Haringey Council

NHS
Haringey
Clinical Commissioning Group

APPENDIX 4

Service Specification

for

Haringey residents aged 18+

Neighbourhoods Connect service – West Haringey

Glossary

Contract monitoring	A formal agreement between the commissioning agency and service provider
Core Requirement	Obligation to do something in a form prescribed by the commissioner
Key Stakeholder	Council Officers and voluntary sector providers and organisations
Measure	The means to evaluate an outcome
Outcome	The expected end result to a process or completion of a work activity in the form of an output
Output	Output is defined as the act of producing something, the amount of something that is produced or the process in which something is delivered
Partnership	A triangular relationship of co-operation that will exist between the Council, the service provider and voluntary sector organisations in Haringey
Specification	A set of instructions, presented in the form of a plan that provides the information needed to produce, build or develop a service
Tender applications	The formal process used to determine who the Council will contract with and on what basis that contract will be formed
Building Capacity	Supporting voluntary sector groups and organisations in

	Haringey to identify and apply for public sector and non-public sector revenue funding, grants and capital. Work with voluntary sector groups and organisations to develop business and financial plans that focus on long term stability, and resilience to change. Promote partnership working between the Council, voluntary groups and local people
Contractor	The service provider
Statutory sector	Publicly funded bodies or organisations that include the local Council, NHS, public health and or any other organisation or body set up and funded by Government
Partner	Any voluntary sector organisation who is in receipt of funding from the Council or statutory sector body or function. Organisation in the strategic partnership with Haringey (referred to as partner in this specification)
Strategic partnership	Two organisations who work together to deliver agreed outcomes; in this case between Haringey and the successful organisation.

1. Introduction

Haringey Council's Commissioning Unit is responsible for the commissioning of adults and children's services that support the residents of Haringey. Haringey Council has worked in partnership with colleagues in Haringey Clinical Commissioning Group (the CCG) to develop this specification. Both the Council and Haringey's Clinical Commissioning Group are committed to enable all people to directly manage their own care and maximise choice, independence and control.

The Council and the CCG are keen to ensure that a wide range of preventative and early intervention offers are available to the residents of Haringey as this will support people maintaining a better quality of life and increasing their ability to maintain their independence.

2. Specification

This specification is intended to set the requirements by which the contracted service provider is expected to comply**.** However, it is not the purpose of this specification to limit or restrict the service provider's innovation or ability to deliver a responsive service, but is intended to set the performance requirements and minimum expectations the Council require from the service provider.

3. Health and Wellbeing

Haringey's Health and Wellbeing Strategy (2012 – 2015): A Healthier Haringey mutually supports the Council's Corporate Plan and five principles, listed here;

1) Every child has the best start in life

2) A reduced gap in life expectancy

3) Improved mental health and wellbeing

These three outcomes are supported by 14 priority work areas. This service has been designed to contribute to these outcomes and priority work areas.

4. Council Priorities

Haringey Council's Corporate Plan, Building A Stronger Haringey Together 2015 - 2018 sets the Council's priorities and outcomes.

The Council sets out five strategic priorities in the Plan:

- Priority 1: Give every child and young person the best start in life, including providing high-quality education for children and young people.
- Priority 2: Help people live healthy, long and fulfilling lives
- Priority 3: Ensure Haringey is a clean, green and safe place where everyone has a good quality of life and feels proud to call home
- Priority 4: Encourage growth and bring new jobs to the borough
- Priority 5: Create homes and ensure our communities are places where people choose to live and can thrive

These strategic priorities will be delivered in line with six cross-cutting themes:

- Prevention and Early Help
  Providing support earlier to prevent problems from occurring or escalating
- Tacking Inequalities
  Tackling the barriers facing the most disadvantaged and enabling them to reach their potential
- Working with communities
  Building resilient communities where people are able to help themselves and support each other
- Value for Money
  Achieving the best outcome from the investment made
- Customer Focus

Placing our customers at the heart of what we do

- Working in Partnership
  Delivering with and through others

These priorities and themes will be used to inform this service's aims and objectives, delivery and outcomes.

5. CCG Priorities

Haringey CCG's five year strategy sets out the CCG's vision and plans until 2019 to improve health and well-being in Haringey. The strategy sets four core objectives to deliver the vision:

- Explore and commission alternative models of care
- More partnership working and integration as well as a greater range of providers
- Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing
- A re-defined model for primary care providing proactive and holistic services for local communities, supporting "healthier Haringey as a whole".

These objectives will be used to inform this service's aims and objectives, delivery and outcomes.

6. Better Care Fund Intentions

The Haringey Better Care Fund seeks to reduce the number of emergency hospital admissions in Haringey through the reorientation of health and social care provision from reactive care (mainly provided in acute and institutional settings) to proactive care (mainly provided in people's homes and by primary, community and social care). To deliver this people will not be defined by their disabilities, but by their abilities, their potential and what they can do for themselves, with and without support.

Two hundred local people have helped develop the following priorities. Integrated services will be:

- Easy to access, through a single point of access
- Well managed and provided by competent professionals and staff
- Person Centred and personalised to the experiences and views of people who use them
- Provide good and timely information, from a variety of sources including the voluntary and community sector
- Enable individuals to do things for themselves through prevention, self-management and reablement
- Work together as one team, including the patient/service user, with clear and constant communication
- Promote wellbeing and reduce loneliness through community capacity building.

These priorities will be used to inform this service's aims and objectives, delivery and outcomes.

7. National legislation, Guidance and Good Practice

It will remain the responsibility of the service provider to be aware of current and changing legislation governing and informing the delivery of services, and will remain the responsibility of the service provider to ensure that it complies with all and any changes to national legislation and published guidance on good practice.

8. Freedom of Information Act and Information Sharing

The service provider will assist and supply the Council with information when requests for information are made of the Council under the Freedom of Information Act 2000.

The service provider will develop and hold an information sharing policy that is responsive to the Data Protection Act 1998 and Human Rights Act 1998.

9. Staffing, Management and Recruitment

This service provider will:

The service provider will be responsible for checking that the people it employs and those deployed to work in this service have the right to work in the UK.

https://www.gov.uk/check-job-applicant-right-to-work

Only engage and deploy staff members to work with people using this service who have had a Disclosure and Barring Service check.

Ensure that all volunteers deployed and supported to work with people using this service have been subject to a Disclosure and Barring Service check.

Only engage and deploy a workforce that has demonstrated the necessary management and people skills required when working with the people who will use this service.

Always deploy a sufficient number of paid employees to enable this service to operate at capacity.

Ensure training is available to all staff and managers that is relevant to the delivery of this service.

Make training available that measures competence levels, promotes knowledge and offers new skills relevant to the delivery of this service.

Ensure an adequate number of operational managers are always available to support staff and volunteers in their duties.

10. Health and Safety

All parts and elements of the service and its delivery must be compliant with the relevant parts of the Health and Safety at Work Act 1974 and compliant with all the necessary Fire Safety Regulations.

The service provider will ensure a policy and guidance on safe working is in place and is made available to the workforce.

The service provider will ensure it is compliant with all health and safety regulations when undertaking all and any activities related to the work specified in this service specification.

11. Safeguarding and Whistle Blowing

This service and the delivery of this service will follow and act upon the guidance set out in London's multi-agency Pan London Safeguarding Policy and Procedures, a link to which can be found below.

www.scie.org.uk/publications/reports/report39.pdf

The service provider will take instruction and act on advice from Council Officers on the delivery of services related to safeguarding and any changes to safeguarding policy.

The service provider will create and, or adopt a Whistle Blowing Policy. The Whistle Blowing Policy will be both informed and responsive to the Pan London Safeguarding Policy and Procedures and or any other safeguarding policy or procedures the Council adopt.

The service provider will update the Whistle Blowing policy annually and make the policy available to staff and volunteers working for and, or representing the service provider. The policy will likewise be available to people and interested parties who use this service.

This service provider will always alert Council officers when any safeguarding concern, allegation or complaint is raised, or made know to the service provider by contacting the Council's Adult Social Services or First Response (Children and Young People Safeguarding Team). Information on how to contact these teams is available on the Council's web site or by calling the Council's switchboard.

It will remain the responsibility of the service provider to keep all information up to date and available to its staff and volunteers.

12. Communication

It will remain the responsibility of the service provider to ensure it is always aware of the named officers in the Council who are responsible for contract liaison, finance, commissioning and safeguarding.

All and any individual enquires relating to any individual person using this service, or who are connected to this service must be made by contacting Haringey Council's Customer Services. Customer services are contactable by e mail and telephone.

The service provider will ensure effective communication exists in all published, printed, verbal and electronic communications with the people who use this service, Council officers and their representatives.

People who use this service will be facilitated to express their views about the service they receive, be involved and included in any decisions made about how the service is delivered, and, or offered to them.

13. Compliments and Complaints

A compliments and complaints procedure will be developed where one does not exist. This will be accessible, easy to follow and available to people who use this service.

The compliments and complaints procedure will be made available to officers from the Council on request.

The compliments and complaints procedure will be reviewed annually.

All compliments and complaints will be recorded and held by the service provider in a log. This log should where possible will be held and maintained electronically. Where this is not possible information should be held in a paper format.

14. Access to the Service

This service will operate within the times and on the days stated in the tender applications, and or negotiated contractual arrangements Council officers have formally agreed with the service provider.

The service provider will advertise, publish and make widely available information that clearly informs people who may wish to use this service, when this service is available and how it can be accessed.

15. Standard Practice

It will be standard practice to:

Treat people who use this service with dignity and respect.

Share all information relevant to the delivery of this service with Council Officers and or any person nominated by the Council.

Record and retain for the purpose of inspection and information, the number of people who:

- Use this service, over what duration or frequency that person uses this service
- Present as repeat users and the frequency of that repeat usage
- Request access to this service, including those who do not ultimately access, or use this service
- Make enquires about the service
- Are held on a waiting list (if this is applicable)

Ensure people who use this service have had their health and care needs considered and included in the delivery of this service.

Ensure all and any policies, practices and guidance are written down and informed by the Race Relations (Amendment) Act 2000 and Equality Act 2006.

Regularly checks on all internal policies will be carried out to ensure that policies are reviewed and updated at regular intervals, are dated and make reference to the most recent and relevant statutory legislation and guidance, informing the delivery of this service.

Work continuously to achieve and improve upon the outcomes described in this specification.

16. Core Requirements

Background to service

"Social isolation has a negative impact on quality of life and wellbeing. Social isolation not only increases the risk of mental health conditions such as depression, but it is also linked with physical health conditions such as hypertension. Such negative impact on health leads to higher health and social care service use, while lonely and socially isolated individuals are more likely to have early admission to residential or nursing care. (Windle et al*)

The benefits to individuals and the wider community of reducing social isolation are therefore self-evident, bringing improved quality of life for individuals and reducing pressure on health and social care services."

* Windle et al: Social Care Institute of Excellence Research Briefing 39: Preventing loneliness and social isolation: interventions and outcomes

Service Description

Neighbourhoods Connect is a community based service that is focused on improving outcomes relating to health and wellbeing and community participation in Haringey residents. The service will have a particular focus on adult population groups who are at increased risk of social isolation, including:

- people with long-term physical and mental health conditions,
- unpaid carers,
- people who are housebound,
- people with dementia and their carers,
- older people living alone or with an unpaid carer.

Four Neighbourhoods Connect Services will be commissioned. There will be one service for each GP collaborative network. The four GP collaborative areas are as follows:

1. West Haringey
2. Central Haringey
3. North East Haringey
4. South East Haringey

Each service has aims and objectives for both individuals and for the wider community:

Service objectives at the individual level:

- Support people to improve their overall wellbeing
- Support people to make connections with local activities and services available that support their wellbeing, including self management of long term conditions, opportunities to take part in physical activity, and social and cultural pursuits.
- Contribute to reducing social isolation and loneliness that can be experienced by people in later life, people with a mental illness or a long term condition.
- Contribute to increasing training, volunteering and employment opportunities for both the client group and the people involved in delivering the service.
- Promote self-care and independence so that clients can, where possible, avoid use of emergency health services, and reduce their dependency on statutory agencies.
- Support people to recognise and develop their coping skills

Objectives at the community level

- To map out the assets that already exist in communities that support people to live fulfilling healthy lives and share this intelligence with partners.
- To contribute to increased community cohesion and strengthened communities
- The service provider is expected to work collaboratively with other providers commissioned by this service and existing and emerging services that are relevant to their service. Commissioners will support this outcome to contribute to building capacity across community networks for grass roots organisations and groups.

It is expected that each of the four services will serve a minimum of 250 clients, improving and measuring their outcomes .

Service outcomes:

The Service Provider will be expected to make a positive impact on the following outcomes amongst people accessing the service. These outcomes are aligned with the objectives of the Service:

1. Improved self-reported wellbeing (as measured by the Warwick-Edinburgh Scale).
2. Increased participation in community groups, services and activities.
3. Increased participation in training, volunteering and employment (among service users, or people delivering the service).

The Service Provider will be expected to have their own delivery model to achieve these outcomes. Innovative approaches are welcome.

When will the service be available

The service will be available to residents for 13 months, from 1st March 2015 until the 31st March 2016.

The service provider will be expected to consider how it would respond to seven day working in line with national policy.

Where the service will be delivered from

The service provider will make available all and any IT and telephone equipment and physical location required to enable the scheme to operate.

Who will deliver the service

The service provider will be responsible for the recruitment and day to day management of all staff, including volunteers. The service provider will ensure that staff and volunteers have access to the most up to date information and advice, or have access to a professional information and advice service which they can call upon and use to support this service offer.

The service provider will be responsible for providing all staff and volunteers with training relevant to the delivery of this service offer. Core training will include:

- Safeguarding children and adults: Basic Awareness e-learning – this training can be access via the Council's website www.haringey.gov.uk/learn
- Whistle blowing
- Dignity and respect
- Equalities and Diversity

In addition, the service provider is expected to take advantage of training opportunities offered by Haringey Council and Haringey Clinical Commissioning Group (over the life of the contract), which may enhance service offers. Training could include:

- Motivational Conversation techniques
- Communicating effectively
- Dementia awareness
- Making Every Contact Count training offer
- Healthy lifestyle – awareness of services available and how to signpost effectively (stop smoking, health eating, etc)

Eligibility and exclusion criteria

To receive the service residents must meet the following criteria:

- Resident of Haringey, or registered with a Haringey GP or be supporting a resident living in Haringey
- Aged 18 or over
- Give consent
- Home and social situation deemed not at risk

Although acceptance of clients will be at the discretion of the service provider, the service must have a particular focus on population groups who are at increased risk of social isolation, including:

- people with long-term physical and mental health conditions,

- unpaid carers,
- people who are housebound,
- people with dementia and their carers,
- older people living alone

For people who fall within the eligibility criteria, the service offer must not discriminate against the protected characteristics of the Equality Act 2010.
Children and young people aged under 18 would not be eligible for the service.

Identification of clients and referral into the service

Clients can be referred into the service through a number of routes:

- Identification by the provider organisation using their own local intelligence
- Referral via GPs (including identification through risk stratification tools)
- Referral via social services
- Referral after hospital discharge or as part of a period of reablement
- Referral from community health services.
- Referral from projects aiming to integrate health and social care including locality teams and value based commissioning (these projects are in development)
- Self-referral or family referral
- Local residents

The service provider will proactively engage with other agencies to establish referral routes.

The service provider is expected to respond rapidly to requests from the commissioner to prioritise certain referral pathways. Enabling people to be able to access social support during a period of physical reablement will be a core part of the approach going forward. An example of a targeted approach would be that the service provider is requested to provide support to a list of housebound people during severe winter weather conditions.

Managing Risk

When it appears to the service provider that the resident has needs that should be assessed by statutory services, including health, housing and social care, an onward referral should be made.

Service offer for eligible residents

For illustration purposes only, the following are examples of evidence-based approaches that could be incorporated into the service or linked to the service.

1. Strength and balance exercise programmes.
2. Peer led self-management programmes for people with long-term conditions.
3. Motivational interviewing techniques to help people achieve wellbeing goals such as stopping smoking or exercising more.
4. Regular face to face or telephone support by volunteers
5. Care navigation approaches.

The service would not be expected to deliver the following:

- Clinical information and care
- Clinical diagnostics
- Staff and volunteers promoting their own commercial services / interests
- And other issues as agreed between the Commissioner and service provider.

How people will receive the service

The service provider will be expected to deliver against the outcomes of the contract. It is at the discretion of the service provider to determine how the service will be delivered in order to achieve the outcomes.

Additional requirements

The Service Provider will be expected to identify alternative funding sources that could be used to support the service before the conclusion of the contract.

Asset mapping

Asset mapping is an important component of the service delivery model, the Service Provider will map out and mobilise the assets that already exist in communities that support people to live fulfilling healthy lives. These assets may include groups, such as religious or community groups, important individuals within the community, or important places where people meet and community skills, knowledge and abilities.

After 12 months of service delivery the Service Provider will provide a written report on the asset mapping process. This report will list and describe the assets that have been identified, and describe how the assets have been utilised as part of the Service.

17. Outcomes and Monitoring

Haringey Council Public Health Team will support the service provider in developing an evaluation framework. The Service Provider will have the responsibility of collecting outcome data and reporting back to the Commissioner on achievement of outcomes on a three monthly basis. Once the contract is awarded, a contract monitoring framework will be agreed with the service provider.

We would expect the service provider to make an impact on the following three core outcomes:

Core Outcome 1	Haringey residents aged 18 and over are supported to improve their wellbeing
Measure	1. Number of residents supported 2. Positive impact on self-reported wellbeing (Warwick Edinburgh Scale) from baseline, with measures at 2 month follow up, 6 months follow up, and 12 months follow up (where possible)

Core Outcome 2	Haringey residents aged 18 and over are supported to connect with their community
Measure	Number of connections made to community groups, services and activities. Comparison of baseline participation in groups and activities, with follow up levels at 2 months, 6 months and 12 months.

Core Outcome 3	Haringey residents aged 18 and over are supported to be active participants in their community
Measure	Number of service users who are supported into: 1. Training 2. Volunteering 3. Employment opportunities. Number of people involved in service delivery who: 1. Volunteer as part of the project 2. Enter into full time employment 3. Enter into full time training 4. Are trained in specific skills such as motivational interviewing

	or as peer

In addition to the three core outcomes, the Service Provider should choose one additional outcome for achievement through the service. This outcome should be selected by the Service Provider based on the needs and priorities of the local community. **The Service Provider can specify any outcome it deems to be of local significance or could select an outcome from the list below:**

1. People aged 18 and over who are at risk of a fall are supported to reduce their falls risk.
2. Increase in number of people trained in dementia awareness
3. People with a long term condition who are supported to self manage their care.

Outcomes for measurement only

The Commissioner will monitor the impact of the service on the use of emergency hospital services. This is so the Commissioner can measure that impact that the service has on this important outcome. The Service Provider is expected to contribute to the measurement of this outcome, but **will not be monitored on performance** against this outcome.

Outcome for measurement only	Reduction in self-reported emergency health service use
Measure	1. Mean reduction in self-reported emergency annual hospital admissions amongst clients of the service. Measured at baseline and 6 and 12 month follow up. 2. Mean reduction in self-reported annual Accident and Emergency attendances at the among people accessing the service. Measured at baseline and 6 and 12 month follow up.

Monitoring

To enable evaluation and monitoring of outcome data, the Service Provider will collect a minimum dataset for **each service user.**

The service provider will be required to provide quarterly contract monitoring reports, using the minimum data set.

Below is a provisional minimum dataset. This is for illustration purposes only and will be finalised after the contract is awarded. Haringey Public Health Team will support this process:

Example of minimum dataset

Data requirement:	
Age	
Gender	
Ethnicity	
Postcode	
NHS number	
Date of first contact with service.	
Duration of support	
Type of support	
Average hours per week of support	
Baseline wellbeing score	
Baseline participation in community activities (number of activities and hours per week)	
Baseline employment status	
Baseline use of emergency health services	
2 month follow-up wellbeing score	
2 month follow-up participation in community activities	
2 month follow-up employment status	

2 month follow-up use of emergency health services	
6 month follow-up wellbeing score	
6 month follow-up participation in community activities	
6 month follow-up employment status	
6 month follow-up use of emergency health services	
12 month follow-up wellbeing score	
12 month follow-up participation in community activities	
12 month follow-up employment status	
12 month follow-up use of emergency health services	

Service user feedback

Haringey Council Public Health Team will support the Service Provider to develop a method for collecting service user feedback. The Service Provider will be asked to collect feedback using this method.

Service Review

A service review will take place at the conclusion of the contract.