PREVENTION & EARLY INTERVENTION SERVICES

Lot 3 (Draft Specification)

Supporting Independence and Inclusion through early intervention (Outcome 3)

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1. Introduction

The purpose of this service is to create a preventative and step-down model for individuals on the edge of requiring primary and/or a secondary care and support.

This service will identify and **reach key groups at risk of escalating need**, provide suitable **early interventions** to maximise independence, maximise health (including mental health) and wellbeing, **maximise social inclusion** and **reduce loneliness and isolation**, maximise the **self management** of conditions and help **avoid crisis** including admissions to hospital.

Shifting the emphasis of health and adult social care services towards preventing the onset of chronic health conditions and intervening early to contain these conditions once they arise. In particular, the low-level support service would focus on primary prevention i.e. maintaining independence, educating and promoting good health and wellbeing and some secondary prevention i.e. identifying individual at risk or living with specific health conditions

This approach is based upon engaging with our diverse community, triaging them to identify the support they need and then working with them to improve or at least manage their health conditions (self management).

Self-Management UK defines self-management as:

“a term that covers a whole range of things you can do to help yourself live a better life if you have a long-term health condition, either a physical or mental condition”

Self-management encourages you to:

- find out more about your condition
- learn new skills and tools to help you manage your health
- work better, and in partnership, with your health care professionals
- take charge of your health and choose what is right for you
- get support from other people in a similar situation to you

Self-management as simple as an individual keeping a journal of the condition and finding triggers to supported self-management where professionals teach people and carers skills and techniques to be able to self-manage at home and a place to go to prevent escalation of mental health conditions. It will also involve trying to live as healthily as possible,

"The Care Act will help to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support."

(Care Act Factsheet No. 1 General responsibilities Department of Health, 2014)

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2. Aims and Objectives of Contract.

The overarching aim is to support people in the community by providing appropriate levels of information, guidance, and support to allow individuals to manage their wellbeing and long-term health needs, gain confidence, engage in their local and wider communities; enhance effective personal support networks; enable individuals to maintain healthy lifestyles; and lead independent, healthy, and fulfilled lives.

This is turn will reduce the demand for primary and secondary services.

The provider will:

- Promote the service, engaging with harder to reach groups.
- Accepting referrals through different pathways
- Act as a triage service; working with a client to identify need
- Refer clients on though 'warm' handovers / or provide information as required
- Build a support plan around identified need, creating positive outcomes through a strength-based approach and monitor their improvement over their journey with the service.
- Load the support plan onto the Council database and keep it updated to create a holistic picture of support for an individual, whether stepping up or down along their recovery pathway.
- Work with people up to a set period, delivering interventions ensuring that there is a positive outcome. With the individual more capable of managing their physical or mental health condition and improve their wellbeing.
- Organise and deliver a range of events and activities that promote and encourage people to engage with to improve their wellbeing.
- Develop strength and balance activities. Forge links to existing falls prevention programmes to capture those who need further help, support and motivation to continue with their bone management plan and to help identified other who are at further risk due to un-reported falls.
- Sensory Impairment – assisting groups to meet and be kept updated of changes in Health and Adult Social Care. Assisting people to participate in co-production events and provide feedback.
- Build relationships:
    - With organisations within the contract
    - With organisations within other Outcome contract areas
    - With external VCS organisations and groups external to these contracts.

  And in doing so keep abreast of opportunities for activities and events for people that will sustain their wellbeing journey beyond the immediate intervention stage of this contract.
- Deliver both healthy eating and physical wellbeing programmes that also
- Focus on affordable options for people. Establishing groups and then handing over the co-ordination and running of them to its members.
- Lead and promote the Autism pathway and bring together a network of support and information to benefit the autism community.

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The provider will support individuals with a range of conditions; physical, autistic, mental health conditions and Learning Disabilities.

The range of expertise and reach into communities is not expected to be undertaken by one provider but by delivering services through a range of subcontractors of best placed providers.

Strategic and Local Context

Preventing needs for care and support is critical to the vision, expressed in the Care Act 2014. By encouraging the creation of care and support systems that actively works to promote wellbeing and independence and does not wait to respond until people reach a crisis point. Prevention and early intervention enable individuals to retain or regain their skills and confidence; and prevents need or delays deterioration wherever possible.

To address the 17% of the population self-identifying, in the census, as having a disability need. The Enfield Joint Local Health and Wellbeing Strategy 2024-2030 under the section; Age Well – The aim is for people to live healthier, more independent and longer lives by supporting people to live healthier and socially connected lives in Communities that nurture and promote independence. Delivering the right support at every stage of life.

Under 'Age Well', the first Priority is that "every Enfield resident is to have the social network they need to support their wellbeing. Social isolation and loneliness are an all-too common feature of older age, but they are not inevitable. Loneliness can lead to poor physical and mental health, and it is estimated that loneliness is as bad for our health as smoking 15 cigarettes a day[1]

Locally, we will be working in partnership to identify those at greatest risk of **isolation**, such as people living with severe frailty and unpaid carers, and helping them to prevent loneliness, by encouraging community engagement and signposting to support. This includes working with our voluntary and community sector organisations to provide opportunities for volunteering, hobbies, and social interaction."

Priority 3 - Enable every Enfield resident to live a resilient and independent life into older age Frailty reduces the ability of people to maintain their physical and mental independence and increases the risk of even minor illnesses. Preventing older people from developing frailty is a key action to help people maintain their independence and live happy and healthy lives. Our existing services are designed to maximise opportunities for maintaining independence with a focus on early intervention and support before people lose vital abilities

The Enfield Council Plan 2023-2026 Priority 2 states "Our residents are living longer, often with one or more long term health conditions, which is increasing

[1] Holt-Lunstad J and others (2010). 'Social Relationships and Mortality Risk: A Meta-analytic Review' PLOS Medicine: volume 7, issue 7

demand for our social care services. We will support people to live independently for as long as possible within their local communities and are helping people living with disabilities to be in control of their own lives."
In the 2021 National Census the following amount of people assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).:

Category	No	%
Disabled under the Equality Act: Day-to-day activities limited a lot	21,145	6%
Disabled under the Equality Act: Day-to-day activities limited a little	23,731	7%
Not disabled under the Equality Act: Has long-term physical or mental health condition but day-to-day activities are not limited	14,442	4%
Not disabled under the Equality Act: No long-term physical or mental health conditions	270,666	82%
Does not apply	0	0
Total	329,984	100%

Data set available
https://www.ons.gov.uk/datasets/TS038/editions/2021/versions/3

Mental Health

The above is not reflective of information gathered for the JSNA, around mental health. Therefore, this specification cannot focus solely on health related conditions and must include common mental health disorders such as: depression, anxiety, phobias and obsessive-compulsive disorder

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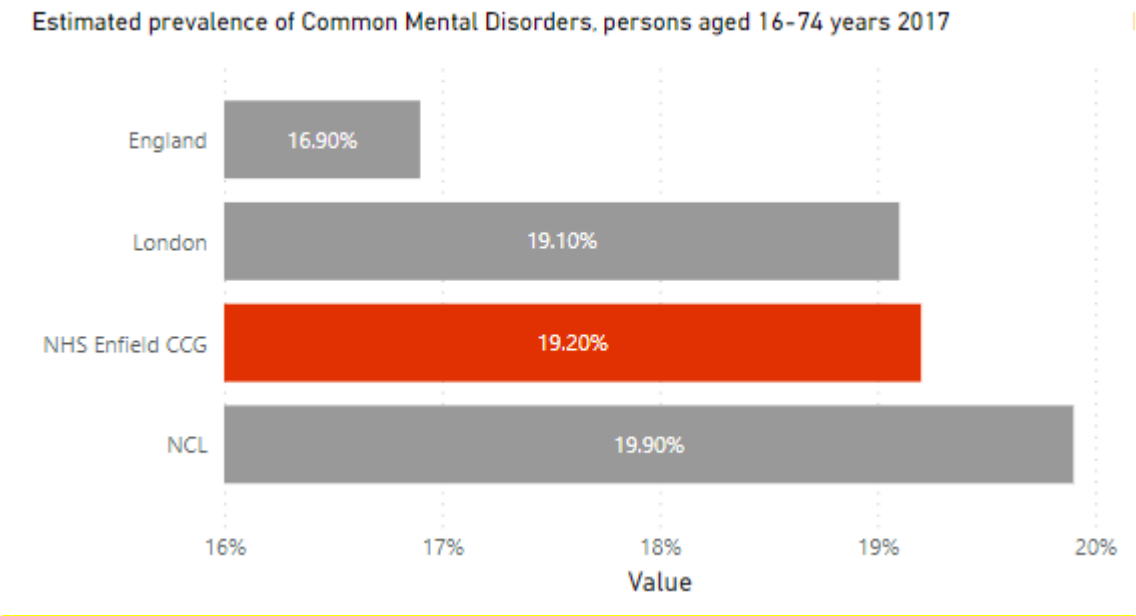

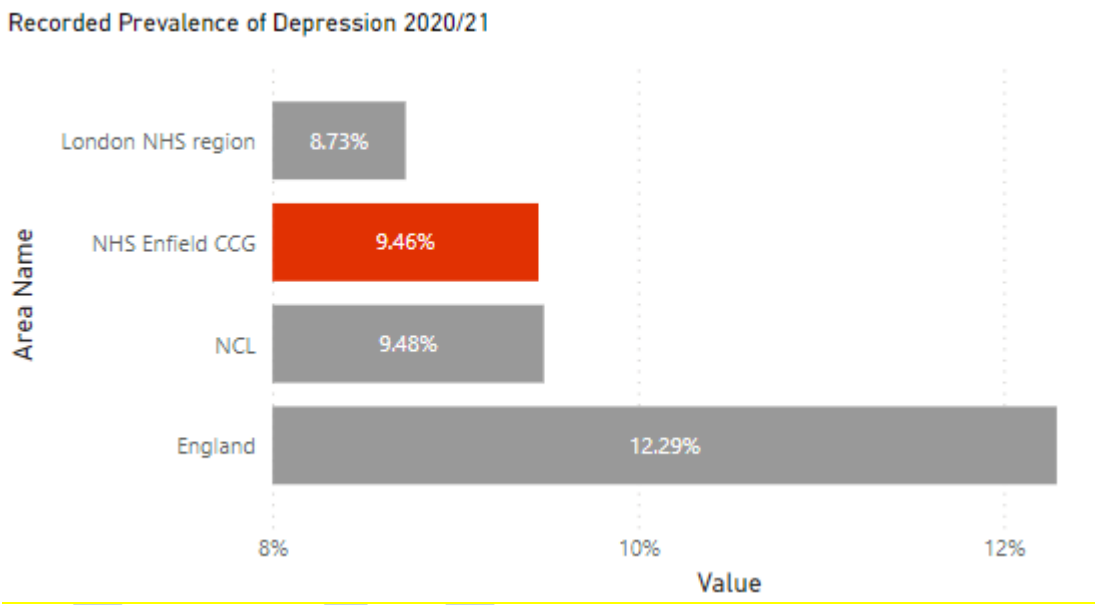

Data Source
https://www.enfield.gov.uk/healthandwellbeing/joint-strategic-needs-assessments/adult-mental-health

3. Outcomes

3.1 Outcome Rationale

This specification requires provider(s) to deliver suitable interventions, ensuring the right support at the right time. To help people and their carers self-manage their health condition(s) and prevent the need for requiring more complex health or social support.

3.2 Expected Overall Outcomes

The service will work in the community providing a level of support to help people maintain and improve their wellbeing and develop resilience and confidence to help them live as independently as possible for longer. Reducing the need for people to access primary or secondary health services.

Working collaboratively with other key partners. - A partnership response to meeting need is likely to be necessary to successfully achieving the outcomes expected within this specification and providers may consider working together under a lead provider an integrated way together with health and social care professionals.

4. Definition

Service provision will be focused on low level support helping people who need support to prevent or self-manage their identifying conditions. The low-level support service for people identified as at risk will be designed to shift the emphasis of health and adult social care services towards preventing the onset of chronic health conditions and intervening early to contain these conditions once they arise. In particular, the low-level support service would focus on primary prevention i.e. maintaining independence, educating and promoting good health and wellbeing and some secondary prevention i.e. identifying individual at risk or living with specific health conditions.

Services will help maintain independence, health and wellbeing by promoting healthy and active lifestyles and improving access to universal good quality information about local services. This will be done in conjunction with the contract for Supporting People to Live Well through Information, Advice, Guidance, Digital Inclusion, Advocacy & Involvement.

In addition, services will facilitate access to local services that are important to vulnerable people and their carer e.g. transport, leisure, health services, housing services, libraries, information and advice and services that support people to maintain a sense of health and wellbeing.

Secondary Prevention – Services will act as an ‘early warning’ system, through a strength-based approach support plan*, put mechanisms in place to ensure that those ‘at risk’ of suffering health related problems, or those struggling with self-management of their conditions. Services will refer to the appropriate agency should risk to a people’s wellbeing increase or as and when required.

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***Strength Based Approach;** A strength-based approach is a way of working that focuses on abilities, knowledge and capacities rather than deficits, or things that are lacking.*

5. Service Description

Part 1 Triage, front door support and handover

The provider will have one gateway for accessing all the services and support provided in this contract. The single point of access will allow for individuals to be triaged for their needs and then an appropriate agreed pathway of support is delivered. (see figure 1 at the end of this section).

Access to the service should be available 24 hours a day with out of office hours available via voicemail, text or email.

The service should be promoted via a range of different social media platforms. Advertising for the service should be made available both electronically for sites such as but not limited to:

- Enfield MyLife
- HealthWatch
- VCS websites
- Electronic letters and circulars.

Where possible the service should be co-located within the other community buildings or hubs. These can include but not limited to:

- Library buildings
- GP surgeries
- Wellbeing hubs
- Faith locations
- Community halls

The Provider will also need to be deliver support into the North Middx Hub as part of shared VCS approach.

Hard copy posters for advertising in public spaces such as but not limited to:

- GP surgeries
- Public Libraries
- Other VCS organisation offices
- CAB
- Food banks

Although there is another contract 'Supporting People to Live Well through Information, Advice, Guidance, Digital Inclusion, Advocacy & Involvement'. Upon entering the service some individuals may only require information, guidance, signposting with introductions to other services, if this can be easily and readily

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provided it should be delivered at that point. If the individual's request is of a more complex nature, then a 'warm' handover for the individual should take place between the two VCS contract providers.

No matter at which point an individual exits the service, people should feel equipped with the right information and have confidence in the next steps. The service will link people with health, support and community services that will help them address any factors or circumstances that contributed to their escalating health and wellbeing need. The provider will have an excellent understanding of Enfield's health and social landscape and neighbourhoods to draw on the wider community resources and assets in the support of people to build their resilience and well-being. Such services may include debt, welfare rights, domestic violence, relationship, housing, substance misuse, religious, cultural, recreational or employment advice.

The service will provide computer and telephone access to those using the service and support them to make use of these resources. This will include helping individuals research and contact local services to make appointments. Where signposting to an appropriate service is requested by the person, this will be facilitated, however, wherever possible the provider should proactively link the person with other services rather than simply point them in the right direction.

The service will offer access to information on relevant services in appropriate formats

Part 2 – Managing Long Term conditions – Strength based support planning

Providers will use a strength-based practice to create support plans for people. Motivational interviewing provides a helpful way of communicating with individuals and families that supports collaborative goal-based planning for behaviour change. These support plans will be loaded onto the Enfield Adult Social Care database to create a holistic picture of support for an individual, whether stepping up or down along their recovery pathway and that can be accessed by other care professionals should the need arise. This will deliver an integrated model for both statutory and non-statutory support.

The provider will balance people's safety and welfare whilst also treating individuals and families with respect and clearly communicating concerns using skills in motivational interviewing to maximise engagement and the possibility of achieving change.

The Provider will work with people to help them think through what they can do for themselves to address problems, manage conditions, or stop them developing and; to bring about longer-term change whilst also helping to identify sources of support within the community.

The importance of these conversations with individuals and families cannot be underestimated. In many cases, these conversations will happen repeatedly over a period of time and the relationship that is formed in the process will be critical to promoting and enabling change. Through this relationship, providers can work with

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individuals and families to explore issues, set expectations, develop skills, provide advice and challenge individuals to make changes where necessary.

The provider will help link people into sources of support in their community that can help them achieve their goals and maintain them after the support is removed.
This could be:

- Linking in with local assets, such as parks or green spaces,
- Involving them with local community groups that reflect their interests or experiences
- Engaging them with a hobby or pursuit,

The starting point for this approach is quality conversations. Conversations should not focus on deficits, highlighting weaknesses or addressing one immediate need.
The strength-based conversations should:

- take time to ask the right questions,
- actively listening to understand a person's context, environment, and experiences,
- Understand the individuals challenges they are facing and their views and feelings.
- Then explore and agree a shared understanding of what the issues are and workable solutions.

Part 3 – Prevention and Early Intervention – Falls

The provider will develop in-depth knowledge of falls and fractures in older people or population groups having that support need. The provider will cultivate closer connections with people, supporting those who need further help and motivation to continue with their bone management plan and to help identify others who are at further risk due to un-reported falls. This can be achieved by linking to existing falls prevention programmes, developing strength and balance activities, establishing good relationships within community networks, specifically with the Falls Clinic, Physiotherapists, Enfield Adult Social Care and GP's as well as knowledge of other community assets in relation to falls.

Part 4 – Providing engagement opportunities for Sensory Impairment

The provider will help and support various sensory impairment groups / organisations to meet to prevent social isolation. Information relating to Health and Adult Social Care is shared with them to ensure that their members are kept informed, and individuals are given the opportunity to participate in co-production events and provide feedback where appropriate. The provider will also make sensory impairment groups aware of opportunities and community events.

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Part 5 - Delivering Health Eating and Physical Activity events with information.

The provider will deliver both healthy eating and physical wellbeing programmes that also focus on affordable options for people. These tie into the National Health Service Better Health Campaign https://www.nhs.uk/better-health/

- Healthy eating events are to be delivered to assist people manage their wellbeing though diet. This could be, but not limited to; cooking demonstrations, taster sessions, recipe cards or guidance for swapping out one ingredient for another to improve dietary needs or lowering cholesterol. By assisting people to change they could be improving blood pressure, reducing salt intake, utilising more affordable food options for balanced nutritious meals.

- Physical activity events help people give their body a boost and lift their mood. This could be, but not limited to: walking groups, gardening clubs, seated yoga or exercise. By assisting people to regularly exercise it could help people reduce hypertension, strokes, type 2 diabetes.

These events also bring people together to share an enjoyable activity and reduce social isolation.

In the case of some of these events/groups the co-ordination and initial momentum will be delivered by this service however longer term there is an expectation that these groups will continue to run independently, with the co-ordination of the event/group being passed onto its members. This will free time the co-ordination of a new group somewhere else in the borough.

Part 6 – Lead the Autism Pathway

Lead and promote the Autism pathway by regularly chairing the Adult Autism Group, ensuring that the group is aware of ASC, Public Health and ICB (Integrated Care Board) activities and provides an opportunity for this community to participate in co-production of future services. The service will help bring together a library of information that if not already on Enfield Mylife could be published there to act as a central repository for people and families in the autistic community to access. The pathway will provide a work programme for the year, focussing on co-ordinating and developing the autism pathway. The achievements of the group will also be spotlighted through an annual conference delivered by the Provider.

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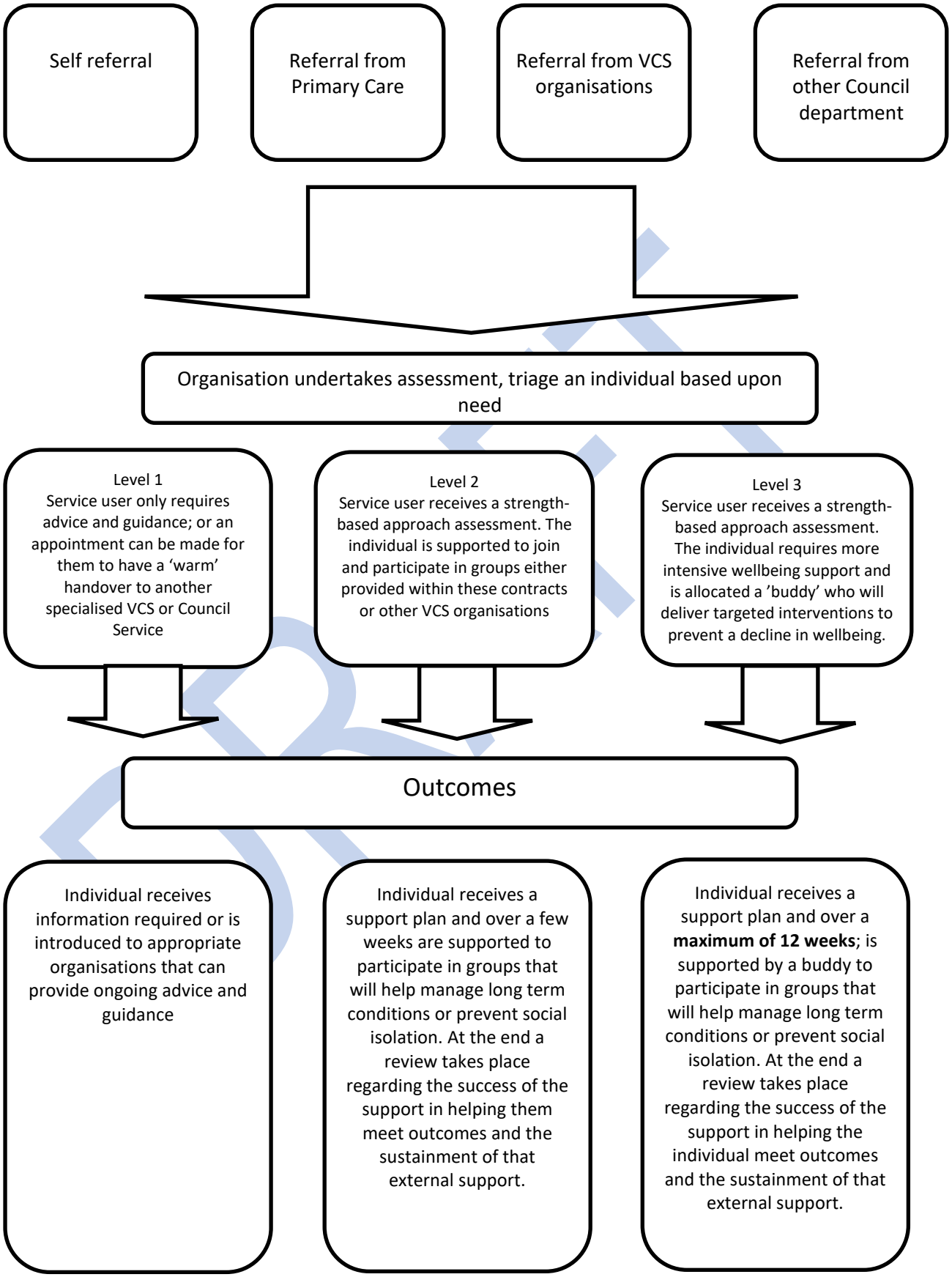
Figure 1


Self referral
Referral from Primary Care
Referral from VCS organisations
Referral from other Council department
Organisation undertakes assessment, triage an individual based upon need
Level 1
Service user only requires advice and guidance; or an appointment can be made for them to have a 'warm' handover to another specialised VCS or Council Service
Level 2
Service user receives a strength-based approach assessment. The individual is supported to join and participate in groups either provided within these contracts or other VCS organisations
Level 3
Service user receives a strength-based approach assessment. The individual requires more intensive wellbeing support and is allocated a 'buddy' who will deliver targeted interventions to prevent a decline in wellbeing.
Outcomes
Individual receives information required or is introduced to appropriate organisations that can provide ongoing advice and guidance
Individual receives a support plan and over a few weeks are supported to participate in groups that will help manage long term conditions or prevent social isolation. At the end a review takes place regarding the success of the support in helping them meet outcomes and the sustainment of that external support.
Individual receives a support plan and over a maximum of 12 weeks; is supported by a buddy to participate in groups that will help manage long term conditions or prevent social isolation. At the end a review takes place regarding the success of the support in helping the individual meet outcomes and the sustainment of that external support.

6. Contract Value

TBC

Payments will be made quarterly in arrears, post discussions with the Enfield Service Develpoment manager around performance and delivery against the contract**.**

7. Performance Measures

Generic KPI's

For generic indicators please see the overarching specification attached with this tender exercise.

Alongside the basic monitoring data. The Service Provider will have a quality assurance system that is capable of monitoring and assessing provision of the service. The Service Provider will be required to collect data to demonstrate compliance to the required Outcomes and Key Performance Indicators and report their performance on the Council's Pentana Performance Measuring Tool on a quarterly basis. The Service Provider and the Council shall manage the performance of the Service Provider to ensure current delivery meets the required standard. The Council and the service Provider shall together agree methods for collecting and collating KPI (Key Performance Indicator) data and shall meet on a quarterly basis to discuss performance and outcomes.

Any future additional performance monitoring requirements shall be introduced through discussion with people and agreement of the Service Provider and will be informed by the review and development of the Service. Details of the current data returns required are contained in this section of the service specification and shall be updated should any amendments be required during the lifetime of this Contract.

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Specific KPI's

No	KPI	Outcome	Target per month
1a	The number of people in a month who collaboratively worked on a new strength-based support plan to meet their needs and improve their wellbeing.	Through strength-based support planning help people improve their wellbeing, preventing them from deteriorating and reducing social isolation	Minimum 25 clients per month (75 in a quarter; each officer carrying a caseload of minimum 25 individuals)
1b	The number of people whose support plan ended and achieved agreed improvement(s) in one or more targets /outcomes.	The number of people who have been successfully supported to meet their initial identified needs.	6 (6.4) = 2b X 80% (will have a positive outcome in any given month or 60 per quarter
1c	The number of people whose support plan ended and there has been no agreed identified improvement.	The number of people who have been unsuccessful in meeting their initial identified needs.	2 (1.6) = 2b X 20% (less than 15 out of 75 will have a negative end to their placement)
1d	Utilisation of the service for individuals identified with requiring support	Ensuring that the service is utilised to help those with support needs.	The % utilisation of service = (No of people supported) / 75 = Target 105%
1e	Average length of time individuals' are supported	Ascertain the average length of time an individual requires support for to deliver an improvement in their wellbeing. (excludes front door advice and guidance and warm handover)	Target 6-8 weeks
2a	No of Exercise sessions delivered in the quarter	The number of exercise sessions delivered to improve their physical and mental wellbeing	Minimum 13.3 per month (40 per quarter)
2b	No of people attending Exercise sessions	The number of people attending exercise sessions to improve their physical and mental wellbeing	overall numbers attending minimum of 200 per month or 600 participants per quarter (40 events x 15 participants)
2c	Year 2 onwards increase the number of exercise sessions available per annum	Additional 5 new events added per annum	Minimum 125 events per annum

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3a	No of healthy eating events delivered	The number of healthy eating events delivered to assist people manage their physical wellbeing though diet. Lower cholesterol, improve blood pressure.	Minimum of 13.3 per month (20 per quarter)
3b	No of people attending healthy eating events	The number of people attending healthy eating events to help them maintain a healthy diet.	overall numbers attending minimum of 66.6 per month or 200 participants per quarter (20 events x 10 participants)
4a	Chair at least quarterly the Adult Autism Group	By regularly chairing the Adult Autism Group, ensuring that the group is aware of ASC, Public Health and ICB activities and allowing an opportunity to participate in co-production.	Minimum 1 per quarter
4b	Deliver an annual Adult Autism conference		1 per annum

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