Report for: Adults and Health Scrutiny Panel on 11th July 2016

Item number:

Title: Addressing community wellbeing: taking forward the findings of the evaluation report of Neighbourhoods Connect**.**

Report authorised by : Charlotte Pomery

Lead Officer: Sebastian Dacre

Ward(s) affected: All

Report for Key/ Non Key Decision: For information

1. Describe the issue under consideration

1.1 As reported to the Adults and Health Scrutiny Panel in March 2016, the Council and the Clinical Commissioning Group (CCG) jointly commissioned a Neighbourhoods Connect service through the Better Care Fund in 2015. The service was intended to address social isolation for those needing or likely to need interventions from health or from adult social care as part of a preventative approach. The evaluation of the service has now been carried out and is attached to this report as Appendix 1.

1.2 In light of the evaluation, the CCG and Council have agreed the importance of commissioning a model which addresses community health and wellbeing and effectively co-ordinates the range of community based services already active in the borough. However, they have agreed to pause any decision to re-commission the Neighbourhoods Connect service itself in order to agree the overarching strategic framework for community based approaches to health and wellbeing and to determine the precise nature of the service to be commissioned.

2. Cabinet Member Introduction

2.1 Addressing social isolation amongst residents at risk of needing health or social care is considered a key way to improve people's health and wellbeing as part of a suite of prevention activity. This evaluation demonstrates both the local impact of the Neighbourhoods Connect service and the need to adopt a strategic approach to ensure community based models are effectively co-ordinated and offer a coherent response to individuals who feel unable to take forward key areas of their lives without additional support.

3. Recommendations

3.1 To note the evaluation of the Neighbourhoods Connect service and the wider work to develop a community wellbeing model for the borough, and to contribute to the emerging approach.

4. Reasons for decision

4.1 The evaluation of the Neighbourhoods Connect service offers very useful information as to the effectiveness of this model of prevention in Haringey. Other community based prevention approaches such as Time Bank, Well London, the Information, Advice and Guidance Service and the Integrated Wellness Service are now operating in the borough and there is emerging thinking about Social Prescribing. It is therefore felt to be important to ensure the limited resources available for this work are used to best effect by adopting a more strategic model and channelling resources through a co-ordinated approach.

4.2 The current pressures on both the Council and the CCG budgets require a robust and coherent approach to prevention which aims to improve wellbeing and reduce need over time. By co-ordinating resources and adopting a strategic approach, there will be greater benefits from the funding for this area of activity.

5. Alternative options considered

5.1 Not applicable.

6. Background information

6.1 The Corporate Plan sets out both the overarching vision for a stronger Haringey and, in Priority 2, the objective of enabling all adults to lead healthy and fulfilling lives. These strategic outcomes form the framework for the emerging community based approach to prevention, with additional outcomes currently identified as:

- Reduction in inequalities across the borough
- Improved wellbeing and social connectivity
- Reduced social isolation
- Increased patient/resident/service user satisfaction
- Reduced levels of service use (whether in primary or secondary health care, social care or other statutory provision)
- Changing type of services used e.g. increased use of the voluntary and community sectors
- Increased self-management and self-support
- Prescribing of specific medications reduced (to be defined)
- Supported primary, community and social care.

6.2 The emerging community wellbeing model is seen as a mechanism for connecting residents/service users and patients with preventative supports in the community, some of which have been traditionally linked to primary care for example through social prescribing although there are various models across the country (for example, community hubs and community navigators) to be further explored for Haringey. In essence, frontline staff and other stakeholders connect residents to a focal point for a discussion on individual goals and match them with appropriate opportunities plus support to engage. Usual activities include arts, creativity, physical activity, learning new skills, volunteering, advice on benefits, housing and debt and social activities to reduce isolation.

6.3 Key elements of the model would include robust information about what is available in the community accessible to and navigable by a range of stakeholders asset the design to be informed by frontline staff and communities; a change in culture across all stakeholders including health and social care frontline staff, other practitioners, local residents and communities; training to develop the skill-set required for the co-ordination role (empathy, local knowledge, wellbeing coaching skills); a range of different interventions to support prevention which enhance resilience and build self-management.

6.4 This model is being developed at pace and will be informed by a multi-agency workshop being held during July. It will also align with the work to develop a new model for day opportunities in the borough which has been co-designed and which builds in a model of independent care co-ordination linked to robust information resources and access to a wide range of community based provision, some of which is offered as a mainstream provision.

7. Contribution to strategic outcomes

7.1 The Corporate Plan, Building a Stronger Haringey Together, sets out the vision and priorities for the Council over the next three years. As well as seeking to enable all adults to lead healthy and fulfilling lives, the Plan's underpinning principles of empowering communities to enable people to do more for themselves and promoting equality are reflected in the Neighbourhoods Connect service.

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

8.1 Finance, Procurement, Legal

Not applicable.

8.2 Equality

8.2.1 An Equalities Impact Assessment was carried out at the point of awarding the contract and the evaluation of the service described in this report has sought to demonstrate the outcomes of the service and its wider impact, including that on protected groups.

9 Use of Appendices

Appendix 1: Evaluation of Neighbourhoods Connect, May 2016
Appendix 2: Emerging Community Wellbeing Model, graphic, July 2016

10 Local Government (Access to Information) Act 1995

10.1 None.

Appendix 1

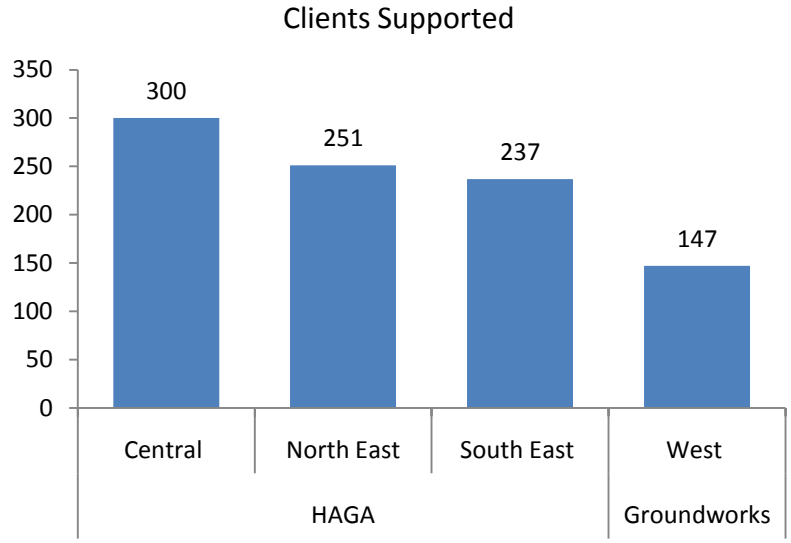
Neighbourhoods Connect Pilot project April 2015 – March 2016 Evaluation

The aim of the Neighbourhoods Connect Service was to target 1,000 people in 2015/16 in Haringey who are at high risk of social isolation. The goals of the intervention include increased self-care (including falls prevention), reducing social isolation and encouraging lifestyle and behavioural changes. It does this by connecting people with existing services and activities in their neighbourhood and supporting people to be active participants.

Haringey residents aged 18 and over are supported to improve their wellbeing

The original target set out in the specification was for the project to engage with a minimum of 1000 people; split evenly (250) across the four geographical project area.

The total number engaged was 935 people (94%of the target).



- Central 300 (25% higher)
- North East 251(0.5% higher)
- South East 237 (6.5% lower)
- West 147 (41% lower)

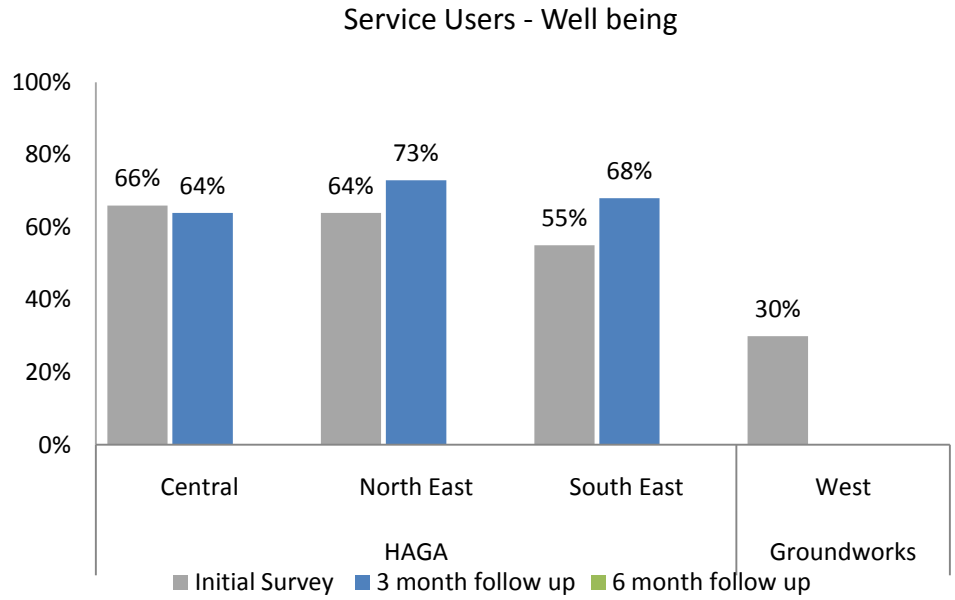
The project did not achieve the minimum engagement target set.

Self-reported well-being

Self-reported well-being was measured using the Warwick Edinburgh Mental Wellbeing Scale (short-form). The person describes their experience over the last 2 weeks against statements about feelings and thoughts. This is carried out at the initial contact (baseline) and again after 3 and 6 months.

- 127 baseline
- 20 three month
- 0 six month

Just over 2% of those engaged in the project completed the WE after 3 months. These showed a slight improvement in well-being and an improvement in connectedness.



Overall a very small response was received to be able to show that the project had delivered an increase in people's self reported wellbeing.

Increased Risk of Isolation

The project had a focus on engaging with people with increased risk of isolation.

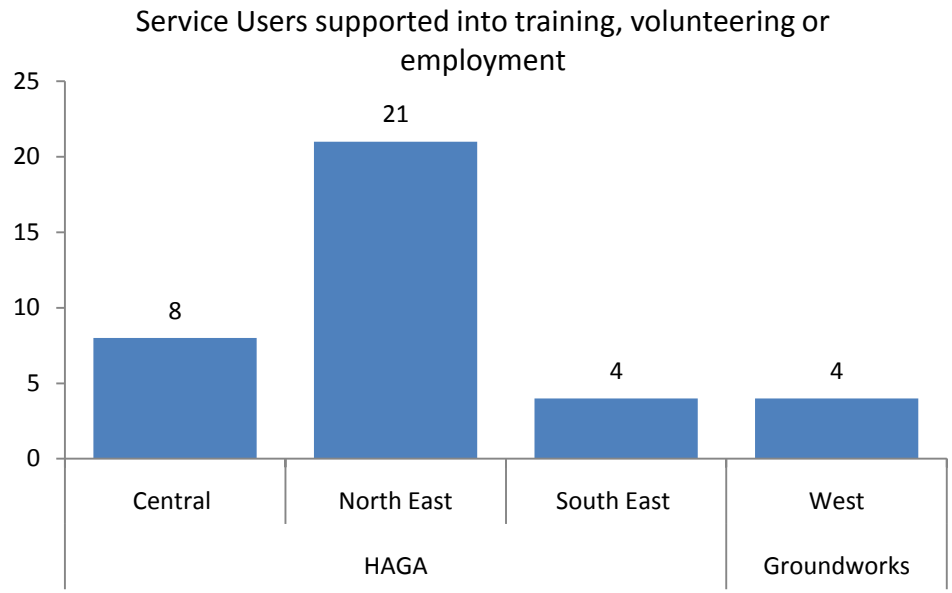
- people with long-term physical and mental health conditions: 384
- unpaid carers: 42
- people who are housebound: 39
- people with dementia and their carers: 7
- older people living alone or with an unpaid carer: No data recorded

Total number of those at increased risk of isolation = between 384 and 472*(41% and 50.5%)

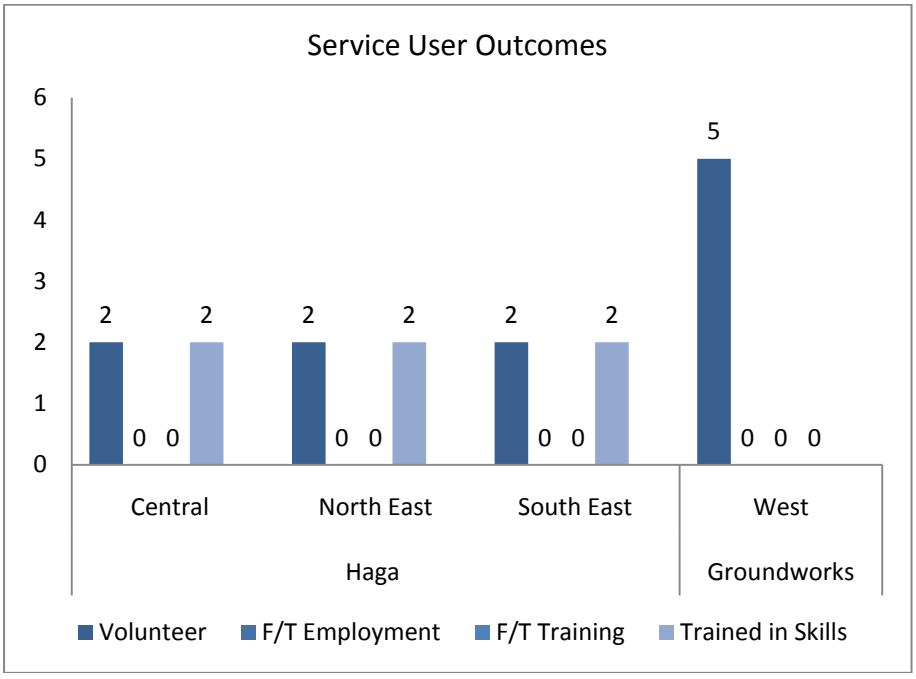
**(The data wasn't captured in a way to distinguish unique users so could have been captured in more than 1 category)*

Despite the focus on these particular groups the project has demonstrated the difficulty in reaching those with an increased risk of becoming isolated.

Haringey residents aged 18 and over are supported to be active participants in their community



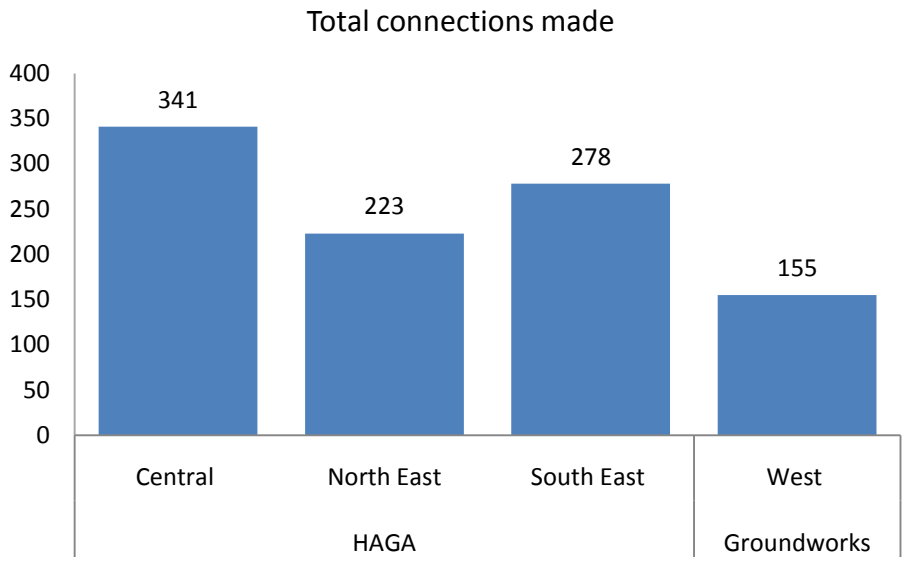
Haringey Neighbourhood connects supported **37** service users to engage in Training, Volunteering, Employment opportunities between April 2015 and March.



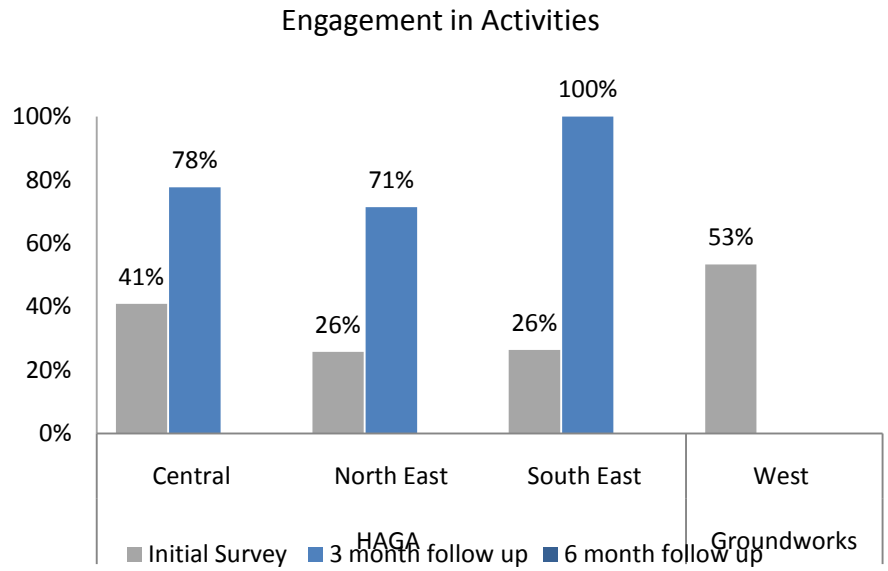
11 Neighbourhood connects services users were supported into volunteering opportunities.

6 Service users were trained in specific skills such as motivational interviewing or as a peer.

Haringey residents aged 18 and over are supported to connect with their community



Haringey Neighbourhoods connect service users made **997** connections with community groups, services and activities.



There was a **50%** increase in HAGA service users engaged in one or more activities a week at the 3 month checkpoint.

Case Studies

Case Study One

A woman attended an evening relaxation session delivered by IAPT at Hornsey Vale Community Centre. She suffers from a long term health condition which makes sitting painful and difficult. With the correct guidance she was able to take part in the relaxation session and found it very beneficial for her physical and mental health. As a result of attending she was able to download guided relaxation tracks from the

internet and practice the technique at home on a regular basis. She said it has really helped her health condition and makes her feel relaxed.

Case Study Two
Elsie is 62 years old, and has been living in the Bruce Grove area for over forty years. She was born in South London. Elsie has always been a very cheerful and highly sociable person. However, she lost confidence after she was attacked and mugged whilst on the way home one evening. When she fell, she fractured her pelvis and broke her arm, the pain of which was exacerbated by her arthritis. Elsie ended up staying in hospital for an extended period of time.

Elsie was referred to Home from Hospital when she was discharged from hospital. The Home from Hospital team worked with her to ensure she could live safely on her own again and had the things she needed. The Home from Hospital team referred Elsie to NC in the hope that we could connect her to community activities that would help her to regain confidence. A Community Engagement Worker talked to Elsie about what she enjoyed doing and what she would like from working with the project. As Elsie is still struggling to leave the house while her injuries heal, the NC Team referred her to the Good Gym befriending project. A runner is currently visiting Elsie twice a week. She really enjoys the company, and says that her 'buddy' laughs at her jokes, and doesn't mind hearing her cat stories.

She is currently housebound but is confident that she'll be able to make unsupervised trips out of the home in the near future. When Elsie is feeling able to, she said that she would like to visit the NC team at Shine Enterprise Centre to thank us for connecting her to Good Gym. She's also a keen knitter, so would like to join in with our new Sewing Group.

Case Study Three
Margaret was referred to HNC from St Anne's Hospital. She is in her late seventies, uses hearing aids and struggles to get out much due to tiredness and ill health. She lives with her 80 year old husband but gets lonely and wants to attend social activities and lunch clubs.

HNC were able to sign post a number of local activities for Margaret and contacted her to see if she had attended any of the events. Margaret wanted to but couldn't as she had become too unwell. HNC directed Margaret to the Good Gym befriending service where a volunteer will visit her at home on their weekly run to ensure she gets the social interaction she seeks while she is unwell. Margaret was very excited about this idea.

Margaret quotes; "Jess has visited twice now, she comes on Sunday afternoons and runs all the way here from Wood Green. She's very quick even with all the hills in Highgate. We always have a lot to talk about and she's very friendly".

Service Objectives

Service objectives at the individual level:			
Objective		Met/Not Met	Comment
IL 1	Support people to improve their overall wellbeing	Partially Met	Only a small sample of questionnaires were completed
IL 2	Support people to make connections with local activities and services available that support their wellbeing, including self management of long term conditions, opportunities to take part in physical activity, and social and cultural pursuits.	met	997 connections with community groups, services and activities.
IL 3	Contribute to reducing social isolation and loneliness that can be experienced by people in later life, people with a mental illness or a long term condition.	partially met	Between 40 and 50% of interventions were in this cohort. Not enough evidence of outcomes although some good qualitative examples
IL 4	Contribute to increasing training, volunteering and employment opportunities for both the client group and the people involved in delivering the service.	met	37 service users to engage in Training, Volunteering, Employment opportunities
IL 5	Promote self-care and independence so that clients can, where possible, avoid use of emergency health services, and reduce their dependency on statutory agencies.	Not met	Some qualitative evidence
IL 6	Support people to recognise and develop their coping skills	Not Met	Some qualitative evidence

Objectives at the community level			
Objective		Met/Not Met	
CL 1	To map out the assets that already exist in communities that support people to live fulfilling healthy lives and share this intelligence with partners.	Met	Have supplied a long list of assets
CL 2	To contribute to increased community cohesion and strengthened communities	Partially met	Has been difficult to measure this outcome but evidence of referrals pathways and partnerships developing
CL 3	The service provider is expected to work collaboratively with other providers commissioned by this service and existing and emerging services that are relevant to their service.	Met	Evidence of working with over 50 different organisations

Value for money

Total 2014-16 budget £200,000 (15 months).
4 projects with equal budgets of £50,000.
The original project had a minimum of 1000 people engage at an average cost of £200 per person.
The average cost of each engagement was £213.90 per person; 7% higher than the minimum target.

- Central £166.67 (17% lower)
- North East £199.20 (0.05% lower)
- South East £210.97 (5% higher)
- West £340.14 (70% higher)

Two of the projects came in below this cost. One was over twice the anticipated cost.
Across the whole project it did not achieve the value for money target due to not meeting the minimum target.

What worked

Neighbourhoods Connect has had some successes in engaging with people in Haringey and connecting them to groups and projects that they have discovered in Haringey. Both providers have collaborated with a number of local providers and have facilitated access through a number of methods including taster sessions and accompaniment. There have been improvements in the service the longer it operated.

Haringey Neighbourhoods Connect has been highlighted as one of three case studies of good practice by the NHS England BCF Team. They highlighted a number of issues as being key enablers for the success of Neighbourhoods Connect.

- Knowledge of existing community services
- Clear identification of target group
- Involving the voluntary sector
- Innovative ways to reimburse people rather than purely monetary
- Identifying champions to move things forward
- Trusting relationships between organisations in the community
- Partnership working
- Using existing services who have local knowledge
- Using local employees/volunteers
- Facilitated opportunities for staff from other organisations to meet and plan together
- Developed relationships and networks in the community
- Right level of staffing with embedded workers

Areas for Improvement

The service had difficulty in engaging with residents using the Warwick Edinburgh Mental Wellbeing Scale (short-form) which is shown by the small sample carried out and smaller scale of the follow up. Therefore it is difficult to draw conclusion on the impact on wellbeing.

There has been difficulty in accessing the truly isolated via community engagement. Commissioning the NC across four different areas meant that there was some confusion about which NC team people should use.

There is a lack of a single information point for activities in the borough.

NC: Conclusion

There have been positive impacts for local residents through delivery of the NC service.

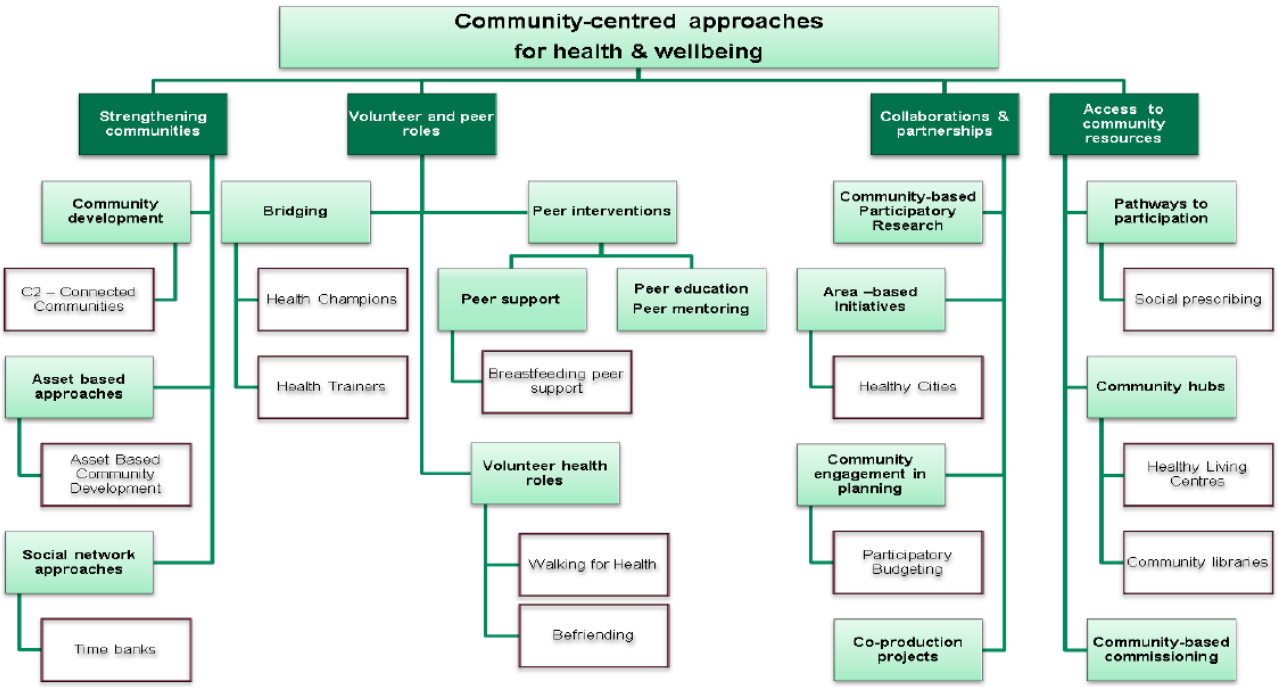
A decision is required on whether to extend further the funding for the current NC service which expires on 30th September 2016.

The learning from NC and from this evaluation need to contribute to the community wellbeing model which is being developed to ensure a strategic framework is in place for similar activity.

Significant work has been carried out to set out the model for social prescribing locally and it is key that these two strands are now aligned into a coherent and strategic community wellbeing framework.

Appendix 2

The family of community-centred approaches linked to health and wellbeing



haringey.gov.uk

Source: Public Health England: Community approaches to health and wellbeing, 2015.