integrated mental health support hub was operational. The new hub opened as the Roger Sylvester Centre in February 2026 which was welcomed by the Panel.

RECOMMENDATION 12:

The Panel welcomed the forthcoming extension of Assertive Community Treatment (ACT), but was concerned that the threshold for this support to be provided post-discharge would only be for patients with the highest needs. The Panel recommended that further clarity was provided on how patients who fall below the threshold for ACT will be supported in the community by the multi-agency teams after discharge from hospital.

RECOMMENDATION 13:

The Assertive Outreach team should be embedded with the multi-agency community teams to ensure that mental health patients receive co-ordinated support post-discharge.

<u>Post-discharge support</u>

[15] Advances in Psychiatric Treatment (Volume 11, Issue 6), RCP: https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/assertive-community-treatment-in-uk-practice/B1244A070606A19808B632B428ADAE9D

9.43 Asked about support for social and practical needs post-discharge, the Discharge Team Manager (Whittington) explained that the role of community teams with different specialities involved visiting the patient to assess their needs, including equipment or adaptation needs. The Discharge Coordinator Lead (Whittington) added that there was also the Bridge Renewal Trust team who could come to the hospital, assist the patient in getting home and settled and to support them with shopping and other household tasks. Support would typically last for six weeks followed by a review to assess the patient's needs again and whether the package of care needed to be increased or decreased.

9.44 Councillors referred to casework examples of elderly residents who hadn't received a visit for a long period of time and asked what could help improve this. The Discharge Team Manager (Whittington) said that sometimes phone calls would be received, perhaps from the family, flagging that carers had not been visiting. In such cases they would contact social services, asking them to look into this. Community services may also do welfare checks. Asked what proportion of patients were typically readmitted to hospital due to this type of breakdown in care she said that she did not have data on readmissions due to care problems but could only recall two or three cases in the past 18 months that would typically be triggered by a fall.

9.45 When asked about this type of support, the Service Director for Adult Social Services said that the NHS had a 'direct payments' process which enabled the purchase of essentials in such circumstances, including items such as blankets or lamps where necessary, up to a total of £200. In addition, the NHS and Council funded staff within the hospital service to support people as part of the discharge and should ensure that the resident had access to essential provisions.

9.46 Asked about assistance with household tasks for people in step-down accommodation who did not have family support, the Head of Support and Wellbeing for Housing Services explained that, when the referral was received, the mattress was changed and new bedding was brought in. There were also conversations with social services about the care package in place for the person coming in, whether they would be accompanied by anyone and whether they had essential supplied. The staff did provide a basic package such as tea, coffee, sugar, milk and bread if it was known that the person did not have this. He acknowledged that there had sometimes been issues where people have come into supported housing outside of working hours having been given the keys and paperwork and so they may not receive support until the next day.

9.47 Councillors were familiar with a service that had previously provided basic practical support to patients after discharge from hospital but were not certain whether it was still running. After making further enquiries, the Panel established that a 'Home from Hospital Service' was operational in Haringey[16]. The service is provided through the Bridge Renewal Trust and provides support to patients discharged from hospital including:

- Assistance on the day of discharge
- Help with essential food shopping

[16] Details on Home from Hospital Service https://www.bridgerenewaltrust.org.uk/the-bridge-home-from-hospital-service

- Prescription collection
- Support with utilities and bill payments
- Telephone check-ins
- Information and referrals to local community services

9.48 The Panel was anxious to ensure that this support was available to all patients who needed it after discharge from hospital, noting that this was a low cost service that could make a significant positive improvement to the physical and emotional wellbeing of people without family support in such circumstances.

9.49 It was noted that, according to the Bridge Renewal Trust, referrals to the Home from Hospital Service can be made by healthcare professionals or by patients and their families. However, this was dependent on people being aware of the availability of the service. The Panel noted that webpages describing the Home from Hospital Service were available on the Haringey Council website and the Bridge Renewal Trust website, though there did not appear to be an entry for the service on the new online Adult Social Care Directory. The Panel was also conscious that some Councillors were not aware of the existence of the service.

RECOMMENDATION 14:

The 'Home from Hospital Service', or similar support services, should be guaranteed to all post-discharge patients who require it:

- **The Council and NHS Trusts should ensure that all patients being discharged from hospital are made aware of the service in the information that they receive prior to discharge.**
- **Information about the service should be provided to all Councillors in terms of the advice about support organisations that they can signpost their constituents to.**
- **Consideration should also be given to whether information about the Service should be prominently advertised in the Council's communications channels.**

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