Report for: Adults and Health Scrutiny Panel, 6th March 2017

Title: Community Wellbeing Framework update.

Report authorised by : Dr Tamara Djuretic, Assistant Director of Public Health

Lead Officer: Tamara Djuretic, Tamara.djuretic@haringey.gov.uk; Negin Sarafraz-Shekary, negin.sarafraz-shekary@haringey.gov.uk

Ward(s) affected: ALL

Report for Key/ Non Key Decision: Non key decision

1. Describe the issue under consideration

1.1 Evidence suggest that non-medical interventions such as social prescribing can be effective in improving health and well being and reducing health care utilisation through promoting self management. Neighbourhood Connect (a social prescribing) project was piloted in Haringey in 2015. Its evaluation suggested some good outcomes however it failed to demonstrate a good value for money and it struggled to engage effectively with certain hard-to-reach communities (e.g. people with disability) to reduce social isolation.

1.2 Our learning so far indicate that in Haringey, a bottom-up approach which focuses on local community assets by building on the existing local resources and expertise is more likely to succeed in improving health as well as being cost-effective and sustainable. Furthermore, it has been recognised that more strategic approach and development of the overall Community Wellbeing Framework is needed to initiate community asset approach, integrate health and care services and concentrate on preventative interventions that would subsequently reduce demand on services and increase health and wellbeing of Haringey residents.

1.3 This paper describes the overall Community Wellbeing Framework, its main components, including an innovative approach in achieving community health and wellbeing by focusing on community assets and better integration across the whole system.

2. Recommendations

2.1 That the Adults and Health Scrutiny Panel notes progress on development and implementation of the Community Wellbeing Framework.

3. Reasons for decision

3.1 The Panel asked for an update on development of Community Wellbeing Framework in 2016.

4. Alternative options considered

N/A

5. Background information

5.1 It is estimated that by 2021 Haringey's population is expected to rise to 289,700 or 10% with the 50+ population expected to show the biggest increase. As people get older, their health needs become more complex and they are more likely to be diagnosed with one or more long term conditions. Currently there are over 47,800 (1 in 5) adults in Haringey diagnosed with at least one long term condition (17%). 17,900 of these have more than one long term condition. Older people are likely to have more non-elective admissions which can lead to higher unplanned spend.

5.2 Due to increasing number of patients with complex needs, providing a well coordinated and coherent care is becoming more challenging, particularly in areas most socially and economically deprived in Haringey. This can result in variation in care provision and consequently increase the health inequality gap. Therefore a system- wide approach is required to make the services more integrated and inclusive by bridging the statutory services with the communities to deliver the outcomes at scale to maximise benefit.

5.3 Local Area Co-ordination and social prescribing model is about providing a well integrated and co-ordinated care pathway with a single point access. The pathway will be designed locally to address the key priority objectives of primary, community and social care, to reduce social isolation, promote social connectiveness and reduce health and care needs.

5.4 The Local area co-ordinators will be recruited from local communities and will be located in a community hub and supported by the existing network of care coordinators/navigators (as part of the integrated/locality teams).

5.5 This approach will support delivery of Priority 1 and Priority 2 of the Corporate Plan and welfare reform implementation, with a particular focus on empowering communities. It incorporates the key objectives of Better Care Fund to reduce

hospital admissions, increase effective hospital discharge and promote independence. This project will be part of a wider transformation programme that aims to build individual/community resilience (reducing need for, and dependence on, formal, expensive services), simplify and connect the service system and embed strength based" thinking, culture and behaviour across the service system.

5.6 Guide to community centred approaches for health and outline the need in change current practice and build new relationship with people[1]. There is also a growing body of evidence demonstrating the value of person-centred and community-centred approaches in terms of improved health & wellbeing, their contribution to NHS sustainability and wider social outcomes, which were reflected in all five London 30 June STP submissions. A recent report by suggested an opportunity for NHS Haringey CCG to save £20,131,351 by 2021[2].

5.7 Over the past few years a number social prescribing models have been evaluated nationally which have shown positive outcomes such as: reduced GP and hospital workload; reduced A&E attendance and improved wellbeing and mental health[3]. Local Area Coordination has a significant evidence base nationally and internationally over the past 28 years. (http://lacnetwork.org/). In England and Wales, Local Area Coordination is now operating or developing in Derby City, Thurrock, Isle of Wight, Swansea, Suffolk, Derbyshire, Neath Port Talbot. There have been many evaluations that show, where it is designed properly with local people and there is strong, connected leadership there are very consistent, positive outcomes. These include:

- Recent independent Social Return on Investment (SROI) evaluations in both Derby City and Thurrock Councils have shown £4 return for every £1 invested.
- Derby City diverted costs/savings of £800k in first 10 months in 2 locations whilst operating at 40% capacity (formative stage).
- Thurrock Council found reductions in referrals/visits to GP, A&E, adult care, mental health and safeguarding services; avoided housing evictions. Reduced isolation through increasing unpaid, natural relationships, employment/volunteering/education opportunities
- Reduced dependence on day services.
- Better health outcomes and improved self management of health.
- People supported to find local, low cost/no cost solutions.
- Preventing more expensive out of home/area/placements.

[1] A guide to community-centred approaches for health and wellbeing (2015) https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

[2] http://www.i5health.com/hlp.html

[3] http://www.pulsetoday.co.uk/clinical/prescribing/gp-social-prescribing-can-reduce-appointments-by-over-one-fifth/20033584.article

5.8 The new model will be delivered within existing services (e.g. primary care, libraries, VSC etc.) and it will work alongside existing local programmes including Community Hubs, Time credit/ time bank, micro-enterprise, healthy living pharmacies, Information Advice and Guidance, welfare & benefits advice services, welfare hubs and newly forming Community Health Integrated Networks (CHINs). An extended stakeholder engagement event will be held during the design phase of the programme to co-develop an evidence based programme that reflects and builds on previous learning and local circumstances and priorities. The model will integrate with other community schemes. We will also ensure that is part of Care Closer to Home Integrated Network (CHIN).

5.9 The project will have a prevention based approach to proactively identify high risk and hard-to-reach group of people, in particular:

Older people (with multiple long term conditions);

- Those groups identified by NHSE work e.g. falls, diabetes
- People with disabilities
- Socially isolated who don't reach out for help before crisis

5.10 The project will initially be rolled out in areas with high prevalence of poverty, health inequality and poor life expectancy such as and northeast of the borough, Tottenham and Northumberland Park. The service will be evaluated before being expanded across the borough.

6. Contribution to strategic outcomes

Priority 1 and 2 of the Corporate Plan, Haringey's Community Strategy, Better Care Fund and Health and Wellbeing Strategy 2015 - 2018

7. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

Finance and Procurement

7.1 This is an update report for noting and as such there are no direct financial implications associated with this report.

Legal

7.2 This is an update report for noting and as such there are no recommendations for action that have a direct legal implication.

Equality

7.3 The project will have a prevention based approach to proactively identify high risk and hard-to-reach group of people, in particular older people, those with disabilities and people with long-term health conditions. Initial roll out of the project will be in areas with high prevalence of poverty, health inequality and poor life expectancy such as and northeast of the borough, Tottenham and Northumberland Park. The person-centred approach of the framework will allow inequalities and isolation issues related to protected characteristics to be tackled.

8. Use of Appendices

Appendix I – Community Wellbeing Framework Update presentation

9. Local Government (Access to Information) Act 1985

Health and Wellbeing Strategy 2015 – 2018

Public Health England Guide to Community centred approaches for health and wellbeing, https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches