**APPENDIX 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:

*Fairness for all*

• Serve the whole borough fairly and tackle inequality

• Provide high quality, affordable and accessible services for all

• Enable young people to achieve their potential

*Growth and sustainability*

• A clean, green and sustainable environment

• Bring growth, jobs and opportunity to the borough

*Strong communities*

• Encourage active citizenship

• Listen to the needs of local people and be open and accountable

• Provide strong leadership to champion the needs of Enfield

• Work in partnership with others to ensure Enfield is a safe and healthy place to live

**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.

1. **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.