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**HHASC Service Specification Outcome 2:**

**Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community**

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**HHASC Service Specification Outcome 2**

**Supporting Vulnerable Adults to Remain Living Healthily and Independently in the Community**

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 preventative services and interventions for vulnerable people residing in the borough of Enfield.

1. **Outcome Rationale**

**Population Needs – Vulnerable People of Enfield**

The focus of this service will be on:

* People living with early onset dementia
* People with diabetes or at risk of developing diabetes and linked conditions
* People at risk of falls or recovering from a fall
* People recovering from stroke
* People facing end of life care
* People at risk of social isolation

***2.1 Dementia***- In Enfield, the number of expected cases of dementia (around

3,100) is significantly higher than the number of cases diagnosed, with 60% of

people living with dementia diagnosed as at end Mar-15. Improving the rate of

dementia diagnosis in the population is a key performance indicator in Enfield’s Better Care Fund Plan, with the target 66% for Mar-16.

***2.2 Diabetes*** - The rate of diabetes in Enfield is increasing and is likely to

continue to rise because of obesity. If obesity continues to rise in Enfield, an

additional 2,000 adults could develop diabetes. In addition, an additional 30,000

adults in Enfield are at increased risk of developing diabetes (known as prediabetes).

Unmanaged diabetes can lead to serious complications that could limit people’s

independence and quality of life.

Diabetes is one of the most common co-morbidity amongst unplanned admission

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 had diabetes as comorbidity while almost two fifths of the renal failure cases

also, had diabetes. Some of these cases could have been prevented if diabetes was

prevented in the first place. It is estimated that more than half 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.

***2.3 Falls***- Enfield’s JSNA Older People with Complex Needs Factsheet estimated 10,925 older people had falls in 2012, of which a smaller proportion result in emergency admission. There were 736 residents aged 65+ (616 aged 75+) with frailty fractures in 2011/12, with this figure increasing to 879 aged 65+ in 2013/14, a 5% increase on 2012/13. Of these 879 patients in 2013/14, 11 had fracture neck of femurs equating to £150k.

The risk of falls increases with age: 23% of people aged 65–79 have falls, but 36%

of those who are 80+ years, whilst the falls risk is known to be greater amongst men

than women. A fall will also increase the risk of recurrent falls. Conditions affecting

mobility & balance, e.g. musculoskeletal conditions, Parkinson’s disease etc. also

increase the risk of falls and recurring falls.

Of those people with hip fractures, it is estimated 50% never regain former abilities

and 20% die within 3 months. Falls contribute up to 25% of care home admissions in

Enfield. Their residents are more likely to fall than those living in community due to

their frailty, and unfamiliarity of home to new residents, e.g. with sight loss or

dementia. 60% living in homes have recurrent falls each year, with up to 25%

resulting in hospitalisation.

***2.4 Stroke*** - It is estimated that there are 550 strokes per year in Enfield. In the total population, it is estimated that there are 4,595 stroke survivors, of which 1,470 have moderate or severe disabilities caused by stroke. These estimates are based on the age/gender/ethnic profile of the population. The African or Caribbean ethnic groups have a higher risk of stroke than the general population.

In 2005-07, 547 people in Enfield died due to stroke. Enfield’s mortality rate due to stroke is falling and continues to be significantly below national rates, but is roughly in line with the London average. However, the rate of fall in mortality rates is not as sharp as seen nationally – if this trend continues, Enfield may see stroke mortality rates exceeding national rates within the next 5 years.

Stroke has a devastating and lasting impact on the lives of people and their families. Individuals often live with the effect for the rest of their lives. A third of people who have had a stroke are left with long-term disability. The effects can include aphasia, physical disability, loss of cognitive and communication skills (e.g. leading to aphasia), depression and other mental health problems.

**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%). Living alone can increase the likelihood that an older person feels isolated in their community.

Social isolation and loneliness is 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>

1. **Contract Value**

Applications are invited up to the value of £ 270,000 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 aims are: -

* To bring together the Voluntary and Community Sector with mainstream health and social care services to respond to local needs, deliver improvements in health outcomes and value for money commissioning.
* To enhance existing services, reduce duplication and demand for health and social care support
* To improve partnership working between social and health care and the voluntary sector,
* To ensure that people stay as well and independent as they can and their risk of ill-health and falls/fractures are reduced, as well as reducing the risk of repeat falls
* To raise awareness and understanding of diabetes and dementia to enable people to live well with the condition
* To promote a person-centred approach to providing support
* Facilitate service users 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 of ill health onwards and to be a point of contact for these individuals, including signposting to services and advocacy
* Monitor and evidence measurable improvements in terms of achieving healthy lifestyles for service users and their carers
* Ensure that people and their families/ carers receive an excellent experience through all aspects of the care pathway
* To ensure service users and their carers are active citizens and can influence and contribute to the design of services and services are flexible and responsive enough to work within the changing landscape
1. **Outcomes**

The key outcome is to provide suitable interventions so that service users and their carers can continue to live independently within their own homes, avoid crisis or presenting themselves to A&E and/or hospital admission. Service pathways will be co-ordinated and streamlined so that those using the service have a better experience and are confident that they have the appropriate advice and information as well as practical home support.

Support will be personalised to the individual and is high quality and responsive so that users of the service are confident to self -care and carers feel they are equipped, 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 organisations working as part of a consortium in an

integrated way together with health and social care professionals.

**Expected Outcome**s

* People feel able to maintain a good standard of wellbeing
* People have a choice of appropriate activities which promote wellbeing
* People are able to live independently and safely in the location of their choosing for longer
* People feel settled and secure in their accommodation choices
* People are less likely to access primary (community) and secondary (hospital) care services
* Reduced emergency hospital admissions
* Reduced admissions to residential care homes
* Those receiving End of Life care can do so in their chosen location
1. **Definition and Eligibility**
	1. **Definition**

Service provision is focused at low level support helping people who need support to

keep them living independently within their own home. 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 i.e. diabetes or events –such

as stroke, dementia or falls –

Primary Prevention – Services will help maintain independence, health and

wellbeing by improving access to universal good quality information about local

services, promoting health and active lifestyles. This will be done through links with

*Outcome 6 ‘Increased and Improved Information Provision’.* Practical support will be

delivered that helps people withsmall tasks, whilst promoting social contact for people and a positive image. 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, diabetes, strokes or falls are identified and supported to self-manage their

conditions and have the ability to live independently in their community.

Services will refer to the appropriate agency should risk to a service user’s well

being increase or as and when required.

* 1. **Eligibility**

This service must be accessible for all adults aged 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 not be accessible to people 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**

***7.1 Prevention and Early Intervention – Falls***

The service model within this specification proposes that organisations/consortium will have in-depth knowledge of specific conditions i.e. falls and fractures in older people or population groups with support needs, and develop close connections with service users to improve the value of their wellbeing and achieve their individual outcomes.

Organisations/consortium will also have good knowledge and working 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.

Signposting to information and advice and helping to establish and maintain social networks for service users and their carers will be an important factor in the delivery of this service.

Organisations/consortium will 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.

Organisations/consortium will provide advice and signposting services for other issues that might be causing stress, including areas like isolation and loneliness, housing maintenance and repairs.

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***7.2 Prevention and Early Intervention – Stroke Services***

This service model aims to deliver a Community Stroke Navigation Service to support rehabilitation, reintegration into the community, volunteering, return to work and support stroke survivors, their families and carers to navigate health and social care systems in the borough of Enfield. Organisations/consortium of this service will add value to the existing community services and build capacity of local organisations to be better able to support people affected by a stroke. Organisations/consortium will support carers and associated others in their journey to ensure a continuous pathway

The Community Stroke Navigator Service will:

* provide practical support to people affected by stroke, their families and carers.
* Support rehabilitation enabling service users to self-care and improve their health and/or to return to work or new employment or volunteering opportunities.
* work alongside a multidisciplinary team of professionals across health and social care. This may include providing additional low level therapies in conjunction with community health professionals
* support service users, carers and family members to navigate how further support/advice can be obtained
* signpost to advocacy services for stroke survivors and their families / carers as they work towards adjusting to the change in circumstances caused by stroke
* link with handyperson services for any repairs or adaptation which may need to be undertaken to help service user continue to live safely at home
* provide a checking in service to ensure service users and their carer are living well and coping at home.

The delivery of this service is based on Organisations/consortium accessing referral through a Hub base within the community health teams and/or direct contact to the stroke service user/families/carers. Referrals may also be accepted from other health and social care professionals who identify stroke service users in need of support who have not been referred or from stroke teams outside of Enfield for service users registered with an Enfield GP.

 ***7.3 Prevention and Early Intervention – Dementia***

This service model is aimed at providing a timely response for service users and their carer/families. Organisations/consortium are expected to work closely with Community Health Services, GP, and the borough Memory Clinic

Organisations/consortium of this service delivery will deliver the following -

* Provide support for service users pre-and post-diagnosis of dementia advising on the range of community services available and signposting to relevant agencies
* Educate, raise awareness and understanding of dementia to enable people to live well with the condition
* Support and facilitate partnership working between Adult Social Care, Health and the other community sector service
* Forge links with ***Outcome 6 Increased and Improved Information***
* Pro-actively work with other voluntary sector partners who might provide opportunities for people with dementia and their carers who may want to access to fulfil their needs and requirements.
* Promote the principles of self-management, self-help, autonomy and independence amongst people with dementia and their families;
* Provide flexible and responsive support at home to service users and their carers encouraging use of technologies to support safe self-care
* Be an accessible point of contact for service users with whom they work, including hard to reach communities.
* Support service users and carers to access community assets, services or activities they identify as important to them to improve their motivation and self-confidence and reduce the risk of isolation;
* Forge links to End of Life Care provision within the borough
* Ensure equality of access and experience for all with dementia

***7.4 Prevention and Early Intervention – Diabetes***

Organisations/consortium will deliver structured education programmes in conjunction with Community Health Services. The Service will provide motivational support and will signpost people to physical activity, healthy eating, and weight/obesity management programmes available in the community.

The Service will provide support to service users at risk to help them make changes to a healthier lifestyle. Organisations/consortium will need to demonstrate how they will deliver the service based on a community setting close to where people live. The Service will use a community development approach and will be specifically designed to integrate within the local community and actively engage with groups including hard to reach communities and care professionals.

Organisations/consortium of this service will

* Have links to the existing health promotion programmes promoted by NHS through community service teams
* Have a person-centred, structured curriculum that is theory-driven and evidence-based, resource-effective, has supporting materials, and is written down
* Have the appropriate trained staff to deliver the educational programme, including the use of different teaching media
* Ensure programmes are flexible enough to suit the needs of the individual (for example individual learning needs and meeting the cultural, linguistic, cognitive and literacy needs of service users
* Offer group education as the preferred option, but with an alternative of equal standard for a person unable or unwilling to participate in group education
* Forge links with members of the diabetes healthcare teams in the borough of Enfield and integrated with existing care pathways
* Enable people with diabetes and their carers to contribute to the design and provision of local programmes

***7.5 Prevention and Early Intervention – Carers***

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 and advice through links with ***Outcome 6 Increased and Improved Information***

**7.6** ***Premises***

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

1. **Quality Provision**
	1. **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 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** |
| People feel able to maintain a good standard of well-being | * Service users survey
* Service user/family feedback
* Number of people securing employment, education or volunteering 20% increase per annum
* Number of people engaged in community activities 20% increase per annum
* People have increased learning and improvements in life skills

and employment and training opportunities |
| People have choice of appropriate activities which promote wellbeing. | * Service users survey
* Evidence of providing choice and control
* Case studies
* Number of service users who have increased levels of social interaction and reduced

levels of isolation increased by 20% per annum |
| People are able to live independently and safely in the location of their choosing for longer | * Number of people taking up new services increase by 20% per year
* Number of service users regularly attending/completing prevention programmes
* Number of service users reporting improved confidence/motivation
* Number of service users reporting increased mobility and independence increased by 20% per annum
* Training evaluation reports
 |
| People feel settled and secure in their accommodation choices | * Evidence of home assessment
* Service users surveys
* Evidence of reduce repeat falls
* Mystery shopping
 |
| People are less likely to access primary (community) and secondary (hospital) care services | * Number of service users supported increasing by 20% per year
* Number of referrals from Access team supported by services provided increase by 20% per annum
 |
| Reduce hospital admissions | * Number of service users reconnected to appropriate community services
* Evidence of reduced repeat presentation to A&E
 |
| Those receiving End of Life Care can do so in their own chosen location  | * Case Studies
* Service users/family feedback
* Service user surveys
* Evidence of action taken in accordance to service users’ needs and wishes
 |

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. 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 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 3, 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 funding 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 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.

* 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