Report for: Adults and Health Scrutiny Panel, 4 September 2018

Title: Community Wellbeing Framework update

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Ward(s) affected: ALL

Report for Key/ Non Key Decision: Non key decision

1. Describe the issue under consideration

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

1.2 Our learning indicated that in Haringey a bottom-up approach, which focuses on local community assets by building on the existing local resources and expertise, is more likely to succeed in improving health as well as being cost-effective and sustainable. Furthermore, it has been recognised that the initiation and implementation of community asset-based programmes require a whole-system approach to enable effective service integration.

1.3 Community Well-Being Framework is our strategic approach to enhance the integration of community, health and social care services in Haringey. The aim of this approach is to use the existing community assets to prevent people from getting into crisis (by building their resilience using their immediate support network), and increase health and wellbeing in order to reduce demand on services. It also has a focus on reducing inequalities by targeting the hard to reach-to- reach communities. Community Wellbeing Framework has the following main components: Local Area Co-ordination role in the community, asset mapping and strength-based training for all frontline staff.

2. Recommendations

2.1 That the Adults and Health Scrutiny Panel notes progress on Community Wellbeing Framework and, in particular, Local Area Co-ordination project.

3. Reasons for decision

3.1 The Panel asked for a progress update for in September 2018.

4. Alternative options considered

N/A

5. Background information

5.1 Local Area Co-ordination (LAC)

LAC is nationally established model of community approach to improving health and wellbeing of local residents (http://lacnetwork.org/). This model was adopted in Haringey across health and social care in 2017 and funded by the Better Care Fund for two years.

This is a long term, integrated, evidence based approach to supporting people (of all ages) with disabilities, mental health needs, older people and their families/carers to:

• Build and pursue their personal vision for a **good life**
• Stay strong, safe and connected as contributing citizens
• Find practical, non-service solutions to problems wherever possible
• Build more welcoming, inclusive and supportive communities

Therefore, it is about:
• Preventing or reducing demand for costly services wherever possible
• Building community capacity and resilience
• Supporting service reform and integration, having high quality services as a valued back up to local solutions

This model reflects the direction of the Care Act (2014), NHS 5 Year FV, Personal Health Budgets and Personalisation and will support local areas/services to meet the requirements of the new legislation.

The pathway has been co-designed locally to address the key objectives of primary, community and social care, to reduce social isolation, be person centred and to promote asset based approach to health and wellbeing (e.g. focusing on positive aspects of ones' life). Recent independent Social Return on Investment (SROI) evaluations in both Derby City (2016) and Thurrock (2015) Councils have shown £4 return for every £1 invested.

5.1.1 Key successes for Local Area Co-ordination project over the past 6 months

Partnership group: A partnership group has been set up with agreed Terms of Reference (ToR) which drive the implementation of local area co-ordination.

This group consists of Public Health, Adult Social Care, Voluntary Sector, Healthwatch and Haringey CCG.

Stakeholders' engagement: Two Local Area Co-ordinators have been recruited in the two geographical pilot sites Northumberland/White Hart Lane and Hornsey (Appendix 1). They Local Area co-ordinators have been successful in establishing a number touch points in the community (e.g. Community Centres, local Libraries, Selby Centre, local supermarkets, foodbanks) and making several connections with a range of community groups.

The service has been working in partnership with a number of statuary, volunteer sector, community groups, health and social care services. Some are listed below:

- Adult social care and receiving introductions/referrals from social care workers
- Adult Safeguarding Board (ASB)
- Homes for Haringey
- Locality Team (NHS)
- Local faith leaders (Rabbi, Hornsey Jewish community groups), Local churches and mosques
- Local community group (e.g. Hornsey Vale community Centre, 163 community hub, The Antwerp Arms)
- Local GP practices in the pilot sites
- Employability services
- Sheltered housing, community hubs and the services addressing homelessness
- Children services
- Mental Health services
- Support and advocacy services
- Community/carers commissioning services
- HAIL and CAB in Haringey
- Women's group, community safety
- Haringey regeneration team and community support workers.

Service integration

The feedback from the service has been very positive. Due to its cross-cutting nature, Local Area Co-ordination has been able to create a great opportunity for joined-up working with the NHS, Council and community services. Through this partnership and multi-agency working, our aim is to use the early learning from this project to develop a place-based community model, which is able to:

- Support people (especially those who have fallen through the gaps or are at the point of crisis) find practical solutions
- Increase the utilisation of the Council digital offer
- Help providers improve their service delivery by identifying barriers and streamlining the access for residents
- Reduce the inequality gap by targeting heard to reach communities and vulnerable groups (people with disability, older people and migrants).

Impact on individuals and addressing the wider determinates of health: Over 220 introductions (including self-referrals) have been made since the project initiation in Nov 2017. Some of the case studies are included in Appendix 2.

Over 60% of the clients introduced to Local Area Co-ordinators have presented with non-health related issues such as housing and employment. Other presenting issues have been due to being older/ vulnerable, mental health issues (including dementia), disability, homelessness, young/family problems and physical health conditions.

The key building blocks for success of this project so far have been:

1) Establishing trusting relationships between the Council, Local communities and residents
2) Encouraging conversation-based approaches across the workforce
3) Inter and intra multi-agency working

Capacity building and community connection: Local Area Co-ordinators have been able to encourage some of the people they have met to volunteer for various community centres. This has really contributed and improved the trusting relationships between the co-ordinators and the community groups. The co-ordinators have also been able to connect small community groups together to encourage joint working (Appendix 3).

Evaluation and monitoring- The evaluation plan has been developed to measure outcomes by mapping them against the Five Ways to Wellbeing themes. For cost saving analysis, patients /individual's stories will be used to map their journey and to calculate cost-benefit of service costs prevented due to local area co-ordination intervention. Leeds Beckett University has been commissioned to undertake an independent evaluation of the project.

5.2 Asset Mapping

The Bridge Renewal Trust developed a comprehensive on-line directory of community services and other assets in Haringey. This project now has been completed and available on line (http://bridges.force.com/directory/). This directory and the Haricare website are used by Local Area co-ordinators to provide information, advice and guidance to residents. The co-ordinators also contribute to keeping the Bridge Renewal Trust's Directory up to date.

5.3 Training for staff and interventions on the ground

Scoping work is undergoing to establish training needs for frontline social care staff on strength-based approach to assessment and more generally, how to use strength-based communications in interactions with residents.

6. Contribution to strategic outcomes

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

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

Finance and Procurement

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

Legal

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

Equality

7.3 The project will have a prevention-based approach to proactively identify high risk and hard-to-reach communities, in particular older people, those with disabilities and people with long-term health conditions. Initial roll out of the project is based in areas with high deprivation, health inequality and poor life expectancy.
The person-centred approach of the framework will allow inequalities and isolation issues related to protected characteristics to be addressed.

8. Use of Appendices

Appendix 1- Haringey Local Area Co-ordination
Appendix 2- Taking time to listen: Haringey Local Area Co-ordination Case studies

9. Local Government (Access to Information) Act 1985

N/A

Appendix 1

Local Area Coordination
in Haringey

Based in the local community, your local area coordinator works alongside individuals and families (of all ages) with disabilities, mental health needs, older people and carers, to help create a vision for the future and build a good life.

Your local area coordinator will:

- take time to get to know people and build trusting relationships;
- help access relevant information, advice and support at the right time;
- enable people and their families to build and fulfil their vision of a good life;
- help to identify and develop strengths, skills, talents and abilities;
- assist in building, developing and using personal and local networks;
- help people stay strong and be heard so they stay in control of services and resources;
- empower people to become more connected, resilient and more actively involved in a welcoming, inclusive and supportive community.

www.haringey.gov.uk

Haringey Local Area Coordination

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Your Local Area Coordinator's support is free; there are no assessments, referral process, and no time limits – just meet up for a cuppa and a chat.

local area coordination network

Haringey LONDON

Haringey LONDON

Appendix 2 Taking Time to Listen: Haringey Local Area Co-ordination

Case study 1- Main themes: carer, disability, family

TC is the mother of two children, a daughter who is 16 and a son aged 18 who has profound and multiple learning disabilities (PMLD). TC is in her early 50s and is married.
TC has a fraught relationship with the special education needs team at Haringey Council and wanted support to communicate with them. She also has huge doubts about her own capabilities, lacks confidence, has very few friends, and suffers from anxiety and depression. She doesn't like technology and finds emailing difficult. She hardly goes out, doesn't feel able to make friends with people, and feels like she's a terrible mother.

LAC intervention:

- Visiting TC in her home, giving her plenty of time to explore her feelings around parenting, isolation and friendships/relationships
- Helping TC to draft a report to the council describing the impact of her son's disability and needs upon her family life
- Helping TC to reply to emails and showing her how to use her laptop
- Encouraging TC to attend Coffee & Computers sessions
- Encouraging TC to attend carers coffee morning
- Giving TC information about parenting courses

Outcomes:

- TC has better (less traumatic, more efficient) communication with the council
- TC has attended a couple of Coffee & Computer sessions and her confidence and skills are improving slowly
- TC regularly attends the carers coffee morning and has made some friends, including one in particular – another mother of a disabled child – and the two are forming a warm relationship
- TC has started to attend the "Open Doors" parent/teenager project

Comments:

- *For the first time since I was a child I have made a friend. I can't tell you how important this is for me and has given me such a boost. I can't thank Andrea enough for helping me to believe in myself. I still falter and wobble at things that happen and I think I can't cope but I am in such a better place now than I was before I had Andrea in my life.*

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Case study 2- **Main themes: social isolation, carer, mental health**
VM is retired and in her late 70s. She is married and is the main carer for her disabled husband who has early signs of memory loss. They are council home tenants and have lived in their current flat since it was built, in the 1970s. VM has been very worried about her elderly neighbour for whom she has become the unofficial carer. VM feels overwhelmed because, although she wants to help, she feels that it's too much responsibility for her. When she has time, VM is a keen amateur photographer and artist.

VM's vision of a good life: "to cope better".

LAC intervention:

- Taking time to really listen and find out what VM wanted for herself, rather than just what she wanted for those she cares for
- Robust intervention and support for the neighbour, relieving VM of her caring role
- Supporting VM to form a WhatsApp group of supporters for the neighbour so that visits to the neighbour are shared
- Encouraging VM to attend the local memory café with the neighbour, and to take her husband with too
- Connecting VM with carers' support group and artists' collective

Outcomes:

- VM feels under less pressure to be the neighbour's carer
- VM feels confident in her ability to help in ways that make her feel empowered, not resentful or overwhelmed
- VM's husband is better connected with early support around dementia issues
- VM's better connected with a group of local people
- VM receives support for her caring issues
- VM is now connected with a local artists' collective, and she is starting to get involved in different art projects there as she feels she has more time

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Case study 3- Main themes: carer, mental health, dementia, employment

MK is a qualified social worker but hasn't worked for many years owing to her anxiety and depression, which can at times be very acute. She lives with her husband and elderly mother who has dementia, for whom MK is a carer.
MK's vision of a good life: "to go back to work and help people".

LAC intervention:

- Building up a rapport with MK over time, to build confidence and trust
- Connecting MK to local community centre who needed volunteer outreach worker
- Making referral to employment service supporting residents with mental health issues

Outcomes:

- MK volunteers at community centre, using her knowledge and background as a social worker to develop a voluntary role which is both interesting and rewarding but not overwhelming for her
- MK is able to develop her experience which will assist her employability
- MK is better connected with her local community which builds her confidence, her social life and her self-worth
- The community centre benefits from a new volunteer and from being able to continue to offer outreach support

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Case study 4- Main themes: older person, family, not digitally literate

AM is in her 80s and lives in a supported living scheme run by Homes for Haringey. She is a widow (her husband died many years ago) and has four grown-up children and several grandchildren whom she sees quite often. A few years ago, one of her sons died from cancer and she was left to deal with all the funeral arrangements; she found this very upsetting. In order to prevent her children from having to be upset at handling arrangements for her funeral, Jeannie wants to make these arrangements now, herself, and have everything dealt with and paid for so that when she passes away, her children won't be burdened. However, her children don't want to talk about it and whenever she tries to bring up the subject with them, they change the subject and say it's too upsetting to think about.
LAC met with AM at a residents' event and asked for help. AM isn't digitally literate and wouldn't be able to access any online information.

LAC intervention:

- Listening and taking time to find out what had happened when her son had died
- Finding out what is important for her now
- Using laptop and search engine to research options for AM to consider
- Allowing AM to have a frank discussion about her death, how this might happen and how her daughters will cope
- Supporting AM to make a decision about what she wanted
- Offering to go with AM to the funeral directors she had selected
- Receiving a call subsequently from AM asking for support to facilitate conversation with daughters
- Attending a meeting at AM's home with her family and supporting AM to share her ideas and plans

Outcomes:

- AM feels content now she has made her plans, she knows what will happen to her and feels like she has taken this control back
- AM feels like she no longer has to worry about how her daughters will cope
- Better communication between AM and her daughters
- "*You have lifted a weight from my shoulders, I cannot thank you enough, I'm just not worrying about this any more. I can face whatever the future holds without thinking about this".*

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Case study 5- Main themes: disability, social isolation, community connections

CP is in her late 50s and is a resident of a sheltered housing scheme. She is a life-long wheelchair user with cerebral palsy that impairs her gross and fine motor skills, and she is visually impaired. She is not learning disabled. She used to work part-time but was made redundant and now volunteers for the RNIB. CP's living conditions are very poor; her home is extremely dirty and messy, she is unable to do most self-care tasks and her disability, together with other long-term health conditions, makes life

very difficult. She has two different types of psoriasis, a stoma bag, a permanent UTI, and is doubly incontinent. She receives only 30 minutes a day of carer support.

When asked what her vision of a good life is, CP answered that she wants help to access her allotment (the gate has been changed and she can no longer open it), and help to manage her paperwork. CP is very distrusting of council services and people. She was adamant that she is not prepared to undergo any assessments (financial or otherwise) and is determined to get on with the little help she gets. She would like a paid part-time job.

LAC intervention:

- Establishing what's really important for CP; it's easy to be overwhelmed by the physical needs but the most important thing for CP is to be fully in control of her own life
- Arranging for a local resident who wants to do some voluntary work to help CP access her allotment
- This same volunteer to help with paperwork
- Maintaining an ongoing relationship with CP to engender trust that nothing will be done "to" her
- Maintaining a level of care with regard to CP's propensity to self-neglect
- Completing referral to locality team (who already knew of CP)
- Making referral to IPS Employment service

Outcomes:

- CP gaining confidence in LAC support
- Shared knowledge with locality team and housing support officer
- Able to access low-level support from volunteer in order to be able to get into allotment
- Volunteer is also helping with paperwork, but this is slower (CP is still not trusting)
- Volunteer has extended CP's social group by introducing her to friends and other people willing to help CP at allotment

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Case study 6- Main themes: social isolation, community connections, older person

PM heard about LAC from her pharmacist, who pointed out the LAC poster when she'd gone in for a prescription. PM feels very lonely and isolated and a recent robbery made her realise that all her neighbours and friends have either died or moved away. She's in her early 80s, is fit and active, likes walking and chatting with people, and also does some occasional informal child-minding, picking up a couple of neighbours' children from Rokesly school and accompanying them home. PM's vision of a good life: to know more people, have more friends, and be better connected, also to use a computer.

LAC intervention:

- Listening and taking time to find out what had happened when she had her recent robbery, and allowing her the space to express this
- Finding out what is important for her now, including sharing that she felt so lonely
- Using laptop and search engine to research options for PM to consider including Jacksons Lane and U3A
- Connecting PM with "Contact the Elderly" and arranging for her to go to a tea party that weekend
- Giving PM information about local social groups including Coffee & Computers
- Inviting PM to Broadway Brunch at Bedale House and attending with her, introducing her to residents there
- Linking PM with manager at The Priory (sheltered scheme) which is 5 minutes' walk away, where there are older residents who want to form a regular walking group

Outcomes:

- Within 48 hours of meeting with the LAC, PM was being collected by car and taken to an older people's tea party
- The "Contact the Elderly" coordinator is staying in touch with PM to help her reconnect with other tea party guests who live close by
- The manager at The Priory is helping residents and PM to form their walking group
- PM still doesn't have the confidence to learn how to use a computer but LAC is hopeful that once PM has made some new friends who might also want to learn how to use a computer, learning sessions could be arranged either via "Coffee & Computers" or through "Generation Exchange" – an intergenerational computer learning scheme
- PM is much happier, feels more energised and less lonely
- *"I cannot believe the difference seeing Andrea has made in my life. I have a long way to go but it feels like I have a new lease of life now."*

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Case study 7- Main themes: Vulnerable group, single mother

Background
TA is a young Polish single mum of a seven-and-a-half-year-old boy. TA was depressed and felt that her situation was hopeless after she moved to Tottenham, following relocation from Enfield due to domestic abuse. After a long while TA found support through a community organisation, where she was provided with the opportunity to build up her skills in people management. TA became a part time Volunteers Coordinator started a master's degree at college.
Unfortunately a year later TA's post became redundant following the end of her contract and she was unsure about what to do next? As the role had provided her with a focus. TA had met with a LAC at a local event and decided to visit one of the local drop ins advertised (The Women with a Voice Group)
TA spoke about her life and current situation and said that her son had not been offered a school place and she was finding it difficult to keep her son entertained and she was struggling with managing her physical back pain and maintaining a positive mental outlook

LAC intervention

- Listens and took time to find out about the main issues
- LAC supported TA to look at her options
- Signposts TA to the local women's group which she did not know existed, although she lived in the next street from where the group takes place
- LAC introduces TA to the community safety offer and founder of the women's group who was able to support a number of concerns that TA had, including support around schooling issues
- LAC signposts TA to the Home start service in Haringey
- Supported conversations with the women's group volunteers around TA becoming involved with the work
- LAC spoke to the Housing officers involved in the case and asked if they could review TA's case

Outcomes

- Joined the women's group as a volunteer and became part of the administration team
- Son was offered a place in the school of her choice
- TA starts Pilates and swimming classes due to feeling more positive and having some time for herself , due to her son starting school
- TA is offered a one bedroom flat in a nice area
- TA is Linked in to a network of women who live in close proximity to her
- Feeling positive for the first time
- Reduced isolation

TA says that it has been like a chain reaction of events after meeting the LAC and feels that she can now peruse her hopes and dreams for the future

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Case study 8- Main themes: Managing a new diagnosis of a physical condition

Background

YT was recently referred by her GP to the LAC after she came into the surgery distressed and in need of support. In January 2018 YT was diagnosed with Mophia Syndrome and explained that it is a rare and debilitating condition which affects the body. YT explained that no one knows about the condition and she is finding it difficult to get the appropriate level of support.

Intervention

- LAC provides time to listen and information advice and guidance to YT .YT lives in the borough of Enfield but her GP Practice is located in Haringey
- LAC signposted YT to an advice service based within her Borough, to enable her to follow up her appeal
- The LAC researches Mophia Syndrome and found a national information helpline
- The LAC provides details of the helpline and specialist support groups running in London for people suffering with Mophia Syndrome and associated conditions
- The LAC supports YT to follow up with information and supported positive communication through the use of different types of social media such as, WhatsApp

Outcome

- YT was able to contact a service which had experience on what she was going through
- Reduced more ill health and depression by limiting isolation
- Enabled YT to speak up about her experiences
- Signposted YT to specialist support groups
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Case Study 9- Main theme: Homelessness

Background

MA is a young man in his 20's. MA approached the LAC whist they walked through a local park. MA said that he was homeless and having some difficulties getting the right information needed to enable him to acquire housing. MA had been travelling on night buses to stay warm and said that it was hard for him to get support because he did not look homeless. MA says he is alone in England, with no one to support him and he was worried about the cold weather. MA has ambitions to become a chef one day and states, this is his "Vision of Good Life". MA and LAC arranged meetings to look at his situation.

LAC Intervention:

- LAC supports MA to learn how to use advice forums and online and telephone enquiry systems to contact the right people and services
- Support to contact Shelter and homeless link
- Support to contact charitable community services providing support to homeless people
- Regular meetings in a community café to plan actions
- support to enable MA to connect with family networks abroad

- Support to make e telephone calls to follow up enquiries
- Support to look at all housing options, including the private renting market
- Support to link in to community groups offering food and a warm place to sit and mingle with others

Outcomes:

- MA is offered support from a local charity
- Family and friends from abroad send some money to help with MA's situation
- MA acquires private rented accommodation via an internet home rental site
- MA moves out of borough to a location that he says is peaceful
- MA is now living in accommodation that is comfortable and affordable
- MA now feels able to connected to volunteering opportunities in his local community
- A chef from a local charity offers to mentor MA
- A community engagement coordinator from a local charity connects MA to a community catering service
- Mohammed states that he has increased confidence around how to support himself in the future

MA says said, having someone to listen to him and take time to see him as a person, saved his life and he now feels that anything is possible.

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Case study 10- Main themes: Vulnerable group and housing

Background
GA is in his late 80's and lives alone in his flat. GA is a council tenant and he has lived in his flat for many years and does not have any family to support him. GA recently experienced a number of falls and his friends from the local "Older People's Group " were worried about his health and his living conditions and contacted the Local Area Coordinator to see if they could help. The LAC meets with GA to find out more about him and to understand what is important to him and what his vision of a "Good Life" looked like. GA said that he would like to live in a sheltered accommodation housing service based within Haringey. Following a conversation around the good life, the LAC identifies a risk around trips and falls and living conditions. The LAC makes a referral to social services with GA.
Recently, GA calls the LAC after his social worker arranges a move to new temporary accommodation, due to the risk associated with his living conditions. GA is distressed and incoherent about his situation and the LAC supports GA to make a list of priorities.
LAC Intervention:

- LAC follows up safeguarding concern and follows up by making an online referral and telephone contact to the First Response Team.
- The LAC follows up with the social worker find out more information regarding the move, support, and work with GA to establish his wishes and priorities
- LAC supports the social worker by assisting GA in facilitating the move and arranging transport
- LAC supports positive communication between GA, his social worker and the new residential home to ensure they are aware of his needs and that everyone is kept up to date with any developments

- LAC communicates to GA's network about what has happened and provides contact details for his temporary home to enable to friends to stay in contact and support GA during his time away from home
- LAC communicates with the social worker to get an approximate timeline around how long GA will be away and what to happen before GA can return to Haringey

Outcomes

- Social worker allocated following SG alert
- GA feels able to talk to the LAC about the issues in his life
- LAC is able to support GA to speak up regarding his concerns and wishes
- LAC is able to facilitate a positive move to temporary accommodation
- Social worker follows up application to sheltered accommodation of choice
- GA is supported by his network of friends through phone calls
- GA feels confident that he will not be left in a respite service out of borough
- GA feels relaxed and is enjoying his time
- Other members of the Older Peoples Group feel able to speak to LAC about issues
- LAC has an introduction with an older person as a result of the support provided to GA

GA says the council used to keep sending young girls round to his house to ask him questions about his personal care, which he found embarrassing. GA says that the LAC listened to him and spoke to him about the things that he wanted to talk about, which helped him to feel more relaxed and able to open up.

Appendix 3

Community Capacity Building

Launch of the Hornsey Housing Trust Befriending service (April 2018)

Volunteers trained by Andrea Wershof (Hornsey Local Area Co-ordinator)

Community Connection

Hornsey Community Day: building resilience and tackling social isolation (May 2018)

- Free event
- Information stalls from 22 community organisations and local businesses,
- Over 90 residents attended
- Average age: 72
- Activities: Laughter yoga, gardening, self defence, handcraft, singalong