NOTICE OF MEETING

ADULTS & HEALTH SCRUTINY PANEL

Thursday 5th September 2019, 6.30 pm - Civic Centre, High Road, Wood Green, N22 8LE

Members: Councillors Pippa Connor (Chair), Patrick Berryman, Nick da Costa, Eldridge Culverwell, Mike Hakata, Felicia Opoku and Matt White

Co-optees/Non Voting Members: Helena Kania

Quorum: 3

1. FILMING AT MEETINGS

Please note that this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on.

By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

3. ITEMS OF URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business (late items will be considered under the agenda item where they appear. New items will be dealt with as noted below).

4. DECLARATIONS OF INTEREST

A Member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interest are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

6. MINUTES (PAGES 1 - 8)

To approve the minutes of the previous meeting.

7. BUDGET OVERVIEW (PAGES 9 - 20)

To provide an overview of the financial performance of the services within Priority 2 (Enable adults to live healthy, long and fulfilling lives) as at the end of quarter 1, 2019/20.

8. PREVENTION AND EARLY INTERVENTION (PAGES 21 - 66)

A presentation and discussion for Panel Members on prevention and early intervention. An evaluation report on Local Area Coordination is provided for background information.

9. OSBORNE GROVE UPDATE (PAGES 67 - 92)

To provide Panel Members with the opportunity to ask questions about the report on the Osborne Grove Nursing Home Feasibility Study which was originally published with the agenda papers for the meeting of Cabinet on 9th July 2019.

10. NEW ITEMS OF URGENT BUSINESS

To consider any items admitted at item 3 above.

11. DATES OF FUTURE MEETINGS

- 14th Nov 2019 (6:30pm)
- 12th Dec 2019 (6:30pm)
- 25th Feb 2020 (6:30pm)

Dominic O'Brien, Principal Scrutiny Officer
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Bernie Ryan
Assistant Director – Corporate Governance and Monitoring Officer
River Park House, 225 High Road, Wood Green, N22 8HQ

Wednesday, 28 August 2019

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Agenda Item 6

MINUTES OF THE MEETING OF THE ADULTS & HEALTH SCRUTINY PANEL HELD ON THURSDAY 20TH JUNE 2019, 6.30 - 9.25pm

PRESENT:

Councillors: Pippa Connor (Chair), Patrick Berryman, Nick da Costa, Eldridge Culverwell, Mike Hakata and Matt White

1. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Felicia Opoku and Helena Kania.

3. ITEMS OF URGENT BUSINESS

None.

4. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

5. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

None.

6. MINUTES

Cllr Connor reported that, following the previous meeting, a useful briefing on mental health had been distributed to all Councillors which had been provided by Tim Miller, Lead Commissioner for Adult Mental Health.

Cllr Connor referred to an action point from the previous meeting where a query had been raised about an assessment fee of £25 charged for counselling by the Haringey Wellbeing Network. An explanation had now been received on what costs these fees cover but Cllr Connor requested that further explanation be requested on what more could be done to help anyone in severe financial difficulties who requires this support. (ACTION)

AGREED: That the minutes of the meeting held on 4th March 2019 be approved as an accurate record.

7. FINANCE UPDATE

Paul Durrant, Head of Finance and Business Partnering, presented an overview of the financial performance of services within Priority 2 (Enable adults to live healthy, long and fulfilling lives) as at the end of quarter 4, 2018/19. Overall the final outturn resulted in an overspend of £4.2m.

The headline placement costs showed an overspend of £7.2m which was broken down into:

- Learning difficulties - £3.6m overspend
- Mental health - £2.4m overspend
- Physical support - £1.42m overspend

A further overspend of £0.7m on Osborne Grove Nursing Home brought the total overspend to £7.9m. This was mitigated by a resilience reserve contribution of £2m from Corporate Services, an underspend on staffing and overheads by £0.8m and the capitalisation of occupational health costs from the revenue budget which altogether resulted in the final figure of a £4.2m overspend.

The report provided to the Panel also provided a breakdown of the budget allocation for Priority 2 services for 2019/20 which shows a gross budget of around £114m and a net budget of around £82m. The column marked “other ASC” on the second table represents staffing and overheads costs.

Cllr Connor thanked Paul Durrant for the report, noting that it had been requested at short notice. She said that the Panel would find it useful to have a more in-depth study of the budget at a future meeting, looking at the budget in its entirety and including both revenue and capital costs. This will help the Panel to have a really robust understanding of the overall budget when looking at budget savings in future. The request from the Chair was therefore for an in-depth look at the budget at the September meeting of the Panel. (ACTION)

Asked about the term “Net budget (not including overheads)” on the second table in the report, Paul Durrant said that the overheads not included related to non-service costs such as accountancy and HR.

8. SUICIDE PREVENTION UPDATE

Chantelle Fatania, Consultant in Public Health, introduced the update report on suicide prevention noting that a previous report had been provided to the Panel in November 2018 and that this new report provided a further update on progress over the last six months. In particular, the Panel had been interested in following up on action to support construction workers which has been identified as a high-risk group for suicide and also has a significant presence in Haringey borough in the moment because of the high level of construction projects. In April 2019, the Chair of the Haringey Suicide Prevention Group (HSPG), Professor David Mosse, had attended a meeting of the Construction Partnership to present to them about the work of the HSPG and the about the range of interventions available locally. His feedback was that while there are several initiatives that the group is engaged with, this engagement is patchy across the partnership as a whole. Further work is ongoing and representatives of the group have been invited to attend future meetings of the HSPG.

Other successes over the last 6 months are covered in the report. These include the provision of funding for a 'postvention' suicide liaison service ['postvention' refers to the support to a local community following a suicide] across North Central London (NCL) which is expected to provide practical and emotional support to around 100 families and social networks affected by suicide each year in the NCL area. Fencing to prevent suicide is currently being installed on Archway Bridge. Several community organisations have recently joined the HSPG and there is now representation from LGBTQ, Turkish, Kurdish and Jewish communities. The HSPG will be preparing the next suicide prevention plan for Haringey which is due to start from April 2020. This is likely to be supported by a new suicide audit in 2020 but the data is currently being awaited. It is no longer possible to access data directly from coroners and the data is being gathered on a London-wide level. There hasn't yet been guidance on what type of data will be provided or whether it will provide enough detail to allow analysis on risk factors.

Asked for further detail on the specific concern about construction workers, Chantelle Fatania said that there is no specific data for Haringey but Professor David Mosse had recommended further action in this area as they are known from other areas to be a high-risk demographic group and require support to maintain good mental health and wellbeing. Cllr Connor commented that it would be useful to hear further feedback from the construction industry after their next meeting. (ACTION)

Responding to further questions from the Panel, Chantelle Fatania confirmed that the CCG commissioner for mental health services is on the HSPG and that the next suicide prevention plan in 2020 will be more specific about how mental health services are linked in. She also confirmed that suicide rates in BAME communities tend to be higher than the general population for multi-factorial reasons.

9. DEVELOPING A PLACE-BASED APPROACH - NORTH TOTTENHAM

Rachel Lissauer, Director of Commissioning and Integration at Haringey CCG, introduced the first part of this item speaking about the practical partnership work around integration and prevention. The context had been signalled in advance by the NHS Long Term Plan published in January 2019 which set the direction through the mandate that all areas are to be become integrated care systems by April 2021. Within each integrated care system there is an expectation that there will be a single CCG which would be at a much higher level than currently so this is likely to require a merger of existing CCGs. The Long Term Plan also signalled that GPs should work as part of primary care networks with more contractually based partnerships and these networks, each covering around 30,000 to 50,000 populations, have now been signed off in Haringey. There has also been a focus on developing integration at Borough level as well as the NCL level and, in addition, a series of workshops have been held which proposed a greater degree of localised working.

Charlotte Pomery, Assistant Director for Commissioning, said that the response from the Health and Wellbeing Board about the Borough partnership had been based on the wider governance arrangements and key outcomes such as reducing health inequalities, ensuring that health and wellbeing outcomes are improved for all residents. The existing joint working across the NCL area, including through the Sustainability and Transformation Plan means that Haringey is starting from a strong position. They were also keen to emphasise that the integrated care system should not just include health and care services but should also include factors that impact on health and wellbeing such as housing and the environment. There is currently an intention to build a broad, inclusive and collaborative approach. There was also some specific feedback about ensuring that there is sufficient capacity at Borough level, that there is enough time to work through the key issues and that the views of local residents are built into the work.

In response to questions from the Panel, Rachel Lissauer said that the signal of the CCGs of their intention to form a single CCG is likely to happen in September. Staff for the existing CCGs will remain in their Boroughs as the governance structures integrate into the single CCG. Charlotte Pomery said that in terms of IT there is already a large digital programme in place across the NCL area including a strand on sharing health and care records. Rachel Lissauer said that the leadership would be shared and emphasised that a lot of joint working had already been established in NCL before the Long Term Plan was published. Beverley Tarka, Director of Adults and Health, added that the NCL has put together a co-design group and has called for nominations from all stakeholders so this is very much a shared endeavour.

Jonathan Gardner, Director of Strategy at Whittington Health NHS Trust, introduced the next part of the presentation. The area of biggest need where the greatest impact could be achieved had been identified as North Tottenham. In October/November 2018 there was a community engagement event led by Bridge Renewal Trust followed by a launch event in December 2018. Various meetings were held from January to March 2019 which aimed to establish a framework and vision for the project. A day discussion with the whole Borough partnership was then held in May 2019 to look at localities and integrated care.

It had been established that there was a need for low-level mental health support and for help with housing, employment and benefits with intervention at an early stage to prevent problems from arising. The public health data showed a higher prevalence of diabetes and hypertension. These and the other factors identified have led to the draft vision statement which emphasises the need to “create a step forward in how well we prevent issues arising and nip them in the bud early, through more integrated public services and more resilient local communities.” This requires more joined up local systems, integrated multi-disciplinary teams that tackle issues holistically and a new system partnership with the voluntary sector. This will be enabled by a joint approach to the shared public estate, integrated data and systems, a more mature approach to finance and more joined-up governance with the Council and NHS. The principles that have been identified are a) a preventative approach, b) partnerships based in local communities, c) a learning approach and d) a strength-based approach. The approach is aimed at all ages and focuses on early intervention, prevention and building strong and resilient communities to shift more people away from specialist care. The Community First work is a key pillar of this and the connection of IT infrastructure, estates and workforces are important enablers. In response to a question from the Panel, Jonathan Gardner said that they were still working on the best model to help people navigate community-based services as this could involve Community First, Local Area Coordinators or the existing knowledge of front-line staff. Will Maimaris, Director of Public Health, emphasised the importance of social prescribing, local area coordinators and building a strengths-based approach through all services.

In response to further questions from the Panel, Viv Acharya, Programme Lead for Community First, said that:

- Community First currently operates from Wood Green Library on Mondays and Tuesdays. The plan is to roll this model out to Marcus Garvey Library and then extend out to work collaboratively with the primary care networks, GP practices and North Middlesex Hospital A&E.
- In practical terms for residents, the previous pathways for something like depression may be more medical but with a more integrated approach the residents could also get access to other help and support such as debt or housing advice that might help to address some of the underlying causes.
- On housing problems he said that the issues could be wide ranging but that Community First can often act as advocates for people while acknowledging that they can only use the pathways available to them within the context of a wider housing crisis. The Homelessness Prevention Team are part of their service offer and Community First is seen as part of their outreach work.
- Community First has 3.5 FTEs on a multi-disciplinary team which includes Citizens Advice Bureau colleagues.

Geoffrey Ocen, Chief Executive of the Bridge Renewal Trust, informed the Panel about their community engagement work in the summer of 2018 which involved speaking to 369 residents, of which around 20% were from the North Tottenham area. This involved focus groups and one-to-one interviews and often involved people with the sort of employment, housing or other problems that this work was targeted at

improving. People understand the pressures on public services in recent years and are also keen to see support at an early stage. Digital engagement worked for some but others want access to face-to-face support.

On a comment from the Panel that more detail on how this will work in practice could be provided, Beverley Tarka said that they are working on the principle that solutions need to evolve from the bottom-up from residents and the workforce, which is why there is such an emphasis on engagement. It is also important to note that in terms of investment, this has been made a high priority for the future of how early intervention and prevention is supported and by bringing partners together resources are being multiplied. Completing the presentation, Beverly Tarka showed slides that mapped out all the different services in Haringey and the resources that are available. The top three risks that had been identified were limited staff engagement with the new way of working, IT systems and estates limiting the speed/scale of change and outcomes not being met.

Asked whether NHS funding could be cut if outcomes are not achieved, Beverley Tarka said that some initial investment would be required but much of the work was about how existing resources are used better, improving knowledge of the existing resources and integrating pathways. Will Maimaris gave an example of a recent initiative on reducing strokes by addressing risk factors and with the number of strokes coming down the Council spend on care is reduced.

Beverley Tarka confirmed that the initiative is due to be reviewed at the end of the financial year so it should be possible to come back to the panel with an update in April/May 2020. (ACTION) Asked whether site visits for Members would be possible, Beverley Tarka said that it would but only from April 2020 onwards as it was currently still at the planning stage. Viv Acharya added that a business case for a more sustainable version of Community First is due to be developed by December 2019.

10. CABINET MEMBER Q&A

Cllr Sarah James, Cabinet Member for Adults & Health, took questions from the Panel on issues within her portfolio.

Cllr White raised improving cycling infrastructure as a way of making a positive impact on health and suggested that Cabinet-wide support is needed to drive these changes. While transport is not specifically within Cllr James' portfolio she said that she is fully signed up to the active travel agenda and recognises the long-term health benefits. Cllr Hakata suggested that healthier travel options should be part of Cllr James' portfolio as a public health issue. Cllr James said that a lot of public health work was already ongoing in this area including mapping areas of pollution, diabetes, asthma and obesity which often correlate. Cllr Connor suggested that a briefing on the public health implications on this issue could be obtained. (ACTION)

Cllr Da Costa said that at a recent briefing, Members had been told that the take up of direct payments in Haringey is only 22% which is lower than other Boroughs and

asked what was being done to address this. Cllr James said that the remedy is to focus on particular groups of social care recipients and new clients to encourage them to switch to direct payments.

Asked about Osborne Grove Nursing Home, Cllr James said that a paper on this would be going to a meeting of the Cabinet in July after the feasibility study was completed in May. Four options were examined by the feasibility study, two of which involved refurbishment of the existing premises and an extension and two of which involved a demolition and rebuild. The study has demonstrated that it is feasible to build a 70-bed nursing home on site and that will be the intended objective but final costing figures are being worked up. Her preference is for demolition and rebuild across the site including the health centre already there. This would enable a state of the art nursing home with outward facing community facilities and possibly also supported housing units. There are difficulties with the existing building which has been found to be at risk of progressive collapse in the event of a fire. There is no lift capable of taking a bed as the doors are not wide enough and some of the rooms are not big enough but enlarging the size of them would be structurally difficult if the refurbishment option was chosen. The whole feasibility study has been conducted with the involvement of the co-design group which has contributed ideas that have been incorporated such as the maximisation of garden space.

Cllr Lucia das Neves, Chair of the Overview & Scrutiny Committee, said that the Cabinet Member's comments on the risk of progressive collapse should be fed into the Overview & Scrutiny Committee ongoing work on fire safety as Osborne Grove had previously been looked at as part of the fire safety scrutiny review and this particular concern had not emerged. (ACTION) Cllr James said that this risk had only became apparent when the structural plans were looked at.

Cllr Connor raised the issue of social care assessments noting that she had recently been informed that there were 160 residents who had needed to wait for around 6 months for an initial assessment for social care. Cllr Connor requested that clarification be provided on those figures and on what is being done to address the long waiting times. (ACTION)

Cllr Connor asked about the consultation on new charges for managed accounts which had previously been examined by the Panel as part of the budget scrutiny process in January 2019. The specific queries were:

- If people tick the box on the consultation opposing the fees how will this be taken into account?
- As some protected groups have been identified as being impacted by this change by the Equality Impact Assessment how will this be addressed?
- Have the savings already been built into the financial structure for the budget plans or is there scope for this to be adjusted?

Cllr James agreed to come back on the details on the first two questions. (ACTION) The saving had been agreed and built into the budget so if the policy was changed then money would need to be found from elsewhere.

Asked about the timescales for the Adult Social Care Review following the Scrutiny Panel's recent review on Day Opportunities, Cllr James said that the piece of work on day centres is due to be up and running by May 2020 with the initial report complete by September 2019.

Cllr da Costa said that the Health Service Journal had recently reported that the Barnet, Enfield & Haringey Mental Health Trust had one of the highest rates of inappropriate out of borough placements (1,180 days in the reporting period) and asked what the Trust is doing to address this. Cllr James agreed to follow this up with a written response. (ACTION)

11. WORK PROGRAMME UPDATE

The updated work programme was noted and Cllr Connor reiterated the request for a public health briefing paper on transport issues to be followed up and considered before deciding whether this could be added as a future item on the work programme. Cllrs da Costa, Hakata and White suggested that commissioning of services could be a topic for a future scrutiny review.

12. DATES OF FUTURE MEETINGS

- 5th Sep 2019 (6:30pm)
- 14th Nov 2019 (6:30pm)
- 12th Dec 2019 (6:30pm)
- 25th Feb 2020 (6:30pm)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

Report for: Adults and Health Scrutiny Panel – 5th September 2019

Title: Finance update – Adults & Health

Report authorised by : Beverley Tarka, Director of Adults Services

Lead Officers: Paul Durrant, Head of Finance for People
Email: Paul.Durrant@haringey.gov.uk

Sandra Robb, Adults and Health Business Partner
Email: Sandra.Robb@haringey.gov.uk

Ward(s) affected: All

Report for Key/ Non Key Decision: Not a key decision

1. Describe the issue under consideration

1.1 This report provides an overview of the financial performance of the services within Priority 2 (Enable adults to live healthy, long and fulfilling lives) as at the end of quarter 1, 2019/20.

2. Priority Two Forecast outturn 2019/20 – Adults and Health (£3.6m overspend)

2.1 Priority Two is projecting overall spend of £89.93m against approved budget of £86.36m resulting in a forecast overspend of £3.6m.

This figure is made up of £2.9m overspend in Adults social care, £0.3m overspend in Public Health and a £0.4m overspend in Commissioning.

It should be noted that £1.3m set aside for the implementation of the London Living Wage has not been forecast as being spent at this stage. However, if this were to be introduced in this financial year, we would have a corresponding increased overspending position. Taking the total overspend to £4.9m.

The areas with material variances are detailed below.

2.2 **Care Packages (£2.7m overspend)**

It is expected that the demand pressures for care packages will be maintained a £2.7m. This is based upon the assumption at this stage the savings plans for £3.1m will be made in full.

The variance is broken down as follows:

- Adult Placements - £1.7m overspend
- Learning Disabilities Placements - £0.6m overspend
- Mental Health Placements - £0.4 overspend

It should be noted that once net savings and growth have been applied, the expected overspend for this area with carried forward pressures is £3.9m. However, the service is currently being delivered with a £2.7m overspend.

2.3 **Osborne Grove Nursing Home (£0.2m overspend)**

Osborne Grove Nursing Home is currently forecasting an overspend of £0.2m.

An additional funding allocation of £0.3m has been provided to the service in this financial year, however, delays in consultation regarding the review of the staffing structure, have caused the service to forecast an overspend of £0.2m

2.4 **Commissioning (£0.4 overspend)**

Reported pressures on the Commissioning budget are being explored to ensure all relevant income has been assigned to the budget and plans are being developed to reduce these pressures in-year

2.5 **Public Health (£0.3m overspend)**

The Public Health Budget is currently forecasting an overspend of £0.3m as a result of service charges being higher than anticipated when this year's budget was set. However, the service will endeavour to deliver in year mitigations to eliminate the current deficit position, which will be reported upon in subsequent budget monitor reports.

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3. Breakdown of Adults Budget 2019/20

3.1 Priority Two Net Budget Allocation

Service	2019/20 Base Budget	Growth and Savings	2019/20 Net Budget
	£ m	**£ m**	**£ m**
Adults (Appendix 1)	67.24	3.41	70.65
Commissioning	4.02	0.57	4.59
Public Health	11.17	(0.06)	11.12
Total for Priority 2	**82.43**	**3.92**	**86.36**

3.2 Breakdown of Adults Social Care Net Budget 2019/20

Area of Spend	Net budget
	£ m
Directly provided	3.9
Care Packages:	
Physical Support	26.7
Learning Disabilities	26
Mental Health	11.1
Memory & Cognition	2.2
Sensory Support	0.7
Adult Social Care Budget 2019-20	**70.6**

4. Capital Budget and Monitor 2019/20 (Appendix 3)

4.1 Priority 2 has a capital budget of £8.6M in 2019/20, divided over 10 projects, and are currently forecasting an underspend of £3M.

5. Savings Monitor 2019/20 (Appendix 4)

5.1 Priority 2 has a 2019-20 saving target of £4.39M and is forecasting that 4.91M will be achieved in the year.

Appendix 1 – Budget Movements
Appendix 2 – Budget Movements by Cost Group
Appendix 3 – Capital Monitor
Appendix 4 – Savings Monitor

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APPENDIX 1

Priority 2 Budget movements

	Adults £	Commissioning £	Public Health £		Total £
Original Budget Plan	**67,235,946**	**4,021,900**	**11,174,580**		**82,432,426**
46000 Charge - Finance	467,300	156,300	62,900		686,500
46004 Charge-PerfrmncePlcy	142,700	55,600	19,600		217,900
46005 Charge-Commnications	78,000	24,400	38,300		140,700
46007 Charge-Directors	73,800	30,000	10,200		114,000
46300 Charge - Info Tech	1,122,100	358,700	115,100		1,595,900
46600 Charge - Human Res	338,000	135,700	46,400		520,100
46900 Charge - Property Mg	266,500	164,600	32,600		463,700
47500 Charge - Procurement	509,100	7,700	10,800		527,600
47800 Charge - Oth Serv	26,800	27,200	12,800		66,800
10000 Salaries - Officer Staff	389,490	273,390	-26,400		636,480
59105 RechgeInc HR			-360,100		-360,100
59097 RechgeInc Perf& Plcy		-851,400			-851,400
Uncontrollable budget movements	**3,413,790**	**382,190**	**-37,800**		**3,758,180**
58551 DCLG- Adults Winter	0				0
58552 DCLG-Social Care Sup	0				0
32502 Vol Sect - Res Long	-44,414				-44,414
34502 Private Sector Care Package	-413,884				-413,884
10400 SalAgen-Est Post	336,468				336,468
58109 CLG-SupportingPeople	119,900				119,900
11000 Train - Post Entry			5,000		5,000
11001 Train - Short Ext			31,000		31,000
22000 Equipment - Purchase			5,100		5,100
23500 Printing - Internal			1,000		1,000
59119 Inc Inttrade Schools			-69,300		-69,300
19210 Travel Exp Employee			400		400
22040 Resources - Learning			3,500		3,500
25112 IT Software Rental			12,000		12,000
26500 Subs - Profess Orgs			3,000		3,000
59128 Traded Services web			-11,000		-11,000
60500 Income & Fees		500,100			500,100
26001 Grant - Vol Org Run		-211,380			-211,380
60701 Rent Income - Commercial		32,300			32,300
34502 Private Sector Care Package		17,700			17,700
32500 Voluntary Organisation		55,750			55,750
22503 Catering Consumables		2,000			2,000
58450 Grant - HO: Prevent Grant		-208,850			-208,850
Controllable budget movements	**-1,930**	**187,620**	**-19,300**		**166,390**
Total Budget Adjustments	**3,411,860**	**569,810**	**-57,100**		**3,924,570**
Revised Budget Plan	**70,647,806**	**4,591,710**	**11,117,480**		**86,356,996**

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APPENDIX 2

Priority 2 Budget movements

Adults Budget	Orig. Plan	Savings	Growth	Recharges	Grant	Realignment	Rev. Plan
Head of Assessment and Safeguar	692,900			215,050			907,950
Adults Assessment	1,027,780			132,600	119,900		1,280,280
Mental Health	2,102,965			638,540			2,741,505
Safeguarding	766,971			168,980			935,951
Service Providers	1,006,350			416,900			1,423,250
Care Purchasing	38,476,840	-780,640			-2,127,500		35,568,700
Assistant Director ASS	772,600			19,900			792,500
Integrated Access & Independenc	3,639,300		366,756	1,237,068			5,243,124
Haringey Learning Disability Pa	2,263,262			451,390			2,714,652
Care Purchasing LD	24,915,238						24,915,238
Winkfield Resource Centre	188,300			81,970			270,270
Haynes Hub	516,200			137,980			654,180
Director ASS	-9,496,130			185,260	2,083,086		-7,227,784
Princpal Social Worker (PSW)	363,370			64,620			427,990
Total for Adults	**67,235,946**	**-780,640**	**366,756**	**3,750,258**	**75,486**		**70,647,806**

Public Health Budget	Orig. Plan	Savings	Growth		Grant	Realignment	Rev. Plan
Director of Public Health	1,525,800			344,020			1,869,820
Sexual Health	4,971,760						4,971,760
Life Expectancy Improvement	500,000						500,000
Substance Misuse	3,574,370						3,574,370
Public Mental Health	133,000						133,000
Miscellaneous Public Health Serv	67,000						67,000
Emergency Planning	326,650			-386,120		-15,000	-74,470
Assistant Direcrot Public Health	15,000						15,000
Non Public Health Expeniture	61,000						61,000
Total for Public Health	**11,174,580**	**0**	**0**	**-42,100**	**0**	**-15,000**	**11,117,480**

Commissioning Budget	Orig. Plan	Savings	Growth		Grant	Realignment	Rev. Plan
Brokerage and Quality Assurance	1,937,000			108,800	-144,300	2,000	2,687,130
Grant to Citizens advice & Voluntary	1,702,900			-510,240	329,920	0	1,522,580
Substance Misuse & HIV Commissioning	382,000				0	0	382,000
Total for Commissioning	**4,021,900**	**0**	**0**	**-401,440**	**185,620**	**2,000**	**4,591,710**

				3,306,718			
Priority 2 Total	**82,432,426**	**-780,640**	**366,756**	**3,306,718**	**261,106**	**-13,000**	**86,356,996**

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APPENDIX 3

Priority 2 Capital Monitor

2019/20 Capital Budget Monitoring Report @ Period 3			Budget	Forecast Outturn	Forecast Variance	Scheme Progress Comments (for SLT, Capital board and Cabinet report) - Please update
SCHEME REF	SCHEME NAME	SCHEME OWNER	19/20 Full year Revised Budget	2019/20 Full year Forecast Outturn	Variance Btw. Forecasts	
			£'000	£'000	£'000	
201	Aids, Adap's & Assistive Tech -Home Owners (DFG)	Pauline Walker-Mitchell	**2,361**	**2,361**	**754**	This is subject to change as the volume of backlogged OT assessments are now coming through via an external provider. We have also met with finance and it has been confirmed that our Framework contractors will have their own PO number by the 1st August 2019. We will be able to call off directly without the need to wait for a RIC to be generated, this will speed up the process of getting the jobs on site.
207	New Day Opp's Offer	Beverley Tarka	**27**	**13**	**0**	
208	Supported Living Schemes	Charlotte Pomery	**1,941**	**0**	**0**	We have identified a number of schemes where there are capital spend requirements which we are working up as part of our wider strategic approach to ensuring residents are able to remain in, or move back to Haringey.
209	Assistive Technology	Jeni Plummer / Caroline Humphrey	**1,120**	**554**	**554**	
211	Community Alarm Service	Jeni Plummer	**177**	**177**	**0**	
212	Linden house Adaptation	Charlotte Pomery	**1,176**	**1,132**	**2**	
213	Canning Crescent Assisted Living	Charlotte Pomery	**842**	**350**	**(492)**	Following initial feasibility, we are appointing architects and are moving forward with them to RIBA Stage 2 Concept Design and RIBA Stage 3 Developed Design by Spring next year. This will deliver the requisite detail to inform the Construction tender.
214	Osborne Grove Nursing Home	Charlotte Pomery	**656**	**635**	**621**	
215	Hornsey Town Hall Supported Living	Charlotte Pomery	**0**	**0**	**(250)**	
216	Homelessness Hub	Charlotte Pomery	**359**	**359**	**35**	
People - Adults			**8,659**	**5,581**	**1,224**	

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APPENDIX 4

Priority 2 Savings Monitor

Red	Saving fully/partially unachievable
Amber	Saving achievable but full/partial slippage required
Green	Saving met in full and on time

MTFS Savings Ref	Cabinet Decision Date	Saving proposal	Description	2019/20 - 2023/24						2019/20 Saving achieved YTD £'000s	2019/20 Projected Full Year Savings £'000s	2019/20 Savings (surplus)/ shortfall £'000s	RAG Status (Delivery of 2019/20 Saving)	Comment on Delivery RAG Status	Proposed action plan to mitigate shortfall	Value of Mitigation £'000s	Net impact on 2019/20 Budget Monitoring £'000s
				2019/20 £'000s	2020/21 £'000s	2021/22 £'000s	2022/23 £'000s	2023/24 £'000s	Total £'000								
People (Adults)																	
B2.7	13-Feb-18	Haringey Learning Disability Partnership	The Haringey Learning Disability Partnership, working jointly with Children's Services and with key partners such as the Clinical Commissioning Group and the London Borough of Islington, will implement a coherent strategy that aims to bring Haringey's demand and spending on adults with learning disabilities in line with our statistical neighbours and limit growth in spending in line with population growth.	1,140	1,430	1,430	1,430		**5,430**	7	1,140	0	**Amber**	Verification of savings in Q1 has been problematic, although the work to deliver the savings is on track and progressing. Further analysis will ensure verification of savings made in period 4.	Additional capacity is being put in place to maintain the savings trajectory		0
B2.8	13-Feb-18	Mental Health	Working with our delivery partner, Barnet, Enfield & Haringey Mental Health Trust, the Clinical Commissioning Group and our communities to strengthen the prevention and 'enablement' pathways for mental health and to ensure the support we provide minimises the long-run dependency of adults with mental health issues. For those whose needs require a social care intervention, we will develop the market and look at new commissioning arrangements to improve value for money as well as promoting choice and control for the service user.	390	490	490	490		**1,860**	92	390	0	**Amber**	The savings are almost on track for Q1, however there are some risks identified around pace towards the end of the period.	Additional capacity in reviewing team and bedding in of enhanced practice will mitigate		0
B2.9	13-Feb-18	Physical Support	Working with the CCG, acute providers and primary care to extend independence, choice and control to those with physical support needs and further strengthen the pathways that prevent, reduce and delay the need for social care.	860	1,070	1,070	1,070		**4,070**	136	860	0	**Amber**	Savings achieved to date of £136,464 is off target but with plans in place to mitigate	External agency engaged to undertake double handed care reviews, this will speed up completion of assessments. Reviews Team have a new interim Team Manager in post who is providing stronger grip and management. Working with Finance and Performance colleagues has begun to establish the impact to date made by Reablement as this has not been included to date.		0
PA1	12-Feb-19	Charging for Managed Accounts	Introduce an administration fee for setting up and maintenance of care packages for Appointeeships and Self Funders. the fee would be comparable to existing charges levied for Deputyship clients.	120					**120**	0	120	0	**Amber**	Given the need for public consultation and a final decision by cabinet the full year effect is reduced by £60k due to the timing of the implementation.	It is expected that the overachievement in savings line PA2 will mitigate the impact		0
PA2	12-Feb-19	Fast tracking financial assessments	Speed up the process of financial assessment so that charging starts as soon after the start of services as possible. The saving lies largely in reducing levels of debt and the costs of recovering overpayments rather than any additional costs to the user of this approach.	140					**140**	140	140	0	**Green**	The annual target has already been exceeded. Modelling is underway to understand the increased impact of this approach in 19/20			0
PA3	12-Feb-19	Capitalisation of CAS	Capitalise the majority of the operating and equipment costs of the Community Alarms Service. Because installation of a CAS solution can be considered the provision or adaptation of fixed assets for the benefit of our residents, there is scope for capitalisation of associated spending within financial regulations	177					**177**	0	177	0	**Green**	Already adjusted in the base budget,so will be achieved			0
PA4	12-Feb-19	Housing Related support	Fund housing advice and support currently provided from Adult Social Care budgets through the Flexible Homelessness Support Grant whilst we transform these services and create longer term, more sustainable funding routes over the next 3 years.	600					**600**	0	400	200	**Amber**	Analysis is still ongoing to confirm if the full savings target will be delivered in year. It is expected to be confirmed in p4.	No shortfall confirmed		200
PA5	12-Feb-19	In-House Negotiator	Expand in house Care Negotiator capacity to work with providerson reducing the cost of care packages in relation to overcharging against service user needs.	116	344				**460**	0	116	0	**Amber**	Attribution of savings related to In-House negotiator in Q1 has impacted on the RAG rating	The approach and methodology is still expected, based on historic evidence, to deliver to target		0
PA6	12-Feb-19	Transfer of High Cost Day Opps	Lease three ex-day centre premises to a local provider to support 15-20 service users at reduced cost, and closer to their existing support networks.		525	15			**540**								
PA7	12-Feb-19	Public Health (Sexual Health)	Realise savings based on efficiencies already achieved in the provision of open access sexual health services	267					**267**	267	267	0	**Green**	Savings have already been delivered.			0
PA8	12-Feb-19	Investment of drug and alcohol savings in preventative services for adults and families, targeting health inequalities	Retendering of the three core substance misuse adult contracts has created savings, available from January 2019. Use these savings for investment in areas to improve health and wellbeing, with a split between cashable savings and investments in preventative services that reduce health inequalities	400			100	100	**600**	0	400	0	**Green**				0
PA9	12-Feb-19	Further savings to be delivered by Adults Services	Further action by service to reduce cost of adult social care over the next 5 years *(re-profiled existing savings)*	180	180	180	180		**720**		180	0	**Amber**	These savings should be considered with in B2. 7,8,9			0
Total: People (Adults)				**4,390**	**4,039**	**3,185**	**3,270**	**100**	**14,984**	**642**	**4,190**	**200**				**0**	**200**

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"Making Haringey a Better Place… where everyone can thrive"

Haringey Local Area Coordination Programme – A Formative Evaluation of Implementation

Leeds Beckett University

Professor Mark Gamsu
Simon Rippon

June 2019

Contents

Acknowledgements

We would particularly like to thank Keesha Sinclair and Andrea Wershof for all of their help during this evaluation. We would also like to thank Chantelle Fatania, Rick Geer, Will Maimaris and Beverly Tarka as well as all of the officers of Haringey Council, the Voluntary Sector and Haringey CCG who agreed to be interviewed.

Executive Summary

"We know that the only way we can deliver our ambitions for Haringey to be a better place in which everyone can thrive is to build greater community resilience, and develop new ways for communities to support all their members. Our local area co-ordinators are a really important part of this mission, connecting people to others who can support them, and providing support in turn to those in the community who want to find more systematic ways of providing that support. They spin webs of support across our local communities, pausing to re-inforce weak points, but always focusing on the strength of the overall network."

Zina Etheridge Chief Executive, Haringey Council.

The Haringey Local Area Coordination Service was established toward the end of 2017. It currently employs two coordinators who work in three wards in the borough. One worker (LAC1) covers most of Hornsey ward and the other (LAC2) covers parts of Northumberland Park and White Hart Lane wards.

The LAC programme within Haringey sits within a wider context of policy reform within the Local Authority and local NHS[1] which sees an increasing focus on action that supports prevention – both as a public health activity and as a key tenet of health service reform and delivery. This policy emphasis also has a focus on place based reform and implementing localism – devolving decision making and promoting involvement.

Implementing LAC in Haringey signals a contribution to these policy agendas as well as augmenting a wider shift and emphasis towards person support that is strengths based and located in identifying personal and collective assets that are located in communities and neighbourhoods.

Haringey Council and partners have made positive steps to understand the impact and initial benefits of LAC, commissioning an early, formative evaluation to explore range of activity, the relational context and personal benefits for people accessing LAC. This evaluative approach is often used in adoption of LAC as commissioners seek to build the case for wider implementation[2].

In this formative evaluation we note positive signs of impacts; personal narratives (case studies) that set out the often complex issues in people's lives, the actions offered by LAC and personal testimony statements of change. We note also the activity from the LACs that is supporting, promoting and developing community and neighbourhood based resources that seek to support local people and promote social connection. Given this is a key tenet of LAC practice further monitoring of such growth is required as a means of substantiating LAC's contribution toward community asset development.

In our early engagement with voluntary sector leaders, we encountered a level of concern regarding the implementation of LAC, in our experience elsewhere this is not unusual or particular to Haringey; we suggest this is perhaps symptomatic of the sectors current challenges in terms of investment and financial allocation in the face of austerity and reform. We see latterly that the LAC relationships with VCS across the three wards is more positive as work has been achieved by the LACs to build relationships and collaborate on activities that demonstrate growth in community resources and activity groups.

[1] Haringey Borough Plan 2019-2023
[2] For examples of other formative evaluations see https://lacnetwork.org/publications/

Another a key concern for the LAC programme and one cited by partner organisations (for example NHS Commissioners) is the return on investment that can be realised across the system. The focus on SROI is one that has been explored in other evaluations (see: Waltham Forest, Swansea, Thurrock and Derby) with noted caveats. Here in Haringey we utilised a method to explore SROI that is based on a peer review process to interrogate a series of case studies provided by LACs and also used a modified costing allocation approach developed in Swansea. In setting out these cost benefits we also highlight a number of caveats, in essence that it is challenging to identify in which part of the system savings can be realised and whether these savings are cashable.

On balance the implementation of LAC in Haringey has similarities to that noted described other evaluations; aligning to wider community models, promoting access and awareness, demonstrating difference and alignment. This has been supported in part by Haringey leadership engaging with the national Local Area Coordination Network and identifying leadership accountabilities. However, we note from other evaluations that in the early and mid term implementation phase supporting action via a Leadership Steering Group has proven to be helpful in terms of monitoring fidelity to the models principles and standards, identifying opportunities and resolving issues of alignment to related community models and in understanding and articulating the required outcomes, benefits and data developments. We note that initially Haringey had such a forum whilst reporting progress is still a requirement into wider reform and transformation fora.

It is clear that Local Area Coordination is valued in Haringey. We were impressed at the general level of understanding and knowledge of the LAC programme within the local authority and with its partners - in particular in the NHS and the Voluntary and Community Sector. It is clear that key leaders are clear about its potential and are keen to ensure that it is aligned to a wider agenda for supporting people to connect and utilise local resources located and led by the community. It is clear that LAC in Haringey is becoming integral to the prevention agenda within the wider care system.

System Level Fit

In terms of building on these established and growing connections and alignments it will be important that the LAC service is involved in the growing Social Prescribing provision that is being rolled out by NHS England as part of the Long Term Plan[3]. Achieving an early and clear understanding about the contributions of both initiatives to supporting local people will be advantageous in avoiding duplication and ensuring that LAC (for example) is able to support and be available to people in local communities more broadly given its open introduction ethos.

Capturing information on activity and impact

When we considered how LAC data is analysed and reviewed we found that development and implementation of the database is still a work in progress. This is not a problem that is specific to Haringey. nationally the emerging LAC services are using a range of different methods to collect activity and impact

[3] Universal Personalised Care. Implementing the Comprehensive Model, NHSE 2019

data. It would be worth reviewing the current approach to data collection and most importantly how it is used.

Operational Issues

Going forward it will be important to consider the best organisational fit for the LAC service. There needs to be a balance between continuing to develop an integrated approach with other services, ensuring that the LAC model's integrity is maintained and being located in a part of the local authority that is able to offer support that is stable and has strong links to social care and housing in particular.

Strategic Relationships

Our work elsewhere and understanding of what organisational features can enable LAC to flourish suggests that stability in the overall management of the LAC resource is crucial and establishing and maintaining a 'leadership' group that helps steer and review implementation and early stage development is beneficial. Such a group not only holds the ring on LACs interface with similar system initiatives but also serves to bring together representatives from the wider system – VCS leads, Health, Social Care, Housing, Communities etc. and sets LAC within a wider determinants frame.

Local Area Coordination – Context and Background

Local Area Coordination emerged in the late 1980's and spread throughout the 1990's across the areas of Western Australia as a means of supporting people with learning disabilities. The model offers direct and open access support, signposting people to community-based resources and networks. The model has a strengths based philosophy seeking to promote access to opportunities towards 'a good life'. (Bartnik and Chambers 2007[4]).

Adoption of the LAC model spread across the UK in the early 2000's with Scotland achieving 59 posts across 25 local authorities that peaked 80 by 2009. Within England there are a number of well established programmes (Thurrock, Derby) and in the last few years schemes have been implemented across England (Isle of Wight, York, Waltham Forest, Swansea). Local adoption is supported by a national Local Area Coordination Network that seeks to share good practice, inform the focus for evaluation and ensure fidelity to the core standards for practice of the model.

The evidence base for LAC in the UK is mainly focused on formative and summative evaluations; such studies are commissioned and undertaken as part of the early adoption phase. Typically, these studies have been small scale with an emphasis on 'satisfaction' and relational activity with people and sector agencies. These report narrative accounts of support through case studies. These approaches and methods are appropriate in the context of LAC maturity in each setting and given the scale of implementation which is often small scale – (Waltham Forest in its early phase deployed four coordinators, Haringey 2). As is the case in Haringey, commissioners are often make tentative steps in implementing novel innovations as they seek to build the case for reform and shift toward community-based models. There is an accepted challenge within LAC toward more extensive and longitudinal research of its impact and benefit. Such longitudinal studies are also the challenge within other community-based programmes – e.g. Social Prescribing.

What is Local Area Coordination?

Local Area Coordination is a model of community-based support which holds as its core vision that 'All people live in welcoming communities that provide friendship, mutual support, equity and opportunities for everyone'[5]. In practice, LACs seek to 'to develop partnerships with individuals and families/carers as they build and pursue their goals and dreams for a good life and with local communities to strengthen their capacity to welcome, include and support all people as valued, contributing citizens.'

In being embedded in specific neighbourhoods, LACs offer an open access resource wherein there is no formal referral process; conversely people can introduce themselves to the LAC and seek support and guidance on a range of issues and aspirations. The premise of LAC practice is based on 'what does a good life look like?'. In asking this question of the person opportunities are developed to begin to progress toward personal goals and ambitions. LACs offer two levels of relationship – Level One which is focused on signposting people to neighbourhood and community based resources and Level Two which is often more longer terms and development, forming a relationship to maintain the actions agreed to realise a 'good life'. The other tenet of LAC is to work on personal and collective strengths to realise change toward a 'good life'. By taking an asset based approach to development LACs also play in role in supporting, growing and networking across community resources and groups.

Increasingly LAC is seen as a having a significant role and impact in the wider prevention agenda that reflects the world of the local NHS health economy and in the wider public health realm as it contributes tackling wider determinants as it often supports people with marked social, economic and living issues. In Haringey and in many other Councils LAC is being seen as a natural contribution to the emerging agenda promoting civic engagement and action as well as informing placed based development.

Background to Haringey Local Area Coordination

The Haringey Local Area Coordination Service was established in November 2017. It currently employs two coordinators whose catchment areas are based within three wards in the borough. One worker (LAC1) is in the Hornsey ward and the other (LAC2) covers part of the Northumberland Park and White Hart Lane wards. However, neither catchment covers the entirety of any ward, since the boundaries of the catchment areas were set to take into account:

- Population numbers (with each LAC covering an area of approximately 12,000 residents) – this number of residents is considered by the national LAC Network as being the optimum number of residents within a catchment area, to attain sufficient numbers of people to the service and to maintain the personal, locally- based element of the role.

[4] Bartnik, E. and Chalmers, R. (2007) It's about More than the Money: Local Area Coordination Supporting People with Disabilities in *Co-Production and Personalisation in Social Care Changing Relationships in the Provision of Social Care* (ed Susan Hunter and Pete Ritchie) Jessica Kingsley Publishers, London and Philadelphia, pp.19-38.

5 See the LAC Values and Core Principles here: https://lacnetwork.org/wp-content/uploads/2018/07/2018-LACN-Eng-and-Wales10- Principles-FINAL.pdf (accessed June 2019)

- Existing community assets, including locations and organisations which could be developed into regular drop-in "touchpoints". These have included GP practices, schools, community centres and faith groups. More information about touchpoints developed by Haringey LACs is below.

- The scope of existing community assets to avoid replication of support offered.

- Funding for the LAC pilot came from the CCG's Better Care Fund. So far, in the life of this service from October 2017 to May 2019, the LAC project supported over 500[6] individual residents – see **Table One** below.

Table One – Number of people who have used the Local Area Coordination Service by level, year and LAC

	2017	2018	2019	Totals
LAC 1 Level 1	7	118	46	171
LAC 1 Level 2	3	78	26	107
LAC 2 Level 1	8	148	53	209
LAC 2 Level 2	0	28	12	40
Level 1 Total	15	266	99	380
Level 2 Total	3	106	38	147
Yearly and Cumulative Total	18	372	137	527

Our Methodology for Undertaking this Evaluation

We see that this change initiative is located across and within a complex system of organisational and community life. Given this level of complexity and that the evaluation is formative[1], we developed an iterative approach based on elements of realistic research wherein emerging findings are tested out with participants and refined from feedback. We were also seeking to utilise participatory methods for engagement, that is appreciative (explores strengths and potentials) and creates opportunities for seldom heard perspectives to shape both learning and knowledge and recognises diverse pathways that contribute to the focal output areas of interest to this project.

We used established methods from social science research and evaluation to generate a representative sample of participants into the evaluation strands; this was instigated by seeking a list of 'contacts' from the LAC Implementation Manager. This contact list was to be representative of the local system in terms of types of roles, organisations and agencies.

[6] All information from Haringey LAC database

In terms of qualitative data capture we gathered data in three ways, undertook a series of face to face interviews from within the sample list and used a semi structured interview schedule to frame the focus and dialogue with participants. Secondly interviewed the Local Area Coordinators, thirdly gathered a number of case studies from the LACs that gave an illustration of the issue people were seeking support on.

We also utilised numerical quantitative data in our approach, this is to illustrate the spread and reach of LAC across the localities as well as to inform the modelling on cost analysis. Given the short timeframe for this evaluation we drew on data that was readily available within the Service – this may have its limitations but also serves a purpose in 'testing out' the utility of the data bank as is.

During the course of our interviews it was clear that there is generally strong support for the Local Area Coordination model (although as we indicate below there are concerns) and this positive view has continued to be affirmed during this evaluation.

Local Area Coordination by its very nature is located in neighbourhoods and communities and interfaces with local people, community based resource groups as well as local statutory sectors.

Where Local Area Coordination has been implemented elsewhere this has been because there is an ambition to change the relationship between people, communities and local statutory services; supporting people and communities to strengthen agency, control and participation. This is a strategic ambition for Haringey; a Senior Council Officer noted that:

"What was attractive (about LAC) was how do you support people so they don't need services - not about VCS or Statutory services this is about community resilience."

"Politicians saw this as a way of building community resilience and playing to a more neighbourhood kind of development support…"

It is also important to recognise that there are some more critical voices, particularly from the voluntary and community sector.

"The council is talking a lot about resilience, enablement and reablement - the idea is that the community can provide support to individuals at no cost and the world will be a better place. However, with austerity the reality is that the VCS has contracted due to cuts."

VCS leader

As Local Area Coordination becomes more integrated into mainstream practice there needs to be a comprehensive shift in the wider workforce to adopt principles of person centred support, to enable community groups and developmental action to flourish - this will not only support Local Area Coordination but serve to contribute to the council's ambition on civic engagement. Local Area Coordination is starting to play an important part in this.

"Local Area Coordination…Helps us think about how we help people to live a community focused life." and "build community and neighbourhood based action outside of infra structures…." (Senior Commissioner)

Results

What are the initial benefits that interviewees are telling us of Local Area Coordination?

Interviewees from a range of sectors have spoken of the positive contribution Local Area Coordination is beginning to make to people - often respondents described these people as experiencing marked social and health related issues; often 'vulnerable' and/or out of touch with services and community resources.

An experienced housing officer described this:

"(the) LA C worker has provided a very immediate response and resource for us and local people….within high need groups…"

Interviewees have spoken of the positive attributes that Local Area Coordinators are bringing to the locality:

"She has been very good at building trust and relationships with these people….who have been challenging for us….LAC as a mediator between people and local services…"

and a Senior Community Leader:

"The Local Area Coordinator is very people focused…approachable… Trusted over relationships…ability to unlock resources for people …service access…community resources…."

A Senior Council Officer noted that:

"What was attractive (about LAC) was how do you support people so they don't need services - not about VCS or Statutory services this is about community resilience."

"politicians saw this asawayofbuildingcommunityresilienceandplayingtoamoreneighbourhood kind of development support…"

We did hear some more critical voices, particularly from the voluntary and community sector.

"The council is talking a lot about resilience, enablement and re-ablement – the idea is that the community can provide support to individuals at no cost and the world will be a better place. However, with austerity the reality is that the VCS has contracted due to cuts."

These concerns fell into the following broad categories:

- *Coherence* - Local interventions did not feel sufficiently joined up with Community Navigators, Dementia Service Navigators, Care Closer to Home Integrated Networks (CHINs) etc.
- *Scale* - that the existing LAC service was too small scale to have a sufficient impact on population level problems and more LACs would be needed to have a greater impact.
- *Location* - a feeling from some voluntary sector services that resources like LAC would be more effective if they were based in the voluntary sector.

As with other asset and strength based approaches when Local Area Coordination becomes more integrated into mainstream practice there needs to be a comprehensive shift in the wider workforce to adopt core principles of person centred support, to enable community groups and developmental action to flourish – such a shift will not only support Local Area Coordination but serve to contribute to the councils ambition on civic engagement. Local Area Coordination is starting to play an important part in this;

> "*Local Area Coordination*…Helps us think about how we help people to live a community focused *life…."* and " *build community and neighbourhood based action outside of infrastructures…."(Senior Commissioner)*

Understanding the spread and reach of Local Area Coordinators across the ward area

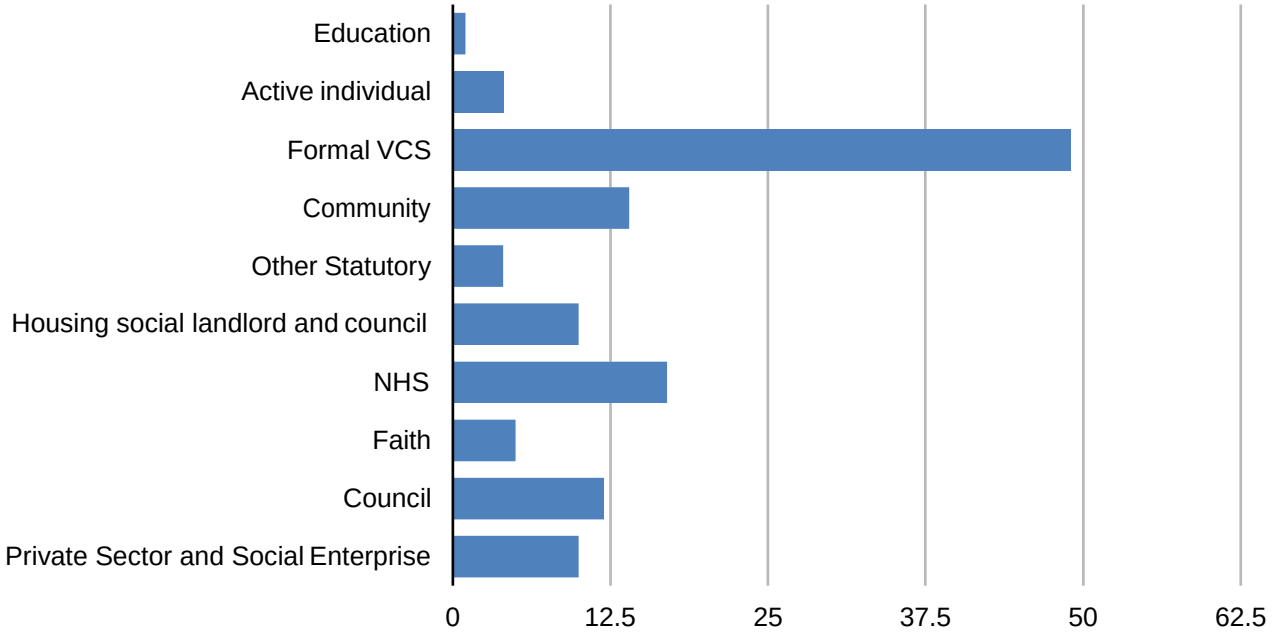
At the beginning of the evaluation we asked the two current Local Area Coordinators to describe the relationships that they have developed over the period November 2017 through to July 2018 (9 months). This is important because it illustrates the connections they have developed – this provides the foundation for their work in three main ways:

- Approachability – these connections make it easier for the public and professionals to contact them.
- Connectivity – their knowledge and relationships with community assets and services means they can be of use to people they walk alongside.
- Development – where appropriate they can harness and develop community assets more effectively.

This is not a static picture – since we undertook this mapping exercise the LACs will have broadened and deepened these relationships.

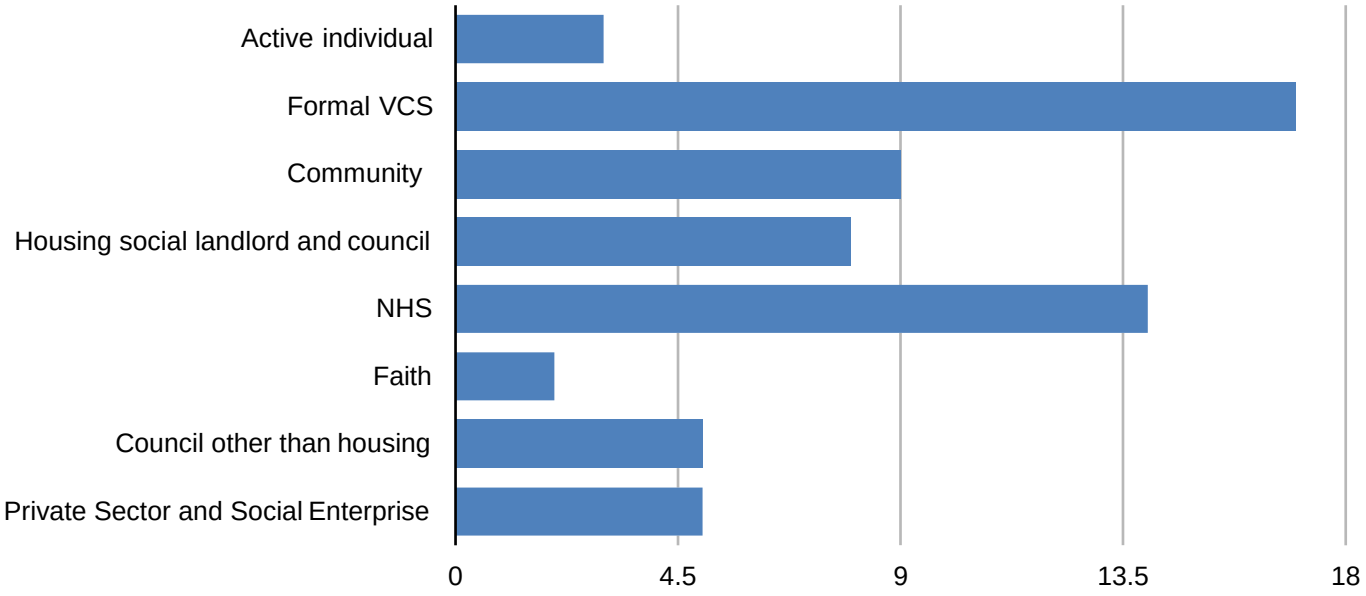
Graph One below shows the range of contacts and relationships that have been made in the first year of the LAC service.

Graph One - Actual number of contacts for LAC service by sector first nine months



In **Graph Two** below we asked the two Local Area Coordinators to identify which of these organisations or individuals they work with on regular (between a week and a month) basis. The voluntary and community sector, housing sector and local authority/NHS have the strongest regular relationship with Local Area Coordinators.

Graph Two - number of organisations by Sector who work regularly with LAC service



Context for Locating LACs - Use of ward profiles

The Haringey LAC project is based in three wards Hornsey, Northumberland Park and White Hart Lane, although neither service covers the entirety of any ward.

In Haringey one Local Area Coordinator (LAC1) is based in the Hornsey ward and the other (LAC2)is based in the wards Northumberland Park and White Hart Lane.

Table Two compares the populations of these wards, this information comes from London Borough of Haringey website[7].

[7] Ward profiles London Borough of Haringey https://www.haringey.gov.uk/local-democracy/about- council/state-borough/ward-profiles

Table Two - Comparison of ward populations served by LAC 1 and LAC 2			
	Hornsey (LAC1)	**White Hart Lane (LAC2)**	**Northumberland Park (LAC2)**
Population	13,356	14043	16,641
Density	12,654/sq Km	8,014/sq km	8842/sq km
Open Space	10%	27.9%	23%
Age Range	Similar to Haringey average	More0-19andfewer20-44 than Hackney average	Largest 39% 20-44 Smallest 8% 65+
Ethnicity	White British 49.2%	BME largest group 28.3%	BME largest 40.3%
JSA Claimants	172/10,000	147/10,000	252/10,000
Housing Tenure	29.5% Social rented, 27.9% private rented	48.7% social rented 18.4% private rented	48.6% Socially rented
Household Composition	35.6% one person 18.9% couples no children	25.1% one person (smallest proportion in borough) 19.9% lone parent households (largest in borough)	18.8% Lone Parent 6.9% Couples with no children
Limiting long term health problem or disability	16.4%	22.7% highest rate in borough	21.4%

There were a range of demographic and population health factors which were considered when setting up this pilot programme. We were told by the Local Area Coordinators that consideration had been given to:

- Demography – one area has a proportion of people aged over 75 while the other has a more diverse and younger population.
- Mental health.
- Long Term Conditions.
- Transience.
- Social Determinants of Health such as food poverty, temporary accommodation use and overcrowding.

Catchment areas for LAC in Haringey

Figure One - Hornsey LAC Catchment Map

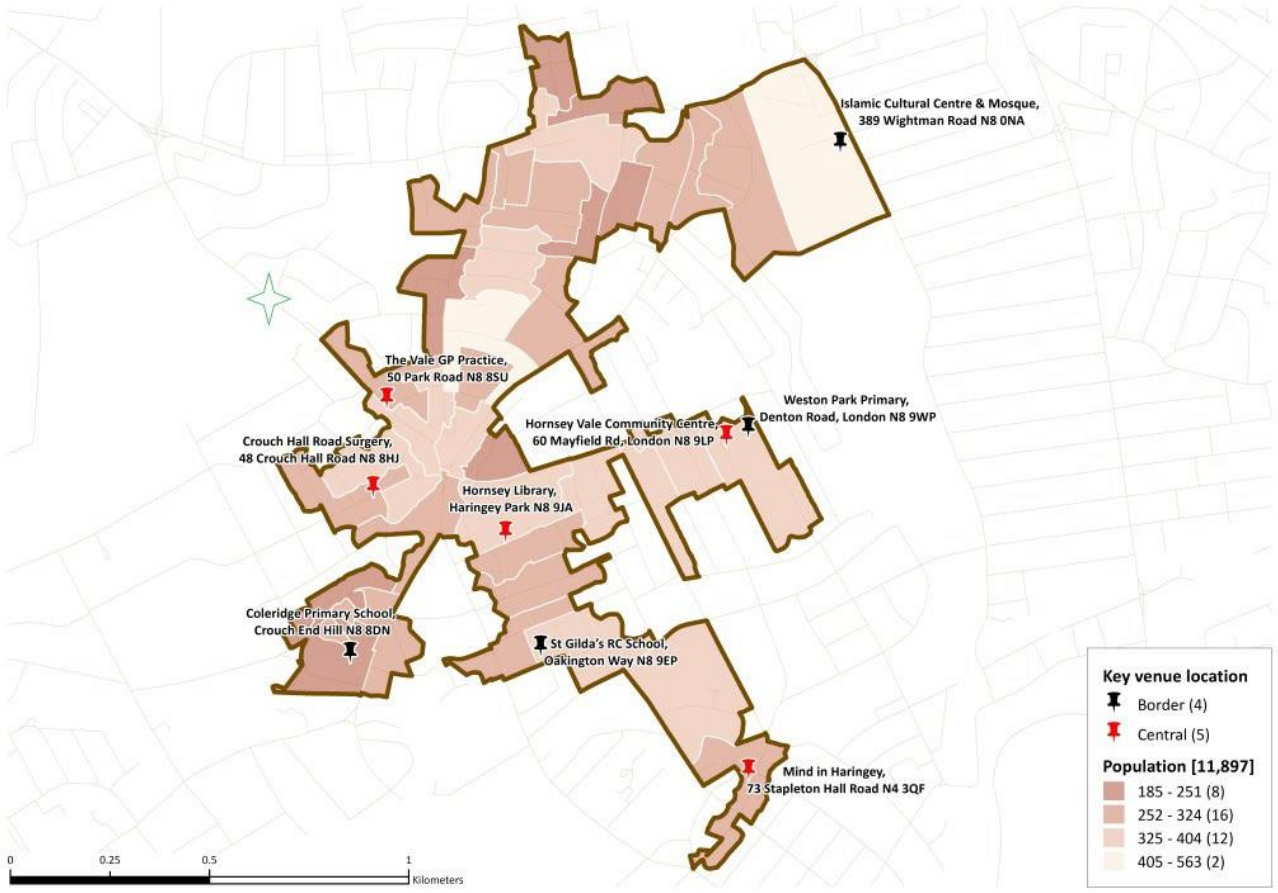
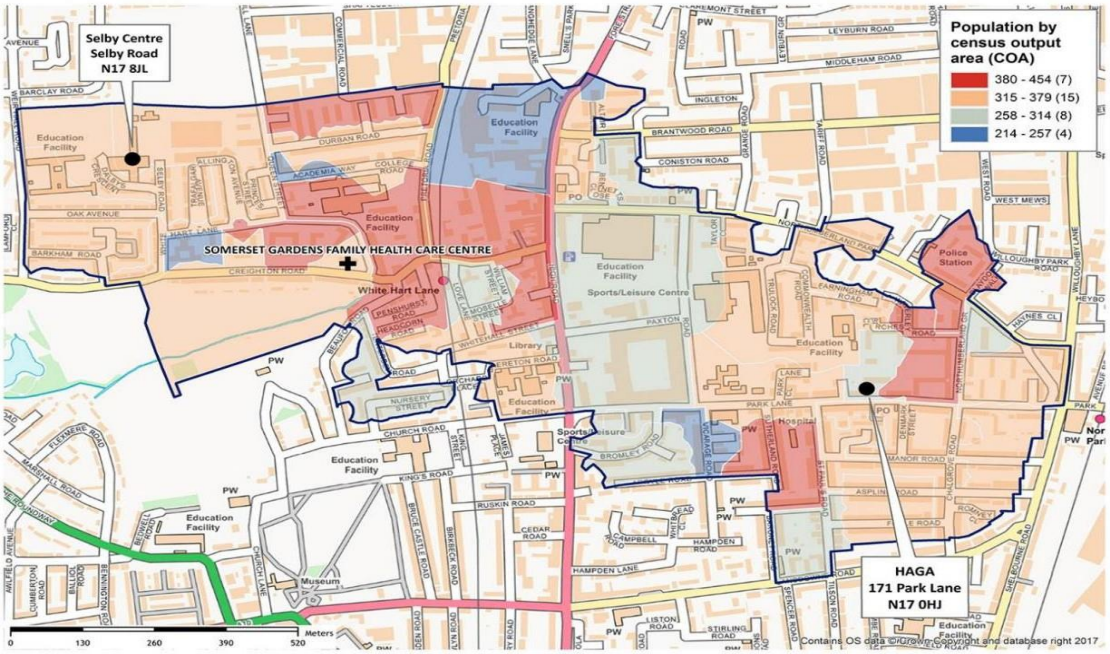


Figure Two - Northumberland Park / White Hart Lane LAC Catchment Map



LAC Activity and Impact

The Haringey Local Area Coordinators use an Excel spreadsheet to record activity and impact information about the people they walk alongside. We attach a list of the types of information that is recorded in **Appendix One.**

We asked the two Local Area Coordinators to provide us with the data they have collected for the calendar year 2018 to understand the range, scope and focus of activity and impact.

Local Area Coordination makes the distinction between people who require "Level One" support and those who require "Level Two". People who access Level One support are more likely to require information or signposting - this has some similarity to social prescribing and community navigator schemes - however the means by which people access these levels are different. In this report we have concentrated on case studies that focus on Level Two - this is where an ongoing relationship with people is much more important and where local area coordination has a more distinct offer to make.

- Level One support is the provision of information and/or limited support. There is no detailed review of personal circumstances made with the person. Anyone can contact the Local Area Coordinator for Level One support. Although information and advice is often given and no further support is needed at that time, a connection has been made that may be of benefit in the future.

- Level Two support is a longer term relationship supporting people (children and adults); who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty and require sustained assistance to build relationships, nurture control, choice and self sufficiency, plan for the future, find practical solutions to problems etc.

In 2018 the LAC service in Haringey supported 367 people. Of these 167 came from White Hart Lane/Northumberland Park and 200 from Hornsey. Of the 367 people who used the LAC service 257 received Level One support and 106 Level Two.

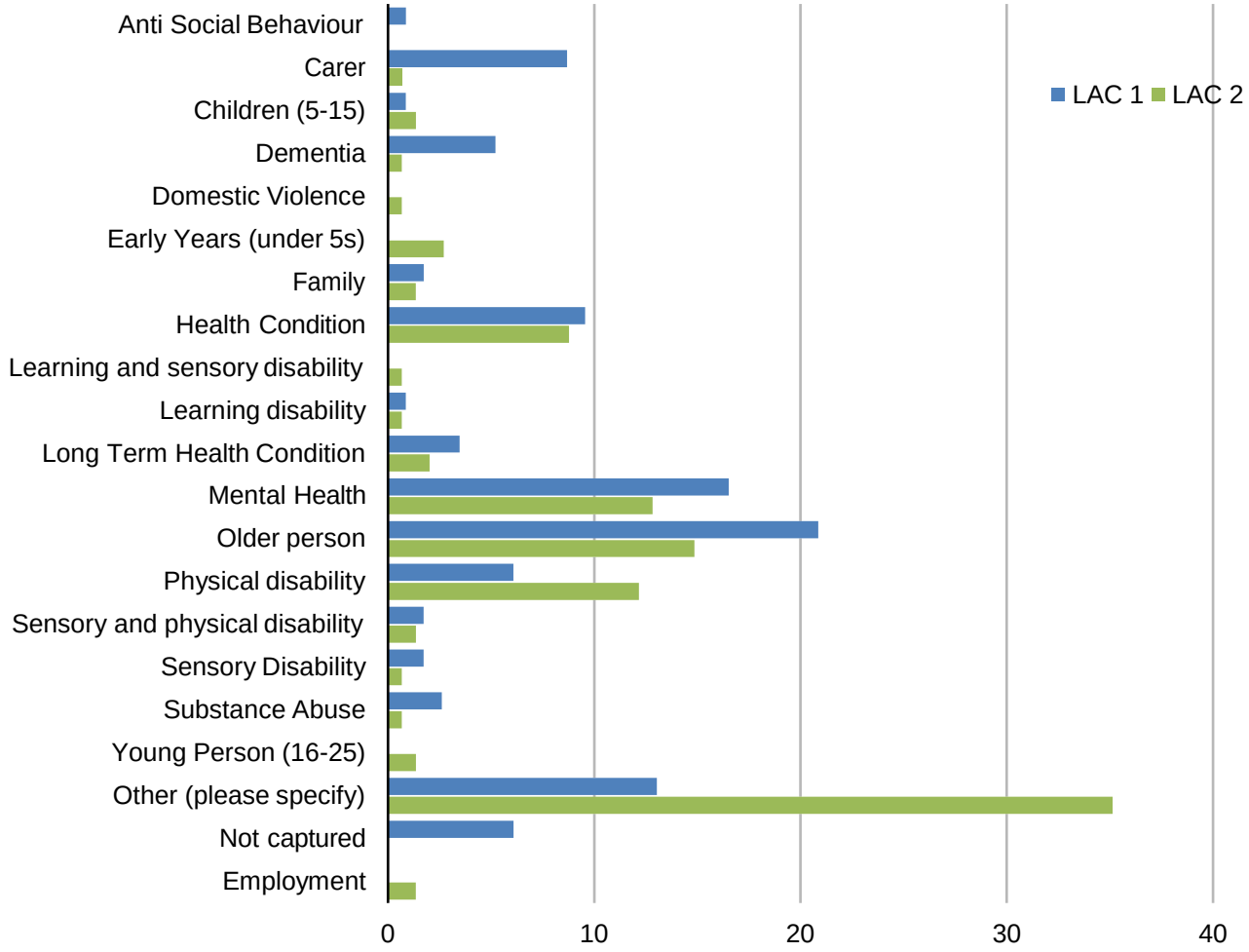
Haringey LAC Activity 2018

<u>Examples of Issues and Concerns Presented to LAC</u>

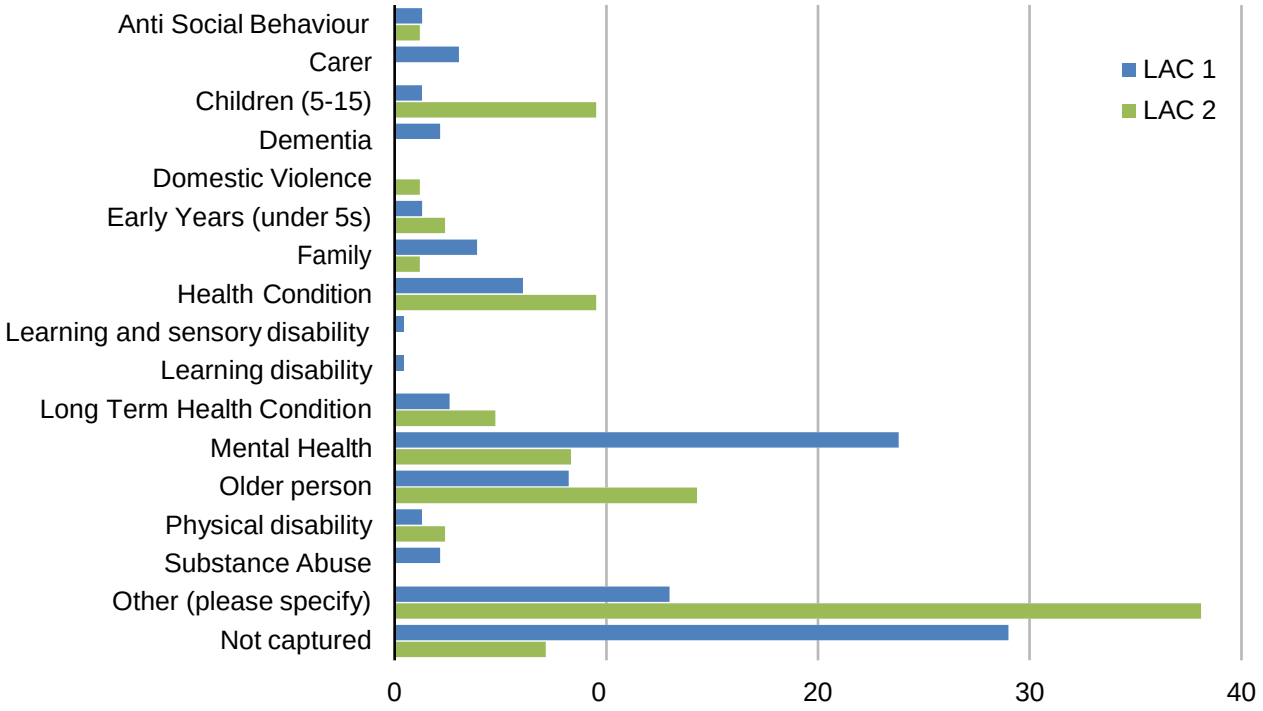
Often when introduced to LAC people set out a range of issues for which they are seeking support, sometimes supporting in understanding what formal service resources are available and importantly what neighbourhood based resources are able to present that can offer support more generally.

The two graphs below show the number of people who the Local Area Coordinators have supported and the issues these people have presented and for which they are seeking support. It is important to be cautious about interpreting this information; while the database used by the LAC service allows for up to three issues to be recorded, in order to reflect the complexity of people's lives, we have only looked at what has been recorded as the presenting or primary issue. These are broken into Level One and Level Two.

Graph Three - Presenting Issues Level One by percentage 2018



Graph Four - Presenting Issues LAC Level Two by percentage 2018



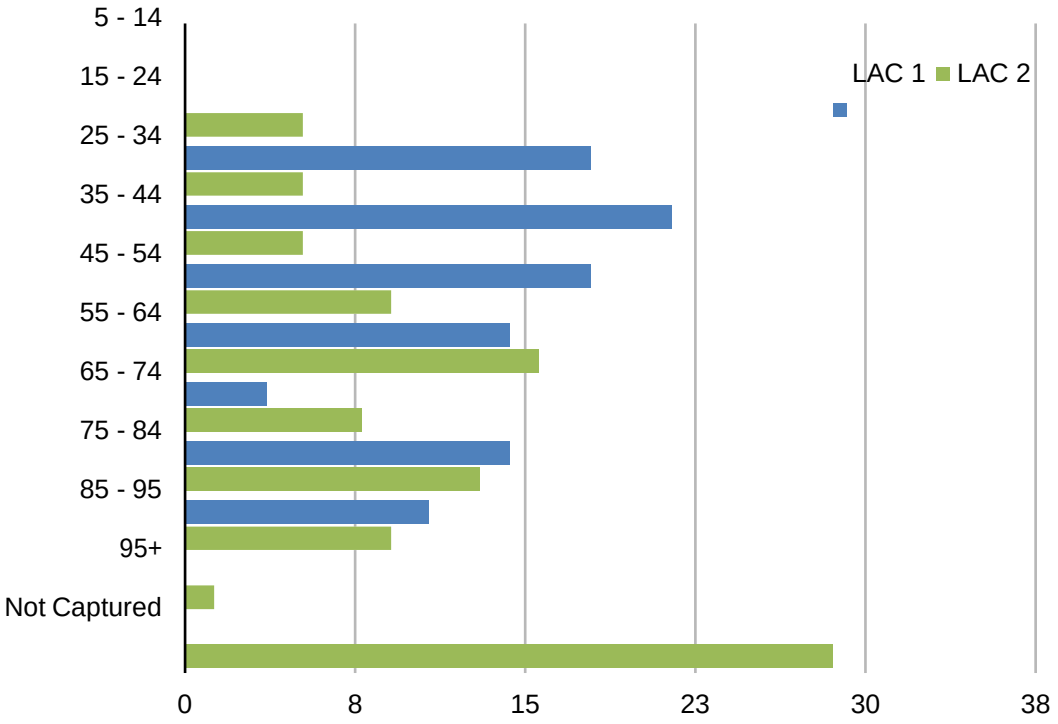
In **Graph Four,** we note that a large number of people who have been placed into category '*other*' together this equates to 31% of Level 1 and almost 40% of Level Two. Many housing related issues were put into the 'other' category, there is no entry box for housing on the dataset at the time of reporting. Looking at the 'other' category in more detail we found that the three largest categories here appear to be:

- Housing
- Finance/Welfare Benefits
- Immigration

Who is using the LAC Resource?

There are some differences with regard to who is using the LAC service. This is to be expected given the different demographic profiles of the populations served. LAC1 works in Northumberland Park and White Hart Lane and is more likely to work with younger adults and with people from Black/African Caribbean communities. LAC2 works in the Hornsey ward and is more likely to work with older and white British people.

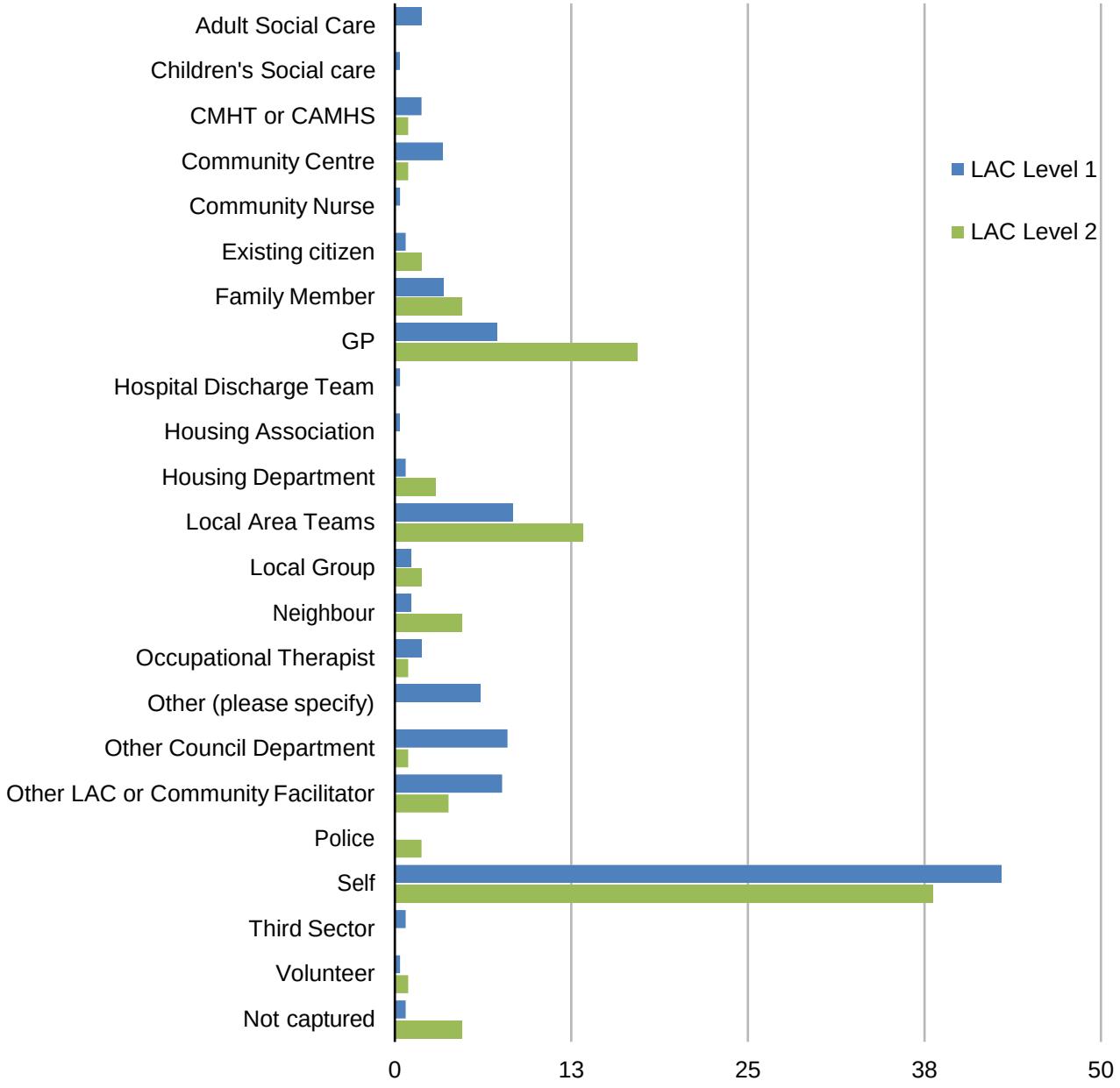
Graph Five - Percentage by age at LAC Level Two for each LAC 2018



Who is introducing people to LAC?

The two graphs below show how people are introduced to the LAC service. Most introductions are self introductions. This is broadly consistent with LAC principles and could be taken as an indicator that the coordinators are accessible and have a profile within the neighbourhoods in which they work and have spent time 'publicising' and profiling LAC. Given that LACs are regularly based at frequent touchpoints within the community, they are known and familiar, and residents feel able to approach them about concerns and issues. This means that it is far more likely that individual residents who are traditionally seen as "hard to reach" will find their LAC a "familiar face" at local events and activities; this means that an authentic, trusting and unofficial relationship can develop, often leading these hard to reach residents to approach their LAC for help of their own accord. It is probably not surprising that the proportion of introductions that are made by statutory services increases at Level Two - as **Graph Six** shows.

Graph Six - Where introductions come from by percentage 2018



Impact of the LAC Programme

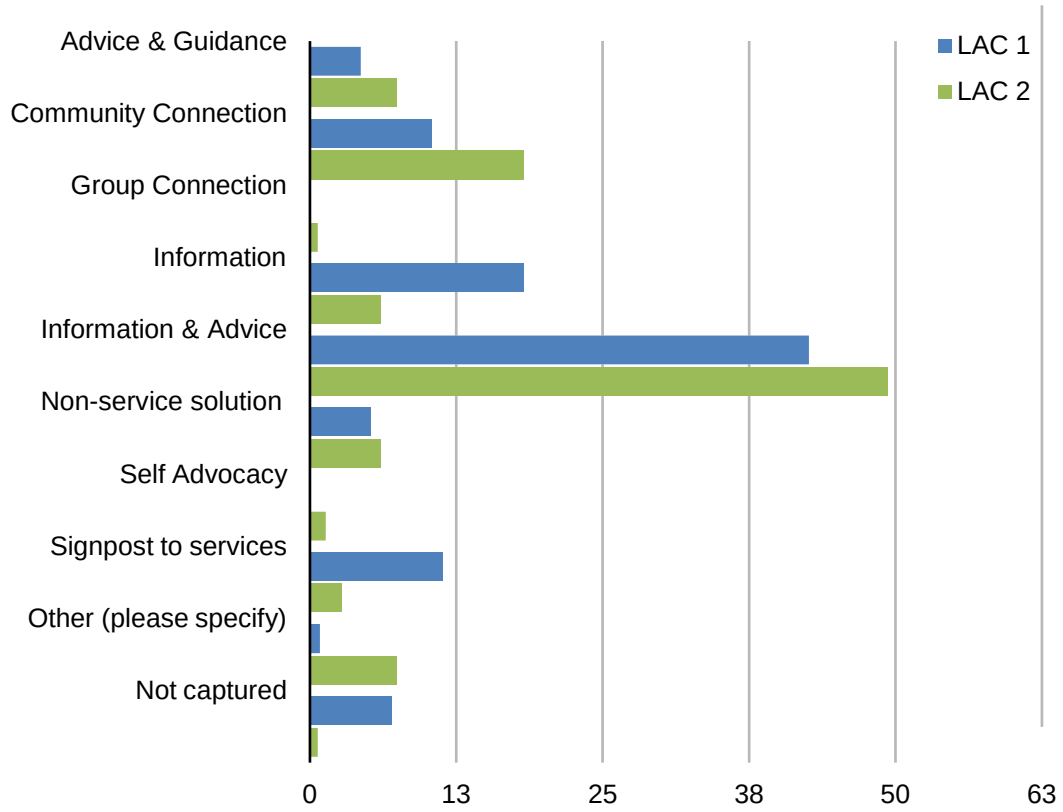
Later in the report we set out in more detail of the personal impact of the LAC programme *using case studies* that have been produced by the two LAC coordinators.

The current database provides a summary of the broad areas of impact that Local Area Coordinators have had through walking alongside members of the public.

We suggest that it is important to take into account Level One actions - which are more concerned with signposting and advice - because Level One actions do give an indication of connection and demand, further it is important to recognise that the role that Level One actions play in the LAC service. The 'open door' of the Local Area Coordinator means that they are able to see a wide range of people and then to make a judgement and negotiate with the individual about when to provide a response that is more focused and longer term.

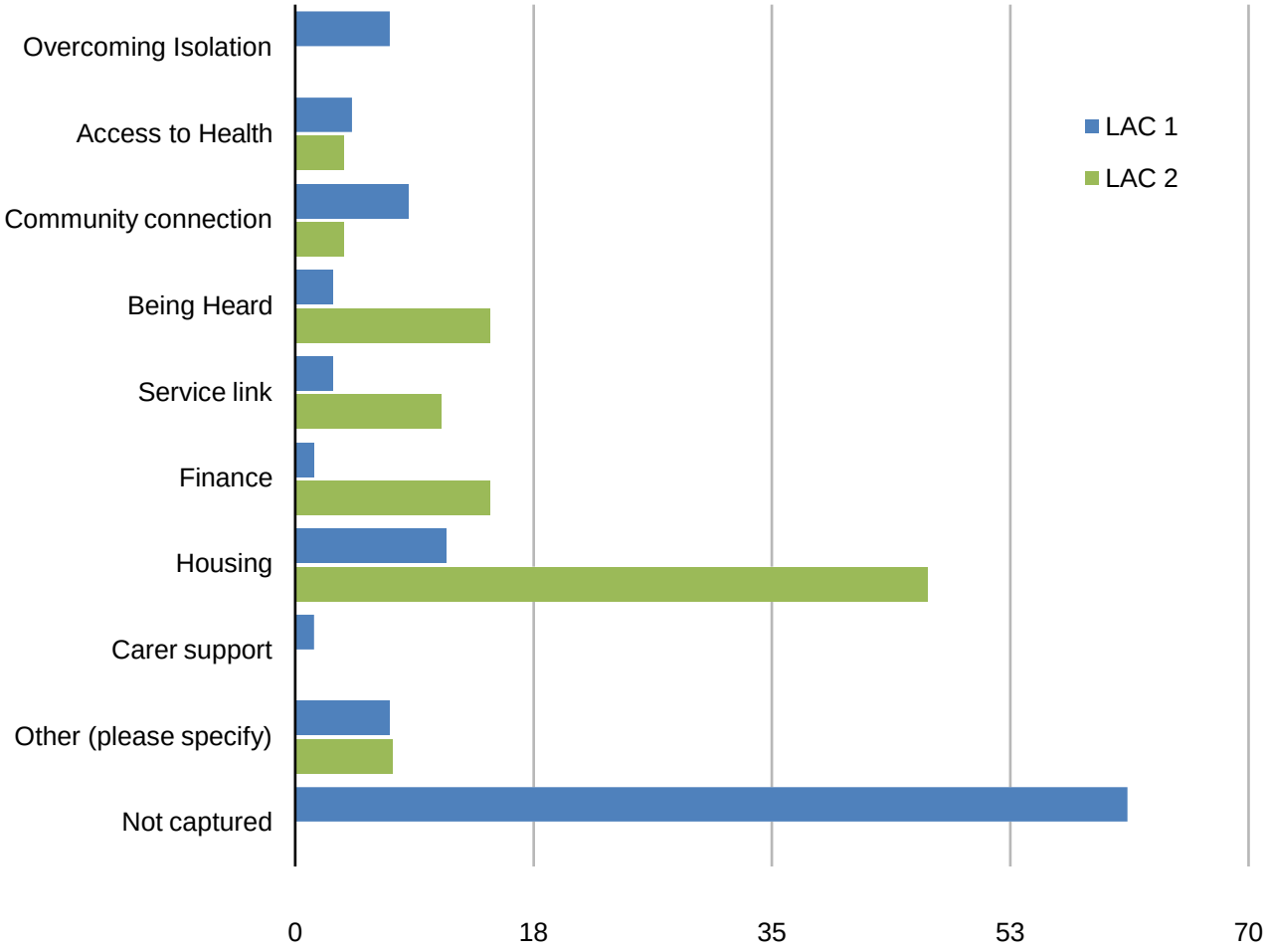
Graph Seven below shows that the majority of Level One actions taken by Local Area Coordinators are concerned with Information and Advice with Community Connection and Signposting to Services also significant.

Graph Seven - LAC Actions Level One by percentage 2018



Looking at LAC involvement in walking alongside people at Level Two we can see the most significant ambition for many people is to improve their housing[8] - there are examples of this in some of the case studies we were given.

Graph Eight - Outcomes from LAC Involvement Level 2 by Percentage 2018



[8] Housing issues included, social isolation, damp, repairs, poor maintenance, inappropriate housing overcrowding, Housing Benefit and concerns regarding personal safety

Financial Impact

Understanding the financial impact of LAC is of increasing interest to commissioners and has been a feature of evaluations across a range of LAC sites in England and Scotland with varying degrees of sophistication and consensus[5].Given the scope of our evaluation and the resources available a full financial analysis and cost benefit exercise was not within scope; however we have utilised some of the methods employed elsewhere to give the LAC Steering Group a sense of the potential cost benefits of LAC.

The 2007 report from the Scottish Executive[9] signaled the challenge in reporting on financial benefits (savings to sector organisations) thus:

"Differences in LAC practice across local authorities and the broad remit of LAC generally meant that clearly identified, measurable outcomes were difficult to extract from the LAC process. However, LACs identified three main areas of achievement: a better overall quality of life for people; specific differences in individuals' lives; and particular areas of work, such as transitions to adulthood, where they believed they had made a wider impact."

Whilst there has been much refinement of LAC implementation in the last decade across the UK as sites mature in their understanding of LAC and a focus on outcomes and benefits becomes more detailed and where the development in the methodologies for undertaking financial cost benefit analysis is growing the caveats from Scotland still serve as a caution.

The 2011 evaluation of the Middlesborough scheme[10] is in many ways similar to our focus in Haringey, it offers a formative review, was undertaken in the early stages of implementation and was similar in scale of operation. The report stated: "LAC can show success across several of the dimensions that what would make up a cost-effective service. These include:

1. Preventing crisis through early intervention;
2. Changing the balance of care by using more informal supports;
3. Using community resources;
4. Bringing in extra resources to support families and communities;
5. Making better use of existing resources;

We see these dimensions as being present in the Haringey Scheme.

The Middlesborough evaluation also emphasised the difficulty in undertaking a review of efficiency savings and social return on investment in a programme that was in its early phases of implementation, but also noted the challenges of demonstrating efficiencies in prevention services per se as often the impacts for people are across a longer term time frame and the variables (e.g. the types of resources and services involved) are multiple and may often include access to resources that sit outside of the established sector system – that is, resources that support people which are delivered and provided at a hyper local neighbourhood level in communities. A pragmatic approach was taken using case stories from which service costs were attributed and hypothesised cost efficiencies likely to be accrued from LAC intervention were assigned to these cases. Whilst not an exact science this offered one view of potential costs and savings.

[9] Evaluation of the Implementation of Local Area Co -ordination in Scotland. The Scottish Executive

[10] Evaluation of Local Area Co-ordination in Middlesbrough Final Report by Peter Fletcher Associates Ltd 2011

A number of recent evaluations[11] have utilised methods to demonstrate the Social Return on Investment (SROI) from LAC however caveats remain in terms of the generalisability and meaningfulness of this approach.Suchcaveatsrelatetothedefinitionoftermsusedtodescribeissues people are experiencing and which require costs allocation - such as 'depression', 'mental health needs', 'older people'.For example, the evaluationof the Leicestershire programme notes that "whilst the SROI findings form one part of the evidence base, they do not provide the complete picture – they should be seen in context of the wider (Leicestershire) LAC evaluation findings as a whole. It is also important to note again that the SROI findings are only a partial reflection of the benefits, and do not take account of the longer-term, generational savings which are likely to accrue…"[15]

The consistent cost benefit attached to LAC in the four SROI evaluations suggests a 1:4 ratio - for every £1 invested into LAC there is a £4 return into the local system, the highest return is seen in the local authority system and then the local health economy - in the main to the CCG. For other partner agencies (e.g. Fire Safety, Housing, Police etc.) it is difficult to demonstrate cost value as data sources are often poor - this is perhaps an indication of the immaturity in data gathering in these sectors.

We suggest that where work is to be undertaken on SROI an agreement needs to be reached with all sectors agencies on the focus, detail and specificity of data collection to ensure each sector has a stake in the analysis and benefits. This would be a key component for development in any SROI modelling in Haringey.

In framing an approach to cost benefit and savings in the Haringey systems we consider that the national evaluations and our evaluation demonstrate that the Local Area Coordination approach is successful at improving the quality of life and self-efficacy of people who would otherwise remain vulnerable and disconnected from their community and neighbourhood resources and formal sector services.

As we describe above work on SROI shows that Local Area Coordination does offer a strong return, however we are not convinced that this is cashable. We note above the data sets required to drive a full analysis are still being developed and are incomplete in some sectors both in Haringey and within LAC programmes more generally.

Further, a strong SROI does not automatically translate into direct savings. There are a range of reasons for this for example - scale of services - a comparatively small scheme such as LAC may not impact on demand in statutory services sufficiently for many years. Similarly it may be the case that some services which are not so heavily rationed - such as welfare benefits or NHS services, may see a reduction in spend, but others that are already heavily rationed because of high demand and limited resources may find that they are just able to respond better to other people who need the service more.

With these caveats in mind we recommend that going forward further consideration is given in the LAC Steering Group to the attention and resources given to capturing data on activity, outcomes, and utilisation to inform any planning on a return on investment model.

[11] Local Area Coordination - A 14 month Evaluation Report. . Thurrock Council.

[12] Social Value of Local Area Coordination in Derby - A forecast Social Return on Investment Analysis for Adult Social Care. October 2015.

[13] Evaluation of Leicester Local Area Coordination. M.E.I Research. October 2016.

[14] FormativeEvaluationandSummaryReport-LocalCommunityInitiatives.WesternBay.SwanseaUniversity. December 2016.

[15] Evaluation of Leicester Local Area Coordination. M.E.I Research. October 2016

As part of our work we have been asked to produce an estimate of the potential value for money of the Haringey Local Area Coordination Scheme. We are extremely cautious about drawing any conclusions from this exercise. This is for a number of reasons that include:

- Many of the people who are walking alongside a Local Area Coordinator have experienced a wide range of challenges in their lives. Some of these affect their utilisation of statutory services and their ability to contribute financially or through other means such as volunteering. We contend that it is not possible to comprehensively and definitively describe future patterns of service utilization – it is only possible to estimate it.

- Further the impact of a particular relationship may not be apparent for some time (certainly longer than this short evaluation) and it may be that patterns of service utilisation could change negatively over time, for example because support drops away or someone becomes more dependent because their vulnerability increases through natural circumstances such as ageing or progression of a particular condition.

- We have also noted that in some cases, more so where pre-existing health conditions are present, service utilisation may actually increase in the medium term - as people are re-connected with services and support that they were not accessing before.

- The abilities of some services to generate savings due to reduced demand is limited. This applies particularly to services that operate on a fixed budget who manage demand through some form of rationing such as waiting lists. In many cases, the effect of reducing demand by some people just means that others might be slightly more likely to access a service more quickly. Ironically, those services that might benefit are central government services where the budget is not formally capped and where there is no official waiting time - such as social welfare benefits provided by DWP.

Finally, while it is important to be accountable for the spend of public funds it is also important to recognise that Local Area Coordination is fundamentally concerned with supporting people to improve the quality of their life, to take more control, to seek support from neighbourhood-based resources and to be able to contribute as citizens.

Approaches to Cost Analysis in Haringey

We have taken a twin track approach as follows:

- Model One - we have run the Swansea return on investment model to estimate potential financial benefits.
- Model Two - we have run a case conference scenario workshop with local authority and NHS professionals in Haringey to consider the potential impact on statutory services if the LAC service had not been involved.

Model One - Swansea return on investment model

We have used the financial model developed by the University of Swansea in the formative evaluation of LAC/LLC in Swansea, Neath Port Talbot and Bridgend. There is more detail on this attached as **Appendix Two.**

The University of Swansea has done the following:

- Based on discussion with LAC staff they created six profiles to describe the people who have used the LAC service. These profiles were used to determine the case mix for the scheme.
- Calculated the service utilization for each of these profiles using a mixture of local and national financial data.
- Presented three possible scenarios for service utilisation as *Optimistic*, *Base* and *Pessimistic* with pessimistic being the most costly.
- Identified what the saving would be if (with LAC support) people were to move from Pessimistic to Base service utilisation and from Base to Optimistic.
- Made assumptions about the potential saving if different proportions (for example 20%) of the total number of people supported by LAC were to move from one service utilization scenario to one that cost less.
- Swansea have also based their calculations on all people who have used the LAC service - in other words at Level One and Level Two - see our comments below.
- Finally, Swansea have allowed for the cost of the LAC service and taken this into account when considering final savings. We have used this model and assumed from the data we gathered through interviews and case studies that the Haringey case mix categories are the same as Swansea and using the same calculations come to a set of costs for Haringey.

We stress that:

- We have not had sight of the details behind the Swansea calculations.
- The Swansea model does not appear to make any allowances within each profile with regard to the number of people who may be in each service utilisation/resource category – base etc. This means it is only possible to give a very rough estimate of savings.
- We are not sure what the proportion of successful outcomes should be but include estimates below based on 20%, 30% and achievement of outcomes.
- The Swansea report is based on a calculation of potential savings to the system estimated over a two year period.
- Finally, we stress the point made above - in many cases, there may be no direct saving to a local health and care system because of fixed budgets, high demand and use of rationing mechanisms such as waiting lists.

All of these caveats mean that the figures produced must be seen as illustrative only. We show this comparative model in **Appendix Three**.

Unlike the Swansea evaluation we have only looked at people who have used Level Two LAC support. This is because we suggest that this is where LAC service provision has the greatest and most unique impact. As we note earlier we recognise the importance of Level One provision - it is an important pathway to Level Two as well as a valuable standalone intervention - however, we suggest that the impact on services here is significantly lower.

Table Two shows that, based on the 106 people who received support from the LAC at Level Two in 2018 the potential return on investment in Haringey is between £500,000 a year and £1,250,000 a year.

However, this assumes that all support is successful. It is arguably more realistic to assume that not all outcomes will be achieved. The two subsequent columns consider the success rate at 20% and 30%. For example, if 20% of outcomes were achieved the potential return on investment is between £100,000 and £250,000 a year.

Table Three – Estimate of financial benefit of LAC service based on Swansea synthetic estimate and LAC Level Two activity in 2018

Haringey Financial Benefit based on different level of outcome success			
LAC ongoing - Impact Value	Total potential value over two years	20% Outcomes achieved	30% Outcomes achieved
Improvement: Base to Optimistic	1,042,599	208,520	312,780
Improvement: Pessimistic to Base	2,444,010	488,802	733,203

Model Two - Haringey Case Conference Scenarios Workshop

A more detailed description of this workshop is attached as **Appendix Four**.

In summary, we asked the Director for Adult Services to nominate a group of service managers from adult social care and the NHS to consider a set of case studies drawn from the Haringey LAC service caseload and to answer the following question:

"If the LAC service had not been available what do you think would have happened to this person and what impact might this have had on health and care services?"

In effect we were asking these health and care professionals to act as a multi-disciplinary team and make decisions about potential need and service access.

We include the case studies in Appendix Four. A total of seven case studies were considered. It is important to note that in all cases the workshop participants considered that there were likely to be needs that would have to be met by statutory services.

Table Four below summarises some of estimated potential future service need with regard to these case studies.

Table Four - Assumptions about service utilisation if LAC had not been involved

Service							
	CS1	CS2	CS3	CS4	CS5	CS6	CS7
Hostel	Y						
Accident and Emergency	Y					Y	
Rehousing Assessment		Y					
Adaptations		Y					
Equipment and Adaptations Assessment		Y					
Adult Safeguarding Assessment	Y	Y		Y			
Primary Care	Y	Y			Y		
Residential Care		Y		Y			
Mental Health Assessment		Y	Y		Y	Y	
Mental Health Community Support		Y	Y		Y		
IAPT						Y	
Housing assessment		Y			Y	Y	Y
Carer Assessment			Y	Y			Y
Home Care			Y				Y
MH/Dementia Pathway				Y			Y
Carers Support				Y			
VCS referral					Y		

What is most striking from the table above is the unanimity of the responses. Of the case studies presented based on real examples of people who had received Level Two services – there was a strong agreement within the 'case conference' workshop that LAC involvement had delayed or prevented the involvement of statutory services.

This is important, because it demonstrated the additionality of the LAC service and it affirmed the professional judgement and actions taken by the Local Area Coordinators. Most of the people who have accessed LAC Level Two have in addition to their personal ambitions for a good life a range of often complex problems. It is the interrelationship and interaction of these that can vary over time that create additional demand on local health and care systems.

The current PSSRU unit costs of health and social care manual[16] does not explicitly recognise this complexity - with the exception of people receiving Personal Health Budgets which are concerned with costs to the NHS.

Further there are a number of costs that are not included explicitly such as adult carers assessments, housing assessments and adult safeguarding assessments.

Nonetheless, it is useful to consider some of the PSSRU costings that relate to issues that arose in the workshop if only to illustrate some of the costs here:

- Mental Health Assessment £305 to £1457 (DoLs)
- Equipment and Adaptation Assessments (major adaptations) £636 to £3267
- Convert Room £10,761
- General Practice costs per consultation £37.40
- General Practice costs per consultation including prescription costs per consultation £71.30

During the workshop participants also noted that Haringey (probably like many local authorities) does not have a systematic approach within the local authority or across the health system to keep track of costs of individual services and brings these together to consider the total cost of services used by individuals.

Monitoring Wellbeing - Residents Self Reporting

There are significant challenges in introducing outcome measures and tools into community based programmes[17] [18], In Haringey there has been positive steps taken to introduce progress and monitoring tools for the LAC that align to wider performance and related outcomes for the Council, CCG and partners; we note that in the development phase of LAC in Haringey a pragmatic and iterative approach has been adopted to refine approaches to capturing outcome data.

We note that the LAC programme has trialed the use of a modified Outcomes Star tool for people accessing Level Two; this tool enables people to evaluate their own wellbeing prior to, during and after LAC intervention. The tool was adapted in consultation with CCG.

Five of the eight outcomes around the star relate directly to the New Economics Foundation's *Five Ways to Wellbeing*[19]*;* these statements were arrived at as part of wider evidence review and synthesis and are now well established in the field of mental wellbeing in the UK.

[6] Unit costs of Health and Social Care 2018 PSSRU Curtis L and Burns A

[17] Promoting Asset Based Approaches for Health and Wellbeing: Exploring a Theory of Change and Challenges in Evaluation - Rippon, S and South, J (2017) *Promoting Asset Based Approaches for Health and Wellbeing: Exploring a Theory of Change and Challenges in Evaluation.* Project Report. Leeds Beckett, Leeds.

[18] What quantitative and qualitative methods have been developed to measure health related community resilience at a national and local level? WHO (Europe). South.J, Jones.R, Stansfield.J, Bagnall. A.M. 2018.

[19] (https://neweconomics.org/2011/07/five-ways-well-new-applications-new-ways-thinking)

The five wellbeing statements are:

- Keep Active
- Keep Learning
- Give
- Be Mindful
- Be Connected

The remaining three points around the star relate directly to LAC aims of feeling confident, feeling in control, and feeling able to achieve a vision of a good life.

This use of the Five Ways is already being championed by Haringey Council's *Mental Health & Wellbeing* project hence LAC is aligned to a wider context within the Council in terms of its impact and contribution to supporting mental health wellbeing. Details of this wider Council approach can be seen here: https://www.haringey.gov.uk/social-care-and-health/mental-health-and-wellbeing/wellbeing

The Outcomes Star is shown in **Appendix Five with a supplementary note on its use.**

The implementation of the Outcomes Star helps support one of the core tenets of LAC, that is, focusing on strengths based action, and on action and opportunities that are desired by the person and which have a high relevance to their personal 'good life' aspirations. These outcome statements help the LAC to hold a focus on what their role is in 'walking along' side the person.

When the Star has been competed the LAC and resident complete a '*shared outcomes agreement'* which sets out the needed actions to make change and progress, this enables both parties to be an active participant in a joint endeavor.

Community Development

Reflections on Practice: Given that this formative evaluation is seeking to identify areas for further development, refinement and improvement the LACs can provide valuable reflections from practice that support and serve to underpin key practice and delivery attributes and challenges. These reflections can also help shape improvements and change as the programme progresses through its implementation and development phase. In other LAC sites we know of steps taken to provide more formalized 'learning from practice' including action learning projects, contact review meetings where LACs share stories from their field work.

Below are two themed summaries that capture examples of LACs impact and involvement in the local system, firstly in terms of community development and secondly on action on wider system influence that frames practice more towards a strengths based and person centred ethos.

i) LAC and Community Development

Given the specificity of the LAC model and its core statements for practice, LACs are tasked to develop relationships in and with local community groups whilst seeking to support and develop opportunities for community led resources to flourish. LACs in Haringey have done this in a creative and diverse way.

The aim of LACs community development role being to promote community led groups and resources which people can access for support and community connection and which the LAC can recommend to people as a valuable local resource toward a 'good life'.

In developing community based resources the ethos is more toward citizen led solutions and not 'service' or sector led solutions. **Table Five** summarises some examples of this progress through LAC action.

Table Five - LACs and Engagement with Community Groups – Examples from Practice

LAC1 or 2	Group	Project	LAC intervention	Residents reached
LAC1	Hornsey Housing Trust	Befriending, November 2018	Delivering befriender training to 12 volunteers; working with volunteer manager to set up befriending scheme including safeguarding.	12 residents trained
LAC 1	Hornsey Vale Community Centre	One Hornsey Community Day, 12 June 2018	Arranging a community event for older / isolated people, which brought together many different organisations from across Haringey. This included commercial companies (eg care agencies), legal firms (re Wills and LPoA), charities (for volunteering) and community groups (eg Jacksons Lane). 22 organisations had information stands Activities included: Laughter yoga, gardening, handicrafts, treasure trail, singalong, self-defence, circus skills. Everything was free – including lunch.	92 residents attended Average age of residents: 72 years old

LAC 1	Dementia carers (Tom's Club)	Anticipatory grief	Creating and delivering six one-off workshops for carers of loved ones with dementia on the subject of anticipatory grief.	45 carers
LAC1	Hornsey Vale Community Centre **and** Bridge Renewal Trust	Big Up My Street	Bringing the volunteering manager from Bridge Renewal Trust and the chair of trustees of Hornsey Vale Community Centre together to jointly set up "Big Up My Street" – a micro-volunteering project supporting residents in 3 nearby streets to help vulnerable /needy neighbours. As a LAC I know lots of people in this area who need low-level, quick bursts of support (eg help with shopping or taking washing to launderette, mowing lawn, help with letters / admin); I also know lots of capable residents who'd like to help. This project aims to put one group of people in touch with the other, while offering support with safeguarding and boundaries.	The project launched in April and 12 local residents have signed up. After some preliminary admin and safety checks, we are now beginning to match people.
LAC 2	Women with A Voice	International Women's Day (IWD) Supporting the women's group to develop a community event for women, to enable them to extend their reach in to the	Sourced and recruited female entrepreneurs to speak at the event. Booked the Deputy Mayor Sheila Peacock (now the Mayor of Haringey) to open the event. Applied for food a food delivery for the event.	Over 30 residents reached

		local community and promote their group.	Arranged for a local resident to supply lunch for the event. Arranged for a local resident and cake maker to supply a cake to mark the occasion. Arranged for gifts to be supplied to give out to women and children at the end of the event. Arranged a market place for women to get information and this was made up of the following services. Wellbeing network, Spurs, Breastfeeding Service, Massage, Henna Art, One You, I-Care, T3 and Body Works and HyaRanks Jewellery.	
LAC 2	Lorenco House	Silver Sunday /Celebrating Older People and Immersive Technology Launch. Enabling local residents to come and experience some new interactive technology and to get to know more about Lorenco House. The Toverfel Technology uses interactive light projections to enable the user to interact	Supported the planning and organizing of the event. Liaised with Lorenco marketing in order to promote on social media. Supported the local Tottenham community press to come and do feature story. Registered with Silver Sunday and invited Public Voice in Haringey to have a stall to engage with Local residents.	Over 30 residents reached

		with games designed for people with projections.		
LAC 2	Women with A Voice	Food Drop/ Women's Group/capacity Building and Reducing food Poverty.	Observing and accessing the need for community food delivery on another day in Northumberland Park. The Local Area Coordinator applied for the women's group to have food supplies delivered from the Felix Project to their group, to enable them to cook a hot meal for people attending the group and also to enable group members to take home a bag of food .The group are now in a position able to assist smaller local group to have food for their lunch clubs . The group also provides food bags to local residents in need of food as they	Over 45 women have benefitted from food supplies Food supplies and currently, between 10 and 15 residents benefit from food parcels per session. The Women's Group have also been able to support non funded groups through food outreach they have access to regular food supplies. A minimum of 5 additional bags of food are being delivered to local residents who have been identified by the LAC as experiencing food poverty.

LAC 2	Christmas Dinner in partnership with LILLS and Lorenco House	Christmas social	LAC worked in partnership with LILLS (London Independent Living Service) to put on a Christmas lunch to reduce loneliness and isolation. LILLS provided a variety of excellent free hot meals to residents and in return, Ills were able to advertise their service to a wider community The Event was hosted at Lorenco House and they were able to combine the switching on of their Christmas lights and a Christmas Party The LAC also arranged for some Christmas stalls and a musician	60 residents

ii) LAC and System Influence

A significant number of unexpected additional benefits have been apparent because of the existence of the LAC service in Haringey. These are described as:

1. *Developing Opportunities and New Resources* - This has included influencing and working with commissioners to develop a Hoarding Working Group (within which LAC1 participates) that brings together a wide variety of council departments with a view to commissioning a service for residents. This occurred as a result of direct work with a number of local residents living with hoarding issues.

2. *Influencing wider workforce practice* – The strong person-centred work ethic of the LACs has clearly inspired other council teams to adapt their way of working with residents. For example, the NHS multi-disciplinary team who are engaged with LAC, have adopted the *"what's your vision of a good life?"* question when working with their patients. LACs have jointly worked with many agencies and

departments across the borough to foster a relationship-focused element to engagement with seldom heard residents. This has included work with environmental health enforcement officers, Homes for Haringey and social care teams.

3. *Being a Broker* – LACs have worked to support residents who have had long-running conflicts with various council departments which have gone unresolved for years. For example, a LAC supported a resident with high functioning autism and anxiety issues, who had a dispute with finance over her deceased mother's care that had been ongoing for over 18 months. This experience was causing great distress to the resident. The LAC was able to arrange and facilitate a meeting with all parties, support the resident at the meeting to manage her anxieties and to speak up for herself, a LAC also advocated on her behalf. This illustrates the potential for LACs to broker dialogue and solution focused outcomes with people and sector agencies, it also examples LACs as cooperative and mediating in complex issues.

   Another example is the overwhelming response by council colleagues to a request made by a LAC for donations to a vulnerable resident who had just moved home and had no furniture or household items. Donations of toiletries, small electrical goods, clothes, kitchenware, cleaning products and money were given generously and even the donation to pay for the "man and van" to move. Council colleagues reported that they were keen to help a resident who they knew was local, was already being helped by the council, and to whom these donations would make a huge difference. In fact, requests have been received for more opportunities to make these kinds of donations to needy local people. One Public Health colleague said: "*I am incredibly proud to be part of the amazing work that the LACs are doing to help residents*".

4. *Challenging Stigma* - Often people from socially disadvantaged groups are described as '*hard to reach*' or '*seldom heard'*. These terms are often used inconsistently to describe any form of minority groups such as people identifying as homeless, disabled people and old people and people from ethnic groups. These are the groups that are often identified as being those most difficult to engage in the political process and from which to gauge opinions. However many commentators argue that using an umbrella term such as 'hard to reach / hear' to describe such groups implies a homogeneity within groups that does not exist (Brackertz 2008[20], Freimuth and Mettger 1990[21]). In so doing '*it defines the problem as one within the group itself, not within your approach to them'* (Smith 2006[22]). The result of such an approach in language and categorisation is that the terms 'hard to reach / hear' can become loaded and can result in potentially stigmatising or pejorative terminology (Murphy 2006[23]). Many of the people who are introduced to LAC are often described as 'complex' or 'heard to reach or engage' and service teams experience challenging situations due to mental ill health or long-term health conditions. However, most commonly, the LAC encounter people who want to have the opportunity to tell their story as they feel unheard and disregarded by a mostly digital and automated system of support, which can be a barrier for some groups, when English is not their first language. LAC can have a role in addressing issues of stigma by engaging with people in a flexible and relational manner that is focused on enabling the person to give a personal account of their situation and aspirations for change. This can be enhanced and enabled by:

[20] Brackertz, N (2007) – Who is Hard to Reach and Why – ISR Working paper - http://library.bsl.org.au/jspui/bitstream/1/875/1/Whois_htr.pdf (accessed April 2019)
[21] Freimuth, V.S; Mettger W, M (1990) – Is there a Hard to Reach audience? – Public Health Reports May – June vol 105 no 3
[22] Smith, G (2006) – Hard to reach groups don't exist, http://www.delib.co.uk/dblog/hard-to-reach-groups-don-t-exist (Accessed6/12/08)
[23] Murphy, P (2006) – Practical: Reaching the hard to reach -

5. *Working at grass roots* – By adhering to the core practice statements LAC situates itself in a neighbourhood and community environment and by using an asset based approach to community engagement and development can readily collaborate with local people to enhance local community assets and help in bridging relationships across informal resource groups. This is an integral component of LAC practice.

Conclusions

It is clear that Local Area Coordination is valued in Haringey. We were impressed at the general level of understanding and knowledge of the LAC programme within the local authority and with its partners - in particular in the NHS and the Voluntary and Community Sector. More so how key leaders were articulating the alignment of LAC as a contribution to the wider agenda for supporting people to connect and utilise local resources located and led by the community. It is clear that LAC in Haringey is becoming integral to the prevention agenda within the wider care system; this is not unusual and mirrors the situation in other localities.

System Level Fit

In terms of building on these established and growing connections and alignments it will be important that the LAC service is involved in the growing Social Prescribing provision that is being rolled out by NHS England as part of the Long Term Plan[24]. Achieving an early and clear understanding about the contributions of both initiatives to supporting local people will be advantageous in avoiding duplication and ensuring that LAC (for example) is able to support and be available to people in local communities more broadly given its open introduction ethos.

Capturing information on activity and impact

When we considered how LAC data is analysed and reviewed we found that development and implementation of the database is still a work in progress. This is not a problem that is specific to Haringey. nationally the emerging LAC services are using a range of different methods to collect activity and impact data. Haringey is currently using a mixture of:

a. A spreadsheet developed in York.
b. An outcome star – capturing the journey taken by individuals.
c. Capturing individual stories and community development activity.

We think it would be worth reviewing the current approach to data collection and most importantly how it is used. We suggest that as part of this it would be useful to consider the time taken by Local Area Coordinators to gather information, the information required at an operational level and the information needed at a strategic or system level. As part of this it will be important to consider how the LAC service is understood across the system as a whole not just in Adult Social Care.

[24] Universal Personalised Care. Implementing the Comprehensive Model, NHSE 2019

Operational Issues

During the course of our evaluation which was primarily in 2018 and the early part of 2019 the LAC team experienced three changes in line management. They have met weekly or twice monthly with their line managers for support and to feedback on emerging work/cases and projects. They were also in regular contact by phone or email to support with specific issues.

Throughout this period the Consultant in Public Health ensured that the LAC were integrated with emerging community based projects to support integrated care. For example, the Consultant in Public Health ensured that LACs were a key parts of the proactive preventative component of the Community First project which was designed to pilot a multidisciplinary approach to care and was based in Wood Green. In addition LAC were also part of the Connected Communities project which was designed to support migrants to navigate services and become embedded within Haringey. Subsequently programme leads for both of these community projects have secured funding to expand the number of LACS in Haringey and any future recruitment will be supported by the Consultant in Public Health and LAC manager.

Going forward it will be important to consider the best organisational fit for the LAC service. There needs to be a balance between continuing to develop an integrated approach with other services, ensuring that the LAC model's integrity is maintained and being located in a part of the local authority that is able to offer support that is stable and has strong links to social care and housing in particular.

We noted that there is a difference between the caseloads of LAC1 and LAC2. We suggest that it would be useful to explore the reasons for this. For example is this due to different working practices or is it to do with a variation in pressures and challenges in different parts of the borough?

Strategic Relationships

We have seen evidence from practice that LACs have forged a wide range of relationships in the community system; whilst there was some initial concern raised about the advent of LAC from a senior VCS leader this was in the context of wider challenges in the VCS sector regarding access to funding and financial sustainability for the sector more generally. There is perhaps value for commissioners to explore how LACs have been successful in their interface and joint working with the VCS sector and how all have progressed growth in neighbourhood based resources (community groups, activities etc.). This might be helpful in framing elements of local commissioning plans with the sector.

We note that in its early stages of implementation there was a LAC Steering Group through which key partners were engaged in the development plan for LAC across the localities. We understand this group no longer meets. During the timeframe of this evaluation we see there have been three management changes in LAC. Our work elsewhere and understanding of what organisational features can enable LAC to flourish suggests that stability in the overall management of the LAC resource is crucial and establishing and maintaining a 'leadership' group that helps steer and review implementation and early stage development is beneficial. Such a group not only holds the ring on LACs interface with similar system initiatives but also serves to bring together representatives from the wider system – VCS leads, Health, Social Care, Housing, Communities etc. and sets LAC within a wider determinants frame.

Recommendations

1. Sustain and Grow - the progress made by the pilot LAC service in Haringey should be acknowledged and used as a basis for further development of the scheme. Part of this approach should include making sure that the LAC service is developed alongside other initiatives such as the NHS England Universal Personalised Care Model.

2. Managerial Support – we note the appointment of a LAC manager, the location of the service in Public Health should be reviewed and consideration given to best fit with regard to ensuing integration, sustainability and integrity to the LAC model.

3. Data Base –current data collection should be reviewed and consideration given to what information is required and how often at a system, organisation, service and individual level. As part of this the workload of LACs need to be taken into account to ensure that they do not spend too much of their time 'feeding the beast'.

4. Advisory Group – the Advisory Group should be reviewed with a view to considering whether it should be reinstated or developed further to create a forum where stakeholders involved in bridging the gap between local services and civic society come together.

Appendix One - ***Information recorded in Local Area Coordination spreadsheet***

Level One Data	Level Two Data
Area	Area
Date	Date
LAC Reference	LAC Reference
Gender	Gender
Initial Method of Contact	D.O.B
Introduced by	Age
Action	Employment Status
Comments	Ethnicity
Presenting Issue	Introduced by
Active/Inactive	Main reason for introduction
Completed Date	Comments
Time Spent	Two reason for introduction
Date Reactivated	Comments
Time Spent	Third reason for introduction
	Comments
	Outcomes or first agreed action for a good life
	Summary of shared agreement/work agreed
	Connected with services paid by Haringey Council?
	If yes which service?
	Completed
	Date Completed
	Time Spent
	Well being scores completed
	Story completed
	Outcomes - theme 1 feel connected individual with those around me

Level One Data	Level Two Data
	Score at beginning (these scores are repeated for each theme)
	Score after three months
	Score after six months
	Score at end
	Outcome theme two I keep active
	Outcome theme three I have an awareness of the world around me
	Outcome theme four I have gained new skills or rediscovered old interests
	Outcome theme five I volunteer or take part in a community
	Outcome six I feel confident about life in general
	Outcome seven I feel in control of my own life
	Outcome eight I feel able to achieve my vision of a good life

Ethnicity
White - British
White - Irish
White - Gypsy or Irish Traveller
Any Other White Background
Mixed - White & Black Caribbean
Mixed - White & Black African
Mixed - White & Asian
Any Other Mixed/Multiple Ethnic Background
Asian - Asian British
Asian - Indian
Asian - Pakistani
Asian - Bangladeshi
Asian - Chinese
Any Other Asian Background
Black - African
Black - Caribbean
Black - British
Any Other Black Background
Other Ethnic Group

Community Lists
Youth
Family
Older
Residents
Mental Health
Disability
Substance Misuse
Advice
Faith
Employability
Creative
Learning
Hobby
Food
Social
Sports
Community
Other (Please Comment)

Action/Info given
Advice & Guidance
Arranging joint visit
Community Connection
Group Connection
Information
Information & Advice
Non-service solution
Self Advocacy
Signpost to services
Other (please specify)

Introduced By
Adult Learning
Adult Social Care
Be Independent
Carers Support
Children's Centre
Children's Social care
Church
CMHT or CAMHS
Community Centre
Community Nurse
Debt Management
Existing citizen
Explore Libraries
Family Member
Foodbank
GP
Handyperson
Home Care
Hospital Discharge Team
Housing Association
Housing Department
Inclusion Support
Internet/Facebook/Twitter
Job Centre Plus
Local Area Teams
Local Group
Neighbour
Occupational Therapist
Other (please specify)
Other Council Department
Other LAC or Community Facilitator
Parish Council
Police
Self
Third Sector
Volunteer

Presenting Issue
Anti Social Behaviour
Carer
Children (5-15)
Dementia
Domestic Violence
Early Years (under 5s)
Family
Health Condition
Learning and Sensory Disability
Learning disability
Long Term Health Condition
Mental Health
Older Person
Physical Disability
Sensory and Physical Disability
Sensory Disability
Substance Abuse
Young Person (16-25)
Other (please specify)

Appendix Two – *The Swansea Finance Model*

			Swansea value of improvement			**Haringey value of improvement**		
Generic Case	Swansea Case Mix	Swansea - proportion generic case of total caseload	Swansea value of improvement - base - optimistic	Swansea value of improvement Pessimistic - base	Haringey case numbers (2018 data) if case mix similar to Swansea	Haringey value of improvement base to optimistic	Haringey value of improvement pessimistic to base	
Individual w family caring responsibilities	15	0.056	99,810	206,250	6	39,625	81,882	
Younger/middle aged individual with health and financial challenges	38	0.142	71,858	38,608	15	28,528	15,328	
Single parent with former spouse and wider issues	16	0.060	76,432	979,808	6	30,344	388,987	
Isolated single parent with financial challenges	67	0.251	243,277	795,089	27	96,582	315,653	
Younger/middle aged individual with social issues	19	0.071	59,432	122,303	8	23,595	48,555	
Older isolated individual with health challenges	112	0.419	2,075,360	4,014,080	44	823,926	1,593,605	
Total	267	1.000	2,626,169	6,156,138	106	1,042,599	2,444,010	0
					106			
Caveats and Assumptions	Assumes that: The Swansea work is correct - we do not have the detail of their calculations; that the case mix is roughly the same as Haringey; the table above shows financial benefit IF ALL interventions were successful; these savings are total potential savings at the end of two years; this calculator does not allow for the 'bounce' in service uptake that we saw with some people in Haringey and our earlier work in Waltham Forest.							
	Haringey Financial Benefit based on different level of outcome success							
	LAC ongoing - Impact Value		Total potential value over two years	20% Outcomes achieved	30% Outcomes achieved			
	Improvement: Base to Optimistic		1,042,599	208,520	312,780	521,299	104,260	156,390
	Improvement: Pessimistic to Base		2,444,010	488,802	733,203	1,222,005	244,401	366,601

Appendix Three – Multi-Disciplinary Team Case Conference Workshop

One of the aims of the review of the LAC programme in Haringey was to present an informed view of the potential contribution to savings/efficiencies that LAC support offers.

The format used here was run a workshop - loosely basing it around how a multi-disciplinary team meeting might be structured. It was intended to utilise senior professional expertise in Haringey to stress test the LAC intervention using real case studies to ask the question - what would have happened if LAC support had not been offered?

While hypothetical it was be meaningful because the "what if?" question was asked by experienced senior professionals in Haringey who are trusted to make decisions about health and social care support for vulnerable individuals on a daily basis.

The workshop aimed to provide an insight into the impact that LAC is making on reduce pressure on statutory health and care services.

Participants

Senior professionals who make decisions about vulnerability and statutory responsibility, understand assessment and care pathways and are accountable for the impact these decisions have on budgets. Workshop attendees were invited to attend by the Director of Adult Services and advice was taken by Haringey Adult Social Care and Public Health on who should attend.

The Leeds Beckett Team suggested that the following could be invited:

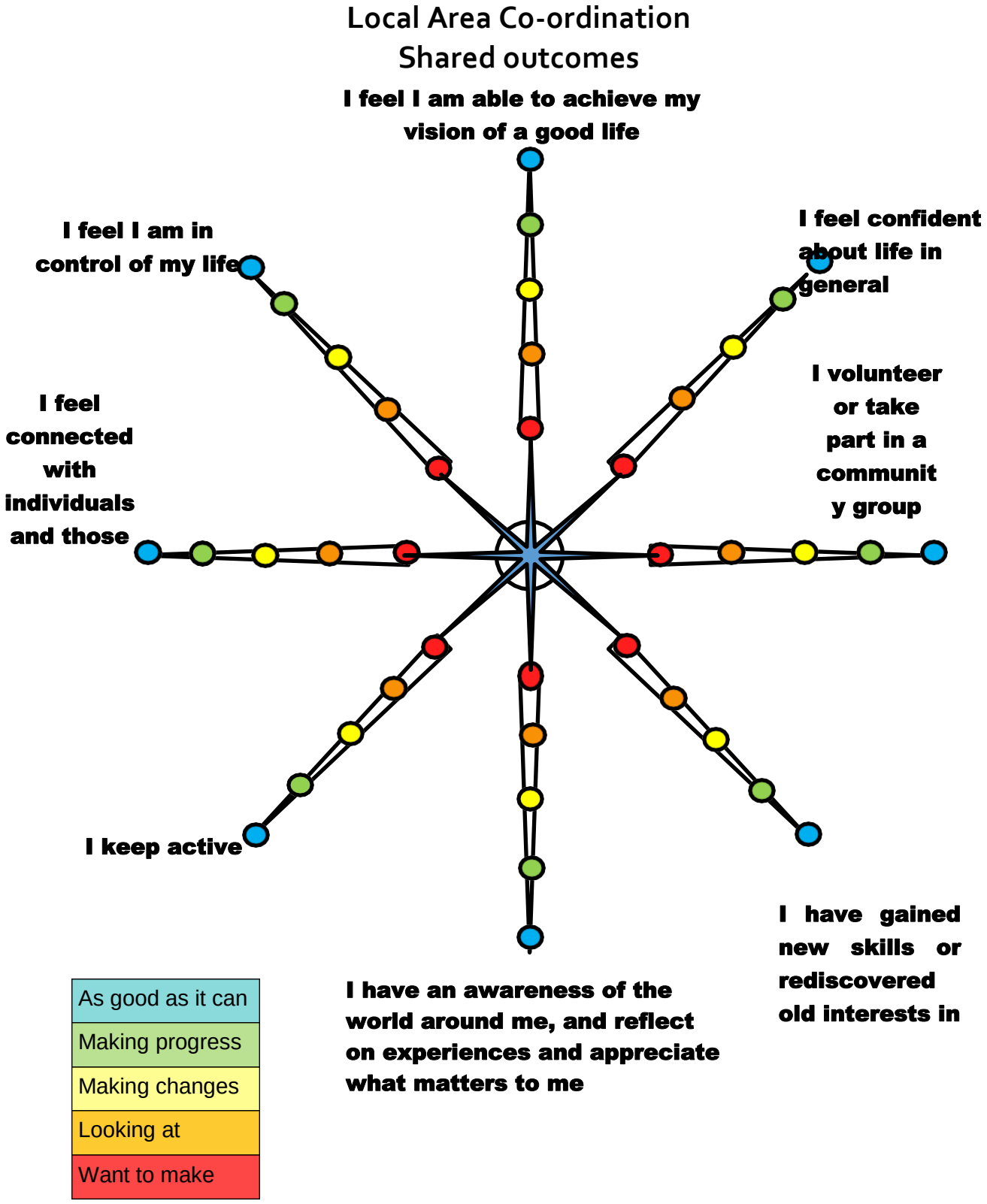
- Adult Social Work
- Mental Health Social work and CPN
- Children and Families Social Work
- Older People Social Work
- Community or Primary Care Nursing
- Housing Management
- Local Authority Finance Manager

How the workshop was managed

The workshop ran for half a day. Participants working in small groups were asked consider two case studies each and then to lead a brief "case conference" discussion to consider what might be the current needs of the person in the case study and how these needs might impact on service utilisation, demand and cost over time if a LAC had not been involved.

These discussions were captured by the Leeds Beckett Team.

Appendix Four – *The Outcome Star*



Notes on using the Outcomes Star:

The Outcomes Star is introduced to the resident seeking support from a LAC in the initial conversation stages where personal planning is being discussed. The resident is asked to consider each of the elements of the Star and to self rate as follows:

1 - I want to make changes
2 - I am looking at options
3 - I am making changes
4 - I am making progress
5 - Things are as good as they can be

It should be noted that a rating of five doesn't necessarily mean that everything is perfect; it just means that the resident isn't looking to make changes in this category at this time.

At the end of the LAC intervention, another self assessment is made by the resident.

The Star can be used at other stages during the support phase to frame a discussion on personal progress or to re frame personal planning etc. if the LAC intervention relationship is over a long period of time; the database allows for four readings in total – at the beginning, after three months, after six months, and at the end.

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Report for: Cabinet 9th July 2019

Title: Osborne Grove Nursing Home Feasibility Study

Report authorised by : Charlotte Pomery, Assistant Director Commissioning
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Lead Officer: Emily Snelling, Commissioning Manager
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Ward(s) affected: All

Report for Key/ Non Key Decision: Key Decision

1. Describe the issue under consideration

1.1 Osborne Grove Nursing Home (the Home) is a 32 bed nursing home, owned and managed by the Council, which is currently under embargo and assessed as Requires Improvement by the Care Quality Commisision, the health and care regulator. Following a Cabinet decision in June 2018, a detailed Feasibility Study has been carried out with the engagement of stakeholders and partners. This paper presents a preferred option for the future development of Osborne Grove Nursing Home and outlines next steps to delivering improvements to the fabric of the building.

2. Cabinet Member Introduction

2.1 This report presents the outcome of a detailed and comprehensive feasibility study into the future development of Osborne Grove Nursing Home, carried out with the engagement of stakeholders and partners. At a time when there is increased demand for local nursing care provision, and limited supply, it is with great pleasure that I recommend this report to Cabinet which which confirms the preferred option for the future development of the Home to expand its capacity to 70 beds, to meet local need.

2.2 The active engagement of stakeholders in this process – and their anticipated future contributions – have strengthened the feasibility work and the current preferred option and I would like to take the opportunity to thank local residents and partners for their support for this work to date.

3. Recommendations

3.1 Cabinet is asked to:

3.1.1 Note the outcome of the Feasibility Study carried out with regard to the future development of Osborne Grove Nursing Home;

3.1.2 Agree to endorse Option 4 as the preferred option of the Feasibility Study: that is, to demolish the current building and rebuild a 70 bed nursing provision including the clinic site, ensuring that the use of the site overall is maximised;

3.1.3 Note that Option 4 allows for a number of uses, identified as examples in s. 6.2.8, aligned to the delivery of nursing care for older people to be accommodated on the site for which further design work is needed and delegate the oversight of this work to the Assistant Director of Commissioning in consultation with the Lead Member for Adults and Health;

3.1.4 Note that none of the future development Options including the preferred Option 4 can be safely commenced with the current residents in situ;

3.1.5 Note that a further report will be presented to Cabinet in September 2019 on proposals for consultation to close the Home (for the purpose of the development and other reasons) and relocate existing residents to suitable alternative accommodation that will meet their needs and promote their wellbeing;

3.1.6 Continue to support the active engagement of a range of stakeholders including the OGNH Co-Design Steering Group, partners, nursing care providers and officers;

3.1.7 Note the ongoing work by officers with partners in the NHS, with the care sector and with neighbouring local authorities to develop a sustainable partnership approach to future delivery of care at Osborne Grove.

4. Reasons for decision

4.1 The detailed Feasibility Study, concluded on 31st May 2019, demonstrates that this land offers significant opportunity for development, increasing provision to a 70-bedded nursing unit. The feasibility study provides the council four potential development options for the future of the site at Osborne Grove.

4.2 Further reviews of activity and demand for nursing care in Haringey and across North Central London have restated the continued need for increased nursing bed capacity in the area. The site, owned by the Council, offers considerable potential for expansion of nursing care capacity which would help to meet the increased demand for nursing care in the borough.

4.3 The proposed approach aims to develop a high quality provision to improve outcomes for residents through a model of nursing care which is responsive to need. The existing site is demonstrably not fit for purpose with a number of design issues making the provision of high quality care particularly challenging

for an increasingly frail resident population. The approach to quality will be developed to better address future demand, whilst also mitigating the quality of care issues that led to the previous decision to close the home under current management by the local authority.

4.4 The feasibility study, as requested in the brief, includes a plan demonstrating how the current residents (now two in number) could be rehoused on site during the construction by phasing the redevelopment. However, the design team have identified that it would not be advisable for the residents to remain on site during the development given the levels of disturbance, including noise and dust, that demolition and subsequent construction would inevitably have, particularly on vulnerable residents who have significant health needs.

5 Alternative options considered

5.1 The option to close the Home and not to revisit an options appraisal for future use of the site was identified but discarded early on as the Home is an asset of great value to local residents and to the Council.

5.2 A detailed feasibility study was considered to be the most effective way to explore all viable options for the site. The alternative options are explored in detail in the Feasibility Study and in this report, which now seeks Cabinet approval to implement the preferred design option.

5.3 The option to retain a 32 bed dual registration residential/nursing home on the site was considered but rejected, primarily because it would not increase the registered nursing capacity within the borough and because it would not address a number of fundamental design issues with the current building which prevent it functioning effectively as a nursing home and which could not be fully addressed due to structural limitations of the building.

6 Background information

6.1 Local context

6.1.1 On 12th December 2017, Cabinet made a decision to close the Home, following an extended period of consultation with residents, users, carers and other stakeholders. This was in the context of the seriousness of care quality issues raised through internal and external audits and inspections including those carried out by the Care Quality Commission, staff from the Brokerage and Quality Assurance Service of the Council and the Safeguarding and Quality Assurance function of the Clinical Commissioning Group (the CCG). An embargo, which can be placed on any care provider where there are concerns about the quality of care and it is not considered safe to place new residents, has been in existence since August 2016. This embargo on any new placements means that numbers of residents in the Home have been falling and at the time of the December Cabinet paper there were only 17 residents in the Home. Since that time, and bearing in mind the frailty and age of the current residents, there are now only 2 residents living in the Home (down from 32 at full occupancy). In order for the Council to maintain its focus on quality of care, there are no plans to increase the number of residents or for the current embargo to be lifted.

6.1.2 The closure of the Home was made on the basis of serious care quality concerns, but the options appraisal on the future development of the Home was resumed in December 2017 and presented to Cabinet in June 2018. A set of recommendations were agreed which led to the carrying out of a Feasbility Study into the future development of the Home and also provided for the Home to remain open for existing residents who chose to remain. Two potential development options for the Osborne Grove site were identified:

> 1) Maintaining a reduced-capacity service at Osborne Grove to allow the current residents to remain and building a new 70-bed Nursing Home on site following demolition of the existing building; and
>
> 2) Maintaining a reduced-capacity service at Osborne Grove to allow the current residents to remain and building an expanded 64-bed Nursing Home on site with the existing residents in situ.

And the decision was made to procure a design partner to undertake a detailed feasibility study into these potential options for future residential and nursing care provision on the site of Osborne Grove. It was agreed that the feasibility work would include the construction works to be undertaken, whether this can be undertaken with residents in situ, the risk to and likely impact on residents and whether and how residents can be safeguarded.

6.1.3 The future of Osborne Grove is of critical importance to the Local Authority and a number of contextual factors shaped the feasibility study, the process of determining the preferred option and the implementation of the agreed way forward. The contextual factors shaping the feasibility study were identified as set out below in the June 2018 Cabinet paper, informed the brief for the Feasibility Study and have continued to influence the preferred option being placed before Cabinet today and include quality; local provision; community facing; co-design; sustainability; delivery model; affordability.

6.1.4 In addition, the current premises were noted to have a number of shortcomings which have been confirmed through the Feasibility Study, although the scheme was a new build only completed in 2008. The building was originally designed as a residential care home, but has been used as a nursing home as the acuity of needs of residents has increased. The design of the building is unsuitable to cater for the needs of an increasingly frail resident population. Below is a list of some, though by no means all, of these issues:

- The building only has one lift located some distance away from a large proportion of residents' bedrooms. The lift is not wide enough for a hospital bed which creates significant problems from a mobility perspective and to ensure bed bound residents have an opportunity to move with some ease around the building or in an emergency.
- Department for Health: Care Homes for older people national minimum standards/care home regulation 3rd edition's guidance for the provision of all new build nursing homes that Bedrooms should exceed 12sq metres of usable floor space excluding ensuite facilities. The bedrooms in the current building inclusive of ensuites are 15.5m2 which means the rooms fall short of current standards for new build

older peoples care homes. In practical terms, this means that care staff cannot access the beds from both sides, but only from one side.

- There is a lack of en-suite wet rooms in the building which impedes the ability of residents to wash within their own rooms (as opposed to washing in assisted bathrooms) or independently should they be able to.
- The width of the doors in a number of bedrooms is not sufficient for a hospital bed or for residents with mobility issues.
- The layout of the building creates numerous 'blind-spots' which necessitate a more intensive staffing structure than that generally associated with schemes of the current size. Each wing comprises 8-beds and there is a separate nursing station for each wing within the unit. This compares with most purpose-built nursing homes where there is a nursing station for every 12-15 beds.
- There are a number of additional fire safety concerns with the property which the Council has been addressing with the London Fire Brigade relating to the building's ability to withstand heat for an adequate length of time in the event of a fire.
- The building is not built to withstand progressive collapse. Current building guidance states that only residents who are able to mobilise would be able to reside in these rooms therefore this limits which residents the council could place in these beds.
- Structural walls limiting design team ability to adjust room composition.

6.1.5 Finally, a recent review of activity and demand in Haringey has confirmed the need for increased nursing bed capacity in the area. There are currently 191 over 65-year-old Haringey service users in receipt of nursing care and this figure is projected to grow to around 250 by 2022/23. On the supply side, there are only 2 nursing homes (including Osborne Grove) in Haringey. It has not, therefore, been possible for local demand for nursing care to be met in borough for some time and Haringey purchases over 72% of its nursing care out of borough. Traditionally, Haringey's demand for nursing care would have been met by nursing homes in North Central London but increasingly, Haringey is having to look beyond the sub-region to meet this demand with 20% of nursing beds purchased out of North Central London at present. The reason that Haringey now purchases beds across a wider geographical area is that – despite the widely reported and increasing demand – the capacity in the market-place for nursing and residential care is shrinking. For example, there were 56 nursing homes across North Central London (Barnet, Camden, Enfield, Haringey and Islington) in 2015 and now there are 48. A number of other providers are restricting access only to self-funders or reducing the proportion of local authority placements they are willing to accept. This means that the absolute capacity of nursing care beds available for Haringey to commission is decreasing. This is a national picture reflecting the fragility of this sector of the social care market, the uncertainty over future funding mechanisms and the challenge of delivering nursing care to frail, older people with complex needs.

6.1.6 With Haringey's over 65 population expected to grow by 59% by 2035 and numbers of residents aged over 90 expected to increase by 73%, it is projected that there will be a 60% increase in residents requiring residential and nursing

care therefore. Therefore, it is imperative to increase available provision for Haringey residents allowing service users to remain close to their support networks.

6.2 Feasibility Study

6.2.1 Following the Cabinet decision in June 2018 to explore 3 potential design options for the future development of Osborne Grove, stakeholders were involved in co-designing the feasibility brief to ensure that it met all the design and other requirements identified. The feasibility brief was then used as the core of a a competitive procurement process to select a design team with a track record in this area, following which the Frederick Gibberd Partnership were appointed to lead the feasibility study. A Quantity Surveyor, Currie and Brown, was also appointed to ensure the costs and financial modelling input was as robust as possible.

6.2.2 The design team engaged with stakeholders and made several visits to the site as well as meeting with technical experts and appointing a range of consultants to input into the study itself. One of the first visits by the design team to the Home and its wider site, led to the identification of the potential to include adjoining land (also in the Council's ownership) located to the front of the property, where currently a clinic is sited. It is on this basis, therefore, that the feasibility options being presented to Cabinet are:

Option 1: Extension of the current building to 70 nursing home beds (not including the clinic site).

Option 2: Extension of the current building to 70 nursing home beds (including the clinic site).

Option 3: Demolition of current building and build 70 bedroom nursing home (not including the clinic site).

Option 4: Demolition of current building and build 70 bedroom nursing home (including the clinic site).

6.2.3 In order to guide and shape the appraisal of the feasibility options, the Council has used a set of design principles, developed with stakeholders through a co-design process and approved at Cabinet in June 2018

- The design of the home is geared towards meeting the current and future needs of Haringey residents
- A financially viable and sustainable future for the continuation of nursing care provision on the site
- Recognition of the benefits of outstanding design to flexible care delivery now and into the future
- Aspiration for outstanding provision
- 'An open home', which is outward facing and supports engagement with the wider community, and health & care partners
- Partner and community engagement in supporting OGNH to operate to the full benefit of residents and other older people

- Focus on working in ways which build relationships and start from people's strengths
- Increased access to the most enabling help even for those with high and complex needs

6.2.4 The brief for the design team was in summary to develop a high quality provision to improve outcomes for residents through a model of nursing care which is responsive to current and future local need.The proposed provision was described as follows:

A) Nursing Beds, Learning Disabilities/Autism:10 Beds
B) Complex Care Nursing Needs:10 Beds
C) Nursing Beds 1, Dementia and/or Challenging Behaviour: 25 Beds
D) Nursing Beds 2, Physical Frailty:15 Beds
E) Inpatient Nursing Rehabilitation Beds:10 Beds

In addition, the brief was to support provision for bed-based intermediate care and therapies with space for non-resident community uses including day opportunities and hire by local residents.

6.2.4 In responding to the brief, the design team undertook a wide range of studies and assessments, including an Ecology Study, Environmental Assessment and Fire Safety assessment. The design team attended the Co-Design Steering Group in February to gain initial feedback and an extended stakeholder event was held at Osborne Grove on 27th March, with all stakeholders involved in the work at the Home, followed up by a meeting with clinical and quality leads from the council and the clinical commissioning group and local care home staff members to collect further insights from professionals in relation to the new design. The responses from these intensive meetings were collated into a specification for the design team detailing what stakeholders would like to retain, what stakeholders would like to change, and what stakeholders would aspire to in the new Osborne Grove. This specification was shared with the design team in a handover meeting on 11th April which was the deadline for consultation during this phase of the project. Feedback included:

- Make home more prominent in the community -relocate clinic?
- Cloister/Quadrangle design reflecting original street layout
- Bigger rooms with ensuitewet rooms
- Space for healthcare professionals/therapy areas
- Increase visibility of staff within households
- Improve sight lines/monitor remote areas with CCTV
- Separate Dining and Lounge Areas
- No Corridors
- Flexible/Adaptable Community Space
- Clinical standard rooms for storage/preparation of medication
- Better storage for supplies and equipment
- Laundry facilities to ensure residents clothes are kept separate
- Parking for minibus in lieu of cars

6.2.5 A further meeting with stakeholders was held on 15th May again at the Home, in which the design team set out how they had responded to the initial brief and

set out the high level options for consideration. In summary, these points are set out below:

6.2.5.1 Pair households together with similar need for flexibility of staffing and response: ‘Swing zones’ allow a proportion of bedrooms to be allocated to either household at any given time

6.2.5.2 Distribute households vertically based on ability to access garden areas include terraces where possible

6.2.5.3 Optimise size of bedrooms to meet or exceed current standards:

- All ensuites to be wet rooms
- Make room doors wider
- Opportunities for personalisation
- Integrate hoist tracks
- Alter proportions of windows
- Wifi, comms, entertainment
- Some storage outside of rooms

6.2.5.4 Lounges arranged to serve cluster subgroups within larger households for max 10 residents:

- Separate dining rooms for whole households.
- Lounges open to corridors (subject to fire regulations). Glazing to corridors
- Dining in dedicated rooms, sited to allow distribution from main kitchen, and control food smells.

6.2.5.5 Reminiscence rooms as multipurpose activity spaces or quiet zones

6.2.5.6 Staff bases within each household and centralised workspace for therapist teams:

- Open format desks for staff
- Related where possible to treatment rooms
- Precautions to ensure patient confidentiality
- Active and passive surveillance measures
- Flexible open plan office space with confidential interview space on each floor

6.2.5.7 Corridors

- Wide enough to move easily
- Remove pinch points in existing corridors
- Opportunities to sit
- Natural lighting, sun pipes, roof windows
- Ability to ‘wander’ safely

6.2.5.8 Bathrooms and Showers

- All residents have private showers
- Accessible bathrooms/showers 1 per household or 1 per 15 residents max in largest unit
- Staff showers and changing

- Separate kitchen staff changing

6.2.5.9 Reprovide/optimise day opportunities

- Access to be controlled by main reception
- Use sliding walls to create flexible spaceto support a range of activities
- Optimise use for handovers, training sessions and other uses
- Separate residents cafe with garden acces

6.2.5.10 Gardens

- Secure access to a central greenspace
- The garden as ‘an outdoor room’
- Combination of hard/soft landscape to support range of activities
- Green perimeter, low maintenance ‘living walls’ to boundaries
- Permeable paving to service areas

6.2.5.11 Infection control: separate rooms in rehabilitation area, barrier laundry design

6.2.5.12 Fire Strategy

- stairs relocated to perimeter
- planned for horizontal evacuation
- sprinklers
- divided into max 10 bedded compartments

6.2.5.13 Security: Consultation carried out with ‘Secure By Design’

6.2.5.14 Use of car park

- Subject to planning, reduced number of parking spaces to increase garden space or other uses on the site
- Improved access for emergency vehicles
- Adequate turning space for delivery of supplies

6.2.5.15 BREEAM: Building Research Establishment Environmental Assessment Method

- A well-insulated envelope
- a combined heat and power plant
- energy efficient appliances and controls
- underfloor heating underfloor heating to optimise space usage for residents by eliminating radiator space

For Options 1 and 2: Refurbishment rated BREEAM Very Good, with potential for Excellent
For Options 3 and 4: New Build rated BREEAM Very Good, with potential for Excellent

6.2.6 The design team was also asked to consider how the existing residents (2) could be accommodated on site during the works. Two options from a design perspective were put forward, which are subject to appraisal below.

6.2.7 The outcome of the study was that each of the four options set out at 6.2.2 is feasible to deliver on the site, given the brief, the physical constraints of the site and the input from a wide range of stakeholders. Appraisal of the Study, therefore, considers all four options, presenting a preferred option for consideration based on testing the options against a set of criteria.

6.2.8 On receipt of the Feasibility Study, and prior to the Appraisal detailed at 6.3, the design team and colleagues from across the Council considered the intensity of use on the site and agreed that there are opportunities to increase usage on the site, focused on the needs of older people, particularly in relation to Option 4. By making use of the whole site, and intensifying usage, the prospect of delivering additional services on the site – for the benefit of older residents and the wider community – is generated. Early ideas include the provision of a small intensive rehabilitation scheme, a co-housing offer or a specialist extra care sheltered housing scheme. Whilst these would add costs to the scheme overall, they would also ensure local residents have access to a wider set of provisions which are complementary to the offer at the Home. Care staff at the Home could also deliver into these additional provisions should that be appropriate to increase the value for money of such options. Additional provision in this vein would support the overall impact of the offer for older people at Osborne Grove and enable older people to move into the Home from such an additional setting.

6.3 Appraisal of feasibility study

6.3.1 The appraisal of each feasibility option looked at the following:

- The capital cost implications of each option
- The revenue cost implications of each option – comparing the costs of provision being public-sector run and run by an external partner
- The impact on existing residents
- The impact on nursing care capacity
- The benefits of each option and integrity to the brief
- The intensity of use on the site

6.3.2 At this stage, based on the above criteria and as detailed in the appraisal below, the preferred option for further design and subject to approval by Cabinet, is option 4: Demolish current provision and new build 70 bed nursing home including the site of the current clinic, for the following reasons:

6.3.2.1 It is the most viable in terms of securing the most value out of the site and allowing for the development of a well-designed nursing home which is designed to meet the future needs of Haringey residents and allows for a more manageable cost of care.

6.3.2.2 Residents will benefit from the space standards in each bedroom and from the communal and community offers in place.

6.3.2.3 The financial modelling demonstrates that over a 45 year period there is a return on investment which both allows for repayment of the capital loan required to undertake the works and for revenue savings to be made. The increased efficiency of the building and the site overall affects life cycle costs as well as enabling for more efficient use of health and care staff on ths site.

6.3.2.4 This option allows consideration be given to intensifying usage on the site to ensure quality of design and care to Haringey residents and best value in terms of potential savings to the local authority.

6.3.2.5 The current scheme is based on achieving a BREEAM rating of Very Good, however a rating of Excellent can potentially be achieved. Going for a rating of Excellent will have a financial impact on the scheme which is projected to increase by circa 5% of the construction costs. Options for increasing the rating to Outstanding have been explored but not deemed feasible due to constraints within the site.

6.3.2.6 Whilst this is the most expensive scheme in terms of capital and construction costs, it delivers the optimal scheme from a number of perspectives including:

6.3.2.6.1 Overall design and ability to blend with the current frontage onto the streetscape

6.3.2.6.2 Community facing aspect of a nursing home provision

6.3.2.6.3 Improved access to outdoor space for all users of the Home

6.3.2.6.4 Multiplicity of aligned uses on the site to the benefit of older residents and the wider community

6.3.2.6.5 Future proofing to ensure the long-term sustainability of the Home over the next 50 – 70 years

6.3.3 As noted above, the feasibility study has considered the viability of the current residents (2) in the home remaining during the construction of the design and there are two potential options for accommodating current residents onsite during the construction phase. However, in appraising these options, officers and the design team consider it inadvisable for current residents to remain on site from a safeguarding perspective, due to the impact that construction works would have on the health and wellbeing of this vulnerable patient group. Highlighted impacts include but are not limited to:

- Noise
- Health and Safety
- Construction Dust impacting on air quality.
- Relocating residents twice

The preferred option therefore is for alternative nursing provision to be sought for the 2 existing residents, within Haringey or neighbouring boroughs. In light of the previous Cabinet decision, and as reflected in the recommendation at 3.1.5, any proposals to close the Home, whether they be for the purpose of the development or other reasons, would be subject to formal consultation. Cabinet decisions would be needed both to launch and to make a decision based on the outcome of such a consultation in order to determine the future of the Home.

6.3.4 The following tables set out the appraisal of each of the four options, demonstrating their overall compliance with the brief and highlighting benefits and risks.

6.3.4.1 **Option 1:** Extension of the current building to 70 nursing home beds (not including clinic site).

Design Summary	This option involves the remodelling and refurbishment of the existing building within the limits of the original site. The existing wings are linked by a new extension to form a quadrangle enclosing a garden courtyard and a third storey is added on all aspects of the building. The east and west stairs are relocated and arranged to discharge directly to the perimeter in the event of an emergency. A small wheelchair lift is included adjacent to the east stair to enable access from the upper floors to the garden.
Size	4,219m²
Capacity	70 Nursing Beds
Risks	Satisfies brief but there would be no innovation. However, the existing building has a number of outstanding design issues which affect its functioning as a nursing home which could not be fully addressed by an extension. Whilst the design would attempt to mimimise these issues (visibility, width of corridors and doors etc.) cannot be addressed owing to the structural limitations of the building. With this design there would be some limitation on use of rooms as the structure of the current building is not built to withstand progressive collapse in the event of a fire therefore it would not be possible to accommodate bedbound residents in bedrooms located in the existing structure . Only residents who able to mobilise would be able to reside in these rooms. If the residents health subsequently deteriorates and they are no longer able to mobilise they would be required to move, to either an alternative room within the new build part of the home or alternatively if this wasn't available to another nursing home provision. The size of the bedrooms located in the existing structure cannot be adjusted and therefore 26 rooms would remain at 15.5m2 which is smaller than current new build guidance. This could potentially cause equity issues in terms of the sizes of rooms provided as rooms in the new parts of the building will be larger as they are required to meet statutory requirements of new build care home provision set out by Department of Health

	standards. Similarly the size of the proposed wet rooms in the older parts of the building can be provided as per specification however, the size of these rooms would be limited due to the current structure of the building this could potentially have impact on the quality of care and dignity of resident whilst showering due to the limited space available to staff to assist with self care tasks. Construction of a second floor and its impact on the Perth Road properties due to proximity with the south west boudary, not withstanding that the new roof would be below the ridge line of the existing buildin g maybe a planning concern.
Benefits	Flexibility of building to ensure future proofing and meet demand by introducing flexible walls that can increase/decrease the size of households to respond to needs of residents or demand Improved communual spaces such as separate living and dining rooms within each household. Small Cafe space that could improve homes links to the community and offer space for relatives and friends to visit with residents. current residents could remain in situ during redevelopment. A new trolley/bed lift is included outboard of the existing structure and the existing lift retained. Integrated Hoists between bed and bathroom in bedrooms within 60 bedrooms where structurally possible to provide. Improved infection control through provision of handwash stations, staff facilities, flooring and wall coverings that support cleaning regime.
Timetable	August 2022
Recommendation	Not Recommended on the basis that this design cannot meet existing quality standards and would deliver 26 rooms at a smaller size than is optimal.

6.3.4.2 **Option 2:** Extension of the current building to 70 nursing home beds (including clinic site).

Design Summary	This option takes in the clinic site and existing wings are linked by a new extension to form a quadrangle enclosing a garden courtyard and avoids the need for building an additional storey over the whole site as seen in Option One. It allows the formation of a three storey block on Upper Tollington Park with the clinic on the ground floor, and the creation of more generous pedestrian entrance outside the existing Day Centre.
Size	4,440m²
Capacity	70 Nursing Beds
Risks	With this design there would be some limitation on use of rooms as the structure of the current building is not built to withstand progressive collapse in the event of a fire therefore it would not be possible to accommodate bedbound residents in bedrooms located in the existing structure . Only residents who able to mobilise would be able to reside in these rooms. If the residents health subsequently deteriorates and they are no longer able to mobilise they would be required to move, to either an alternative room within the new build part of the home or alternatively if this wasn't available to another nursing home provision. However, the existing building has a number of outstanding design issues which affect its functioning as a nursing home which could not be fully addressed by an extension. Whilst the design would attempt to mimimise these issues (visibility, width of corridors and doors etc.) cannot be addressed owing to the structural limitations of the building. The size of the bedrooms located in the existing structure cannot be adjusted and therefore 17 rooms would remain at 15.5m2 which is smaller than current new build guidance. This could potentially cause equity issues in terms of the sizes of rooms provided as rooms in the new parts of the building will be larger as they are required to meet statutory requirements of new build care home provision set out by Department of Health standards. Similarly the size of the proposed wet rooms in the older parts of the building can be provided as per specification however, the size of these rooms would be limited due to the current structure of the building this could potentially have impact on the quality of care and dignity of resident whilst showering due to the limited space available for staff to assist with self care tasks.

Benefits	Flexibility of building to ensure future proofing and meet demand by introducing flexible walls that can increase/decrease the size of households to respond to needs of residents or demand There would be an improvement to street frontage of property improving the homes link to the community. Improved communual spaces such as separate living and dining rooms within each household Small Cafe space that could improve homes links to the community and offer space for relatives and friends to visit with residents. A new trolley/bed lift is included outboard of the existing structure and the existing lift retained Integrated Hoists between bed and bathroom in bedrooms within 60 bedrooms where it is structurally possible to provide. Improved infection control through provision of handwash stations, staff facilities, flooring and wall coverings that support cleaning regime.
Timetable	September 2022
Recommendation	Not Recommended on the basis that this design cannot meet existing quality standards and would deliver 26 rooms at a smaller size than is optimal.

6.3.4.3 **Option 3:** Demolition of current building and build 70 bedroom nursing home (not including clinic site).

Design Summary	This envisages the demolition of the existing nursing home and the reprovision of the service in its entirety. This would follow the quadrangle plan but with a larger garden courtyard, and accommodation confined to two storeys apart from the wing located behind the clinic which would extend to three storeys.
Size	4,084m²
Capacity	70 Nursing Beds
Risks	The clinic building will remain at the front of the property which will continue to reduce community integration of the home.

	The garden space is limited to a relatively small courtyard in comparison to Option 4. This option requires the current building to be demolished despite the fact that the current building was only built 11 years ago.
Benefits	Relocation of Plant and services to car park side offers improved vehicular access for deliveries and increases the numbers of residents able to outlook over the garden space. Improved size of bedrooms and wet rooms in line with current standards for older peoples care homes new builds. Improvement in size of Day opportunities space which would now be community facing. Intermediate Care area on top floor with flexible therapy space and access to roof terrace for short term placements (up to 6 weeks). Flexibility of building to ensure future proofing and meet demand by introducing flexible walls that can increase/decrease the size of households to respond to needs of residents or demand Cafe space that could improve homes links to the community and offer space for relatives and friends to visit with residents overlooking garden space. Entire building meets standards from progressive structural collapse therefore all rooms would be able to accommodate bedbound patients. Improved communual spaces such as separate living and dining rooms within each household Improved infection control through provision of handwash stations, staff facilities, flooring and wall coverings that support cleaning regime. 2 trolley/bed lift are included within new build design. Improved width of doors and corridors which includes turning spaces from rooms for wheelchairs and beds. corridors allow residents to wander safetly and have opportunities to sit along corridors allowing mobile residents to rest. Provision of integrated hoists between bed and

	ensuites in all rooms.
Timetable	February 2023
Recommendation	Not recommended on the basis that this design does not make best use of the site and deliver the integrated option possible.

6.3.4.4 **Option 4:** Demolition of current building and build 70 bedroom nursing home (including clinic site).

Design Summary	This would take in the clinic site and be a new development which maximised the potential for the central garden courtyard. It would be generally two stories in height but with the frontage to Upper Tollington Park increased to correspond to the streetscape of the terraces fronting the original Osborne Grove. This option allows for the development of an additional older people's offer, as set out in paragraph 6.3.8 by using the land currently occupied by the NHS Clinic to the front of the site. This generates a wider mix of uses on the site, whilst offering flexibility in the care offer. There is further design work required to finalise the form of this option.
Size	4,759m²
Capacity	70 Nursing Beds
Risks	This option requires the current building to be demolished despite the fact that the current building was only built 11 years ago. This option would require the largest capital investment.
Benefits	A re-build would address all the structural issues with the building and facilitate a reduction in the unit cost of care. Re-building the site also represents a strong opportunity to re-design the site to support good, community-facing care with a community building with prominent frontage. Improve size of garden, communal and garden spaces and 2 storey building on back end of property would improve light into garden space. Relocation of Plant and services to car park side offers

	improved vehicular access for deliveries and increases the numbers of residents able to outlook over the garden space. Improved size of bedrooms and wet rooms in line with current standards for older peoples care homes new builds. Improvement in size of Day opportunities space which would now be community facing. Intermediate Care area on top floor with flexible therapy space and access to roof terrace for short term placements (up to 6 weeks). Flexibility of building to ensure future proofing and meet demand by introducing flexible walls that can increase/decrease the size of households to respond to needs of residents or demand Cafe space that could improve homes links to the community and offer space for relatives and friends to visit with residents overlooking garden space. Entire building meets standards from progressive structural collapse therefore all rooms would be able to accommodate bedbound patients. . Improved communual spaces such as separate living and dining rooms within each household. 2 trolley/bed lift are included within new build design. Improved width of doors and corridors which includes turning spaces from rooms for wheelchairs and beds. corridors allow residents to wander safetly and have opportunities to sit along corridors allowing mobile residents to rest. Provision of integrated hoists between bed and ensuites in all rooms. Improved infection control through provision of handwash stations, staff facilities, flooring and wall coverings that support cleaning regime.
Timetable	March 2023
Recommendation	Recommended option ensuring that the use of the site is maximised.

6.3.5 All the financial assumptions above will require further work and detailed modelling as part of the proposed feasibility studies.

6.3.6 The table below shows a summary of total estimated capital expenditure over five years for each option:

	2019/20	2020/21	2021/22	2022/23	Total
Option1	1,259,454	1,091,686	15,812,134	5,850,326	24,013,600
Option 2	1,278,883	1,108,611	17,109,556	4,909,195	24,406,245
Option 3	1,422,341	1,233,581	14,525,655	10,123,867	27,305,443
Option 4	1,597,057	1,385,781	15,112,190	12,741,323	30,836,351

6.3.7 Sprinkler system

The Options have been designed in accordance with the applicable parts of Regulations 2018 for an unsprinklered facility. The least mobile residents would be accommodated on the ground floor to obviate evacuation by mattress, evachair or lift, in the event of an emergency. Should the sprinklers be required the Extra over Constructions Costs for each option are as follows

Option	Area (m2)	All up construction costs
1	4,219	£310,000
2	4,440	£325,000
3	4,084	£300,000
4	4,759	£385,000

6.4 Health and Care Delivery model

6.4.1 In line with the decision made by Cabinet in June 2018, the revenue costs for the delivery of health and care on site have been drawn up for delivery by a public sector partnership led by the NHS. This is in recognition of the fact that the care delivered at Osborne Grove in the future will continue to be at its core nursing care, for older people with very complex health needs, rather than residential care. This requires clinical staff on site at all times, to oversee and monitor medication, to ensure appropriate health care, to provide treatment and to intervene appropriately to avoid hospital admissions and to improve the health of residents and older people in the wider community. In order to build the revenue model summarised in the table below, staffing and other costs have been calculated in line with the NHS Agenda for Change pay scales. The Council will continue to take forward discussions with NHS Partners on the delivery of care at the site, which may extend to the wider uses identified in 6.2.8 above.

7 Contribution to strategic outcomes

7.1 The Borough Plan 2019-2023, sets out the vision and priorities for the Council and partners in Haringey over the next four years.

7.1.1 The development of Osborne Grove Nursing Home contributes to Priority 2: People, Our vision is a Haringey where strong families, strong networks and strong communities nurture all residents to live well and achieve their potential.

7.1.2 Osborne Grove Nursing Home development links directly with Outcome 7: All adults are able to live healthy and fulfilling lives, with dignity, staying active, safe and connected in their communities.

a. Objective 7b: People will be supported to live independently at home for longer.

Increased intermediate care provision will enable more people to regain the skills and confidence they require to live independently in the community and will deliver the following outcomes for residents:

- More people are supported to avoid going into hospital unnecessarily
- More people are supported to remain as independent as possible after a stay in hospital
- More people are prevented from moving into residential care unnecessarily

b. Objective 7d: Adults with multiple and complex needs will be supported to achieve improved outcomes through a coordinated partnership approach.

7.2 This work is also aligned to the Better Care Fund plan, a joint plan between the Council and the Clinical Commissioning Group, the aim of which is for people in Haringey to be healthier and have a higher quality of life for longer. It aims to give people more control over the health and social care they receive, for it to be centred on their needs, support their independence and be provided locally wherever possible.

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

8.1 Finance

8.1.1 The report is informing Members of the outcome of the feasibility study undertaken at the Osborne Grove Nursing Home and is recommending that option 4 of the feasibility study is progressed. Each of the options were assessed against a range of criteria and option 4 is the one that scored the highest.

8.1.2 Capital Implications

8.1.2.1 The OGHN scheme was included within the approved capital programme as a self-financing scheme with a budet estimate of £10.750m and was subject to the completion of a satisfactory business case. At this stage, high level capital costs have been estimated and will be firmed up as the option is developed.

As set out below, any of the four options generate savings so the business case for investment in a new OGNH is made even at the higher capital expenditure

level. Once the detailed design has been tendered the business case will be refreshed and, subject to the outcome of the refreshed business case, a revised capital budget will be included in the capital programme. The total capital costs for each option are set out below.

OGNH Capital Costs

	Option 1	Option 2	Option 3	Option 4
Construction Costs	17,128	17,412	19,513	22,072
Furniture & ICT	2,589	2,632	2,947	3,330
Fees and Contingency	4,296	4,362	4,845	5,434
Total	**24,013**	**24,406**	**27,305**	**30,836**

8.1.3 Revenue Implications

8.1.3.1A detailed revenue income and expenditure account has been modelled for the four development options at Osbourne Grove Nursing Home

8.1.3.2In calculating the net revenue cost of each of the options (which include the cost of the capital financing charge) and comparing it to the available budget, the available budget has been calculated by adding together the recurrent net budget of the OGNH and the current cost of the care placements for current clients. In each case the development of the OGNH generates savings against the current budgetary provision. The operating model of the OGNH will be refined and further reported upon.

8.1.3.3From 2022 the Council will only place clients in settings that are LLW employers. Accordingly, the costings set out below assume the LLW will be paid. Also, as the model is one using NHS staff, staffing and other related costs have been calculated in line with the NHS Agenda for Change pay scales.

8.1.3.4The financing cost has been calculated using an asset life of forty five years. It ranges from £0.945m for option one to £1.215m for option four and are included within the gross cost line in the table below.

	Option 1	**Option 2**	**Option 3**	**Option 4**
Financial summary by option	**Redevelopment**			
	£'000s	£'000s	£'000s	£'000s
Gross cost	5,268	5,283	5,217	5,356
Gross income	(2,309)	(2,317)	(2,294)	(2,370)
Net cost	2,959	2,966	2,922	2,986
Cost of placements externally	2,510	2,510	2,510	2,510
OGNH budget	1,175	1,175	1,175	1,175
Saving (Cost of placements less net OGNH cost plus current OGNH budget)	(726)	(718)	(762)	(699)

8.2.3.4 The revenue budget to operate the new Osborne Grove Nursing Home will refreshed at the time that tenders for the construction of the facility are returned. The savings identified in the table above, along with the adjustment required to account for the capital financing charges, will be factored into the MTFS.

8.2 Strategic Procurement

8.2.1 Strategic Procurement (SP) acknowledges the contents of this Report.

8.2.2 SP has no objection to the approval of the recommendations highlighted in section 3 of this report.

8.3 Legal (Assistant Head of Legal, Stephen Lawrence-Orumwense)

8.3.1 Cabinet is being asked to make a decision on the preferred option for the future development at the Osborne Grove Nursing Home site The options are on the premise that: a) the design of the current building is unsuitable for residents; b) there is an increased need and demand for nursing care beds; c) there were concerns about the quality of provision at the home and consequently the safety and wellbeing of residents; and d) there is a pressing need to grow capacity and develop a high quality provision locally. The options including those recommended are within the legal powers of the Council in the discharge of its social services functions under the Care Act 2014.

8.3.2 Section 1 of the Care Act 2014 *(Promoting individual well-being)* requires the Council when exercising its care and support functions in respect of an individual, to promote the individual's wellbeing. "Well-being", in relation to an individual, means that individual's (a) personal dignity (including treatment of the individual with respect); (b) physical and mental health and emotional wellbeing; (c) protection from abuse and neglect; (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided); (e) participation in work, education, training or recreation; (f) social and economic well-being; (g) domestic, family and personal relationships; (h) suitability of living accommodation; and (i) the individual's contribution to society. The Department of Health has issued statutory guidance under the Care Act 2014 named Care and Support Statutory Guidance (The Guidance) which the Council must have regard to in exercising its function under the Act. The guidance at Paragraph 1.13 provides that "*Although the wellbeing principle applies specifically when the local authority performs an activity or task, or makes a decision, in relation to a person, the principle should also be considered by the local authority when it undertakes broader, strategic functions, such as planning, which are not in relation to one individual. As such, wellbeing should be seen as the common theme around which care and support is built at local and national level."*

8.3.3 Section 5 of the Act *(Promoting diversity and quality in provision of services)* requires the Council to promote an efficient and effective market in services for meeting care and support needs with a view to ensuring service users (a) has a variety of providers and services to choose from; (b) has a variety of high quality services to choose from; and (c) has sufficient information to make an informed decision about how to meet the needs in question. In performing this duty, the Council must have regards to, amongst others, the need to ensure it is aware of

current and likely future demand for such services and how it could be met; and the importance of ensuring the sustainability of the market. This is often referred to as the duty to facilitate and shape the market for care and support. The Guidance provides that *"4.2. The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support."*

8.3.4 The Council must ensure that there is sufficiency of provision *"in terms of both capacity and capability – to meet anticipated needs for all people in their area needing care and support – regardless of how they are funded"* (Paragraph 4.43 of the Guidance*).*

8.3.5 When an adult is found to have care and support needs following a needs assessment under section 9 of the Act (or in the case of a carer, support needs following a carer's assessment under section 10), the Council must determine whether those needs are at a level sufficient to meet the "eligibility criteria" under section 13 of the Act. Sections 18 and 20 of the Act set out the duty of Council to meet those adult's needs for care and support and those carer's needs for support which meet the eligibility criteria. For residents at the Home or likely to be affected by the recommended option, the Council must continue to meet their eligible needs and promote their wellbeing.

8.3.6 Section 8 of the Act *(How to meet needs)* enables the Council to meet an adults needs for care and support by, amongst others, the provision of accommodation in a care home. The recommended option would facilitate the discharge of this duty.

8.3.6 Section 42 of the Act *(Enquiry by local authority)* places a duty on the Council to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in its area is at risk of neglect or abuse, including financial abuse. The purpose of the enquiry is to establish with the individual and/or their representatives, what, if any, action is required in relation to the situation; and to establish who should take such action. This safeguarding duty apply to an adult who: a) has needs for care and support; b) is experiencing, or at risk of, abuse or neglect; and c) as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect. This duty apply to residents at the Home and where there is a risk of harm from the future development works. The Council also owe a common law duty of care to residents if in situ during future development works not to cause them harm or injury.

8.3.7 The report acknowledge that the future development works cannot be undertaken with current residents in situ. This may require closure of the Home and that residents are moved into alternative nursing accommodation. There is a legal duty to consult the residents and stakeholders on any proposals to close the Home and relocate residents before a decision is made by Cabinet.

8.3.8 As part of its decision making process on the options, the Council must have "due regard" to its equalities duties. Under Section 149 Equality Act 2010, the Council in exercise of its adult care and support functions, must have "due regard" to the need to eliminate unlawful discrimination, advance equality of opportunity between persons who share a protected characteristic and those who do not, foster good relations between persons who share a relevant protected characteristic and persons who do not share it in order to tackle prejudice and promote understanding. The protected characteristics are age, gender reassignment, disability, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Council is required to give serious, substantive and advance consideration of the what (if any) the options would have on the protected group and what mitigating factors can be put in place. This exercise must be carried out with rigour and an open mind and should not be a mere form of box ticking. These are mandatory consideration. In line with its equalities duties, the Council have undertaken an Equality Impact Assessments (EQIA) of the options on the protected groups and are set out in Appendix B and at section 8.4 of the report.

8.4 Equality

8.4.1 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between people who share those protected characteristics and people who do not;
- Foster good relations between people who share those characteristics and people who do not.

8.4.2 The three parts of the duty apply to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

8.4.3 An Equality Impact Assessment has been completed for the future development of Osborne Grove Nursing Home, and is included as Appendix A to this report, and uploaded on to the Haringey Council website.

8.4.4 The recommended option is to to demolish the current building on the Osborne Grove Nursing Home site and rebuild a 70 bed nursing provision. The objective is to increase in-borough capacity to support older residents in need of nursing care, noting that there is currently a shortage of nursing care in the borough. This represents a course of action to meet the needs of older residents, and particularly those with long-term health conditions and/or disabilities, where these are different to the needs of other groups, thereby advancing equality of opportunity. The EqIA notes that women and BAME residents are over-represented among the current service user profile, and so these groups can be reasonably expected to benefit from expansion of in-borough nursing care capacity. It is not expected that proceeding with the recommended option will

have any negative impacts on individuals or groups who share the nine protected characteristics.

9. Use of Appendices

9.1 Equality Impact Assessment

10. Local Government (Access to Information) Act 1985

10.1 Feasibility Study produced 31st May 2019

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