Schedule 5

SERVICE SPECIFICATION

Supporting People to Improve their Health and Wellbeing and Improving Self-management (HHASC Service Specification Outcome 3)

CONTENTS

HHASC Service Specification Outcome 3:
Supporting People to Improve their Health and Wellbeing and Improving Self-management

1 Introduction

The changing pattern of care needs requires greater integration – that is, much better alignment – in the commissioning of health and social care services. In view of this the London Borough of Enfield is to commission prevention and early intervention services meeting the care and support needs of the communities in the borough. These services will require collaborative and joined up working from the voluntary and community sector in order to meet the requirements of the commissioning process.

As part of this process, the Council wishes to work with organisations able to demonstrate an ability to support the care needs of service users to focus on outcomes, using a person-centred approach. Organisations are encouraged to work together as partners within a consortium structure to deliver support flexibly in meeting individual service user's needs. This will be our key driver in procuring services for vulnerable people in Enfield.

The purpose of this specification is to set out the minimum standards and requirements that the Council will expect from the successful organisation/consortium who are delivering preventatives services and interventions for vulnerable people residing in the borough of Enfield.

2 Outcome Rationale

It is recognised that one of the best ways to maximise the social care and health budgets is through prevention and self-management of common conditions. Whilst healthy living for the general population is promoted by the Council, the voluntary and community sector has an important part to play in supporting people vulnerable to, and those just diagnosed, with long term health conditions and supporting individuals and family members in times of crisis.

The national picture shows us that:

- 70% NHS budget is spent on long-term conditions (approx. £72 billion)
- Diabetes nationally costs the NHS £25,000 per minute
- Two thirds of Enfield's adults are either overweight or obese
- Diabetes prevalence has risen 10% in last 4 years
- Long-term conditions can be either prevented or eased through lifestyle change
- Long-term conditions can be reduced by 20–40% by meeting physical activity recommendations

2.1 Prevention and Public Health

The message from Public Health is encouraging Enfield residents to take their 'MEDS'. MEDS simply means

- **M**oving regularly

For a good standard of health and well-being, it is essential to be physically active. Recommendations for those aged 19+ are to undertake 150 minutes a week of moderate activity or 75 minutes of vigorous activity. The Chief Medical Officer has stated that the easiest means of doing this is to integrate physical activity into everyday life, often through walking and / or cycling. Further recommendations for those aged 65+ are to undertake activity to improve muscle strength on at least 2 days a week.

This is a key area because as a Borough, Enfield has a very low rate of physical activity uptake. Health Survey for England 2016 indicated that 66% of males and 58% of females aged 19+ reported meeting physical activity guidelines. No national objective data has been collected since 2008 when data from accelerometers indicated that only 6% of males and 4% of females aged 16+ met the (then) physical activity guidelines of 5 x 30 mins moderate physical activity per week.

- **E**ating

A healthy diet is also important to good and improved health and wellbeing. Eating 5 pieces' fruit and/or veg a day is recommended. However, this is the minimum – for example guidance differs throughout the world with Canada advising 5 –10 portions and Japan a huge 17 servings. A quarter of adults in Enfield are obese and almost a quarter of children aged 10-11years are obese.

- **D**rinking

For better health and wellbeing, it is advised not to consume more than 14 units of alcohol per week. It is also advised to spread that throughout the week and having drink free days. Alcohol misuse is the third largest contributor to ill-health after cardiovascular disease and smoking; Between 2008/9 and 2017/18 the number of people from Enfield admitted to hospital for alcohol related conditions increased by 180%.

Smoking

The advice on smoking is very clear -Don't! And also, persuade your family/friends to follow that example. Smoking contributes to 1 in 5 deaths in Enfield. Smokers have a life expectancy ten years less than non-smokers.

2.2 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 maybe as simple as an individual keeping a journal of the condition and finding triggers to supported self-management where professionals teach service users 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, see MEDS above.

2.3 Population Needs – Vulnerable People of Enfield

The target groups are those from the list below and who do not meet the thresholds for specialist statutory support. This service is not to replicate existing services.

The focus of this service will be on:

- Early diagnosis of long-term conditions – dementia, diabetes, mental health, heart disease, COPD and respiratory disease
- Identification of those who would benefit from public health services – stop smoking, sexual health, alcohol and substance misuse services
- People living with early onset dementia
- People with diabetes or at risk of developing diabetes and linked conditions
- People with COPD or at risk of developing COPD and linked conditions
- People with mental health issues being treated within primary care or at risk of developing mental health conditions, including perinatal mental health
- People at risk of social isolation
- Carers of the above groups
- Partnership working with London Borough of Enfield to promote and refer to existing services

Dementia – In July 2019 92.1% of older people aged 65 + living in Enfield and registered with a GP was recorded has having a diagnosis of dementia This number is expected to rise over the next 3 years Improving the rate of dementia diagnosis in the population is a key performance indicator in Enfield's Better Care Fund Plan. This will require partnership working with the lead partner of '*Outcome 2: Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community Including Avoiding Crises' which* also provides support to dementia patients.

Diabetes – Prevalence of diabetes in Enfield is increasing and is likely to continue to rise with increased prevalence of obesity. If obesity continues to rise in Enfield, an additional 2,000 adults could develop diabetes. Unmanaged diabetes can lead to serious complications that could limit people's independence and quality of life. It is estimated that diabetes costs the NHS some £25,000 per minute.

Diabetes is one of the most common co-morbidities amongst unplanned admissions due to amputation (228 cases), angina (129 cases), heart attack (311 cases), renal failure (266 cases) and stroke (575 cases). Almost three quarters of amputation cases recorded diabetes as a comorbidity as did almost two fifth of cases of renal failure. Some of these cases could have been prevented if diabetes was prevented in the first place. It is estimated that more than 60% of new cases of type 2 diabetes can be prevented. Being overweight or obese, smoking, drinking excess

amounts of alcohol are all risk factors for developing diabetes.

For more information please refer to the Annual Public Health Report 2016 –Diabetes in Enfield

https://new.enfield.gov.uk/services/health/public-health/health-publications/annual-public-health-report/health-information-enfield-annual-ph-report-2016-diabetes-in-enfield.pdf

This will require partnership working with the lead partner of *'Outcome 2: Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community Including Avoiding Crises'* which also provides support to diabetes patients.

COPD – Chronic obstructive pulmonary disease (COPD) is one of the most common respiratory diseases in the UK. It's a name used to describe a collection of lung conditions previously known as emphysema. People with COPD have difficulties breathing, primarily due to airflow obstruction, which is a narrowing of their airways. COPD is a condition which is
predominantly found in people who smoke. It is also prevalent in passive smokers and in people who have been exposed to pollutants over a significant period of time.

In Enfield, 3,000 people have been diagnosed with COPD and a further 6,500 people are estimated to be undiagnosed. Roughly 50 people aged under 75 die from respiratory disease (includes COPD) in Enfield each year. Almost half of these deaths are considered preventable. Late diagnosis results in poorer outcomes and hospital admissions.

Mental Health - This service will support those who do not meet the threshold for statutory support through social care but require support to prevent developing a mental health condition or managing a condition where support is provided through primary care (e.g. a GP).

In Enfield over 32,000 adults are estimated to be living with a common mental
health disorder with 3,400 additional adults expected to be living with a common mental health disorder by 2020. 4.3% of people over 18 years are recorded as suffering from depression by Enfield GPs. Mental illness accounts for 23% of all years of healthy life lost in high income countries.

In addition, parental mental health is a significant indicator for children developing mental health issues themselves. Many parents do not meet eligibility for statutory support but are experiencing significant mental health issues which can have a long-term effect not only on themselves, but also their children. Ensuring the adult is identified and supported early limits the impact on the family as a whole.

Research shows that peer support is particularly effective for mental health prevention and management. Due to the stigma of mental health conditions many do not wish to speak openly about their experiences. Meeting others that understand in a safe and non-judgemental environment can be key to recovery.

Social Isolation – In Enfield there are around 12,108 adults over the age of 65 who reported themselves as living alone. This equates to 31% of the total population of residents aged over 65 in Enfield. The areas with higher proportions of older people living alone are predominately in the North West of Enfield, with 15.1% of all households in Cockfosters being lived in by a lone person aged 65 or over, with similarly high proportions in Highlands (14.3%), Grange (13.5%) and Bush Hill park (13.4%). Social isolation and loneliness are a key determinant of the current and future health and social care needs of the older population. Loneliness and social isolation have been shown to have significant negative impacts on people's health status, including a demonstrable effect on blood pressure and a strong association with depression

For further information please access the Enfield's Joint Strategic Needs Assessment which can be found at

http://www.enfield.gov.uk/healthandwellbeing/info/56/introduction

3 Contract Value

The maximum annual budget available for the contract is £284,148 plus £10,000 additional budget for the lead organisation to cover the cost of their strategic leadership. Bidders must submit their prices within this budget envelope.

4 Aims and Objectives of the Contract

The key objective is to provide suitable interventions so that service users, potential service users and their carers can prevent or self-manage the mentioned conditions (not exhaustive) and improve their wellbeing and mental health. The community café will be run from a central hub located in the borough of Enfield from which you can reach out into the community via satellite sites. This in turn will relieve pressures upon primary and secondary care, reduce crisis or A&E presentation and/or hospital admission. Service pathways will be co-ordinated and close working is required with the Public Health and Mental Health teams in prevention work.

5 Outcomes

Support will be personalised to the individual and is high quality and responsive so that users of the service have anxiety reduced, are confident to self -manage and carers feel they are trained, healthy and able to undertake their caring role.

A partnership response to meeting need is key to achieving the outcomes expected within this specification with providers considering to work as part of a consortium in an integrated way together with health and social care professionals.

Expected Outcomes.

Service design and models should be based on the following outcomes:

- Increased confidence and ability to self-manage health conditions
- Increased opportunity and people accessing monitoring of health conditions in non-medical settings
- Increased ability, confidence and skills for preventative self-care – e.g. healthy eating, exercise, peer support, creative therapies
- Increased education and information around preventative and self-care
- Decrease in numbers of people accessing primary and secondary care due to LTC
- Reduction in emergency hospital admissions associated with existing conditions
- Increased numbers of health checks/monitoring –PH
- People reporting better levels of self-management confidence
- Evidence of increased working with Children's Services to support a whole family approach
- The running of a new community café supporting and signposting individuals and working in partnership with Enfield Mental Health services. Run from the community hub from 17:00 to 23:00, 7 days a week, 365 days a year. Further detail can be found on Appendix 1.

6 Definition and Eligibility

a. Definition

Service provision will be focused at low level support helping people who need support to prevent or self-manage their identifying conditions. The low-level support service for service users identified as at risk will be one of several newly commissioned services 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 coordination with *Outcome 6 'Increased and Improved Information Provision'.*

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 by putting 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 service user's wellbeing increase or as and when required.

b. Eligibility

This service will be accessible for all residents in Enfield. Carers who live in another borough but care for a resident in Enfield will also be eligible.

However, services available through this specification must not duplicate provision given to those with a diagnosis through health and social care services e.g. if a patient is receiving support from a professional on a regular basis. This is to ensure consistent care and that the provider does not provide conflicting activities and/or information.

7 Service Description

From consultation, the following areas for development were suggested:

7.1 Community assets

Enfield has a wealth of resources that can improve or maintain health without the need for service provision; physical activity can be increased by walking or cycling for transport purposes thereby building physical activity into everyday life. A healthy diet will reduce the risk of cancer, heart disease, diabetes and obesity. Residents will be encouraged to consider how they might adopt and maintain a healthy lifestyle.

7.2 Community Health champions

Enfield has a wide range of resources, both through statutory and voluntary organisations, to support resident's health and wellbeing. The role of a Community Health Champion would be to collate and coordinate the information on services available and promote them to both the community and professionals and signpost/refer when necessary.

7.3 Health checks and Monitoring Technology

Health checks to monitor risk factors for ill health should be encouraged or provided. When a person is entitled to an NHS Health Check (aged 40-74 years of age) they must be directed towards their GP (these are only available to people who are not already registered on a disease register).

People should be encouraged to use the Wellness Kiosks based at GPs and community locations in Enfield. People should also be introduced to helpful websites, apps and other technology to enable them to enhance their health and wellbeing.

Promotion of Enfield Connected, and assistive technology, as a whole must be incorporated into the service.

7.4 Healthy Lifestyle Classes and Activities

Classes and activities should be provided to complement the MEDS Public Health model. Managing your diet, taking regular exercise, reducing alcohol intake and stopping smoking all has a significant impact on a person's health and wellbeing and will prevent the development of some long-term conditions. Any activities should be accessible and appropriate for the diverse Enfield community.

7.5 Peer Support Networks

Peer support networks should be run to support those with diagnosed conditions. Such networks should provide information, support and a chance to meet others with similar conditions.

Carers peer support groups will be provided through Outcome 1 and not this contract.

7.6 Community Café

The Community Café based in the borough should focus on supporting the preventative interventions and self management of individuals health issues. Helping people manage their mental health wellbeing in the community reducing the need for statutory services. Further details can be found as Appendix 1.

7.7 GP Outreach and Socials

The service should be promoted through the GP surgeries and networks within Enfield. GPs and practice staff should also be briefed and trained on the services available, so they know how to refer. Referrals pathways should be designed to ensure ease of referral.

Support should be given to practices who wish to engage further with their patients and to promote self-management and appropriate discussions at appointments. In addition, the service could look at providing services and information through GP presence or events hosted jointly with the practices.

7.8 Whole Family Support

The service will look at providing support to the whole family, not just the service user and carer. This is to recognise the need for a coordinated approach, the impact on the family when there is a health condition and to identify risks to carers and family members, especially children.

7.9 Carers

Carers will be provided with education and training to support those to self-manage. They will also be encouraged to look at their own health and wellbeing.

Organisations/consortium of this specification will engage with the wider carers agenda, and will link into the main *Outcome 1 – 'Helping people to Continue Caring'*

The following principles underpin the desired approach:

- Promoting carers' wellbeing: helping carers to remain in their caring role, cope with stress, to recognise their own health needs and to maintain a sense of well-being
- Enabling carers to recognise their status as carers and recognise their own personal limitations in preventing or delaying a crisis, helping carers to build networks of peer support, engaging with families, local communities, employers and external agencies to identify support.
- Provide information, advice through links with Outcome 6 Increased and Improved Information

7.10 Premises

There will be a requirement that the provider of Outcome 3 will coordinate services from the Community Wellbeing Centre (once established). The café will provide a safe place for the community to go to in order to avoid isolation and preventative interventions and self management of individuals mental health issues. The provider will oversee the managing of community café within the building, this café will be expected to run out of hours from 17:00 to 23.00 at night 7 days a week. The rent for any premises used by organisations/consortium will be included within the contract price for this specification and will form part of the organisations pricing schedule for the contract.

.

8 Quality Provision

a. Quality Assurance

Organisations/consortium must achieve continuous improvement in the quality of service as measured by internal review and reviews by the Council and feedback from past and present Service Users.

Enfield Council will set targets for performance directly as demonstrated in Section 9 on page 12. Targets will be reviewed annually, or more frequently as necessary in response to performance issues.

Organisations/consortium will be expected to be proactive in monitoring their own performance against the contract and immediately report to the Contract Manager any

areas where it is encountering difficulties in fulfilling the terms of the Contract; and proposing to the Council new ways of improving the services arising from technology and other developments.

Organisations/consortium will work to maximise the appropriate skills, awareness and qualifications of its paid staff and volunteers. It will agree with the Council minimum level of staff and volunteers and their qualifications for key areas including;

- Customer services
- Advice work
- Systems for monitoring
- Safeguarding Training
- Managing risk

Organisations/consortium will undertake a programme of appropriate training for all their staff and ensure an on-going learning and development programme is in place.

b. Confidentiality

The service will have a written policy on confidentiality, stating that information about a person using the scheme is confidential and any circumstances under which confidentiality might be breached. Organisations will be expected to be compliant with General Data and Protection Regulation (GDPR) legislation.

c. Complaints

The service will have a written policy describing how to make complaints or give feedback about the scheme or members of staff. Where necessary, the scheme will use its services to access external independent support to make or pursue a complaint.

d. Safeguarding Policy and Procedures

All organisations applying for this funding stream must have their own Safeguarding Policy and Procedures. All applicants must have a named dedicated Safeguarding Officer who has undertaken London Borough of Enfield Safeguarding Adults training. If applying as a consortium the Safeguarding Officer must be an employee of the lead organisation. In addition, all organisations directly delivering services to vulnerable people will have undertaken safeguarding training.

Organisations/consortium need to ensure that all individuals engaged in one to one and group activities with people accessing the service are subject to a valid enhanced disclosure check for regulated activity undertaken through the Disclosure and Barring Service (DBS); and: -

a) monitor the level and validity of the checks for each member of staff;

b) not employ or use the services of any person who is barred from, or whose previous conduct or records indicate that he or she would not be suitable to carry out Regulated Activity or who may otherwise present a risk to Service Users

c) shall immediately notify the Council of any information that it reasonably requests to enable it to be satisfied that its safeguarding obligations have been met.

d) shall refer information about any person carrying out the Service to the DBS where it removes permission for such person to carry out the Service (or would have, if such person had not otherwise ceased to carry out the Service) because, in its opinion, such person has harmed or poses a risk of harm to the Service Users.

e) maintain a policy regarding confidentiality of information about Service Users. Service staff and volunteers must have knowledge and understanding of this policy

9 Performance Measures

Performance Measures must be linked to all the outcomes under the Section 5 of this specification. Organisations/consortia are invited to create their own performance indictors using a mixture of outcomes and outputs measures. Good measures will combine both qualitative and quantitative information and data.

All targets must be **SMART**; **S**pecific, something you can **M**easure or observe and **A**chieve, something that is **R**ealistic, and have a **T**ime limit.

The Charities Evaluation Service has a number of tools and documents which can support you in establishing a performance measurement system:

http://www.ces-vol.org.uk/tools-and-resources.html

Performance Measures will be formally agreed following the contract award and in partnership with the successful awardee and the Local Authority.

Outcomes	**Outcome Indicators**
Increased confidence and ability to self-manage health conditions	• Numbers of referrals to service • Numbers of people feeling more confident and able to self-manage • Breakdown of demographic information of those accessing service • Service user/family feedback • Service user surveys • Evidence of partnership working

	• Number of referrals to other services and types of services • Case study evidence
Increased opportunity and people accessing monitoring of health conditions in non-medical settings	• Numbers received monitoring in community locations • Numbers accessing community café and referral pathway in. • Service user feedback • Satisfaction level with service • Numbers using community service instead of primary/secondary care
Increased ability, confidence and skills for preventative self-care e.g. healthy eating, exercise, peer support, creative therapies	• Number of people confident to self-care • Number reporting improved health and wellbeing • Numbers referred to other service and types of services • Service user feedback • Case studies
Increased education and information around preventative and self-care	• Number of people who feel better informed about their condition • Number of people who feel better informed about prevention and self-care • Service user feedback • Case studies
Decrease in numbers of people accessing primary and secondary care due to Long Term Conditions and Mental Health.	• Numbers for each condition accessing primary care • Numbers for each condition accessing secondary care • Service user feedback • Case studies
Reduction in emergency hospital admissions and accessing blue light services associated with existing conditions	• Hospital data (provided by CCG) • Emergency Service data (provided by CCG) • Service user feedback • Case studies
Increased numbers of community health checks/monitoring	• Numbers referred for a community health check • Numbers receiving a community health check • Numbers using community setting for health monitoring • Number of people accessing the Community Café.

	• Number who felt they were better able to manage their health and wellbeing following the health check • Summary of issues from analysis of health checks • Reasons for requesting a health check • Service user/family feedback
Demographic and Equalities Data	• Demographic profile of service users including equality characteristic profile • Analysis of emerging patterns of referrals and non-referrals that could indicate discrimination of any group • Analysis of service users using accessible information • Number of new services taken up from hard to reach group • Evidence/case studies regarding impact on social isolation

10 Delivery Arrangements

It is expected that the successful organisation/consortium will have a specific knowledge and understanding of Enfield, its populations and the challenges they bring. The organisation/Consortium must deliver the function in the Borough of Enfield.

It is encouraged that the successful organisation/consortium approach service delivery from a Hub and spoke model, including home visiting, to ensure accessibility for all.

Due to the broad nature of the outcome, and necessity to reach all elements of the diverse Enfield population, it is expected that applications will be from consortium or partnerships rather than singular organisations. This is to ensure specialism in the service provision and recognition of the good practice for individual client groups that currently exists in Enfield.

Applications will be expected to provide services to all residents of Enfield, with a focus on the following key risk groups:

- People with a Mental Health condition
- Older People
- Carers
- Vulnerable Children transitioning to adulthood
- End of Life;
- People with a Learning Disability;
- People on the Autistic Spectrum
- People with Dementia

- Physical Disability; and or a sensory impairment
- People with a long-term condition
- Challenging behaviour
- Muscular Dystrophy/Multiple Sclerosis
- Those not meeting eligibility criteria for statutory services

All services funded through this funding stream will also have to demonstrate how their work will help to reduce social isolation and reach people and communities otherwise not in contact with statutory services.

11 Contract Period and Payment Terms

This contract is for 3 years, from May 2020 until 31st March 2023, with the option to extend for a further 20 months, to 29th November 2024. Contracts will only be extended where all monitoring has been provided on time and outcomes have been fully met.

The organisation/consortium will be informed by October 2022 whether the contract will be extended until 29th November 2024,

In the final contract year (Year 3, 2023 and Year 4 2024 (if applicable) organisations/consortium must provide evidence of sustainability beyond the contract funding or how the service will be discontinued, and transition of clients managed

Payment will be made quarterly, with the first quarter upfront. Other quarters funding will be released on receipt of satisfactory monitoring information.

12 Contract Monitoring

Contract monitoring will be expected every quarter. The Councils Pentana system will be the operating model used for reporting monitoring information. The lead Provider will be the organisation responsible for reporting on the whole contract using the Council's Pentana system. The format of such monitoring will be agreed between the successful organisation/Consortium

Monitoring visits may take place at least once every six months, with an annual service report and review visit at the end of each financial year.

Demographic and equalities monitoring will be required every quarter.

Successful organisations/consortium must agree to submit all aspects of monitoring as requested, including personal details of the clients they work with obtaining their permission when necessary.

The successful organisation/consortium will be required to attend regular meetings for all contracted providers under this funding stream to feedback on their services, share good practice and develop formal working relationships and pathways. attendance is mandatory.

Any difficulty in providing said information or attendance at meetings must be discussed with the named Council Officer at the earliest opportunity.

Each successful organisations/consortium will have a named Council Officer throughout the length of the contract to ensure clear communication and service management from both parties. It is expected that issues may arise throughout the life of the contract with this new approach, particularly in the first year. Open and honest communication is encouraged between both parties and any difficulties must be flagged at the first possible opportunity.

13 Key Risks

a. Organisational Failure

All organisations/consortium must produce a mobilisation plan demonstrating how they plan to work to meet the outcomes of this specification taking into consideration the deployment of resources required. In addition, organisation/consortium must produce an exit plan should the service become unsustainable.

All Consortia should have a formal written plan agreed between all partners on how to manage the failure or underperformance of each individual organisation within the Consortium. Expectations of delivery must be agreed between the organisations prior to contract award.

b. Sustainability

It is expected that the organisations/consortium, in particular the lead partner, will look to add value to this contract through additional fundraising and income generation. Each financial year the contract value will be reduced by 5% of the annual total cost. It is expected that the organisation will raise a minimum of 10% of the contract value in addition per annum from Year 2 onwards.

With local government and health resources reducing, all organisations/consortium should be providing a plan for alternative and supplemental funding streams.

14 End of Contract

In the final contract year (Year 3, 2023 and Year 4 2024 (if applicable) organisations/consortium must provide evidence of sustainability beyond the contract funding or how the service will be discontinued, and transition of clients managed

Appendix 1

	Summary	Summary Description	Outcomes
Daytime Service	Supporting people to improve health and wellbeing	As per main specification	As per main specification
Twilight Service	Out of Hours Community Café	The Community Café will be under a pilot from launch and for the first 12 months and this specification will be updated regularly as part of ongoing evaluation and improvement. The out of hours community café will be a twilight service. Hours of availability: 17:00 to 23:00 Inclusion Criteria: • Adult (18 years +) residents of Enfield who are known to mental health services and have written in their crisis intervention plan that they should access the OOH Community café and this is flagged on RIO and / or the SIM register • Those presenting in crisis to MHLS, CRHT and SIM emergency services and the services have checked on RIO and / or SIM register that the person should be diverted to the OOH Community Café Exclusion Criteria: • Adults with dementia. • Children or adolescents • People exhibiting violent or aggressive behaviour • Active suicidal ideation and who may need admitting to hospital • Those requiring assessment under s136 of the Mental Health Act • Those who need to be detained under the Mental Health Act • Homelessness – those requiring a housing intervention. • intoxicated, or primary problem is related to addiction to drug and/or alcohol	• Reduction in overall number of people known to mental health services falling in to mental health crisis • Reduction in subsequent use of emergency services by those accessing the café • Improved user experience of access, response and intervention from services when in crisis • Reduction in psychiatric inpatient admissions • Decrease in intensive health and social care packages following discharge • Increase in people better able to self- manage their mental health and avoid further incidence of crisis • Decrease in high and intensive health and care packages following discharge from inpatient care

SERVICE SPECIFICATION DOCUMENT END

ANNEX A
HHASC Service Background to Specifications

1. Introduction

Enfield has a proud history of working with a strong, vibrant and innovative voluntary sector. As part of our work to recommission early intervention and preventative services to support the people of Enfield, we are keen to work with local organisations to deliver the kind of joined up services which the people of Enfield expect and need.

We strongly welcome collaborations across VCS organisations that broaden the offer and strengthen the resilience of the services available to support the principles of truly independent living, recognising people's strengths and aspirations and personal resilience where people are enabled to work in a variety of ways to do more for themselves and live healthier lives with access to the information, advice and support they need to make informed decisions about the things that matter to them most.

Enfield has a growing and aging population and the number of people who need care and support from Health and Social Care continues to increase. Early intervention and prevention support is critical in enabling more people to avoid crisis and to continue to live independently within their own homes. National legislation is clear about this:

"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)

There is an increasing emphasis from legislation and guidance on how statutory provision should support people to remain independent and avoid the need for services. This support can range from advice and guidance on healthy living to ensuring that those people in receipt of services are able to remain as independent as possible. The aim is to prevent needs for care and support from developing where possible. This approach has the dual benefits of enabling people to retain independence and autonomy over their care as well as ensuring public funds are spent economically and effectively.

The Better Care Fund is a Government initiative launched in 2013 to increase and enhance integration of Health and Social Care services. The aim is to improve people's experience and the outcomes achieved with a more efficient use of resources overall. The fund creates a single pooled budget for health and social care in order that they can work more closely together.

Enfield Council is commissioning outcome focused early intervention support based on independence and social inclusion principles for people with health and social care needs in Enfield for Adults aged 18 and over. This support is intended for people at risk, to halt or slow down any deterioration and actively seek to improve their situation.

Social care has evolved nationally and the Personalisation Agenda is key to this. The focus of service now relates more to the person as an individual, enabling them to make their own informed choices and live as independently as they are able. This specification has taken into account national guidelines, reports and legislation. Also, taken into consideration were the views of Service Users and Providers. This specification reflects the Council's values of:

Good homes in well-connected neighbourhoods

- Continue our pioneering approach to regeneration to create thriving, affordable neighbourhoods and places.
- Increase the supply of affordable, quality housing options for ownership, social rent and private rent.
- Drive investment in rail, roads and cycling infrastructure to improve connectivity and support economic development.
- Create an enterprising environment for businesses to prosper with world-class digital infrastructure and access to the right skills and networks

Sustain strong and healthy communities

- Protect those most in need by continuing to deliver the services and safeguarding measures they rely on.
- Work smartly with our partners and other service providers so that as many people as possible are able to live independent and full lives.
- Build measures into all our strategies and projects that will help improve public health and people's wellbeing.
- Work with partners to make Enfield a safer place by tackling all types of crime and anti-social behaviour; and protecting the local urban and green environment

Build our local economy to create a thriving place

- Work with local businesses and partners to develop a strong and competitive local economy and vibrant town centres that benefit all residents.
- Support residents to take more responsibility and play a greater role in developing active and safe communities.
- Enable people to reach their potential through access to high quality schools and learning; and create more opportunities for training and employment.
- Embrace our diversity, culture and heritage and work on reducing inequalities to make Enfield a place for people to enjoy from childhood to old age.

2 Understanding Enfield's Community

2.1 Population

The demographics of Enfield are changing. The population of the Borough is increasing and the people are living longer. Enfield is the fourth largest Borough in London by population. The total population is set to increase from 331,500 in 2015 to 376,800 in 2025. The number of people over 65 years of age is forecast to increase by 23% in the next 10 years from 42,400 in 2015 to 52,500 in 2025. This poses a

significant local challenge in terms of resources and developing service to meet future demands.

2.2 Deprivation

Enfield is also one of the most highly deprived Outer London boroughs. Within the borough of Enfield itself, the most deprived wards are Edmonton Green, Upper Edmonton, Lower Edmonton, Edmonton, Ponders End and Turkey street. Enfield ranks as the 14th most deprived London Borough. Nationally, Enfield is ranked 64th most deprived out of the 326 local authority areas in England. Levels of deprivation vary considerably across the borough, and there is a stark east-west divide.

Economic deprivation has been associated with an increased risk of a number of health conditions and lower life expectancies. These include:

- increased risk of mental health conditions,
- increased risk of obesity and diabetes
- increased risk of heart disease,
- premature mortality -> male life expectancy in the most deprived areas is 6 years lower than in the least deprived wards.

This indicates that people in more deprived area may require social care support at a younger age than people in less deprived area, and may have different circumstances and needs.

Deprivation is also associated with a number of hazardous behaviours, such as:

- lack of physical activity
- smoking
- excessive drinking
- social isolation
- poor diet

These are all risk factors of long term conditions such as stroke and indicates more opportunities for preventative programmes.

2.3 Life Expectancy

Life expectancy in Enfield also varies hugely by geography. For males in Enfield, lower life expectancies are generally found in the North and East of the borough.
The difference between life expectancy and healthy life expectancy in Enfield is 11.7 years for men and 18.2 years for women. This means that Enfield residents live their last 12 years of life for men and 18 years for women in poor health.

The health needs of older people become more complex, as 61% of people aged 80 and over report having at least one limiting condition (over 8000 individuals).

- Depression affects 1109 people aged 80 and over (8.4%)
- Dementia affects 2142 people aged 80 and over (16.3%)
- 4533 people aged over 80 are at risk of falls (34.5%)
- Among people aged 75 and over:
  - 13778 are affected by a hearing impairment (62.2%)

- 13550 suffer from hypertension (61.1%)
- 2358 suffer from diabetes (10.6%)
- 1286 are affected by a visual impairment (5.8%)
- 1069 suffer from heart attacks (4.8%)
- 536 suffer from stroke (2.4%)
- 337 suffer from COPD (1.5%).

Often older people suffer from two or more of these conditions at once.

2.4 Deaths

The largest numbers of deaths in Enfield are due to circulatory (cardiovascular) diseases, cancers and respiratory diseases. Circulatory diseases, which include deaths from heart disease and strokes, accounted for 32% of all deaths, while cancers and respiratory diseases (including deaths from pneumonia) accounted for 29% and 14% of all deaths respectively.

The most common cause of death among adults aged 65 and over in Enfield between 2012-2016 were cardiovascular diseases (21%) followed by lung cancer (14%).

Deaths among adults aged 65 and over accounted for 41% of all deaths in Enfield.

3 Purpose of the Service

The specifications are aimed at supporting adults aged 18 and over who have or are at risk of developing long term health and social care needs. The objective is to improve quality of life by ensuring timely and appropriate interventions are in place that support people to continue to live independently within their own homes through

- Prevention through early identification – working with service users to ensure they can self-manage their care within their home environment and avoid hospital admission
- Preventing individuals' situations from reaching a crisis point
- Ensuring people are well informed and enabled to take more control over the things they need to do to or any help they need, to remain independent with a focus on diabetes, stroke, falls prevention, dementia and end of life care and support
- Linking in with ***Outcome 6 'Increased and Improved Information Provision*** 'for signposting and the provision of information and on how service users can self-manage their long-term health conditions
- Helping people to become more engaged in their community through social and leisure activities to manage depression and isolation, and improve physical activities
- Contributing towards carers support by identifying people with caring responsibilities by signposting them to ***Outcome** 1' 'Helping people to Continue Caring to enable carers continue to their caring role*

The successful Consortium will work in partnership with Enfield Council, specifically the Adult Social Care teams, Enfield CCG and other community organisations. We expect each lead partner to adopt a champion and strategic role in the promotion of the services offered and to lead on reducing inequalities in terms of age and disability.

3.1 Core Service Principles

The Service embraces the following key principles, all of which should seek to promote the maximum possible independence for Service Users and to assist them to lead fulfilled lives:

- **Working in Partnership –** organisations will bring their own specialist skills and knowledge of the community to a consortium creating links to the community and with statutory health and social care services.
- **Respecting Diversity and Promoting Independence:** Working in partnership with Service Users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity. People are supported to learn or relearn skills which promote independence and to make informed choices.
- **Focussing on inclusive community participation*:*** Where appropriate, people are supported to access existing opportunities and universal services in their local community rather than creating or attending segregated activities, and increase the capacity of communities to accommodate those at risk of developing health and social care needs.
- **Delivering sustainable local services –** organisations must demonstrate their ability and plans to access other non-council funding sources and promote local volunteering opportunities which reflect our diverse community.
- **Demonstrating a strong evidence base –** each partnership will demonstrate how it will focus on:
    - demand management (reducing the number of people accessing statutory health and social care services)
    - reducing levels of dependency and need and promote self-management
    - reducing costs of statutory service provision
- **Working with Health and Social Care services –** to develop pathways into early intervention services and working towards recording data on the Council's client information system (Care First) to demonstrate activity and outcomes
- **Demonstrating strategic leadership –** each partnership must demonstrate how it will provide leadership and represent the Age and Disability equality strands

4 Outcomes Based Commissioning – A New Approach

Outcomes Based Commissioning promotes prevention and early intervention at the heart of health and social care services. The overall objective is to improve health and wellbeing of the Enfield population therefore reducing the demand for statutory

services. It rewards both value for money and delivery of better outcomes that are important to people.

‘Outcomes’ refer to the impacts or end results of services on a person’s life. As such, outcome-focused services aim to achieve the aspirations, goals and priorities as defined by service users.

It enables provider organisations to find innovative solutions to deliver improved outcomes for services users at a lower cost. This will enable the delivery of new models of support.

Our aim is to transform the way services are provided by putting what matters most to the service users, carers and their families at the heart of everything we do. We want to deliver services that meet the peoples' needs with greater emphasis on prevention and by working together improving the quality of care provided to Enfield residents.

This approach also gives clear responsibility and increased flexibility to providers in terms of service delivery. It is recognised that providers will know the needs of their client population best and can often come up with more creative solutions, at a lower cost, to meet needs and improve service user and carer’s outcomes.

This is a new approach for Enfield Council and therefore this contract will depend on good communication and collaboration between the provider and the Council to ensure success.

ANNEX B

DATA SHARING AGREEMENT (DRAFT)

Data Sharing Agreement between Signatory Organisations for the Purposes of VCS Outcome 3 Supporting People to Improve their Health and Wellbeing and Improving Self-management

Version Control

Version No.	Date	Reason for Change	Author
1.0	19 Dec 2019	Initial draft for tender	Steve Durbin steve.durbin@enfield.gov.uk

Contents

Purposes of the data sharing initiative

This Data Sharing Agreement is made between the signatories for the purposes of:

- VCS outcome 3 - Supporting People to Improve their Health and Wellbeing and Improving Self-management
- Monitoring and management of deliveries, expenditures and outcomes from the above

The signatories aim to:

- Deliver services to people who have requested them under the purposes
- Share information with consent to avoid people having to repeat themselves
- Monitor and manage the delivery outcomes to ensure success

The expected benefits of the data sharing are:

- Better health and wellbeing of persons requiring support, leading to improvements in society in general.

The organisations that will be involved in the data sharing

This agreement is made between the organisations listed at Signatories and Contact Details (Appendix A - below), individually referred to as signatory, collectively known as the Signatories. Contact details for each organisation are provided at the appendix noted

Organisations may be added to this agreement by consent of all the current signatories. Organisations may be removed from the agreement by the objection of any one of the signatories to inclusion.

For all changes, including additions and removals, a new version of this agreement will be circulated to all parties and the versioning updated in the Version Control section above.

Any organisations not listed above will NOT be involved in this data sharing. However, each party will have its own delivery partners (e.g. cloud providers, outsourcers) who may have access to data under processing agreements with the organisations listed.

Each signatory to the agreement is required to ensure that their own processing and storage arrangements for the data does not create a breach of the terms of this agreement.

Each signatory warrants that their processing, storage and use of the data shared is fully compliant with the data protection law in force in the UK, and guarantees to maintain this compliance throughout the life of the agreement.

Failure to comply with any of the terms of this agreement constitutes a breach of the agreement and will result in removal of the organisation from this agreement.

Data items to be shared

The list below covers all data items permitted to be shared under this agreement.

Data Item Details	Reason for sharing	Special conditions e.g. restrictions on access/storage, permissions
Name, address, contact details, other identifiers	Ensure correct individual is identified; to be able to contact the individual.	None
Details of medical conditions e.g. type of condition, issues with self-management	Information to help the signatory organisation performing delivery provide appropriate service.	Special Category Data - - health and social care data.

Basis for Sharing

Data will be shared between the signatories only on the basis of consent of the data subject.
The data subject will be provided with a consent form which will include details of which signatories data will be shared with, the data to be shared and details of their rights, including the right to withdraw consent at any time. This provides a legal basis under GDPR Article 6 1(a) for the personal data and GDPR Article 9 2(a) for the health and social care data, which is special category personal data.

Access and individuals' rights

Right to be informed should be covered by each signatory at time of sharing is discussed; consent to the data sharing MUST be explicitly given by the data subject.
Each signatory is responsible for responding to requests under data protection law from the data subjects. Specifically, requests should be handled as follows:

- Right to access (Subject Access Request): Should be fulfilled by the signatory to whom the request is made; as part of normal subject access request provision, the data provided will include the source of the data, so the subject may make further requests to the signatories
- Right to rectification: Should be shared with signatories so that data can be amended on all systems (this may be automated). All signatories must confirm to the signatory receiving the request within 10 working days that they have updated the data
- Right to erasure: Should be shared with signatories so that data can be deleted from all systems. All signatories must confirm to the signatory receiving the request within 10 working days that they have deleted the data, or that they have a basis for retaining the data that should be communicated back to the data subject
- Right to restrict processing/Withdrawal of consent: The receiving signatory must fulfil the request and communicate it onward to the signatories if required
- Right to data portability: It is expected that this will be covered in the same way as a Subject Access Request
- Right to object: Should be considered by the receiving signatory. If the objection is valid, processing must stop and this must be communicated to all signatories
- Rights in respect of automated decision-making and profiling: These must have been dealt with by each signatory as part of their Data Protection Impact Assessment.

Information governance

Sharing Details

These are given above in "Data Items".

Data Quality

Each signatory is responsible for ensuring the quality of data in its datasets. To ensure that integrity is being maintained, each signatory may on an annual basis request from the signatories a separate sample of data items in order to audit their systems; this may be no more than 5% of total data records.
Negative outcomes of the audit should be reported to the signatories so that action can be taken to improve systems.

Retention Period

Each signatory has a published retention policy which applies to all data in this agreement, available from the signatory website.

Data Security

All signatories are required to maintain suitable levels of security for all data at all times. This includes:

- Transmission of data between signatories online may only be via encrypted means with a suitable cipher (e.g. AES256 over TLS1.2). Signatories must immediately stop using any ciphers or protocols known to have vulnerabilities as published by the UK CERT.
- Offline data transmission must use encrypted media e.g. Microsoft BitLocker, with access passwords consisting of a minimum of 16 random printable characters.
- All signatories must ensure that data is backed up as per industry norms and that these backups are protected via secure storage and transport, encryption or other suitable methods.
- Data shared is at the security classification of OFFICIAL-SENSITIVE unless otherwise stated

Data Breach

In the event of a data breach affecting data in this sharing agreement, the organisation(s) suffering the breach must inform the signatories within 24 hours of detection. This should contain full disclosure of knowledge of extent, method of breach and potential consequences to data subjects, and be updated as quickly as practicable as new information is discovered. The organisation(s) suffering the breach are responsible for reporting to the ICO and the data subjects.
The outcomes of investigations into the breach will be shared on a confidential basis with all signatories so that learning can be undertaken and security improved.

Review of agreement

This agreement will be reviewed annually by all signatories for effectiveness, necessity and compliance with current practice. The reviews will be recorded in the Version Control section above, but re-signing of the agreement will not be required unless substantial change is made.

Termination

This agreement may be terminated for a signatory by:

- Removal of the organisation for breach of agreement as noted in the sections above
- The organisation wishing to exit as the agreement is no longer in their interest
- Legal action or other outside requirement necessitating the exit of the organisation

The whole agreement may be terminated by agreement of more than 50% of the signatories.
On termination, either for an organisation or for the agreement, each organisation must securely remove from their systems all data not owned by them that has been shared under this agreement, and inform the organisation that shared it in writing that the data has been removed. Organisations must complete this action within 1 calendar month of the termination.

Appendix A - Signatories and Contact Details

Organisation	Key Contact Email	Data Protection Officer Email	Signatory name and Signature
Enfield Council	Someone.Important@enfield.gov.uk	Enfield.Data.Protection.Officer@enfield.gov.uk	A. Director-Enfield
Organisation A	Someone.Important@example.com	Data.Protection.Officer@example.com	A. Director-OrgA

Appendix B - Glossary of Key Terms

Term	Meaning
Data Subject	Takes the meaning in data protection law i.e. the natural person about whom data is held

Appendix C - Key Legislative Provisions, Regulations and Guidance

Law, regulation or guidance	Applicability
Data Protection Act 2018 (including the Applied GDPR)	All personally identifiable information is covered by this law
Information Commissioner Guidance on Data Sharing Agreements	Used to create this template

Appendix D - Model Consent Form

[TO BE ADDED FOLLOWING DISCUSSION WITH SIGNATORIES]

Appendix E - Data Sharing Decision Diagram

[GUIDANCE: This section should contain a flow diagram showing how decisions about sharing data are made]