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**HHASC Service Specification Outcome 5**

**People Recover from Illness, Safe and Appropriate Discharge from Hospital**

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**HHASC Service Specification Outcome 5**

**People Recover from Illness, Safe and Appropriate Discharge from Hospital**

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 delivers support flexibly 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.

1. **Outcome Rationale**

The basis of this specification is informed by a number of key drivers, which include the Corporate Plan, ‘Health and Social Care Integration Agenda (Better Care Fund); The Care Act 2014 (Information ‘key delay and prevention of dependence’); and continuous improvement in terms of providing quality services to the citizens of Enfield.

***2.1 Population Needs - Vulnerable People of Enfield***

This integrated model of care has been developed specifically to focus on the needs of adults at risk who require mental and/or physical support and frail older people aged 65 plus who require support to enable them to continue to live safely in the community. These groups and individuals are characterised as having health and care needs associated with: -

* having long term care and support needs
* living alone and experiencing loneliness, depression and isolation
* high level dependencies for activities of daily living
* risk of admission to long term care or acute hospital
* being cared for by people who themselves are frail and elderly

In Enfield, it is estimated 7,200 people aged over 65 have 2 and more problems with daily task, and 4,050 have 3 and more problems. 31% of Enfield’s population of people aged 65 plus live alone with limited social networks and have difficulty in accessing information advice and support. Accommodation can influence care needs specifically those with complex needs who have a greater risk of falls and live in isolated conditions

***2.2 Population Needs –Hospitals: Delayed Transfers of Care (DToC)***

The number of delayed transfers of care for people leaving hospital settings has risen markedly, both locally and nationally, over the last 3-4 years. In 2012-13 Enfield had154 patients delayed for a total of 3,914 days. For Apr-Dec 2016 223 patients were delayed by 5,527 days. National Data (ADASS) shows that DToCs have risen nationally by 42% in four years (individual days from 119,736 to 169,928).

DToC in Enfield is dominated by local providers, with 85% of DTOC within the first nine months of this year occurring within three trusts, the Royal Free London NHS Foundation Trust (20.5%), North Middlesex University Hospital NHS Trust (25.3%) and Barnet, Enfield and Haringey Mental Health NHS Trust (BEHMHT) (39.8%).

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>

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1. **Contract Value**

Applications are invited up to the value of £ 120,000 per annum.

As stated in the guidance this must cover the outcomes stated in this specification.

The successful organisation will be invited to bid for an additional £10,000 towards strategic leadership of the service and to promote the services outcomes across the borough. This will be awarded to the Lead Partner to cover additional management and administrative costs, and for service promotion.

1. **Aims and Objectives of the Contract**

The overarching aim is to: -

* Help people care for themselves at home for as long as possible.
* Provide information for service users and their carers to stay well e.g. healthy eating, well-being and lifestyle
* Assist and enable smoother, safer discharge processes by supporting carers to be involved in discharge care planning
* Take a person-centred approach, facilitate people and their carers to navigate the care system and make choices both now and in the future about the help, care and support available to them from diagnosis onwards and to be a point of contact for these individuals, including providing advice, information and signposting to advocacy services;
* To help users of the service to feel more confident and safe in their home
* To ensure service users have an increased and improved individual positive experience of services in the community and in hospital
* Reduce length of stay in hospital through facilitated early discharge by supporting users to self-care at home
* Reduce emergency admission and readmission to hospital
* Reduce delayed discharges for people not otherwise eligible for social care support
* Ensure carers are adequately informed, consulted and prepared to care
* Provide time limited education and support to service users and carers including support in self-care to improving adherence, risk factor modification, symptom control, functional capacity and overall well-being
* Information and support for patients and families considering supported living or residential care

1. **Outcomes**

The key outcome is that people are confident and enabled to live independently at home rather than in a hospital setting by ensuring that the quality of support in the home is right. Should the need to be admitted to hospital arise then the service user should have a clear understanding of how their care and support will be managed during their stay.

Service users who are medically stable and have reached an appropriated level of

physical and cognitive recovery will be discharged as soon as possible. The

discharge process will be more efficient and effective taking into consideration the

person’s continued rehabilitation/enablement in their home environment and the

support needs of their carer to continue their caring role and maintain their well

being.

Emphasis is placed on the heightened need to coordinate the activities to provide support across health, social care and the voluntary communities for vulnerable older people and those with physical or mental health needs. It is therefore essential that the outcome based approach to supporting vulnerable people is person-centred, holistic and integrated across health, social care and the organisations/consortium

**Expected Domain Outcomes:**

* Contact with in-patients at an earlier stage to discuss needs (eg housing/tenancy sustainment, sustaining employment) – planning is timely
* People feel consulted, involved and supported through the discharge process
* Increased awareness of services available to support recovery
* Reduced hospital readmission
* Reduced recovery times
* Carers feel confident to continue to care
* More people in contact with support service before and after discharge
* Reduced number of complaints

1. **Definition and Eligibility**
   1. **Definition**

To support service users who are at risk of hospital admission or re-admission and enable those in hospital who are medically stable and have reached an appropriate level of physical and cognitive recovery to be discharged safely back into their community.

To provide support to service users at home allowing them to reach their full potential to live safely and independently in their community by ensuring appropriated intervention and support is provided by the voluntary and community sector in a personalised way and reduces the demand for health and social care support.

* 1. **Eligibility**

This service will be accessible for all adults age 18 and above and those transitioning into adulthood who have non-statutory care needs and reside in Enfield. Carers who live in another borough but care for a resident in Enfield will also be eligible.

This service will be not accessible to services users who live outside the Borough, or to carers who care for someone outside of the Borough. In these instances, referral for support should be made to their home borough.

1. **Service Description**

This will be a whole-system partnership model of integrated care. It ranges from

supporting users to access information and advice to sub-acute support in the

community and the front door of the acute hospitals of the Royal Free London NHS

Foundation Trust, North Middlesex University Hospital NHS Trust and Barnet,

Enfield and Haringey Mental Health NHS Trust. Facilitated early or timely discharge

from acute in-patient care, back into the community is also a key component of the

service.

Services delivered should provide an opportunity for significant improvement to

service user’s ability to care for themselves and improved pathways through a focus

on: -

1. Linking into ***Outcome 6 Increasing and Improving Information*** for the provision of information and advice for those who are able to manage their own needs
2. Prevention and early intervention services for people at risk of deteriorating health
3. Working in partnership with Mental Health Services, Community health services, GPs and in the acute hospitals to ensure coordinated, effective planning of discharge to a person’s own home.
4. Providing support for service users in need of rehabilitation, and those at risk of admission to a care home
5. Providing support for people who are ill and at risk of admission and re-admission to hospital
6. Provide support at home for End of Life users wanting to stay in familiar surroundings

For this to be successful the following will be required: -

* A point of Access – to include GP referrals, Hospital base, Multi-Disciplinary Meetings through the Integrated Model of Care
* Working with key health and social care partners in the identification of those service users at risk and assessment process as an outcome from the multi-disciplinary meetings
* Sharing Information Protocol

**7.1 Key Features of the Service**

Organisations/consortium will work within GP based practices where referrals will be made by the GP for service users who live on their own and who are deemed ‘at risk’. The referral will guide the appropriate intervention that will need to be provided to users of the service in their own home/place of residence i.e. support with medication, nutrition, identifying trip hazards for those experiencing repeated falls. Organisations/consortium will ensure high quality co-ordinated support so the service user at risk can live safely in their home through the self-management of their care.

Risk stratification tools, clinical experience and data on service user episodes of care will be used to identify the actions to be taken. Criteria includes:

* Type of Hospital admissions
* Frequent A&E attendances
* Long Term Conditions
* Level of multi-agency input

Organisations/consortium will also work with Enfield Adult Social Care, BEH Mental Health Trust, the acute hospitals as well as the CCG to develop a safe discharge pathway to ensure safer discharge planning with service users and their carer. Organisations/consortium will support service users identified as ready for discharge through the ‘Discharge to Assess’ initiative and will work alongside care professionals at ward level to ascertain what the patient would need to support a safe discharge back into their home together with any carer’s support needs.

## Once discharged Organisations/consortium will assist with the assessment at the service user’s home along-side key professionals and provide the appropriate intervention i.e. falls prevention, stroke, diabetes or dementia specialist services. Organisations/consortium will link in with *Outcome 2 – ‘Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community Including Avoiding Crises’* to support this function.

Organisations/consortium will ensure that the service user is safe, confident and comfortable in their home following discharge and provide a range of re-settlement services to include: -

* Preparing home prior to discharge i.e. checking home is presentable, putting heating on or airing
* Supporting people with issues around their tenancies or employment
* A time limited health and well-being check
* Collection of medication from the pharmacy
* Basic shopping requirements
* Checking prescribed medication is being taken
* Ensuring equipment or assistive technology has been delivered and is being used correctly
* Effective self-management of personal care and mobility in the home
* Effective self-management of nutrition and cooking ability where appropriate
* Checking domiciliary care arrangements are in place and active
* Identifying and managing risks which may impact on the service user’s ability to stay safe in their home i.e. housing condition, identifying and managing trip hazards, housing maintenance and support to pay bills or claim benefits
* Act on any presenting changes to symptoms not normally associated with the service user and refer or liaise with specialist services
* Direct assistance with, or regular encouragement to perform, tasks of daily living i.e. bathing, dressing, cooking and domestic cleaning
* Advise and support skin care such as moisturising very dry skin
* Providing advice and support on self-care skills including signposting to sites such as Dementia Care and Carers Support
* Signpost to and help arrange social/leisure activity to alleviate depression and isolation
* Assistance with putting on appliances with appropriate training for example leg calliper, artificial limbs and surgical stockings and assistance with visual and hearing aids e.g. glasses care, hearing aid battery checks
* Support to attend day services and any GP, memory clinic or hospital appointments

**7.2 Carers support**

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 underpins 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***

**7.3 Premises**

Rent for any premises used by organisations/consortium are included within the contract price for this specification

1. **Quality Provision**
2. **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 10. Targets will be reviewed bi-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

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.

1. **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.

1. **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.

1. **Safeguarding Policy and Procedures**

All organisations/consortium 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 Regulated Activity 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

1. **Performance Measures**

Performance Measures must be linked to all of 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>

As part of the application process, organisations/Consortia will submit at least one performance measure directly linked to each outcome point and demonstrate how this measure has been met.

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

|  |  |
| --- | --- |
| **Outcome** | **Performance Indicator** |
| Peoples feel consulted involved and supported through the discharge process | Service user/family feedback  Service user surveys  Case studies |
| Increased awareness of services available to support recovery | Service user/family feedback  Service user surveys  Mystery shopping |
| Reduced hospital readmission | Number of service users reporting increased confidence post discharge  reporting increased by 20% per annum |
| Reduced recovery times. | Number of service users reporting increased mobility post discharge increased by 20% per annum  Number of service user reporting increased independence post discharged increased by 20% per annum  Number of service users reporting increased independence post discharged increased by 20% per annum |
| Carers feel confident to continue caring. | Carer feedback  Evidence of improved well-being for carers |
| More people in contact with support services before and after discharge | Number of service users using new services. Increased by 20% per annum |
| Reduced complaints | Complaints monitoring  Positive feed back |

1. **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 a service to all residents of Enfield, prioritising focus on the following key risk groups:

* Older People
* Carers
* Vulnerable Children transitioning to adulthood
* End of Life;
* People with a Learning Disability;
* People on the Autistic Spectrum Disorder
* People with a Mental Health condition
* 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 funding 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.

1. **Contract Period and Payment Terms**

This contract is for 3 years, from 1st December 2017 until 30th November 2020, with the option to extend for a further 2 years, 2022 + 2 years to 30th 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 April 2020 whether the contract will be extended until 30th November 2022, and again by April 2022 to confirm extension to 30th November 2024.

In the final contract year (Year, 2020 and Year 5 2022 and Year 7, 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 will be released on receipt of satisfactory monitoring information

1. **Contract Monitoring**

Contract monitoring will be expected every quarter. The Councils Care First 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 Care First 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 organisations/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.

1. **Key Risks**
   1. **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 organisation/consortium 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.

* 1. **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.

1. **End of Contract**

In the final contract year (Year 3, 2020 and Year 5/7, 2022 and 2004 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.