Agenda Item 7

Report to:	**Audit, Best Value and Community Services Scrutiny Committee**
Date:	**5 November 2013**
By:	**Acting Director of Public Health**
Title of report:	**Public Health Commissioning Update**
Purpose of report:	**To update the Scrutiny Committee on progress with the public health service review process**

RECOMMENDATION: The Committee is recommended to note the progress made with reviewing and re-commissioning public health services

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1. Financial Appraisal

1.1 There are no specific additional financial implications associated with this report. Activity is within the scope of the agreed public health budget allocation funded through the ring-fenced public health grant.

2. Background

2.1 The current Public Health Portfolio Plan commits to a three year programme of reviewing and where appropriate re-commissioning all public health services.

2.2 A timescale for review and re-commissioning services was set and activity areas/services were divided into 2 tranches. The timescale for Tranche 1 services, which includes existing health improvement services and new health improvement interventions which had not been commissioned in East Sussex previously, but which had been identified as an urgent priority to meet population need, is January 2013 to June 2014. The timescale for Tranche 2 services, which includes the rest of the public health services, is July 2014 to December 2015.

2.3 This paper updates the committee on Tranche 1 review and re-commissioning of services.

3. Tranche 1 and Tranche 2 Services

3.1 The areas for inclusion in each Tranche are set out below. This also identifies whether the service is to be commissioned/re-commissioned or whether it is for review and scope/re-specify as required.

3.2 Tranche 1: Services to be commissioned/re-commissioned:

Tobacco control and smoking cessation services
Interventions to tackle obesity (weight management adults/children)
Health Trainers
Health Promotion Resource Centre
Alcohol and substance misuse (primary prevention)

3.3 Tranche 1: Services for review and scope/re-specify as required

Locally-led nutrition initiatives
Smoking cessation (GP/pharmacy Locally Enhanced Services (LES))

NHS Health checks coverage and promotion (GP LES)
Exercise referral (GP LES)
Active Hastings (partnership agreement)
Active Rother (partnership agreement)
Active Women (partnership Agreement)
Community Food and Vegetable project (partnership agreement)
Child accident prevention (partnership agreements)
ASSIST tobacco control (partnership agreement)
Workplace health

3.4 Tranche 2: Services to be commissioned/re-commissioned:

NHS Health check review and re-commissioning if required
Children's Health Promotion Interventions
Commissioning Grants Prospectus services (review and identify future priorities)
Capacity and workforce development
Workplace health programmes
Community capacity/asset based programmes
Sexual health services

3.5 Tranche 2: Services for review and scope/re-specify as required:

Low level ongoing health improvement activities, including:
Accidental injury prevention;
Population level interventions to reduce and prevent birth defects;
Population mental health promotion services (link to adult and child mental health strategies);
Behavioural and lifestyle campaigns to prevent cancer and long term conditions;
Local initiatives to reduce excess deaths as a result of seasonal mortality;
Local initiatives on workplace health;
Promotion of community safety and the prevention of violence;
Local initiatives to tackle social exclusion

4. Update on Tranche 1 Services

4.1 For services to be commissioned/re-commissioned:

- A health improvement commissioning group has been established within the council to oversee re-commissioning of health improvement services.
- Notice was given to the current provider (ESHT) for the following health improvement services: smoking cessation, health trainers, health promotion resources centre.
- A soft market testing event (SMT) for lifestyle services took place in August and was well attended by prospective providers. Practitioners will be supported to access health promotion resources in a variety of different ways in future, rather than through a Resource Centre.

- Service specifications were developed incorporating feedback from the SMT event and an opportunity to tender to provide the following health improvement services has been advertised with a closing date for bids of 22nd October:

  - Smoking cessation
  - Health Trainers
  - Weight management adults
  - Weight management children

- The service specifications are attached as appendices to this report. The Public Health Team is currently in the middle of a live commissioning exercise, and tenders to provide these services are currently being assessed.

  Re-commissioned services will start on April 1st 2014.

- Competitive quotations have been invited for the provision of Alcohol Identification and Brief Advice (IBA) and it is expected that a contract will be awarded by the end of October.
- Decision Support tools were completed to identify low level health improvement intervention resource suitable for inclusion in the East Sussex Commissioning Grants Prospectus. Funding awards for 1 year from October 2013 were made through this process to align with existing Prospectus investment ending October 2014.

4.2 For services to be reviewed and scoped/re-specified as required

- LES services currently operate as an element of the GMS contract and consequently services contracted under LES agreements cannot continue as such beyond March 2014. Contractual arrangements for current public health Locally Enhanced Services remain with the NHS England Area Team for 13/14. Future arrangements for contracting these services will need to include all required contractual terms, conditions and KPI's within the contract.
- Processes for agreeing the provision of public health services by GPs and pharmacies are in development and appropriate contractual formats for locally authority use have been identified. This is necessary as LES services currently operate as an element of the GMS contract and consequently services contracted under LES agreements cannot continue as such beyond March 2014.
- National requirements for elements to be included in NHS Health Check have changed and consequently a revised specification to include dementia awareness and alcohol assessment is being agreed through NHS England Area Team processes.
- Services currently operating under Partnership Agreements are being reviewed and future arrangements commissioning and contracting arrangement will be agreed by the end of 13/14.
- An internal agreement for the delivery of the ASSIST programme by the Targeted Youth Support (TYS) service has been put in place.

4.3 Although part of Tranche 2, NHS Health Check coverage and uptake is being reviewed. Additional requirements to support full roll out of health checks across East Sussex have been identified and procurement options to support Point of Care Testing (where test results are immediately available and patients do not need to come back to the surgery at a later date) and community health checks are being scoped.

5. Recommendation

5.1 Members are recommended to note progress made with Tranche 1 review and re-commissioning of services.

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Local Members: All

Background Documents
Public Health Portfolio Plan

East Sussex County Council

Service Specification

Specialist Stop Smoking Service

B03 – Service Specification

Contents

Specification

Part One - Background information

1 Introduction

1.1 East Sussex County Council intends to commission a service provider to design and deliver a Specialist Stop Smoking Service which aims to reduce the prevalence of Smoking across the County and directly support approximately 7,944 smokers to quit over 3 years and support primary care providers to enable a further 3613 people to quit with their services

1.2 The primary purpose of the Specialist Stop Smoking Service is to provide a series of evidence based treatment and behavioural support to smokers making quit attempts and provide support to primary care providers of stop smoking services. The successful reduction of smoking prevalence will reduce levels of smoking related illness, disability, premature death and health inequality.

1.3 Interventions will be Service User centred, delivered in a variety of settings, and include, education and support programmes that aim to empower Service Users to quit smoking, enhance quality in stop smoking services and provide professional specialist smoking cessation advice, support and guidance.

1.4 Services will be delivered in with the most recent best practice recommendations for stop smoking services issued by NICE and the Department of Health.

2 Evidence base

2.1 Evidenced based NHS stop smoking services are highly effective in both cost and clinical terms. The evidence based is summarised in:

- National Institute for Health and Care Excellence Public Health Guidance 10 Smoking Cessation Services
- Department of Health's Stop Smoking Service and Monitoring Guidance 2012/13

  https://www.gov.uk/government/publications/stop-smoking-service-monitoring-and-guidance-update-published

The Specialist Stop Smoking Service will enable the implementation of national and local policy and strategy, which contains references to evidenced based health improvement services and programmes, aligned to local need as highlighted in the following documents:

- *Healthy lives, healthy people: The East Sussex health and wellbeing strategy 2013-2016* (East Sussex County Council, 2012)
- *Joint Strategic Needs Assessment* (NHS Sussex/East Sussex County Council)
- *East Sussex Tobacco Control Plan (2012/13)*

3 Health impact of Tobacco Use

3.1 Reducing the prevalence of tobacco use is one of the most important interventions in improving and protecting the public's health. Tobacco use is the single greatest cause of preventable deaths in England – killing over 80,000 people per year (1000 people per year in East Sussex). Smoking prevalence in East Sussex is estimated at 19.7% just below the England average 20.2%. Whilst it is estimated there to be around 84,000 smokers as whole, there is variation in smoking rates across the county with Rother having the lowest prevalence at (14%) rising to 26.4% in Hastings, which is almost 7% higher than the England average.

3.3 Smoking can contribute to many diseases but is most commonly linked with coronary heart disease, stroke, lung cancer, asthma and chronic obstructive pulmonary disease. For those who smoke, quitting is most often the single most effective method of improving health and preventing illness. Following surgery, smoking contributes to lower survival rates, delayed wound healing and postoperative respiratory complications (US Department of Health and Human Services 2004).

3.4 Smoking is also the primary reason for the gap in healthy life expectancy between rich and poor and is a key factor in health inequalities. Smoking prevalence is highest in deprived communities but reductions in smoking prevalence have been slower in these communities than in other population groups. Reducing the prevalence of smoking among routine and manual workers, some minority ethnic groups and disadvantaged communities will help reduce health inequalities more than any other measure to improve the public's health. Among men, smoking is responsible for over half the excess risk of premature death between the social classes (Jarvis and Wardle 1999).

4 Policy context

4.1 The new Public Health Outcomes Framework, Improving Outcomes and Supporting Transparency (2012), sets out the desired outcomes for public health and how they will be measured. Tobacco Control features in the following domains:

Domain 1: Improving the wider determinants of health

- Improvements against wider factors which affect health and wellbeing and health inequalities

Domain 2: Health improvement

- People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

4.2 The following indicators which will be used to measure the impact of services and interventions which aim to reduce the prevalence of smoking in adults:

- Smoking status at time of delivery
- Smoking Prevalence – Adults over 18

4.3 The East Sussex Health and Wellbeing Board (ESHWB) is committed to reducing smoking and has set this as a key priority within the Health and Wellbeing Strategy 2013 – 2016 in seeking to 'Enable people of all ages to live healthy lives and have healthy lifestyles' (ESHWB, 2013).

5 Key contacts

5.1 East Sussex County Council teams relevant to this contract will be as follows:

5.2 Public Health Department - Health Improvement Specialist Team

This team is comprised of health improvement principals and specialists each of whom leads on a specific area. As well as commissioning and reviewing services, the team is able to provide technical advice and guidance to partners. Areas covered currently include:

- Healthy eating, physical activity and obesity
- Alcohol use and tobacco control
- Health checks
- Sexual health
- Communities and settings
- Children and younger people
- Older people and mental wellbeing

5.3 Public Health Department - Public Health Intelligence Team

This team provides a range of data and information which supports and underpins evidence-based working within the council and its partners. Major pieces of work include:

- Delivery of the Joint Strategic Needs Assessment (JSNA); an ongoing assessment of the local population's future health, care and wellbeing needs, which informs and guides commissioning of health, wellbeing and social care services. www.eastsussexjsna.org.uk.

- Production of the Director of Public Health's Annual Report. The report draws on information from the JSNA and sets out a plan for improving the health and wellbeing of local people and reducing health inequalities.

5.4 Contracts and Purchasing Unit

5.5 The Contracts and Purchasing Unit (CPU) is responsible for procuring and managing contracts of care-managed services to meet the eligible needs of people who receive health and social care support. The Council is a commissioning organisation and the role of CPU is essential to this process.

The role of CPU is to:

- procure the services that are identified by Commissioning;
- support, alongside operational staff, the process of service users accessing those services; and
- ensure they are provided in the way that had been intended.

Part Two - Detailed specification for a Specialist Stop Smoking Service

1 General Overview

1.1 The provision of high quality stop smoking services is a high priority. Stop Smoking Services have already helped many people to stop smoking successfully and are a key part of tobacco control and health inequality policies at local and national levels.

1.2 Stop smoking interventions must be delivered by a stop smoking advisor, accredited with stop smoking service training that meets the established National Centre for Smoking Cessation and Training (NCSCT) standards for one to one or group support. Stop smoking services are time limited interventions to support people who smoke to successfully and permanently stop smoking.

1.3 Stop smoking services comprise an offer of behavioural support and pharmacotherapy. Success is assessed at 12 weeks after the Service User has stopped smoking with progress assessed four 4 weeks of stopping. Stop Smoking Services should be offered to anyone who expresses an interest in stopping.

1.4 Support to help people stop smoking in East Sussex comprises two elements:

- **A Specialist stop smoking service**

This is the service we are seeking to commission, and which we describe in this service specification and primary care based stop smoking services.

- **Primary Care based stop smoking services**

Primary care services are provided by General Practices and Pharmacies in their own premises to their patients and customers only. Smokers are largely recruited opportunistically from patients using primary care services.

1.5 **Specialist Stop Smoking Service**

This service provides support to people wishing to stop smoking in community locations and settings. Service users are drawn from the general population and are recruited into the service using behavioural and social marketing techniques; through the development of relationships with key organisations, agencies and referral pathways e.g. with acute and community care health and social care providers.

In particular the specialist service will target priority groups and people who may find it more difficult to stop smoking e.g. pregnant women and people in Routine and Manual occupation groups.

The Service will also provide training, support and resources to those who work with smokers in a range of settings, to enable them to move people around the motivational cycle (from pre contemplation to action) such that they are ready to stop smoking.

In addition to the specialist service, the stop smoking service will also be responsible for supporting primary care providers, to achieve the expected number of quitters from these settings. This will include supporting set up of any new primary care services, the provision of advisor training and continuing professional development (CPD) technical and professional advice relating to smoking cessation, provision and maintenance of all materials associated with providing the service in primary care. The specialist service will also act as an expert voice on smoking cessation, providing ad hoc advice to all partners on smoking cessation issues, participate in the East Sussex Tobacco Partnership and other relevant partnerships, respond to media queries on smoking cessation (in conjunction with the commissioner) and seek to promote the benefits of stopping smoking in all their activities.

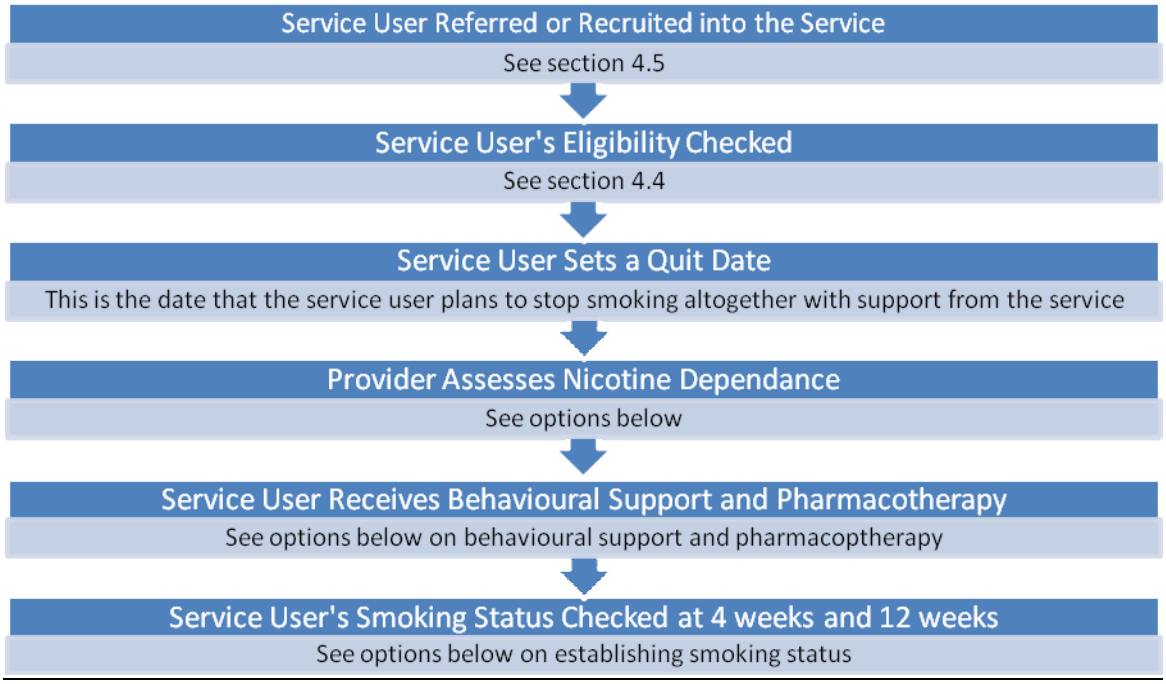
1.6 The Service will provide professional and technical support for primary care stop smoking service providers, ensuring that they are consistently able to meet and evidence defined quality based standards of service delivery and performance achievement through this element of stop smoking service provision, including practice visits, telephone support, training and continuing professional development and the provision and maintenance of equipment and consumables.

2 Service Model

The Service delivery model for the Specialist Stop Smoking Service should be consistent with the following framework:

- Service User referred or recruited into the services
- Service Users eligibility checked

- Service User sets a quit date (this is a date that the Service User plans to stop smoking altogether with support from the service)
- Provider assesses nicotine dependence (see options below)
- Service User receives behavioural support and pharmacotherapy (see options below)
- Service User's smoking status check at 4 and 12 weeks (see options below)



3 Service Aims

The aims are to provide a Stop Smoking Service that:

- Offers choice of treatment options appropriate to Service Users
- Is equitably accessible to all smokers
- Offers the most effective evidence based treatments available
- Supports people to successfully quit smoking
- Achieves high levels of Service User satisfaction

4 Specialist stop smoking service objectives

4.1 The Service will be offered to all smokers in the general population who both express a desire to quit smoking and demonstrate sufficient motivation to do so. The expected proportion of smokers seen through the specialist service is

between 67% and 70% of all people quitting with a service with the remainder treated in primary care smoking cessation services

The Service offer will be targeted to priority groups, with approximately 70% of eligible smokers drawn from the general population and the remaining 30% drawn from the target groups defined under this service specification.

4.2 The Service will be required to provide specific stop smoking support to reduce smoking prevalence in the following priority (target) groups:

- pregnant smokers
- people in routine and manual occupations who smoke
- People with diagnosed long term conditions and those mental health problems who smoke

4.3 The Service will be required to provide and recommend appropriate and evidence based behavioural and pharmacological support:

- NRT (Nicotine Replacement Therapy) in accordance with relevant NICE (National Institute for Health and Clinical Excellence) Guidance.
- Provide advice and recommendation for Service Users to use appropriate Prescription Only Medicines (POM) including Varenicline (Champix) and Buproprion (Zyban) on prescription via their GP.in line with relevant current prescribing guidance and practice e.g. NICE Guidelines.

4.4 The Service will be responsible for providing all smoking cessation service related equipment and consumables for the specialist service and to GP and pharmacy providers of stop smoking services. e.g CO monitors, calibration, mouthpieces

4.5 The Service will be responsible to provide specialist stop smoking advisor training and (CPD) for its own staff and for primary care providers of stop smoking services, in accordance with national standards defined by the (NCSCT).

4.6 The Service will be required to co-ordinate and deliver brief intervention training to an extensive range of health and social care organisations in order to increase access and referral to the Specialist Stop Smoking service, in accordance with national standards defined by the NCSCT.

4.7 The Service will be responsible for the collection of data and maintaining a database of all clients, including those smokers who use the service with primary care providers, in accordance with the (DH) Stop Smoking Service Gold Standard

Monitoring Framework. In addition the Service will be required to monitor all activity, analyse data and submit regular quality and performance reports as set out in Appendices B and C of this specification.

4.8 The Service provider organisation should seek and obtain the necessary permission to enable Service User data to be shared with the commissioner.

4.9 The Service will be required to develop the flexible and responsive routes to access for Service Users including effective signposting to all stop smoking services via website, telephone and email referrals. The Service will also need to ensure equitable operating times to ensure that the needs of all Service Users are accounted for.

4.10 The Service will be required to co-ordinate and manage all service promotion material, local awareness initiatives and Stop Smoking campaign activity in order to increase local awareness, effectiveness and uptake. This element of service includes contribution to the East Sussex Tobacco Control Partnership and campaign and awareness raising work associated with the partnership.

5 Support Service Objectives

5.1 The following table summarises the number of primary care providers currently involved in delivering stop smoking services in East Sussex.

Provider	**Maximum number provider may be required to support under this specification**	**Currently Providing Service**
General Practices	75	62
Pharmacies	107	44

5.2 The Service will be required to work with the full range of primary care providers ensuring that Service User choice and access requirements can be fully met across these settings.

5.3 The expected proportion of smokers to be offered a service through primary care is 35% of all quits with a service in East Sussex.

The Service will be required to provide professional and technical stop smoking support to GP practices and pharmacies who deliver stop smoking services to their patients and Service Users in these settings, the support service component of the stop smoking service will need to incorporate and provide evidence of the following elements:

5.2 Stop smoking advisor training for staff delivering interventions within the primary care setting in order to ensure full compliance with evidence based treatment and support and, in accordance with national standards and guidelines defined by the Training (NCSCT) and Department of Health Stop Smoking Service and Monitoring Guidance 2012-13.

5.3 Comprehensive management and co-ordination of all data collection, reporting and service evaluation by all stop smoking providers in primary care including the transfer and analysis of all stop smoking service data from these settings to the Stop Smoking Service Database.

5.4 The Service will be responsible for ensuring that GP practices and pharmacies achieve the relevant proportion of 4 week quitters for the stop smoking targets (see Appendix C)

5.5 The support service will be responsible for providing all smoking cessation service related equipment and consumables to primary care providers of stop smoking services. e.g. CO monitors, equipment calibration, mouthpieces and t-pieces.

6 Detailed service description and its outputs

6.1 Assessing Nicotine Dependence

Assessing nicotine dependence is the process by which a Provider establishes the extent to which Service Users are addicted to tobacco products.

- Quantitative Approach
- Heaviness of Smoking Index
- Objective Approach (biochemical testing such as carbon monoxide or cotinine)

6.2 These approaches are described in the Department of Health's Stop Smoking Service and Monitoring Guidance 2012-13

6.3 Even where nicotine dependence is established through the Quantitative Approach or Heaviness of Smoking index, biochemical testing (as in the Objective approach)

should still take place at the beginning of a Service User episode as it is a measure of smoking impact that a Service User can see and observe changing during their subsequent period of abstinence. This demonstrable indicator of change can encourage fidelity to the programme and increase the chances of a successful quit attempt.

Table 1.

	Assessing nicotine dependence	Behavioural support	Pharmacotherapy	Establishing smoking status	Other service components
Must offer	at least one of; • Quantitative approach • Heaviness of smoking index • Objective approach	at least one of; • One-to-one support • Closed group support • Proactive telephone outreach	• at least one of; • Nicotine Replacement Therapy (NRT) Products: o NRT Patch o NRT gum o NRT nasal spray o NRT inhalator o NRT lozenge o NRT micro-tab o NRT oral mist • Combination therapy (2 or more NRT products together) • Recommendation for Varenicline (where most appropriate option) • Recommendation for Bupropion (where most appropriate option)	at least one of; • Carbon-monoxide (CO) testing • Cotinine testing	
May offer			• Preloading / nicotine-assisted reduction to quit	• Self-report (maximum of 15% of cases)	
May offer with the commissioner's agreement		any of: • Open (rolling) group support • Drop-in support • On-line support		• Opportunistic lung function	

Must not offer		• Any method where there is insufficient evidence to recommend its use. (As outlined in the DH Stop Smoking Service and Monitoring Guidance.	any of: • Anxiolytics (e.g. diazepam) • Nicobrevin • NicoBloc • St John's wort • Glucose • Lobeline		any of: • Hypnosis • Acupuncture, acupressure, laser therapy and electro-stimulation

6.4 Behavioural Support

6.5 Behavioural support consists of advice, discussion and exercises provided face to face individually or in groups).

6.6 All Service Users must be offered behavioural support, Providers must offer at least one of the following behavioural support:

- One to one or group support
- Closed group support
- Proactive telephone support

6.7 Behavioural support aims to make a quit attempt successful by:

- Setting a quit date
- Helping Service Users to cope with urges to smoke and withdrawal symptoms
- Maximising the motivation to remain abstinent and achieve the goal of permanent cessation
- Boosting self-confidence
- Improving self control
- Optimising the use of pharmacotherapy
- Developing strategies to cope with behavioural triggers for smoking.

6.8 In addition, the Provider may offer any of the following types of behavioural support:

- Online Support (supplementary)

6.9 With the prior agreement of the commissioner. Providers may offer any the following types of behavioural support:

- Open/rolling group support
- Drop in support
- Online support

6.10 Providers must not offer support where there exists an insufficient evidence-base to assess efficacy.

6.11 Pharmacotherapy

6.12 Commissioning behavioural support with pharmacotherapy increases a smoker's chance of successfully stopping by up to four times. Pharmacotherapy is the provision of pharmaceutical products and medicines. The only types of stop smoking medications currently approved by NICE are NRT, varenicline (Champix) and buproprion (Zyban). Current experimental statistics from stop smoking services nationally indicate that varenicline was the most successful smoking cessation aid between April 2009- March 2010. Of those who used varenicline 60% successfully quit, compared with 50% who received buproprion only and 47% who received NRT only.

6.13 It is anticipated that varenicline or buproprion will be the chosen treatment option in around 30% of patients. Where recommendation for PoM falls outside the expected level the provider will be required to provide an exception report detailing the reasons for this.

6.14 NRT is available in several forms. Providers should ideally be able to offer or recommend all types and forms of stop smoking medication either directly (in the case of NRT), or on prescription or via a voucher or letter for a general practitioner to prescribe or a pharmacy to issue.

6.15 Following an assessment of the most appropriate option for each Service User providers must offer, or recommend as prescription from the patient's G.P, at least one of the following types of pharmacotherapy:

- Nicotine Replacement Therapy (offer)
- Combination Therapy (a combination of NRT products) (offer)
- Varenecline (Champix). A prescripton only drug (recommend)
- Buproprion (Zyban). A prescription only drug. (recommend)

6.16 Where a provider supplies NRT to a patient they should collect a charge per item equivalent to the NHS Prescription charge. The Service will retain this fee towards the costs of purchasing NRT. The Service will report the value of all fees collected and this will be deducted from payment by the Council.

6.17 All Service Users must have the key risks and benefits of pharmacotherapy explained and offered pharmacotherapy within prescribing guidance. The table in Appendix C sets out the types forms and brands of stop smoking medication showing the dosage and duration for adults and adolescents. The full summary of product characteristics (SPC) for the following products can be found the electronic medications compendium website: http://emc.medicines.org.uk

6.18 The use of other brands of NRT including generic products and own brands is also permissible. Nicorette 'Quickmist' 1 mg oral spray may also be used where this is found appropriate.

6.19 In addition providers may also offer the following in the form of pharmacotherapy:

- Preloading / nicotine-assisted reduction to quit

6.20 There is some evidence that using the nicotine patch for a short period before a quit attempt results in higher cessation rates. Using NRT while cutting down on cigarettes can be helpful for heavy smokers who find stopping in one step too difficult. Systematic reviews found that NRT while smoking significantly increases the likelihood of long-term abstinence and the odds of cessation. However, there is insufficient evidence about the long-term benefits of interventions intended to help smokers reduce but not stop smoking. All approved pharmacotherapies are described in the Department of Health's Stop Smoking Services and Monitoring Guidance 2012-13.

6.21 Providers must not offer any of the following forms of pharmacotherapy. Please note this list is not exhaustive.

- Anxiolytics
- Nicobrevin
- Nicobloc
- St Johns Wort
- Glucose
- Lobeline

6.22 Establishing smoking status

6.24 This is the process by which a Provider establishes the smoking status of a Service User 4 weeks and 12 weeks after the Service Users quit date to determine whether the Service User has successfully quit. Providers must establish the smoking status of Service Users at 4 and 12 weeks after the quit date.

6.23 4 week smoking status must be established between 25 and 42 days after the agreed quit date.

6.24 12 week smoking status must be established between 79 and 98 days after the agreed quit date.

6.25 Provider must use one of the following two methods to attempt to establish the smoking status of at least 85% of successful 4 week and 12 week quitters:

Carbon-monoxide (CO)

6.26 As self-reported smoking status can be unreliable, CO verification rates are an important marker of data quality. CO testing should be carried out on all adult smokers, wherever possible, to provide both a baseline (pre-quit) level and a four-week validation (post-quit) level. CO testing is quick to carry out, non-invasive and provides a cost-effective means of validating the smoking status of a significant number of Service Users. To achieve as accurate a reading as possible, Service Users should be asked to hold their breath for 20 seconds (15 seconds minimum) before blowing into the CO monitor. Some Service Users may not be able to physically complete CO testing due to the inability to hold their breath for 15 or more seconds.

6.27 Service Users with a CO reading of less than 10ppm at 4 and 12 weeks can be regarded as successful quitters.

6.28 An ‘attempt’ to carry out CO verification should comprise a minimum of three separate attempts to contact the Service Users via telephone, text or email in order to arrange a face-to-face CO validation.

Cotinine

6.29 Cotinine is a metabolite of nicotine that can be detected in the blood, urine or saliva. CO monitoring is currently the most cost-effective method of validating four-week quits, due to the relatively high cost of other biochemical monitoring methods. For specific projects or groups such as pregnant women, however, using either urinary or salivary cotinine samples may be an appropriate validation method as the results will be more accurate and consistent over time. Further information on this can be sought from the UK Centre for Tobacco Control Studies (UKCTCS): www.ukctcs.org.

6.30 In addition, Providers may use the following method for establishing smoking status:

Self-reported Smoking Status

6.31 Although less reliable than carbon-monoxide and cotinine verification, a Service User can be asked to self-report their smoking status. Service Users should be asked the question *"Have you smoked at all in the last 2 weeks?"* Their responses should be coded into one of the following categories:

- *"No, not even a puff"*
- *"Yes, just a few puffs"*
- *"Yes, between one and five cigarettes"*
- *"Yes, more than 5 cigarettes"*

Only those responding *'No, not even a puff"* should be classified as successful quitters.

Whilst it is preferable to obtain a self-reported smoking status via a face-to-face consultation, it is permissible to gather the required information via a telephone consultation.

The smoking status of no more than 15% of successful 4 week and 12 week quitters should be established using this method.

Lung function / Spirometry

6.32 Lung function and lung age measures provide biomedical feedback for smokers and are increasingly used to recruit smokers into stop smoking services and improve quit rates. A Spirometer measures the volume of air expelled in the first second of a forced expiration, most commonly expressed as FEV1. Applying the FEV1 result to an individual gives them a 'lung age'.

There is some evidence that Spirometry giving results in the form of “lung age” is an effective positive motivational tool that significantly helps improve abstinence rates in smokers after a one year interval. The use of Spirometry in smoking cessation practice can support early diagnosis of COPD and can also be used to support Service Users with established comorbidity, such as COPD. The use of hand held spirometry should be supported by the stop smoking service. The service provider will be expected to work with the commissioner to pilot the use of hand held spirometry in routine smoking cessation practice.

6.33 Providers must not offer any of the following service components. Please note that this list is not exhaustive.

- Hypnosis
- Acupuncture
- Acupressure
- Laser therapy and electro-stimulation

7 Targeted populations

7.1 Whilst the Provider can offer the service to any eligible person, the Provider is particularly encouraged to recruit and support Service Users from specific demographic subgroups.

- Pregnant Women – women will be asked if they are pregnant at registration with the provider

- People from Routine and Manual Social Groups – a Service User’s socio-economic group will be recorded by the Provider. The Service User’s socio-economic group will be determined by the Service User using the methods set out in The National Statistics Socio-economic Classification User Manual (http://www.statistics.gov.uk/methods_quality/ns_sec/downloads/NS-SEC_User_2005.pdf)

7.2 Whilst stop smoking services should be available to all people who smoke tobacco products, the service may be particularly appropriate to individuals who are identified through existing care pathways, notably (but not exclusively):

- Primary care chronic disease management programmes for:
    - Stroke and transient ischemic attach
    - Coronary heart disease

- Chronic Obstructive Pulmonary Disease
- Asthma
- Hypertension
- Diabetes

7.3 People with Severe Mental Health Difficulties – the location of service delivery will be recorded by the Provider. In addition, when checking a Service User's eligibility, the Provider will ask the Service *User "Have you received support in that last few months from one or more of the following mental health services: a community mental health team, assertive outreach team, early intervention, crisis intervention or a home treatment team?''.*

8 Expected outcomes

8.1 The service will support people to successfully quit smoking for 12 weeks. Quitting will be measured at 4 weeks and follow up will occur at 12 weeks. It is anticipated that many of these Service Users will permanently stop smoking and as a result, will have:

- improved health outcomes and
- lower levels of healthcare utilisation

9 Other Service Components

9.1 Although not required, Providers may wish to offer additional service components. Providers may, with the prior agreement of the commissioner, offer the following service components:

Relapse prevention

9.2 There is currently little evidence suggesting which interventions are most likely to prevent people from partially or totally resuming smoking, although research in this area is ongoing. As yet, we are not aware of any published data on relapse rates by time among treated smokers either.

Exercise

9.3 There is some evidence to suggest exercise can have a positive effect on relieving tobacco withdrawal symptoms and short-term abstinence rates. Furthermore, exercise may increase self-esteem and assist in managing post-quit weight gain. A systematic review of 12 studies that compared exercise with a passive condition found positive effects on cigarette cravings, withdrawal symptoms and smoking behaviour. This suggests that exercise can be a useful aid to managing cigarette cravings and withdrawal symptoms.

CO Monitor Protocol (Infection Control)

9.4 All monitors should be calibrated every six months and in accordance with the manufacturers guidance.

Cardboard Tubes

9.5 Single-use only, change for every Service User/Service Users. Ask the Service User to put their own tube into machine and remove after use.

Plastic adaptor/t-piece

9.6 The adaptor contains a one-way valve that prevents inhalation from the monitor.

9.7 Changing adaptors depends on manufacturers' guidance:

- Micromedical: the adaptor should be discarded and replaced every six months
- Bedfont (Pico): the adaptor should be discarded and replaced monthly
- BMC-2000: adaptor should be changed quarterly, unless usage is heavy, in which case change monthly.

Usage guidance

- Less than 50 uses per month: change quarterly
- Between 51–200 uses per month: change bi-monthly
- More than 200 uses per month: change monthly.

Cleaning

9.8 The monitors should be wiped down using non-alcohol wipes, ideally at the end of every session.

Service Promotion and Awareness

9.9 Local service awareness initiatives should be integrated with regional and national campaigns, and use nationally branded materials provided for local promotion, to help smokers identify with local support services and thereby promote self-referrals. This will avoid confusing smokers by bombarding them with conflicting messages from different sources, and also enables local services to capitalise on the significant impact of national multi-media campaigns, saving them resources and effort while doing so. Imaginative use of customised national materials by services in a variety of local media and channels (e.g. local stakeholder networks that the national campaign cannot reach) will ensure that service promotion is effective.

9.10 In addition to routine awareness raising activities to promote the service the Service will be expected to offer a minimum of 3 marketing campaigns per year in agreement with the commissioner.

The Service will ensure that the following information is supplied to all Service Users:

- Department of Health accredited and NHS branded materials
- Details of the NHS Smoke Free website http://smokefree.nhs.uk/)

9.11 The Provider will ensure that the following information is available to all Service Users on request:

- Information about stopping smoking in a variety of languages and in large print.

9.12 The Provider may wish to encourage the Service User to refer eligible friends and family members to the service.

10 Training and Continuing Professional Development

10.1 Service Users interventions must be delivered by a stop smoking advisor who has received stop smoking service training that meets the published NCSCT standards for one-to-one and/or group support.

10.2 All interventions should be multi-sessional with a total potential Service Users contact time of, on average, around 1.5 hours (from pre-quit preparation to four weeks after quitting). This will ensure effective monitoring, Service Users compliance and ongoing access to medication.

10.3 There should be a strong emphasis on verifying the smoking status of 4 week and 12 week quitters using stated validated biochemical markers across all areas of service activity including primary care.

10.4 Interventions should offer weekly support for at least the first four weeks following the quit date. Appointments should be scheduled when Service Users are booked into treatment. People recorded as 12 week quitters may be supported by the service for the whole of the 12 week period or for any period between the first four weeks and twelve weeks.

10.5 All staff involved in stop smoking delivery across all settings will be trained to National Centre for Smoking Cessation Training (NCSCT) standards.

10.6 Stop smoking advisers should show empathy for their Service Users and adopt a motivational approach.

10.7 Prior to treatment, Service Users should be informed of all available (evidence-based) treatment options both locally and nationally.

10.8 Interventions should be efficiently managed with sufficient administrative support for general organisation, Service User contact processes and data handling. There should be sufficient administrative support to ensure that Service Users are contacted within a week of being made known to the Specialist Stop Smoking Service.

10.9 Staff delivering rolling groups or drop-ins should be trained to NCSCT standards and such interventions should be delivered or supervised by experienced specialists with sufficient expertise to support quitters at different stages of the quitting process simultaneously.

11 Evidence based interventions

11.1 Workplace interventions should follow principles laid down in NICE workplace guidance and should be free for employees.

11.2 Strategies for promoting local services should be based on local intelligence wherever possible. Integration with regional and national campaigns should enhance their effectiveness, so they should also be planned in co-operation with tobacco control and communications colleagues from local authority, the East Sussex local tobacco partnership and NHS, as agreed with the commissioner.

11.3 Local service awareness initiatives should be integrated with regional and national campaigns, and use nationally branded materials provided for local promotion, to help smokers identify with local support services and thereby promote self-referrals. This will avoid confusing smokers by bombarding them with conflicting messages from different sources, and also enables local services to capitalise on the significant impact of national multi-media campaigns, saving them resources and effort while doing so. Imaginative use of customised national materials by services in a variety of local media and channels (e.g. local stakeholder networks that the national campaign cannot reach) will ensure that service promotion is effective.

12 Rewards and Incentives for Service Users

12.1 Providers may offer support services such as transport, where this is considered to be a barrier to accessing the service, or refreshments to participants as part of the normal delivery of the Service.

12.2 Providers may offer non-cash rewards to Service Users where the rewards are meaningfully linked to the Service and the coordinating commissioner has given prior permission.

12.3 Providers must not make cash payments or its equivalent (eg. Vouchers) to Service Users, without prior agreement with the commissioner.

13 Eligibility

13.1 All Service Users should be assessed as eligible, utilising the following criteria:

- They are living within the county of East Sussex.
- They are aged 12 or over.

13.2 People who do not meet the eligibility criteria and are not eligible to access the service. If a Provider has concerns about the suitability of a Service User that has been referred to the service, the Provider must seek agreement from the Commissioner before refusing to provide the service.

13.3 A Provider must seek prior approval from the commissioner to provide a service to a Service User aged under 12 who meets the remaining eligibility criteria. The commissioner will respond to the request for prior approval within 2 working days. Where approval is granted, the commissioner will provide a prior approval code which the Provider must quote in its record of activity accompanying its (monthly) invoice.

13.4 Where a Service User meets all other eligibility criteria but is neither registered with any GP nor has a fixed abode, the Provider may support the Service User to stop smoking.

14 Service referral, criteria and sources

14.1 Before delivering a service a Provider must confirm the Service User's eligibility. The eligibility check will include confirmation that the Service User:

- would like to stop smoking and receive support from the service
- is not receiving a stop smoking service from another Provider
- lives, works or is registered with a GP in the County of East Sussex.
- is a current smoker of a tobacco product
- is aged 12 or over

14.2 There are three methods by which Service Users can access the service:

- Referral - Service Users can be referred to a service by a healthcare professional such as a GP, practice nurse, community nurse or a hospital consultant or social care professional or community/voluntary organisation worker
- Recruitment - Providers can actively recruit Service Users into a service
- Self-Referral - Service Users can access a service directly in response to general information about available services provided by the commissioner or in response to advertising from the Provider.

14.3 The service provider should accept self-referred individuals as well as referrals from local health professionals such as primary care, the NHS Health Checks programme, Health Trainers and any local referral management function (call centre online triage system) which may subsequently be developed..

14.4 Providers must work with primary care practitioners and local community organisations to generate and maximise referral opportunities and uptake of the service.

15 Service standards

15.1 The service provider is expected to comply with the following standards:

15.2 The Provider will deliver the service in a sensitive and non-judgmental manner, with due regard to the individuality of Service Users.

15.3 The individual needs and wishes of the Service User are to be recognised and taken into account when providing the service.

15.4 The Provider will promptly supply copies of formal complaints to the complaints manager of the commissioner.

15.5 Statutory health and safety requirements are met, including clear incident reporting policies and processes in place in line with local authority procedures for incident reporting.

15.6 Local and national safeguarding requirements are met.

15.7 The Provider will ensure Data Protection and information governance policies and procedures are in place and abide by the established principles in the handling of Service User sensitive information and ensure appropriate arrangements are in place to maintain Service User confidentiality.

15.8 The service is regularly evaluated annually with Service User feedback and a Service User complaints policy is in place.

15.9 Recruitment, training and development policies and procedures are in place to ensure that staff and volunteers have the appropriate competences to deliver the service effectively.

15.10 An implementation plan is in place which illustrates how the service will be delivered within agreed timescales, and how risks will be prevented, ameliorated or controlled.

15.11 The service should have the ability to meet initial demand as agreed with the commissioner and to increase capacity if demand rises.

15.12 All referrals to the service should be contacted by the service within 1 week wherever possible.

15.13 Services should be delivered across East Sussex within venues which are DDA compliant, risk assessed and have good access to public transport.

15.14 The service is open to all, regardless of their background or ability and is delivered in a culturally appropriate manner.

16 Interdependencies

16.1 It is expected that the service provider will have mutually dependant working relationships with the following organisations:

- Maternity Care Services
- Secondary Care/acute services
- Health Improvement community service providers
- Weight Management Services
- Any referral management function (call centre, online triage system which may subsequently be developed)
- NHS Health Checks service
- Health Trainer Service
- Primary care services including GPs and Pharmacies

17 Partnership working with external agencies

The Provider is required to:

17.1 Demonstrate a commitment to co-operate to achieve effective communication and excellent working relationships with commissioners and partner organisations.

17.2 Work and liaise with other professionals and services within Health, Social Care and local community and voluntary organisations and groups to support the achievement of the stated outcomes.

17.3 Refer to and liaise with Health, Social Care and Third Sector services as appropriate and provide the necessary information as requested by that organisation (subject to the Data Protection Act).

17.4 Endeavour to develop meaningful relationships with minority groups including relationships with organisations that represent the particular needs of people that face specific barriers and or risks.

18 Equality and diversity

18.1 The Equality Act 2010 sets out the protected characteristics where any Service must pay due regard for the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EA;
(b) advance equality of opportunity between persons who share a relevant protected characteristic (as defined by the EA) and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The protected characteristics set out in the EA are age, disability, race, pregnancy/ maternity, religion or belief, gender (including gender reassignment) and sexual orientation. Marriage and civil partnership are also protected characteristics for the purposes of the duty to eliminate discrimination.

When making decisions the Council also considers other matters such as the impact of rurality, deprivation and being a carer.

18.2 The Provider is required to have a fair access, fair exit, and equality and inclusion policy that is consistent with requirements of the legislation outlined in Section of the Terms and Conditions of Contract.

19 Safeguarding vulnerable adults and children

19.1 The Provider must ensure that Service Users, and anyone visiting the service, are safeguarded from any form of abuse or exploitation in accordance with written policies and procedures to be agreed with the commissioner prior to the commencement of the service and meet the standards and regulations set out in:

- The Sussex Multi Agency Policy and Procedures for Safeguarding Vulnerable Adults produced by the Safeguarding Adults Boards of Brighton and Hove, East Sussex and West Sussex (2007)
- Section 3.13 of the Terms & Conditions of Contract ('Safeguarding Vulnerable Adults and Children')

20 Security, health and safety

20.1 The Provider must ensure that the service complies with all the Health and Safety standards outlined in Section 3.5 of the Terms and Conditions of Contract and in addition must ensure that all relevant council policies procedures and processes are place for incident reporting.

21 Service User involvement

The Provider is required to:

21.1 Ensure Service Users are well informed so they can communicate their needs and views and make informed choices.

21.2 Ensure Service User feedback is used to improve services.

22 Managing the service (see also terms & conditions of contract)

The Provider is required to:

22.1 Ensure sufficient staff coverage to be able to address all the needs of Service Users.

Ensure that the service operates to a defined set of quality customer service standards in the following areas (but not limited to):

- Accessible operating hours that meet the needs of a range of different Service Users.
- Full and flexible range of evidence based support options made available to Service Users
- Maximum 1 week from referral or lead generation to Service User contact with an immediate offer of service
- Recorded telephone helpline queries (maximum 48 hours)
- Telephone pick up (maximum 3 rings) during Service opening hours for approximately 80% of calls
- Minimum offer of 2 face to face appointments during quit attempt
- Record a minimum of 3 attempts to follow up DNA clients by telephone or letter before coding lost to follow up
- Record waiting time between clients requesting and receiving a service, and provide details of any waiting list held by the service

22.2 Ensure that all staff comply with the requirements of the Disclosure and Barring Service (DBS) and the Independent Safeguarding Authority.

22.3 Ensure management time is available to provide effective management of the service including regular individual and group supervision.

22.4 Ensure that sufficient management time is available for Contract Management, including attendance at the Quarterly contract review meetings and any requested meetings in relation to the Contract.

22.5 Demonstrate that the organisation is sufficiently financially robust and will use the allocated funds for the purpose of delivering and developing the service.

22.6 Demonstrate that the organisation is able to put risk management and contingency procedures in place.

22.7 Seek necessary permissions to share all relevant Service User data with the commissioner.

22.8 Manage a database of all client activity in accordance with service outputs and monitoring activity and effectively utilise information technology (IT) to facilitate accurate recording and monitoring data.

22.9 Ensure adequate cover arrangements are put in place for holidays and sickness.

22.10 Ensure all staff members that have contact with Service Users carry and make available easily recognisable appropriate forms of identification.

22.11 Submit accurate and timely monitoring and performance data.

23 Employment and training

The Provider is required to:

23.1 All staff involved in delivery should have been trained to National Centre for Smoking Cessation Training (NCSCT) standards.

23.2 Support, train, supervise and appraise all staff who are employed to ensure they remain competent and engage.

23.3 Ensure staff members are trained to collect and submit accurate and timely monitoring and performance data.

23.4 Ensure staff members engage with continued professional development, including appropriate training provided by key partners.

24 Communications

24.1 Strategies for promoting local services should be based on local intelligence wherever possible. Integration with regional and national campaigns should enhance their effectiveness, so they should also be planned in co-operation with tobacco control and communications colleagues from Local Authorities and NHS, as agreed with the commissioner.

24.2 A communications plan should be developed by the service provider to illustrate how and when marketing and promotion of the service will take place. The

specific elements of the plan will align with social marketing segments and characteristics identified in the East Sussex Healthy Foundations Social Marketing framework. The plan will also include promotional and awareness raising activities within the support element of the contract for GP practices and pharmacies. This plan should be agreed with the commissioner before delivery of services commences.

24.3 Marketing and promotion should be delivered in different formats (electronic and printed) to ensure effectiveness.

24.5 The service provider is required to ensure that the communication needs of different groups are met.

Part Three - Detailed specification for monitoring the quality and performance of the Specialist Stop Smoking Service

1 Monitoring and Review Arrangements

1.1 The contract will be monitored monthly and reviewed quarterly and annually by the commissioning lead in conjunction with the Contracts and Purchasing Unit.

1.2 Monthly data reporting on agreed key performance areas will inform quarterly reports. Indicators of a drop in performance e.g. lower 4 and 12 week quit figures from previous months should be identified; the cause of the drop should be ascertained and a proposed action should be in planning or implementation stage when quarterly report is received by commissioners e.g. supporting an underperforming clinic by training staff or increasing lead generation work.

1.3 The foregoing should be included in the quarterly report. The quarterly report format should be amended to correspond with agreed 2014/15 service specification for Stop Smoking Services.

1.4 The Provider will be required to report against Key Performance and Quality Indicators as set out in appendices B and C of this document.

1.5 The annual review will consider compliance with the contract. Any aspect of compliance with this Service Specification can be considered.

1.6 All reviews will consider (not exhaustive):

- Outcomes for Service Users
- Quality of service
- Performance against agreed targets
- Who gains access to the service
- Service User satisfaction

1.7 Providers are expected to submit monthly monitoring reports.

1.8 Providers are expected to submit quarterly update reports which include information as set out in section the following performance and quality indicators, and service expenditure.

2 Performance and quality indicators

2.1 Performance and quality indicators (Appendix B and C) are a measure against which we can judge how well the service is performing. They have been selected to evaluate specified outcomes and requirements. These will

be regularly monitored and comprehensively reviewed at least quarterly and annually.

2.2 Where underperformance against indicators occurs, the service provider will be expected to produce recovery plan in agreement with the commissioner.

2.3 The targets set will be reviewed with the Provider after the first year of service.

3 Prices and costs

3.1 The total maximum budget available for the delivery of this service is outlined in the Contract, for each year during the period of contract delivery.

3.2 Payments will be made as per the terms of the contract.

3.3 The service provider will be responsible for ensuring the cost of securing equipment, facilities and materials necessary to deliver the service is met within the budget available.

Appendix A: Approved NRT products

Brand	Product	Treatment Duration
NiQuitin CQ	24hr patch 21mg 14mg 7mg	adults (18+): 6 weeks 2 weeks 2 weeks adolescents (12-18) As adult
	Lozenge 4mg 2mg	**adults (18+)** 12 weeks **adolescents (12-18)** 12 weeks maximum
	Gum 4mg 2mg	**adults (18+)** Use for up to 3 months and then gradually reduce gum use. When daily use is 1-2 pieces use should be stopped **adolescents (12-18)** 12 weeks maximum
Nicotinell	**24hr patch** 21mg 14mg 7mg	**adults (18+)** 3 months **adolescents (12-18)** 12 weeks maximum
	lozenge 2mg 1mg	**adults (18+)** Withdraw treatment gradually after 3 months. Discontinue use when dose is reduced to 1-2 lozenges per day Maximum period of treatment: 6 months **adolescents (12-18)** Not to be used in under 18s without recommendation from a physician
	Gum 4mg 2mg	**adults (18+)** Reduce dose gradually after 3 months. Discontinue use when dose has been reduced to 1-2 pieces per day **adolescents (12-18)** 12 weeks maximum
Nicorette	**Invisi patch** 25mg 5mg 10mg	**adults (18+)** 8 weeks 2 weeks 2 weeks **adolescents (12-18)** The dose and method of use are as for adults, as data is limited in this age group. The recommended treatment duration is 12 weeks. If longer treatment is required, advice from an HCP should be sought
	16hr patch 15mg 10mg 5mg	**adults (18+)** 8 weeks 2 weeks 2 weeks **adolescents (12-18)** The dose and method of use are as for adults, as data is limited in this age group. The recommended treatment duration is 12 weeks. If longer treatment is required, advice from an HCP should be sought
	Nasal spray	**adult (18+)** 12 weeks For 8 weeks use as required within maximum daily use guidelines. Reduce dose to 0 over following 4 weeks **adolescents (12-18)** 12 weeks maximum
	Inhalator	adults (18+) 12 weeks adolescents (12-18) 12 weeks maximum
	Gum 4mg 2mg	**adults (18+)** Reduce dose gradually after 3 months. When daily use is 1-2 pieces, use should be stopped **adolescents (12-18)** 12 weeks maximum. Use for 8 weeks and then gradually reduce the dose over a 4-week period
	microtab	**adults (18+)** Gradually reduce after 3 months **adolescents (12-18)** 12 weeks maximum. Use for 8 weeks and then gradually reduce the dose over a 4-week period
Nicopatch	**Nicopatch** 21mg 14mg 7mg	**adults (18+)** 3-4 weeks 3-4 weeks 3-4 weeks **adolescents (<18 years)** Should not be used by people under 18 years of age without recommendation from an HCP
Nicopass	**Lozenge** 1.5mg	**adults (18+)** Maximum use 6 months. Treatment should be stopped when the dose is reduced to 1 to 2 lozenges daily **adolescents (<18 years)** Should not be used by people under 18 years of age without

		recommendation from a physician
Varenicline	**Varenicline** (champix)	**adults (18+)** 12 weeks + 12 weeks - refer to NICE adolescents (12-18) **Contraindicated for under-18s and pregnant women**
Bupropion	**Bupropion** (Zyban)	**Adults (18+)** 8-9 weeks adolescents (12-18) **Contraindicated for under-18s and pregnant women**

Appendix B: Key performance and quality indicators (in addition to minimum data set)

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
4 and 12 week Quit Rates	Number of Service Users successfully quitting at 4 and 12 weeks follow-up as a percentage of all those eligible for a 4 and 12 week follow-up	Between 35% and 70%	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit explanation for failure to meet standard and planned corrective action
CO, cotinine or spirometry validation	Of Service Users who successfully quit at 4 or 12 weeks, the percentage whose smoking status was self-reported without an 'attempt' to otherwise check smoking status via CO, cotinine or spirometry	No more than 15%	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit explanation for failure to meet standard and planned corrective action
Number of Service Users that successfully stop smoking 4 or 12 weeks after setting a quit date from general population	Of Service Users who successfully quit at 4 and 12 weeks, the percentage whose smoking status was self-reported without an 'attempt' to otherwise check smoking status via CO, cotinine or spirometry	70% of quit target general population	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Monthly Monitoring and Quarterly Review
Number of Service Users that successfully stop smoking 4 or 12 weeks after setting a quit date from priority groups	Of Service Users who successfully quit at 4 and 12 weeks, the percentage whose smoking status was self-reported without an 'attempt' to otherwise check smoking status via CO, cotinine or spirometry	30% of quit target priority groups	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Monthly Monitoring and Quarterly Review
Equity of access and outcomes	the percentage of Service Users from all groups, including general and priority groupsquitting at 4 and12 weeks	Reflects equity of access and outcomes measures	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit plans to improve uptake and quit rates in all groups
Training and Continuing Professional Development	Specialist Advisor Training	-	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit plans to ensure relevant training and development

Training Support Service	Minimum 2 CPD update events Annually for Primary Care Minimum 2 practice support visits per practice year	-	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit plans to ensure relevant training and development
Managing referrals and pathways Brief Intervention Training	Numbers of quitters referred to the service	In line with expected numbers of quitters per target	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit plans to ensure relevant training and development
Service Awareness Initiatives including Campaign activity	Service Referrals (including Self Referred)	Minimum of 3 campaigns annually	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit plans to ensure relevant training and development
Service User Experience	Of all Service Users responding to the satisfaction question, the percentage reporting that they were satisfied with the service	At least 80%	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit explanation for failure to meet standard and planned corrective action
Complaints	Number of complaints received	-	Provider to collate and submit as part of the Quarterly Service Quality Performance Report	Provider to submit plan to address issued raised in complaints

Appendix C: Activity Targets

Activity Volumes include total activity volume expected for East Sussex (including Local Enhanced Service Providers for which the Specialist Stop Smoking Service is expected to support).

a) Smoking Quit Targets for the specialist stop smoking service

Contract Targets	14/15	15/16	16/17
Total number of persons attending East Sussex Specialist Stop Smoking Service who quit smoking 4 weeks after setting a Quit date ***Of these 4 and 12 week quitters at least the numbers indicated below should be drawn from the priority groups as defined in the service specification:***	2,400	2,640	2,904
(At least) the following number of persons from priority groups attending East Sussex Stop Smoking Services who quit smoking 4 weeks after setting a Quit date	728	801	881
(At least) Number of pregnant women attending East Sussex Stop Smoking Services who quit smoking 4 weeks after setting a Quit date	141	155	170

b) Smoking Quit Targets for primary care providers

Targets for Primary Care Providers	14/15	15/16	16/17
Total Number of Persons attending East Sussex Stop Smoking Service in primary care who quit smoking 4 weeks after setting a Quit date (all categories)	1,169	1,204	1,240

Appendix D: Activity Performance Indicators

Activity				
Activity Performance Indicators	**Method of measurement**	**Baseline Target**	**Thresholds**	**Frequency of Monitoring**
Number of Service Users that successfully stop smoking 4 and 12 weeks after setting a quit date from **general population** **Expected Service Volume**	Provider to collate and submit as part of monthly invoice	70% General Population 50% Quit	*35%-70% Quit	Monthly Monitoring and Quarterly Review
Number of Service Users that successfully stop smoking 4 weeks and 12 weeks after setting a quit date from **priority groups**	Provider to collate and submit as part of monthly invoice	30% targeted population 50% Quit	35%-70% Quit	Monthly Monitoring and Quarterly Review

The Provider will comply with the Russell Standard for reporting of quitting activity and outcomes (http://www.scsrn.org/clinical_tools/russell_standard_clinical.pdf)

Appendix E: Core Values and Principles

ESCC seeks to ensure that all contracted Providers deliver services, which reflect its core values and principles. In accepting the contract the Provider will be agreeing to these as follows:

- to ensure that Service Users and Carers are informed about decisions taken by ESCC and the reasons for them
- to work in partnership with Service Users and their Carers
- to target services to those in greatest need
- to value difference and to ensure that services are sensitive to the diversity of need
- to be innovative in seeking to develop flexible and responsive services
- to value staff
- to recognise that all staff are accountable for the delivery of a high quality service that respects the rights of Service Users and their Carers
- to focus on the outcomes of interventions to ensure that resources are effecting real change
- to encourage feedback and be open to constructive criticism
- to seek value for money
- to ensure that equal opportunity principles underpin all its services and actions
- to set clear standards for all aspects of service provision

East Sussex County Council

Service Specification

Tier 2 Children and young people's weight management services

B03 – Service Specification

July 2013

Contents

Specification

Part One - Background information

1 Introduction

1.1 East Sussex County Council intends to commission a service provider to design, deliver and evaluate an accessible tier 2 weight management service for children and young people, within a specified aged range, which aims to support overweight and obese service users to reach and maintain a healthier BMI.

2 Evidence base

2.1 The programme of work will enable the implementation of national policy and strategy (which contains references to evidenced based health promotion programmes and projects) aligned to local need as highlighted in the following documents:

- *Healthy lives, healthy people: A call to action on obesity in England*. (DH, 2011).
- *PH42, Obesity: Working with local communities* (NICE, 2012).
- *CG43, Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (NICE, 2006).
- *Treating childhood obesity through lifestyle change interventions: A briefing paper for commissioners* (The National Obesity Observatory, 2009).
- *Standard evaluation framework for weight management interventions* (The National Obesity Observatory, 2009).
- *Healthy weight, healthy lives: Commissioning weight management services for children and young people* (2008).
- *Joint Strategic Needs Assessment* (NHS Sussex/East Sussex County Council).
- *Healthy lives, healthy people*: *The East Sussex health and wellbeing strategy 2013-2016* (East Sussex County Council, 2012).
- *Reducing health inequalities among children and young people in East Sussex*: *Director of Public Health report 2012/13* (NHS Sussex/East Sussex County Council, 2013).

3 Health impact of overweight and obesity on children and young people

The health effects of excess weight are increasingly apparent even in children; the incidence of both type 2 diabetes and non-alcoholic fatty liver disease used to be rare in children, but is now increasing (DH, 2008). In addition, overweight and obesity in children and young people are associated with an increased risk of teasing, bullying and social isolation (Lobstein T et al., 2004) Without intervention, overweight and obese children are more likely to become obese adults (National Obesity Observatory, 2013) which has serious implications for their future health, increasing their risk of developing various conditions including hypertension, coronary artery disease and cancer.

The National Child Measurement Programme uses BMI results plotted on to a gender-specific centile chart to indicate different degrees of excess weight and its associated risk of disease. These are set out in the table below.

Classification	BMI centile
Underweight	≤2nd centile
Healthy weight	>2nd centile - <91st centile
Overweight	≥91st centile - <97th centile
Obese	≥98th centile

According to the *Health Survey of England* (2011):

- 30% of children (aged 2-15) were overweight or obese.
- 16.3% of all children were obese.

The East Sussex Joint Strategic Needs Assessment; utilising data from the National Child Measurement Programme (2013), found that the percentage of reception year children classified as overweight or obese during academic years 2009/10 to 2011/12 was 21% (n. 2842). For year 6 students during the same period, this rate rose to 31% (n. 4212). For both year groups, there was a relationship between deprivation and obesity prevalence.

The following table illustrates rates at district / borough level:

District	Reception year students classified as overweight/obese		Year 6 students classified as overweight/obese	
	%	n.	%	n.
Hastings	23	653	35	920
Eastbourne	23	613	32	766
Rother	20	407	32	692
Lewes	20	477	30	705
Wealden	19	692	29	1129

The following table details wards within East Sussex where rates were significantly higher than the county average:

District / Ward	Reception year students classified as overweight/obese		District / Ward	Year 6 students classified as overweight/obese	
	%	n.		%	n.
Hastings / Hollington	33	89	Rother / Bexhill Sackville	44	28
Hastings / Tressell	30	42	Lewes / Peacehaven East	43	44
Lewes / Peacehaven West	30	29	Hastings / Braybrooke	42	53
Eastbourne / Devonshire	29	115	Rother / Bexhill Sidley	40	85
			Hastings / Hollington	39	105

A local survey of children and young people conducted in the spring term of 2012 by the Schools Health Education Unit. (*Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012*), identifies the following as a list of key findings relating to obesity:

- 17% of students reported eating five or more portions of fruit and vegetables the previous day. 20% had said this in 2007. The percentage was lower in Hastings (12%), Eastbourne (13%), and Rother (14%) and higher in Wealden (18%) and Lewes (25%).
- 11% said they had none (13% Eastbourne and Hastings, 11% Rother, 9% Lewes and Wealden).
- 28% of students five times or more in the previous week (39% of boys and 185 of girls. This finding was similar for most

districts/boroughs in East Sussex apart from Wealden where the percentage was higher at 33% (43% of boys and 22% of girls).

- 6% of students aid that they didn't do any physical activity (9% Eastbourne and Hastings, 6% Lewes, 4% Wealden and Rother).

4 Policy context

4.1 The department of Health published its latest policy document focused on tackling overweight and obesity in October 2011. *Healthy people, health lives: A call to action on obesity in England* starts by describing the basis of the 'new approach' as being:

- The latest evidence of underlying issues and causes, starting with the Government Office for Science's Foresight report of 2007.
- The latest evidence of 'what works' – and in particular good practice from a range of initiatives at local and national level.
- Extensive engagement with a wide range of delivery partners and experts over the past months.

The call to action then goes on to describe the key components of a successful approach. These are:

- Empowering individuals through the provision of guidance, information, encouragement and tailored support on weight management.
- Giving partners the opportunity to play their full part – e.g. Responsibility deal.
- Giving local government the lead role in driving health improvement and harnessing partners at a local level.
- Building the evidence base on effectiveness and cost-effectiveness.

The government believes that if these components will help deliver a new national ambition which it has set to act as a 'rallying cry' for us all:

- To achieve a sustained downward trend in the level of excess weight in children by 2020

The public health outcomes framework, *Improving outcomes and supporting transparency* (2012), sets out the desired outcomes for public health and how they will be measured. The following indicators which will be used to measure the impact of services and interventions which aim to reduce obesity in children and young people:

Domain 1: Improving the wider determinants of health.

1.16: Utilisation of outdoor space for exercise / health reasons – the number of people reporting that they have taken a visit to the natural environment for health or exercise over the previous seven days

Domain 2: Health improvement.

2.6: Excess weight in 4-5 and 10-11 year olds – the number of primary school children in reception year (aged 4-5 years) and year 6 (aged 10-11 years) with valid height and weight recorded who are classified as overweight or obese.

2.11: Diet – this indicator is yet to be finalised. However, it is likely to focus on an increase in consuming five-a-day and a reduction in intake of saturated fats, sugar, salt and calories.

East Sussex County Council and the East Sussex Health and Wellbeing Board are committed to reducing obesity and have set this as a key priority within the East Sussex Health and Wellbeing Strategy 2013 – 2016 in seeking to "Enable people of all ages to live healthy lives and have healthy lifestyles".

5 Key contacts

5.1 East Sussex County Council teams relevant to this contract are:

Health improvement specialist team

This team is comprised of health improvement principles and specialists each of whom leads on a specific area. As well as commissioning and reviewing services, the team is able to provide technical advice and guidance to partners. Areas covered currently include:

- Healthy eating, physical activity and obesity
- Alcohol use and tobacco control
- Health checks and primary care
- Sexual health
- Communities and settings
- Children and younger people
- Older people and mental wellbeing

Public health intelligence team – this team provides a range of data and information which supports and underpins evidence-based working within the council and its partners. Major pieces of work include:

- Delivery of the Joint Strategic Needs Assessment (JSNA); an ongoing assessment of the local population's future health, care and wellbeing needs, which informs and guides commissioning of health, wellbeing and social care services. www.eastsussexjsna.org.uk.
- Production of the Director of Public Health's Annual Report. The report draws on information from the JSNA and sets out a plan for

improving the health and wellbeing of local people and reducing health inequalities.

Contracts and Purchasing Unit

The Contracts and Purchasing Unit (CPU) is responsible for procuring and managing contracts of care-managed services to meet the eligible needs of people who receive social care and health support. East Sussex County Council is a commissioning organisation and the role of CPU is essential to this process.

The role of CPU is to:

- procure the services that are identified by Commissioning;
- support, alongside operational staff, the process of service users accessing those services; and
- ensure they are provided in the way that had been intended.

Part Two - Detailed specification for a tier 2 children and young people's weight management service

1 Aims of the service

1.1 To design and deliver an evidence-based and accessible tier 2 children and young people's weight management service which aims to assist children and young people aged between 2 and 18 years (or a specific age group within that range, as agreed with the commissioner), who live in East Sussex and are on or above the 91st BMI centile to reach and maintain a healthier BMI as set out in section 3 of part 2 of this document.

2 Objectives of the service

2.1 To provide an evidence-based targeted multi-component weight management service, which is NICE compliant and aims to address and improve dietary intake, physical activity/inactivity levels and behavioural issues such as self confidence/self efficacy for overweight and obese 2-18 year olds (or a specific age group within that range, as agreed with the commissioner), living within the locality.

2.2 To address health inequalities by placing emphasis on uptake of the service by target population groups, in line with evidence from the East Sussex Joint Strategic Needs Assessment, through effective promotion and service setting.

2.3 To monitor and evaluate the service as set out in sections 2.6 and 4 within this document.

2.4 To ensure that the service user's family/parent/carer is included within the process wherever possible/appropriate inline with best practice as set out in NICE guidance.

2.5 To focus on long-term behaviour change rather than short term weight loss.

3 Description of the service and its outputs

The service should be a 12 session programme, which is delivered to service users free at the point of access and delivered in a group environment on a weekly basis with the following activities as a minimum to ensure that they follow best practice guidance:

3.1 Completion of initial assessment to ensure referral is appropriate (utilising criteria as set out within section 5).

3.2 Provision of individual Healthy weight plan with goals (weight loss/maintenance, diet, physical activity and behaviour change) which should be reviewed on a weekly basis.

3.3 Provision of support and information regarding dietary goals, physical activity and behaviour change using motivational interviewing techniques where appropriate.

3.4 Facilitation of peer support.

3.5 Follow-up of non-attendees after 2 weeks of not attending meetings (The commissioner should be informed of non-attendance).

3.6 Provision, maintenance and replacement of all equipment necessary for delivery of the programme (e.g. weight scales, height measures, tape measures, stopwatches, pedometers, exercise equipment).

3.7 Provision of post-programme support – this can be in person, by phone, mail or internet as appropriate.

3.8 Assessment of service users long-term weight maintenance at 26 & 52 weeks.

4 Expected outcomes

4.1 BMI maintained or reduced to below the 91st centile.

4.2 Increased physical activity levels and/or decreased periods of inactivity.

4.3 Improved dietary intake and eating behaviours.

4.4 Increased family monitoring of behaviour and progress (e.g. keeping a food diary and/or physical activity diary).

4.5 Improved psychological wellbeing (confidence, self efficacy etc).

5 Eligibility

All service users should be assessed as eligible, utilising the following criteria:

5.1 They are living within the county of East Sussex.

5.2 They are **not** pregnant or breastfeeding.

5.3 They are under the age of 18.

5.4 They have a BMI equal to or above than the 91st centile.

5.5 They do **not** have a BMI equal to or above than the 98th centile with co-morbidities or special needs, such as learning disabilities and mental health issues, unless pre-assessed and referred by their GP.

5.6 They do **not** have an eating disorder.

5.7 They have **not** previously attended tier 2 child weight management services in the 3 months prior to referral.

5.8 They do **not** have an underlying medical cause for obesity and would benefit from more intensive clinical management than a tier 2 service.

6 Referral criteria and sources

6.1 Referral criteria are described within the care pathway (Appendix B)

6.2 The service should be accessible to all children and young people aged between 2 & 18 who have a BMI which is equal to or above the 91st centile and have been referred by a local health professional or any referral management function (call centre, online triage system – subject to being developed in the future).

6.3 The service provider will also be expected to make onward referrals to other health and social care services, and community facilities such as leisure centres where appropriate.

7 Service standards

The service provider is expected to comply with the following standards:

7.1 The service complies with relevant aspects of NICE guidance (CG43. Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children), including that all staff/volunteers delivering the programme should have the relevant competences and specific training.

7.2 Statutory health and safety requirements are met, including having an incident reporting policy in place.

7.3 Local and national safeguarding requirements are met.

7.4 Data protection and information governance policies and procedures are in place.

7.5 A service user feedback and complaints policy is in place.

7.6 Recruitment, training and development policies and procedures are in place to ensure that staff and volunteers have the appropriate competences to deliver the service effectively.

7.7 An implementation plan is in place which illustrates how the service will be delivered within agreed timescales, and how risks will be prevented, ameliorated or controlled.

7.8 The service is evaluated utilising the National Obesity Observatory's *Standard Evaluation Framework for weight management interventions.*

7.9 The service should have the ability to meet initial demand as agreed with the commissioner and to increase capacity if demand rises.

7.10 All referrals should be contacted by the service within one week and, subject to eligibility and capacity, they should be enrolled on to the next scheduled session/programme. Where this is not possible, it should be reported to the commissioner.

7.11 Services should be delivered across East Sussex within venues which are DDA compliant, risk assessed and have good access to public transport.

7.12 The service is open to all, regardless of their background or ability and is delivered in a culturally appropriate manner.

8 Interdependences

8.1 It is expected that the service provider will have mutually dependant working relationships with the following organisations:

- National Child Measurement Programme
- Any Tier 1 and Tier 3 weight management services
- Adult weight management services
- Any referral management function (call centre, online triage system – subject to being developed in the future).
- Primary care services
- Community and school health services
- Educational establishments
- Other local health providers such as CAMHS

9 Partnership working with external agencies

The Provider is required to:

9.1 Demonstrate a commitment to co-operate to achieve effective communication and excellent working relationships with commissioners and partner organisations.

9.2 Work and liaise with other professionals and services within Health, Social Care and local community and voluntary groups to support the achievement of the stated outcomes.

9.3 Refer to and liaise with Health, Social Care and Third Sector services as appropriate and provide the necessary information as requested by that organisation (subject to the Data Protection Act).

9.4 Endeavour to develop meaningful relationships with minority groups including relationships with organisations that represent the particular needs of people that face specific barriers and or risks.

10 Equality and diversity

10.1 The Equality Act 2010 (EA) sets out the protected characteristics where any Service must pay due regard for the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EA;

b) advance equality of opportunity between persons who share a relevant protected characteristic (as defined by the EA) and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The protected characteristics set out in the EA are age, disability, race, pregnancy / maternity, religion or belief, gender (including gender reassignment) and sexual orientation. Marriage and civil partnership are also protected characteristics for the purposes of the duty to eliminate discrimination.

When making decisions the County Council also considers other matter such as the impact of rurality, deprivation and being a carer.

10.2 The provider is required to have a fair access, fair exit, and equality and inclusion policy that is consistent with requirements of the legislation outlined in Section 3.3 of the Terms and Conditions of Contract.

11 Safeguarding vulnerable adults and children

11.1 The Provider must ensure that service users, and anyone visiting the service, are safeguarded from any form of abuse or exploitation in accordance with written policies and procedures to be agreed with the commissioner prior to the commencement of the service and meet the standards and regulations set out in:

- The Sussex Multi Agency Policy and Procedures for Safeguarding Vulnerable Adults produced by the Safeguarding Adults Boards of Brighton and Hove, East Sussex and West Sussex (2007).
- Section 3.13 of the Terms & Conditions of Contract ('Safeguarding Vulnerable Adults and Children').

11.2 The Provider will share information with the following relevant organisations: Police, Probation Service, Adult Social Care and Children's Services if a service user discloses information that would indicate a child or vulnerable adult is at risk of harm and/or admitted to an offence for which they have not been convicted.

12 Security, health and safety

12.1 The Provider must ensure that the service complies with all the Health and Safety standards outlined in Section 3.5 of the Terms and Conditions of Contract.

13 Service user involvement

The Provider is required to:

13.1 Ensure service users and their families are well informed so they can communicate their needs and views and make informed choices.

13.2 Ensure feedback from service users and their families is used to improve services.

14 Managing the service

(see also section 3 of terms & conditions of contract)

The Provider is required to:

14.1 Ensure sufficient staff coverage to be able to address the needs of service users.

14.2 Ensure that all their staff comply with the requirements of the Disclosure and Barring Service (DBS) and the Independent Safeguarding Authority.

14.3 Ensure management time is available to provide effective management of the service including regular individual and group supervision.

14.4 Ensure that sufficient management time is available for Contract Management, including attendance at the Quarterly contract review meetings and any requested meetings in relation to the Contract.

14.5 Demonstrate that the organisation is sufficiently financially robust and will use the allocated funds for the purpose of delivering and developing the service.

14.6 Demonstrate that the organisation is able to put risk management and contingency procedures in place.

14.7 Effectively utilise information technology (IT) to facilitate accurate recording and monitoring data.

14.8 Obtain informed consent from service users for their information to be shared with commissioners.

14.9 Ensure adequate cover arrangements are put in place for holidays and sickness.

14.10 Ensure all staff members that have contact with service users carry and make available easily recognisable appropriate forms of identification.

14.11 Submit accurate and timely monitoring and performance data.

15 Employment and training

The Provider is required to:

15.1 Employ suitably experienced, qualified and skilled staff to successfully deliver and manage the service.

15.2 Support, train, supervise and appraise all staff members who are employed to ensure they remain competent and engage in continued professional development.

15.3 Ensure staff members are trained to submit accurate and timely monitoring and performance data.

15.4 Ensure staff members engage with continued professional development, including appropriate training provided by key partners.

16 Communications

16.1 The service provider is responsible for the marketing and promotion of sessions. This activity should take place within target population groups and communities as agreed with the commissioner.

16.2 A comprehensive communications plan should be developed by the service provider to illustrate how and when marketing and promotion of the service will take place. This should be agreed with the commissioner before delivery of services commences.

16.3 Marketing and promotion should be delivered in different formats (electronic and printed) to ensure effectiveness.

16.4 The service provider is required to ensure that the communication needs of different groups are met.

Part Three - Detailed specification for monitoring the quality and performance of the tier 2 children and young people's weight management service

1 Monitoring and Review Arrangements

1.1 The contract will be monitored monthly and reviewed quarterly and annually by the commissioning lead in conjunction with the Contracts and Purchasing Unit.

1.2 As well as the minimum dataset required by ESCC, the service provider will be required to obtain the following monitoring information for all service users and be able to report it to the commissioners as and when required:

- Referral outcome – successful, unable to contact, placed on waiting list
- Initial BMI centile
- BMI centile at 12 weeks / 26 weeks / 52 weeks
- Programme outcome – successful completion (attendance of at least 75% of sessions), drop out
- Geodemographics of service users – postcode, age, ethnicity, gender

The service provider will be expected to obtain informed consent from service users for this information to be shared with the commissioner.

1.3 The service provider will also be required to report against Key Performance and Quality Indicators as set out in appendix A of this document.

1.4 The annual review will consider compliance with the contract. Any aspect of compliance with this Service Specification can be considered.

All reviews will consider (not exhaustive):

- Outcomes for service users
- Who gains access to the service
- Quality of service
- Performance against agreed targets
- Service user satisfaction

1.5 Providers are expected to submit monthly service activity reports detailing achievement of key performance and quality indicators.

1.6 Providers are expected to submit quarterly update reports which include information as set out in section 1.2, achievement of key performance and quality indicators, and service expenditure.

2 Performance and quality indicators

2.1 Performance and quality indicators (Appendix A) are a measure against which we can judge how well the service is performing. They have been selected to evaluate specified outcomes and requirements and will be reviewed at least quarterly.

2.2 Where underperformance against indicators occurs, the service provider will be expected to produce recovery plan in agreement with the commissioner.

2.3 The targets set will be reviewed with the Provider after the first year of service.

3 Prices and costs

3.1 The total maximum budget available for the delivery of this service is £100,000.00 for each year during the period of contract delivery.

3.2 Payments will be made as per the terms of the contract.

3.3 The service provider will be responsible for ensuring the cost of securing equipment, facilities and materials necessary to deliver the service is met within the budget available.

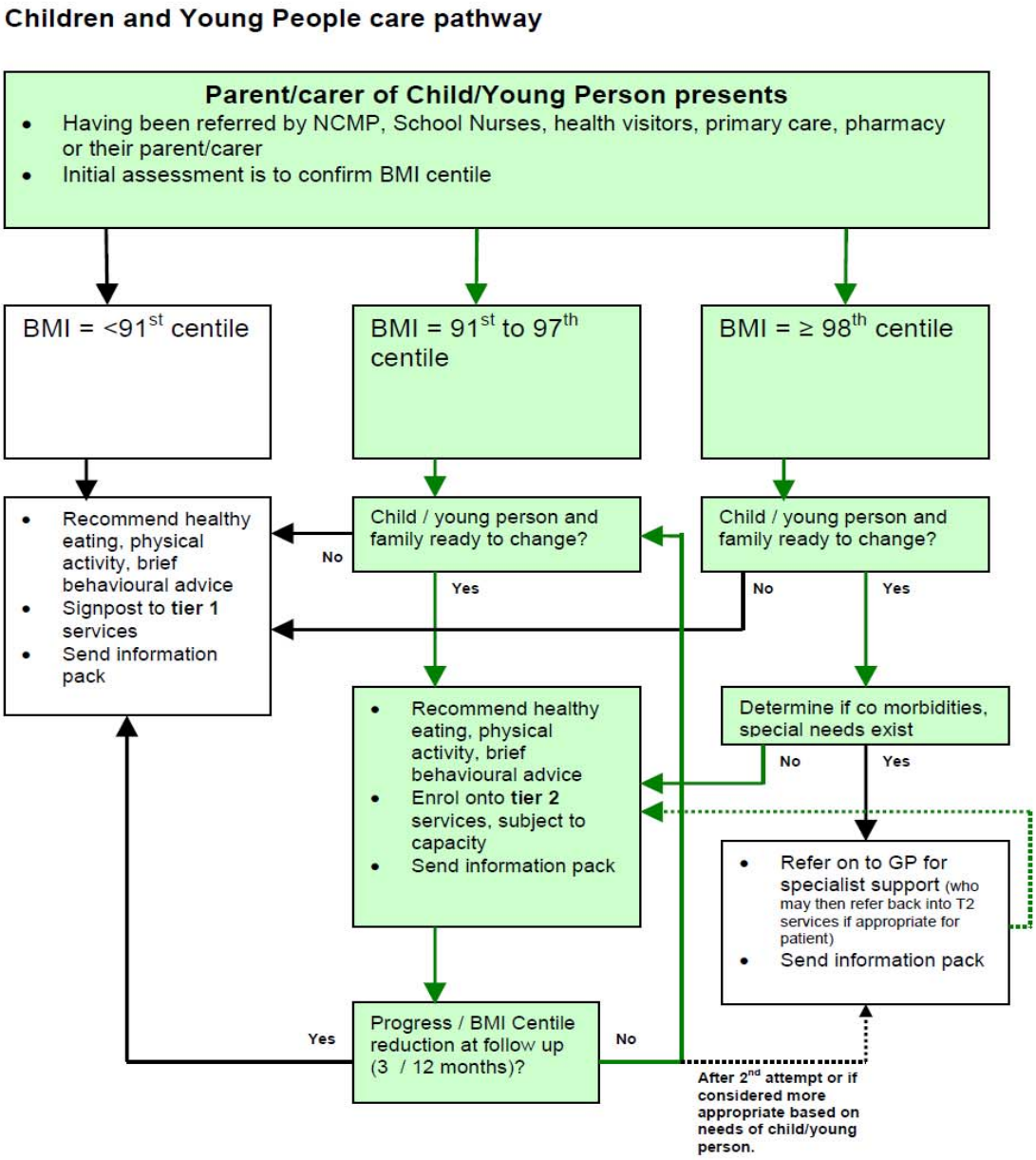
Appendix A: Key performance and quality indicators

Performance / Quality Indicator	*Threshold*	*Method of measurement*	*Report Due*
Number of staff/volunteers who are appropriately trained and competent in delivery of proposed services	100% of staff are trained and competent in the following areas: • Nutrition • Physical activity • Behaviour change	External audit of staff qualifications and competences	Before delivery of services commences
The service is safe, appropriate and complies with legislative requirements	The service has the following in place: • A current health and Safety policy including incident reporting / management procedures • DBS checks for 100% of staff / volunteers involved in the service • Risk assessments for 100% of service delivery venues • A current information governance / data protection policy • Safeguarding procedures	External audit of policies, protocols and adherence to legal requirements	Before delivery of services commences
The service is promoted to target population groups	Develop a service communications plan, which details the different methods which will be utilised in communications with target audiences and local partners/stakeholders, key messages, outputs, timelines etc, and agree plan with commissioner.	Communications plan developed and agreed with commissioner	Before delivery of service commences

	Report achievement of activities as set out in communications plan, as part of quarterly reporting.	Achievement of activities as set out in plan Reports on progress against plan produced and delivered to commissioner	Quarterly
The service is delivered in areas/venues which are accessible to target population groups	Services are delivered in high priority areas as agreed with the commissioner	Implementation plan	Before delivery of services commences
Referrals are contacted within one week and enrolled onto the next available session/programme	80% of referrals are contacted within one week of the referral being received by the service provider Details of numbers of people placed on waiting list is shared with the commissioner	Service activity reports	Monthly
Number of service users who meet eligibility criteria	100% of service users accessing the service meet the eligibility criteria	Service activity reports	Monthly
Number of individuals from high priority areas accessing service	60% of service users accessing the service are residents within high priority areas	Service activity reports	Monthly
Number of initial assessments completed	Initial assessments are completed for 100% of new starters	Service activity reports	Monthly
Number of weight loss plans completed	100% of service users receive a weight loss plan	Service activity reports	Monthly

Number of service users who successfully complete the 12-week programme (attending at least 9 out of 12 sessions)	60% of service users successfully complete the 12-week programme	Service activity reports	Monthly
Number of non-attendees contacted	At least 3 attempts are made to contact all non attendees	Service activity reports	Monthly
Number of service users achieving reduction in BMI	At least 50% of service users achieve reduction in BMI to less than the 91st centile by the end of the programme	Service activity reports	Monthly
Number of service users who are satisfied with the service they have received	At least 80% of service users who complete the programme rate the following as good or very good: • Service quality • Service accessibility • Staff knowledge and skills • Support received from staff • Staff friendliness	Service activity reports	Monthly

Appendix B: Care pathway



Children and Young People weight management service care pathway
Peter Aston July 13

Appendix C: Core Values and Principles

ESCC seeks to ensure that all contracted Providers deliver services, which reflect its core values and principles. In accepting the contract the Provider will be agreeing to these as follows:

- to ensure that Service users and Carers are informed about decisions taken by ESCC and the reasons for them
- to work in partnership with Service users and their Carers
- to target services to those in greatest need
- to value difference and to ensure that services are sensitive to the diversity of need
- to be innovative in seeking to develop flexible and responsive services
- to value staff
- to recognise that all staff are accountable for the delivery of a high quality service that respects the rights of Service users and their Carers
- to focus on the outcomes of interventions to ensure that resources are effecting real change
- to encourage feedback and be open to constructive criticism
- to seek value for money
- to ensure that equal opportunity principles underpin all its services and actions
- to set clear standards for all aspects of service provision

East Sussex County Council

Service Specification

Tier 2 Adult weight management services

B03 – Service Specification

July 2013

Contents

Specification

Part One - Background information

1 Introduction

1.1 East Sussex County Council intends to commission a service provider to design and deliver a tier 2 adult weight management service which aims to reduce the prevalence of overweight and obesity within the population of East Sussex and therefore contribute to a reduction in the numbers of people with diabetes, cancer and heart disease, by supporting service users to lose weight and maintain a healthier weight through improved dietary intake and increased physical activity.

2 Evidence base

2.1 The programme of work will enable the implementation of national and local policy and strategy (which contains references to evidenced based health promotion programmes and projects) aligned to local need as highlighted in the following documents:

- *Healthy lives, healthy people: A call to action on obesity in England.* (DH, 2011).
- *PH42 Obesity: Working with local communities* (NICE, 2012).
- *CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (NICE, 2006).
- *Treating adult obesity through lifestyle change interventions: A briefing paper for commissioners* (The National Obesity Observatory, 2010).
- *Standard evaluation framework for weight management interventions* (The National Obesity Observatory, 2009).
- *Healthy lives, healthy people: The East Sussex health and wellbeing strategy 2013-2016* (East Sussex County Council, 2012).
- *Joint Strategic Needs Assessment* (NHS Sussex/East Sussex County Council).

3 Health impact of overweight and obesity on adults

3.1 Obesity is associated with an increased risk of a number of conditions such as:

- 10 per cent of all cancer deaths among non-smokers are related to obesity.
- The risk of Coronary Artery Disease increases 3.6 times for each unit increase in BMI.
- 85 per cent of hypertension is associated with a BMI greater than 25.
- The risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25.
- Up to 90 per cent of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation.
- The health effects of excess weight are increasingly apparent even in children; the incidence of both type 2 diabetes and non-alcoholic fatty liver disease used to be rare in children, but is now increasing.
- Obesity in pregnancy is associated with increased risks of complications for both mother and baby.
- Social stigmatisation and bullying are common and can, in some cases, lead to depression and other mental health conditions[1].

The department of health uses different classifications of BMI to indicate different degrees of excess weight and its associated risk of disease. These are set out in the table below.

Table: Department of Health BMI Classifications

Classification		*BMI (kg/m²)*	Risk of disease associated with excess weight
UNDERWEIGHT		Less than 18.5	Low, but high risk to overall mortality through underweight and poor nutritional status.
HEALTHY WEIGHT		18.5 – 24.9	Average
OVERWEIGHT		25 – 29.9	Increased
OBESE		30 or more	
	Obesity (Class I)	30 – 34.9	Moderate
	Obesity (Class II)	35 – 39.9	Severe
	Obesity (Class III)	40 or more	Very severe

Source: Adapted from World Health Organisation, 2000

According to the *Health Survey of England* (2011):

- 61.7% of adults (aged 16 or over) were overweight or obese.

[1] DH. (2008). *Healthy weight, healthy lives: A cross-government strategy for England*

- 24.8% of all adults were obese.

The percentage of people classified as obese in East Sussex is estimated to be 25%[2]. Estimated prevalence varies across the county with higher rates expected in Hastings and lower rates in Rother.

The table below illustrates obesity levels at district/borough level and compares them to the England average:

Table 6: Prevalence of obese adults (%)

	Prevalence of obese adults (%)	Significantly different from England
England	24.2	
East Sussex	24.7	Amber
Eastbourne	24.8	Amber
Hastings	27.0	Red
Lewes	24.7	Amber
Rother	22.9	Amber
Wealden	24.3	Amber

Source: Health Profiles, APHO and Department of Health, 2011

Green indicates **significantly better** than England
Amber indicates **not significantly different** from England
Red indicates **significantly worse** than England

The table below illustrates these percentages could translate into numbers of people.

District / Borough	Obese adults (%)	Obese adults (number)
Hastings	27	18,749
Eastbourne	24.9	19,667
Lewes	24.7	19,244
Wealden	24.3	28,456
Rother	22.9	16,888

[2] East Sussex *Joint Strategic Needs Assessment(JSNA)* (2012),

This table suggests that large numbers of people in East Sussex are likely to benefit from losing weight. However, the support requirements to enable individuals to do this will vary. For some, signposting information is all that will be required, for others, where low confidence and self esteem may be an issue, more intensive support such as that provided by the health trainer services may be more effective. The care pathway described within Appendix B explains the process further and this combined with the eligibility criteria described within section 5 of part 2 of this document means that for many people, Tier 2 weight management services may not be the most appropriate service.

Based on the expectation that demand may always outstrip supply, it is crucial that the service provider ensures promotion and placement of services takes place within areas where the need is greatest.

4 Policy context

4.1 The department of Health published its latest policy document focused on tackling overweight and obesity in October 2011. *Healthy people, health lives: A call to action on obesity in England* starts by describing the basis of the 'new approach' as being:

- The latest evidence of underlying issues and causes, starting with the Government Office for Science's Foresight report of 2007.
- The latest evidence of 'what works' – and in particular good practice from a range of initiatives at local and national level.
- Extensive engagement with a wide range of delivery partners and experts over the past months.

The call to action then goes on to describe the key components of a successful approach. These are:

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The government believes that if these components will help deliver a new national ambition which it has set to act as a 'rallying cry' for us all:

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The public health outcomes framework, *Improving outcomes and supporting transparency* (2012), sets out the desired outcomes for public health and how they will be measured. The following indicators which will be used to measure the impact of services and interventions which aim to reduce obesity in adults:

Domain 1: Improving the wider determinants of health.

1.16: Utilisation of outdoor space for exercise / health reasons – the number of people reporting that they have taken a visit to the natural environment for health or exercise over the previous seven days.

Domain 2: Health improvement.

2.11: Diet – this indicator is yet to be finalised. However, it is likely to focus on an increase in consuming five-a-day and a reduction in intake of saturated fats, sugar, salt and calories.

2.12: Excess weight in adults - Number of adults who are classified as overweight or obese.

2.13: Proportion of physically active and inactive adults - Number of adults (16+) doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more.

The East Sussex Health and Wellbeing Board (ESHWB) are committed to reducing obesity have set this as a key priority within the East Sussex Health and Wellbeing Strategy 2013 – 2016 in seeking to ‘Enable people of all ages to live healthy lives and have healthy lifestyles’ (ESHWB, 2013).

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The role of CPU is to:

- procure the services that are identified by Commissioning;
- support, alongside operational staff, the process of service users accessing those services; and
- ensure they are provided in the way that had been intended.

Part Two - Detailed specification for a tier 2 adult weight management service

1 Aims of the service

1.1 To design and deliver a tier 2 adult weight management service which aims to reduce the prevalence of obesity within the population of East Sussex and therefore contribute to a reduction in the numbers of people with diabetes, cancer and heart disease, by supporting service users to lose weight and maintain a healthier weight through improved dietary intake and increased physical activity.

2 Objectives of the service

2.1 To provide an evidence-based targeted multi-component weight management service, which aims to address and improve dietary intake, physical activity/inactivity levels and behavioural issues such as self confidence/self efficacy.

2.2 To place emphasis on uptake of the service by target population groups, in line with evidence from the East Sussex Joint Strategic Needs Assessment, through effective promotion and service setting.

2.3 To monitor and evaluate the service as set out in part three of this document.

3 Description of the service and its outputs

The service should be a 12-session programme, which is delivered to service users free at the point of access and delivered in a group environment on a weekly basis with the following activities as a minimum:

3.1 Completion of initial assessment to ensure referral is appropriate (utilising criteria as set out within section 5 of this document).

3.2 Provision of individual Healthy Weight plan with goals (weight loss, diet, physical activity and behaviour change) which should be reviewed on a weekly basis.

3.3 Provision of support and advice regarding dietary goals, physical activity and behaviour change using evidence based behaviour change techniques where appropriate.

3.4 Facilitation of peer support.

3.5 Follow-up of non-attendees after 2 weeks of not attending meetings (The commissioner should be informed of non-attendance / drop out details as part of monitoring and review arrangements set out in part three, section 1.2 of this document).

3.6 Provision, maintenance and replacement of all equipment necessary for delivery of the programme (e.g. weight scales, height measures, tape measures, stopwatches, pedometers, exercise equipment).

3.7 Provision of post-programme support – this can be in person, by phone, mail or internet as appropriate.

3.8 Assessment of service users long-term weight maintenance at 26 & 52 weeks.

4 Expected outcomes

4.1 Reduced excess weight – between 5 & 10% of original weight.

4.2 Increased physical activity levels and/or decreased periods of inactivity.

4.3 Improved dietary intake.

4.4 Increased self monitoring of behaviour and progress (e.g. keeping a food diary and/or physical activity diary).

5 Eligibility

All service users should be assessed as eligible, utilising the following criteria:

5.1 They are living within the county of East Sussex.

5.2 They are **not** pregnant or breastfeeding.

5.3 They are aged 16 or over.

5.4 They have a BMI of ≥30

5.5 They have a BMI of <40 (-co-morbidities) or < 35 (+co-morbidities), unless pre-assessed and referred by their GP.

5.6 They do **not** have an eating disorder.

5.7 They have **not** previously accessed Tier 2 weight management services or self funded sessions with a multi-component weight management provider in the 3 months prior to referral.

5.8 They do **not** have an underlying medical cause for obesity which would benefit from more intensive clinical management than a tier 2 service is able to offer.

5.9 They do **not** have significant co-morbidity or complex needs as identified by their GP or other healthcare professional.

6 Referral criteria and sources

6.1 Referral criteria are described within the care pathway (Appendix B).

6.2 The service should be accessible to all adults aged 16 years and over who have a BMI which is equal to or greater than 25.

6.3 The service provider should accept self-referred individuals as well as referrals from local health professionals such as primary care, the health checks programme or any referral management function (call centre, online triage system – subject to being developed in the future).

6.4 The service provider will also be expected to make onward referrals to other health and social care services, and community facilities such as leisure centres where appropriate.

7 Service standards

The service provider is expected to comply with the following standards:

7.1 The service complies with relevant aspects of NICE guidance (CG43. Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children), including that all staff/volunteers delivering the programme should have the relevant competences and specific training.

7.2 Statutory health and safety requirements are met, including having an incident reporting policy in place.

7.3 Local and national safeguarding requirements are met.

7.4 Data protection and information governance policies and procedures are in place.

7.5 A service user feedback and complaints policy is in place.

7.6 Recruitment, training and development policies and procedures are in place to ensure that staff and volunteers have the appropriate competences to deliver the service effectively.

7.7 An implementation plan is in place which illustrates how the service will be delivered within agreed timescales, and how risks will be prevented, ameliorated or controlled.

7.8 The service is evaluated utilising the National Obesity Observatory's *Standard Evaluation Framework for weight management interventions.*

7.9 The service should have the ability to meet initial demand as agreed with the commissioner and to increase capacity if demand rises.

7.10 All referrals should be contacted by the service within one week and, subject to eligibility and capacity, they should be enrolled on to the next scheduled session/programme. Where this is not possible, it should be reported to the commissioner.

7.11 Services should be delivered across East Sussex within venues which are DDA compliant, risk assessed and have good access to public transport.

7.12 The service is open to all, regardless of their background or ability and is delivered in a culturally appropriate manner.

8 Interdependences

8.1 It is expected that the service provider will have mutually dependant working relationships with the following organisations:

- Any Tier 1 and Tier 3 weight management services.
- Children and young people's weight management services.
- Any referral management function (call centre, online triage system – subject to being developed in the future).
- Health Checks service.
- Primary care services.
- Other local health providers such as smoking cessation.
- Local health improvement partnerships.

9 Partnership working with external agencies

The Provider is required to:

9.1 Demonstrate a commitment to co-operate to achieve effective communication and excellent working relationships with commissioners and partner organisations.

9.2 Work and liaise with other professionals and services within Health, Social Care and local community and voluntary groups to support the achievement of the stated outcomes.

9.3 Refer to and liaise with Health, Social Care and Third Sector services as appropriate and provide the necessary information as requested by that organisation (subject to the Data Protection Act).

9.4 Endeavour to develop meaningful relationships with minority groups including relationships with organisations that represent the particular needs of people that face specific barriers and or risks.

10 Equality and diversity

10.1 The Equality Act 2010 (EA) sets out the protected characteristics where any Service must pay due regard for the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EA;

b) advance equality of opportunity between persons who share a relevant protected characteristic (as defined by the EA) and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The protected characteristics set out in the EA are age, disability, race, pregnancy / maternity, religion or belief, gender (including gender reassignment) and sexual orientation. Marriage and civil partnership are also protected characteristics for the purposes of the duty to eliminate discrimination.

When making decisions the County Council also considers other matter such as the impact of rurality, deprivation and being a carer.

10.2 The provider is required to have a fair access, fair exit, and equality and inclusion policy that is consistent with requirements of the legislation outlined in Section 3.3 of the Terms and Conditions of Contract.

11 Safeguarding vulnerable adults and children

11.1 The Provider must ensure that service users, and anyone visiting the service, are safeguarded from any form of abuse or exploitation in accordance with written policies and procedures to be agreed with the commissioner prior to the commencement of the service and meet the standards and regulations set out in:

- The Sussex Multi Agency Policy and Procedures for Safeguarding Vulnerable Adults produced by the Safeguarding Adults Boards of Brighton and Hove, East Sussex and West Sussex (2007).
- Section 3.13 of the Terms & Conditions of Contract ('Safeguarding Vulnerable Adults and Children').

11.2 The Provider will share information with the following relevant organisations: Police, Probation Service, Adult Social Care and Children's Services if a service user discloses information that would indicate a child or vulnerable adult is at risk of harm and/or admitted to an offence for which they have not been convicted.

12 Security, health and safety

12.1 The Provider must ensure that the service complies with all the Health and Safety standards outlined in Section 3.5 of the Terms and Conditions of Contract.

13 Service user involvement

The Provider is required to:

13.1 Ensure service users are well informed so they can communicate their needs and views and make informed choices.

13.2 Ensure service user feedback is used to improve services.

14 Managing the service

(see also section 3 of terms & conditions of contract)

The Provider is required to:

14.1 Ensure sufficient staff coverage to be able to address the needs of service users.

14.2 Ensure that all their staff members comply with the requirements of the Disclosure and Barring Service (DBS) and the Independent Safeguarding Authority.

14.3 Ensure management time is available to provide effective management of the service including regular individual and group supervision.

14.4 Ensure that sufficient management time is available for Contract Management, including attendance at the Quarterly contract review meetings and any requested meetings in relation to the Contract.

14.5 Demonstrate that the organisation is sufficiently financially robust and will use the allocated funds for the purpose of delivering and developing the service.

14.6 Demonstrate that the organisation is able to put risk management and contingency procedures in place.

14.7 Effectively utilise information technology (IT) to facilitate accurate recording and monitoring data.

14.8 Obtain informed consent from service users for their information to be shared with commissioners.

14.9 Ensure adequate cover arrangements are put in place for holidays and sickness.

14.10 Ensure all staff members that have contact with service users carry and make available easily recognisable appropriate forms of identification.

14.11 Submit accurate and timely monitoring and performance data.

15 Employment and training

The Provider is required to:

15.1 Employ suitably experienced, qualified and skilled staff to successfully deliver and manage the service as described section 3, *Description of the service and its outputs.*

15.2 Support, train, supervise and appraise all staff members who are employed to ensure they remain competent and engage.

15.3 Ensure staff members are trained to submit accurate and timely monitoring and performance data.

15.4 Ensure staff members engage with continued professional development, including appropriate training provided by key partners.

16 Communications

16.1 The service provider is responsible for the marketing and promotion of sessions. This activity should take place within target population groups and communities as agreed with the commissioner.

16.2 A comprehensive communications plan should be developed by the service provider to illustrate how and when marketing and promotion of the service will take place. This should be agreed with the commissioner before delivery of services commences.

16.3 Marketing and promotion should be delivered in different formats (electronic and printed) to ensure effectiveness.

16.4 The service provider is required to ensure that the communication needs of different groups are met.

Part Three - Detailed specification for monitoring the quality and performance of the tier 2 adult weight management service

1 Monitoring and Review Arrangements

1.1 The contract will be monitored monthly and reviewed quarterly and annually by the commissioning lead in conjunction with the Contracts and Purchasing Unit.

1.2 As well as the minimum dataset required by ESCC, the service provider will be required to obtain the following monitoring information, as minimum, for all service users and be able to report it to the commissioners as and when required:

- Referral outcome – successful, unable to contact, placed on waiting list.
- Initial height, weight and BMI.
- Weight and BMI at 12 weeks / 26 weeks / 52 weeks.
- Programme outcome – successful completion (attendance of at least 75% of sessions), drop out.
- Geodemographics of service users – postcode, age, ethnicity, gender.

The service provider will be expected to obtain informed consent from service users for this information to be shared with the commissioner.

1.3 The service provider will also be required to report against Key Performance and Quality Indicators as described in appendix A of this document.

1.4 The annual review will consider compliance with the contract. Any aspect of compliance with this Service Specification can be considered.

All reviews will consider (not exhaustive):

- Outcomes for service users
- Who gains access to the service
- Quality of service
- Performance against agreed targets
- Service user satisfaction

1.5 Providers are expected to submit monthly service activity reports detailing achievement of key performance and quality indicators.

1.6 Providers are expected to submit quarterly update reports which include information as set out in section 1.2, achievement of key performance and quality indicators, and service expenditure.

2 Performance and quality indicators

2.1 Performance and quality indicators (Appendix A) are a measure against which we can judge how well the service is performing. They have been selected to evaluate specified outcomes and requirements and will be reviewed at least quarterly.

2.2 Where underperformance against indicators occurs, the service provider will be expected to produce recovery plan in agreement with the commissioner.

2.3 The targets set will be reviewed with the Provider after the first year of service.

3 Prices and costs

3.1 The total maximum budget available for the delivery of this service is £100,000.00 for each year during the period of contract delivery.

3.2 Payments will be made as per the terms of the contract.

3.3 The service provider will be responsible for ensuring the cost of securing equipment, facilities and materials necessary to deliver the service is met within the budget available.

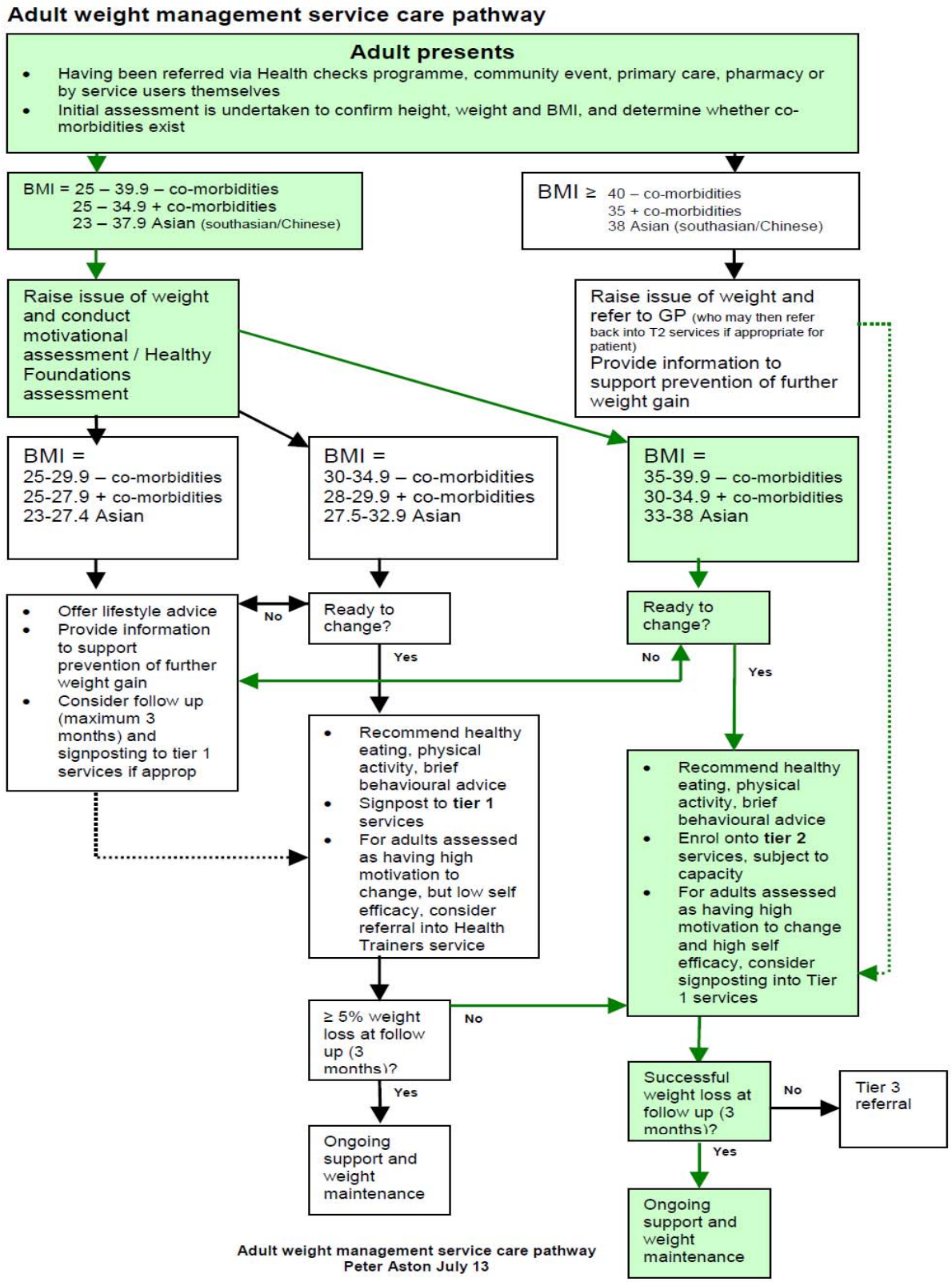
Appendix A: Key performance and quality indicators

Performance / Quality Indicator	*Threshold*	*Method of measurement*	*Report Due*
Number of staff/volunteers who are appropriately trained and competent in delivery of proposed services	100% of staff are trained and competent in the following areas: • Nutrition • Physical activity • Behaviour change	Approved external audit of staff qualifications and competences	Before delivery of services commences
The service is safe, appropriate and complies with legislative requirements	The service has the following in place: • A current health and Safety policy, including incident reporting / management procedures • DBS checks for 100% of staff / volunteers involved in the service • Risk assessments for 100% of service delivery venues • A current information governance / data protection policy • Safeguarding procedures	Approved external audit of policies, protocols and adherence to legal requirements	Before delivery of services commences
Promotion of service	Develop a service communications plan, which details the different methods which will be utilised in communications with target audiences and local partners/stakeholders, key messages, outputs, timelines etc, and agree plan with commissioner.	Communications plan developed and agreed with commissioner	Before delivery of services commences

	Report achievement of activities as set out in communications plan, as part of quarterly reporting.	Achievement of activities as set out in plan Reports on progress against plan produced and delivered to commissioner	Quarterly
The service is delivered in areas/venues which are accessible to target population groups	Services are delivered in high priority areas as agreed with the commissioner	Implementation plan	Before delivery of services commences
Referrals are contacted within one week and enrolled onto the next available session/programme	80% of referrals are contacted within one week of the referral being received by the service provider Details of numbers of people placed on waiting list is shared with the commissioner	Service activity reports	Monthly
Number of service users who meet eligibility criteria	100% of service users accessing the service meet the eligibility criteria	Service activity reports	Monthly
Number of individuals from high priority areas accessing service	60% of service users accessing the service are residents within high priority areas	Service activity reports	Monthly
Number of initial assessments completed	Initial assessments are completed for 100% of new starters	Service activity reports	Monthly
Number of weight loss plans completed	100% of service users receive a weight loss plan	Service activity reports	Monthly

Number of service users who successfully complete the 12-week programme (attending at least 9 out of 12 sessions)	60% of service users successfully complete the 12-week programme	Service activity reports	Monthly
Number of non-attendees contacted	At least 3 attempts are made to contact all non attendees	Service activity reports	Monthly
Number of service users achieving weight loss of between 5-10%	At least 50% of service users achieve agreed weight loss within 12 weeks	Service activity reports	Monthly
Number of service users who are satisfied with the service they have received	At least 80% of service users who complete the programme rate the following as good or very good: • Service quality • Service accessibility • Staff knowledge and skills • Support received from staff • Staff friendliness	Service activity reports	Monthly

Appendix B: Care pathway



Appendix C: Core Values and Principles

ESCC seeks to ensure that all contracted Providers deliver services, which reflect its core values and principles. In accepting the contract the Provider will be agreeing to these as follows:

- To ensure that Service users and Carers are informed about decisions taken by ESCC and the reasons for them.
- To work in partnership with Service users and their Carers.
- To target services to those in greatest need.
- To value difference and to ensure that services are sensitive to the diversity of need.
- To be innovative in seeking to develop flexible and responsive services.
- To value staff.
- To recognise that all staff members are accountable for the delivery of a high quality service that respects the rights of Service users and their Carers.
- To focus on the outcomes of interventions to ensure that resources are effecting real change.
- To encourage feedback and be open to constructive criticism.
- To seek value for money.
- To ensure that equal opportunity principles underpin all its services and actions.
- To set clear standards for all aspects of service provision.

East Sussex County Council

Service Specification

Health trainer service

B03 – Service Specification

July 2013

Contents

Specification

Part One - Background information

1 Introduction

1.1 East Sussex County Council intends to commission a service provider to deliver a Health Trainer service which aims to reduce health inequalities within the population of East Sussex through the delivery of intensive individual-level health behaviour change support.

2 Evidence base

2.1 The role of NHS accredited Health Trainers was first advocated in the Choosing Health, Making Healthy Choices Easier, White Paper (DH, 2004). The Primary Care Development Centre published a review of the evidence in August 2005 relating to the concept of Health Trainers. Examples of good practice cited include: Lay Health Advisors, Peer Educators, and Advocates.

2.2 The National Institute for Health and Clinical Excellence (NICE) has published evidence on supporting behaviour change, PH6 (2007). This guidance supports the role of Health Trainers in various ways including education and training and the delivery of individual level interventions and programmes. It recommends that interventions should motivate and support people to:

- Understand the short, medium and long-term consequences of their health related behaviours, for themselves and others.
- Feel positive about the benefits of health-enhancing behaviours and changing their behaviour.
- Plan their changes in terms of easy steps over time.
- Recognise how their social contexts and relationships may affect their behaviour, and identify and plan for situations that might undermine the changes they are trying to make.
- Plan explicit ‘if-then’ coping strategies to prevent relapse.
- Make a personal commitment to adopt health-enhancing behaviours by setting (and recording) goals to undertake clearly defined behaviours, in particular contexts over a specified time.
- Share their behaviour change goals with others.

2.3 The Health Trainer service and intervention is described in Health Trainer Handbook, which was written for Department of Health by the British Psychological Society and entitled *Improving Health Changing Behaviour: NHS Health Trainer Handbook* (2008). This has 24 referenced peer reviewed papers underpinning the theoretical base for Health Trainer practice.

It describes how Health Trainers are a major policy and workforce innovation specifically designed to tackle individual health related behaviour and address its contribution to health inequalities. Health Trainers are recruited from local communities and work at the earliest stages of a patient/client care pathway to support health related lifestyle change, through using evidence based applied behaviour change tools and techniques. Key to their input is that they work with those populations least likely to choose and maintain healthy lifestyles, and that they work one to one. This approach aims to break down health inequalities by supporting people through a 'next door' approach as opposed to 'advice from on high'.

Health Trainers offer tailored information, motivation and practical support to individuals who want help to adopt healthier lifestyles. They support service users in developing their own personal health action plan, agreeing goals and supporting individuals over a period of time to achieve this. This support could include, signposting to existing specialist services e.g. stop smoking, providing information on other services e.g. Stop Smoking, Exercise Referral scheme, Weight Management services, local Gyms and community groups etc, supporting clients to identify and address barriers to behaviour change, this may include supporting clients to initially attend an activity where this is identified as a significant barrier. Health Trainer is a time limited intervention and clients typically see the Health Trainer for 6 sessions over a period of 3 months. Ultimately clients accessing Health Trainer service will be left with the skills to become their own Health Trainer i.e. apply the tools and techniques themselves to address additional lifestyle behaviour they wish to change, in future.

It is envisaged that Health Trainers are known and trusted by people in their community and have experience and understanding of what it means to live in, or be part of, that community.

Health Trainers offer the potential to reach more members of hard to reach communities and offer support and signpost to existing specialist services to aid health improvement. They are recruited for their knowledge and ability to engage within their own communities, not for pre-existing health skills and knowledge. New recruits participate in a comprehensive training programme to develop the competences required for this behaviour change role. The four key competences are:

HT1 – Make relationships with communities

HT2 – Communicate with individuals about promoting their health and wellbeing

HT3 – Enable individuals to change their behaviour to improve their own health and wellbeing

HT4 – Manage and organise own time and activities

Source: Competences for Health Trainers (Skills for Health, 2006)

The training and development for new Health Trainers starts from entry level, and is flexible to build on participants existing knowledge, including those who have little or no previous knowledge of health improvement and behaviour change. It is adequately and realistically paced providing on-going developmental opportunities, developing a skill escalator. To meet the incremental learning needs of these new workers various layers of training are essential:

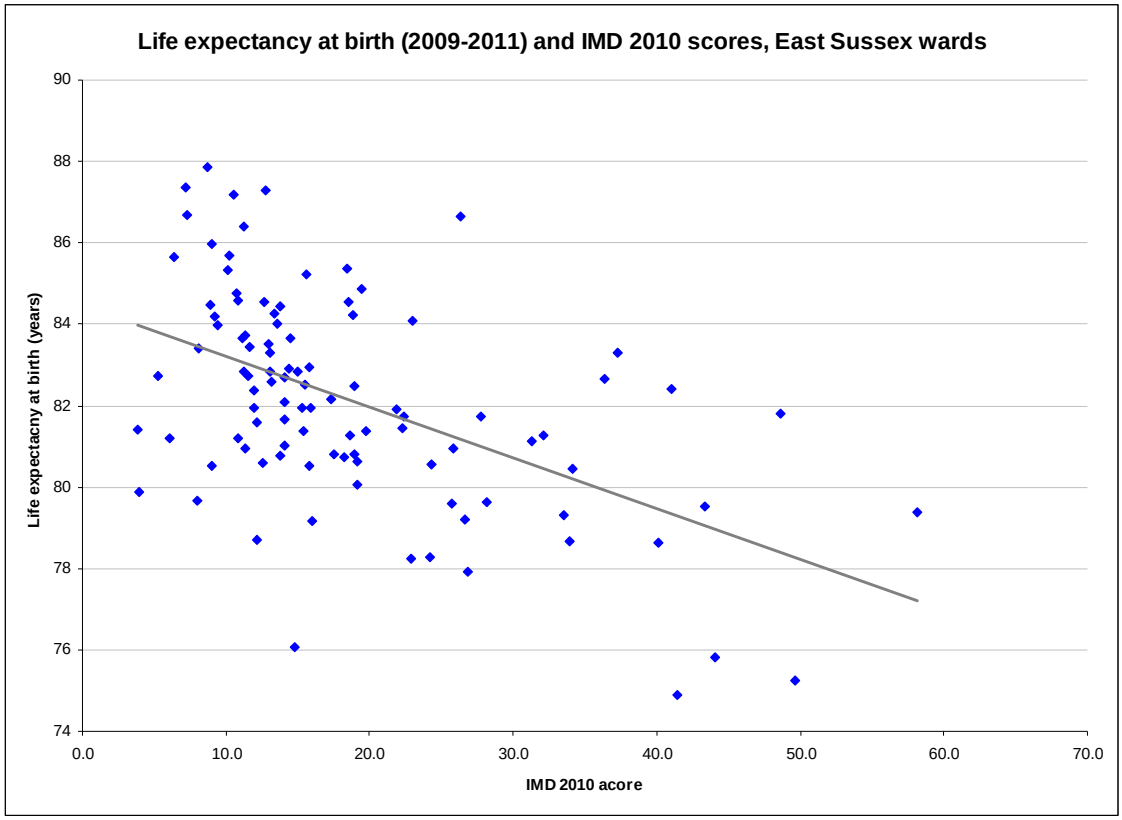
1. Induction training including any mandatory organisational training, health and safety , risk, lone working etc
2. Basic Health Trainer introduction to the role including Level 2 Understanding Health Improvement Certificate (if not already held)
3. Training to support development of competencies (HT1, HT2, HT3, HT4) and to achieve City and Guilds Level 3 Health Trainer Certificate
4. On-going work based training/CPD

3 The impact of health inequalities

3.1 The term ‘health inequalities’ refers to differences in health outcomes which can be observed between different population groups and a key measure of health inequalities is life expectancy.

Health inequalities are a significant issue in East Sussex., with people living in Hastings experiencing a life expectancy 3.6 years lower than people living in Wealden (79.0 years compared with 82.6 years). At ward level, the gap between highest and lowest life expectancy increases markedly with people living in Baird ward (Hastings) experiencing a life expectancy 12.9 years lower than people living in Plumpton, Streat, East Chiltington and St John ward (Lewes) (74.9 years compared with 87.8 years).

There is an association between deprivation and health inequalities. The chart below examines the relationship between life expectancy and deprivation at ward level. It illustrates how life expectancy increases as the ward Index of Multiple Deprivation 2010 (IMD 2010) score decreases.



Association between IMD 2010 score and life expectancy, East Sussex JSNA (2013)

One of the main determinants of health inequalities, alongside deprivation, is lifestyle associated health behaviours such as physical inactivity, poor diet, increasing and higher risk consumption of alcohol, and smoking. These behaviours can be addressed through the provision of effective behaviour change interventions. However, for some population groups who have low self esteem or feel they have low control over their health, changing behaviour can be complex and require intensive individual-level support.

The healthy foundations segmentation tool (DH, 2010) segments the population according to their health related attitudes and behaviour. The table below describes these segments and their motivational differences.

Table 7: Summary of the motivational differences between the Motivational Segments

	Health Conscious Realists	Balanced Compensators	Live for Today	Hedonistic Immortals	Unconfident Fatalists
Value health	High	High	Med	Low	Med
Control over health	High	High	Med	Med	Low
Healthy lifestyle is easy/enjoyable	High	High	Low	Med	Low
Health fatalism	Low	Med	High	Low	High
Risk taking	Low	High	Med	High	Med
Short termism	Low	Med	High	Low	High
Self esteem	High	High	Med	High	Low

Key:

More positive motivation

More negative motivation

Source: Healthy Foundations Life-stage Segmentation Model Toolkit, Department of Health, April 2010

Alongside this Healthy Foundations assesses the communication and intervention preferences for each segment. These are described within the table in Appendix E of this document and should be utilised to ensure that the service is accessible to individuals who have the least healthy lifestyles and who are most likely to require and respond to face to face interventions. The service provider should also ensure that they are minimising the proportion of clients drawn from groups who are more able to make changes with less intensive interventions and who's motivational and communication preferences suggest that the Health Trainer service would not be the most appropriate intervention for them.

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4 Policy context

4.1 The *Healthy lives, healthy people* white paper was published in 2010. It defined the government's strategy for Public Health in England and starts by describing the opportunities which need to be 'seized'. These include:

'Changing adults behaviour could reduce premature death, illness and costs to society, avoiding a substantial proportion of cancers, vascular dementias and over 30% of circulatory diseases; saving the NHS the £2.7 Billion cost of alcohol abuse; and saving society the £13.9 Billion a year spent on tackling drug-fuelled crime'

(DH, 2010).

The paper then goes on to describe 'A radical new approach' which the government believed would:

'Empower local communities, enable professional freedoms and unleash new ideas based in the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats'

(DH, 2010)

It states that the approach will, amongst other things:

- Focus on key outcomes, doing what works to deliver them, with transparency of outcomes to enable accountability through a proposed new public health outcomes framework.
- Reflect the government's core values of freedom, fairness and responsibility by strengthening self esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier.

(DH, 2010)

The new public health outcomes framework, mentioned above: *Improving outcomes and supporting transparency* (2012), sets out the desired outcomes for public health and how they will be measured. Health Trainer services will contribute to a number of the framework's indicators including the following:

Domain 2: Health improvement.

2.11: Diet – this indicator is yet to be finalised. However, it is likely to focus on an increase in consuming five-a-day and a reduction in intake of saturated fats, sugar, salt and calories.

2.12: Excess weight in adults - Number of adults who are classified as overweight or obese.

2.13: Proportion of physically active and inactive adults - Number of adults (16+) doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more.

2.14: Smoking prevalence – adult (over 18’s) – Number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey.

2.18: Alcohol-related admissions to hospital – this indicator is yet to be finalised.

East Sussex County Council and the East Sussex Health and Wellbeing Board are committed to reducing health inequalities within the *East Sussex Health and Wellbeing Strategy 2013 – 2016* (2013). One of the main priorities in the document is to ‘Enable people of all ages to live healthy lives and have healthy lifestyles’ (ESCC, 2013).

It states that:

‘We are committed to helping everyone in East Sussex to maintain and improve their health and wellbeing but we also need to target some of our activity to those individuals, families and communities that are experiencing the worst health and wellbeing outcomes currently and to ‘narrow the gap’ between the best and worst outcomes in the county. Poverty and deprivation is experienced by some communities in East Sussex, can affect all types of families and households from single parents or large multi-generation households to older people living alone, and is known to have a substantial impact on physical and mental health, wellbeing and life chances. Information and advice is also crucial in giving everyone better choice and control over their health and wellbeing including signposting people to relevant health, care and other services such as housing support, social activities and online resources.’

(ESCC, 2013)

5 Key contacts

5.1 East Sussex Adult Social Care and Health teams relevant to this contract are:

Health improvement specialist team

This team is comprised of health improvement principals and specialist each of whom leads on a specific area. As well as commissioning and reviewing services, the team is able to provide technical advice and guidance to partners on specialist health improvement issues. Areas covered currently include:

- Healthy eating, physical activity and obesity
- Alcohol use and tobacco control
- NHS Health check and primary care

- Sexual health
- Communities and settings
- Children and younger people
- Older people and mental wellbeing

Public health intelligence team – this team provides a range of data and information which supports and underpins evidence-based working within the council and its partners. Major pieces of work include:

- Delivery of the Joint Strategic Needs Assessment (JSNA); an ongoing assessment of the local population's future health, care and wellbeing needs, which informs and guides commissioning of health, wellbeing and social care services. www.eastsussexjsna.org.uk.
- Production of the Director of Public Health's Annual Report. The report draws on information from the JSNA and sets out a plan for improving the health and wellbeing of local people and reducing health inequalities.

Contracts and Purchasing Unit

The Contracts and Purchasing Unit (CPU) is responsible for procuring and managing contracts of care-managed services to meet the eligible needs of people who receive social care and health support. East Sussex County Council is a commissioning organisation and the role of CPU is essential to this process.

The role of CPU is to:

- procure the services that are identified by Commissioning;
- support, alongside operational staff, the process of service users accessing those services; and
- ensure they are provided in the way that had been intended.

Part Two - Detailed specification for a Health Trainer service

1 Aims of the service

1.1 To reduce health inequalities and increase confidence and self-efficacy for health within targeted groups, communities and individuals.

1.2 To identify and engage with individuals from communities and groups who are at a high risk of experiencing health inequalities due to lifestyle behaviours such as alcohol consumption, smoking, diet and physical activity, and who are least able to make changes without support.

1.3 To enable individuals to make sustained changes in their health-related behaviour to achieve a positive impact on their health and wellbeing.

1.4 To support individuals to make more effective and timely use of mainstream health and wellbeing services.

1.5 To increase capacity and capability, building a workforce from the communities and groups within which the service operates with the necessary skills to tackle health inequalities.

2 Objectives of the service

2.1 To provide an evidence-based, targeted, one to one, time limited, lifestyle behaviour change intervention service that supports and enables individuals to make changes to their lifestyle, aimed at improving their health, and reducing their future risk of diseases associated with lifestyle choices.

2.2 To provide a service in line with the model described in the Health Trainers Handbook, including the requirement that all Health Trainers hold the City and Guilds Level 3 Award for Health Trainers (or any subsequent replacement qualification indicated by the Department of Health of commissioners). This Service Specification provides scope for the recruitment and development of Health Trainers through a trainee Health Trainer role.

2.3 To provide the service in appropriate settings, that enable access, specifically to priority groups who are most likely to experience health inequalities and have poorer health outcomes. These priority groups will be identified with commissioners and may include (but will not be restricted to):

- People from deprived communities
- Former offenders

- People with mental health support needs (to improve physical health)
- People from Gypsy and Traveller communities
- People from routine and manual occupation groups

In addition the provider will be required to identify the evidence base for delivering the Health Trainer intervention to additional priority groups more likely to have poorer health outcomes e.g. people with learning disabilities, and develop a service offer for this group if this is supported by the evidence base.

2.4 To ensure that the Health Trainer service is underpinned by understanding of motivational and communication preferences in the population as described in Healthy Foundations Lifestyle Segmentation Tool, and the East Sussex Lifestyle Survey. The Healthy Foundations lifestyle segmentation tool should be completed for all clients accessing the service and an analysis of this should be included in quarterly monitoring and annual reporting and evaluation of the service.

2.5 To produce an annual marketing and communications plan to raise awareness of the service and increase referrals and self referrals to the service. This should include marketing for different target audiences, including:

- Primary Care
- Secondary Care
- Voluntary and Community Sector
- Priority groups e.g. Older Adults, geographical locations
- Priority behavioural segments using the Healthy Lifestyle Segmentation Tool

2.6 To ensure the service is underpinned by developments in the evidence base of effective interventions for behaviour change. Any proposed service improvements will be agreed with commissioners.

2.7 To continue to source and provide the full training pathway for new Health Trainers, ensuring high quality service provision is maintained.

2.8 To support partner organisations to refer clients to the Health Trainer service by providing Understanding Health Improvement Level 2 Training.

2.9 To support partner organisations to incorporate elements of Health Trainer skills into their interventions by providing technical advice and support on behaviour change skills in practice.

3 Description of the service and its outputs

The service should be a six-session programme, which is delivered to service users free at the point of use and delivered in a 1:1 environment, with extra telephone/email/social networking support provided as and when required.

The service should be provided in line with the model described by the Department of Health. It should use the skills, tools and approaches set out in the national Health Trainer Handbook and deliver the following activities as minimum:

3.1 Completion of initial assessment to ensure referral is appropriate (utilising criteria as set out within section 5 of this document).

3.2 Completion of personal health plan with primary and secondary goals (described within appendix C) which should be reviewed on a weekly basis.

3.3 Provision of motivational support regarding achievement of personal health plan goals, physical activity and behaviour change using behaviour change techniques.

3.4 Completion of all the expected session components as set out in the Health Trainer Handbook.

3.5 Follow-up of non-attendees after 2 weeks of not attending meetings (The commissioner should be informed of non-attendance).

3.6 Provision, maintenance and replacement of all equipment necessary for delivery of the programme (e.g. weight scales, height measures, tape measures, stopwatches, pedometers etc).

3.7 Provision of post-programme support – this can be in person, by phone, mail or internet as appropriate.

3.8 Assessment of service users maintenance of behaviour change at 26 & 52 weeks.

4 Expected outcomes

4.1 A reduction of health inequalities within target population groups.

4.2 Sustained health improvement of service users through behaviour change support and facilitated goal setting.

4.3 Increased uptake and appropriate use of local health and wellbeing services by service users.

4.4 Establishment and maintenance of a workforce with the necessary skills required to tackle health inequalities.

5 Eligibility

All service users should be assessed as eligible, utilising the following criteria:

5.1 They are living within the county of East Sussex.

5.2 They are aged 18 or over.

5.3 Where service users have an existing health condition or complex health need they should be referred back to their primary care physician to check that the Health Trainer service is appropriate for them, and for advice on any specific requirements for these individuals in engaging in the health Trainer intervention.

6 Referral criteria and sources

6.1 Referral criteria are described within the care pathway (Appendix B).

6.2 The service should be accessible to all adults aged 18 years and over who meet the eligibility criteria (subject to service capacity within the volumes agreed with the commissioner).

6.3 The service provider should accept self-referred individuals as well as referrals from local health professionals such as primary care and other key partners.

6.4 The service provider will also be expected to make onward referrals to other health and social care services, and community facilities such as leisure centres where appropriate.

6.5 Clear referral pathways into the Health Trainer service should be agreed with the following as minimum:

- Primary care
- Mental health services
- NHS health check

6.6 Clear referral pathways into other interventions and support should be established, with the following as a minimum:

- Local Stop Smoking Services
- Local specialist alcohol treatment services
- Weight management services
- NHS health check (where appropriate)
- Exercise referral

- Primary Care

7 Service standards

The service provider is expected to comply with the following standards:

7.1 The service is provided in line with the model described by the Department of Health and uses the skills, tools and approaches set out in the national health trainer handbook. It should also be in line with other relevant guidance such as NICE guidance (PH6: Behaviour change).

7.2 Statutory health and safety requirements are met, including having an incident reporting policy in place.

7.3 Local and national safeguarding requirements are met.

7.4 Data protection and information governance policies and procedures are in place.

7.5 A service user feedback and complaints policy is in place.

7.6 Health trainer staff members are recruited from the communities they are expected to work with.

7.7 All heath trainers are qualified to City and Guilds level 3.

7.8 The Health Trainer Service manager should have the necessary qualifications, skills and experience to ensure that they are able to support Health Trainers effectively, especially in the areas of behavioural psychology and applied behaviour change techniques, leadership, supervision, people management, finance and business planning. They should also be capable of undertaking robust evaluations of the service and capturing experiences of service users in order to learn lessons and develop action plans for service development. It is expected that service management will be qualified to at least National Qualification Framework level 5 or have equivalent experience in a health behaviour change discipline e.g. behavioural psychology and have significant knowledge and experience of developing and delivering behaviour change interventions, and service and business management.

7.9 A local induction programme for health trainers is delivered which includes information on health inequalities and deprivation levels within the area to ensure a targeted approach to service delivery, and details of relevant local health and wellbeing services to ensure effective referrals.

7.10 Data collection, analysis and reporting are carried out via the national health trainer Data Collection and Reporting System (DCRS).

7.11 Minimum quality standards for provision of the service will be agreed with commissioners. This will include responsiveness of the service to telephone, email and postal requests for service.

7.12 Services are required to be delivered across East Sussex within venues which are Disability Discrimination Act (DDA) compliant, risk assessed and have good access to public transport.

7.13 Sessions should be delivered at times which suit clients, including different times of day, early evenings, on weekdays and on Saturdays and Sundays.

7.14 The service is open to all eligible clients, regardless of their background or ability and is delivered in a culturally appropriate manner, and the service meets its obligations under the Equality Act

8 Interdependencies

It is expected that the service provider will have mutually dependant working relationships with the following organisations:

- Local NHS trusts
- Other local health providers such as specialist alcohol treatment services and weight management services
- Local Authorities
- Primary care services
- Pharmacists
- Probation services
- Community care services
- Workplaces, especially those employing routine and manual workers
- Any other health trainer service providers

9 Partnership working with external agencies

The Provider is required to:

9.1 Demonstrate a commitment to co-operate to achieve effective communication and excellent working relationships with commissioners and partner organisations.

9.2 Work and liaise with other professionals and services within Health, Social Care and local community and voluntary groups to support the achievement of the stated outcomes.

9.3 Refer to and liaise with Health, Social Care and Third Sector services as appropriate and provide the necessary information as requested by that organisation (subject to the Data Protection Act).

9.4 Endeavour to develop meaningful relationships with minority groups including relationships with organisations that represent the particular needs of people that face specific barriers and or risks.

9.5 Support partner organisations which contribute to the health trainers care pathway through the provision of Royal Society of Public Health (RSPH) Level 2 Understanding Health Improvement training and assessment.

9.6 Where required, provide support to partner organisations and staff, enabling them to incorporate elements of HT skills into their roles.

10 Equality and diversity

10.1 The Equality Act 2010 (EA) sets out the protected characteristics where any Service must pay due regard for the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EA;

b) advance equality of opportunity between persons who share a relevant protected characteristic (as defined by the EA) and persons who do not share it;

c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The protected characteristics set out in the EA are age, disability, race, pregnancy / maternity, religion or belief, gender (including gender reassignment) and sexual orientation. Marriage and civil partnership are also protected characteristics for the purposes of the duty to eliminate discrimination.

When making decisions the County Council also considers other matter such as the impact of rurality, deprivation and being a carer.

10.2 The provider is required to have a fair access, fair exit, and equality and inclusion policy that is consistent with requirements of the legislation outlined in Section 3.3 of the Terms and Conditions of Contract.

11 Safeguarding vulnerable adults and children

11.1 The Provider must ensure that service users, and anyone visiting the service, are safeguarded from any form of abuse or exploitation in accordance with written policies and procedures to be agreed with the commissioner prior to the commencement of the service and meet the standards and regulations set out in:

- The Sussex Multi Agency Policy and Procedures for Safeguarding Vulnerable Adults produced by the Safeguarding Adults Boards of Brighton and Hove, East Sussex and West Sussex (2007).
- Section 3.13 of the Terms & Conditions of Contract ('Safeguarding Vulnerable Adults and Children').

11.2 The Provider will share information with the following relevant organisations: Police, Probation Service, Adult Social Care and Children's Services if a service user discloses information that would indicate a child or vulnerable adult is at risk of harm and/or admitted to an offence for which they have not been convicted.

12 Security, health and safety

12.1 The Provider must ensure that the service complies with all the Health and Safety standards outlined in Section 3.5 of the Terms and Conditions of Contract.

13 Service user involvement

The Provider is required to:

13.1 Ensure service users are well informed so they can communicate their needs and views and make informed choices.

13.2 Ensure service user feedback is used to improve services.

14 Managing the service

(see also section 3 of terms & conditions of contract)

The Provider is required to:

14.1 Ensure sufficient staff coverage to be able to address the needs of service users.

14.2 Ensure that all their staff comply with the requirements of the Disclosure and Barring Service (DBS) and the Independent Safeguarding Authority.

14.3 Ensure management time is available to provide effective management of the service including regular individual and group supervision.

14.4 Ensure that sufficient management time is available for Contract Management, including attendance at the Quarterly contract review meetings and any requested meetings in relation to the Contract.

14.5 Demonstrate that the organisation is sufficiently financially robust and will use the allocated funds for the purpose of delivering and developing the service.

14.6 Demonstrate that the organisation is able to put risk management and contingency procedures in place.

14.7 Obtain informed consent from service users for their information to be shared with commissioners.

14.8 Ensure adequate cover arrangements are put in place for holidays and sickness.

14.9 Ensure all staff members that have contact with service users carry and make available easily recognisable appropriate forms of identification.

14.10 Submit accurate and timely monitoring and performance data.

15 Employment and training

The Provider is required to:

15.1 Employ suitably experienced, qualified and skilled staff to successfully deliver and manage the service (as described in section 7).

15.2 Support, train, supervise and appraise all staff who are employed to ensure they remain competent and engage.

15.3 Ensure staff members are trained to submit accurate and timely monitoring and performance data.

15.4 Ensure staff members engage with continued professional development, including appropriate training provided by key partners.

16 Communications

16.1 The service provider is responsible for the marketing and promotion of the service. This activity should take place within target population groups and communities as agreed with the commissioner.

16.2 A comprehensive communications plan should be developed by the service provider to illustrate how and when marketing and promotion of the service will take place. This should be agreed with the commissioner before delivery of services commences.

16.3 Marketing and promotion should be delivered in different formats (electronic, printed, face to face) to ensure effectiveness.

16.4 The service provider is required to ensure that the communication needs of different groups are met.

Part Three - Detailed specification for monitoring the quality and performance of the Health Trainer service

1 Monitoring and Review Arrangements

1.1 The contract will be monitored monthly and reviewed quarterly and annually by the commissioning lead in conjunction with the Contracts and Purchasing Unit.

1.2 As well as the minimum dataset required by ESCC, the service provider will be required to obtain the following monitoring information, as minimum, for all service users and be able to report it to the commissioners as and when required:

- Number and WTE Health Trainers in post
- Number and WTE vacancies in service
- Number and WTE of trainee Health Trainers in post
- Referral outcome – successful, unable to contact
- Geodemographics of service users – postcode, age, ethnicity, gender
- Healthy Foundations segmentation groupings of service users
- Behaviour change primary and secondary goals set by service users
- Outcome of goal (achieved/not achieved) by issue – alcohol, diet and activity etc, and goal type – primary/secondary.
- Maintenance of behaviour change at 26 / 52 weeks
- Number of sessions per service user
- Details of referrals out of service (e.g. into local specialist alcohol treatment services)
- Details of signposting out of service (e.g. recommendation to join a local club or activity)
- Summary of barriers to behaviour change

The service provider will be expected to obtain informed consent from service users for this information to be shared with the commissioner.

1.3 The service provider will also be required to report against Key Performance and Quality Indicators as set out in appendix A of this document.

1.4 The annual review will consider compliance with the contract. Any aspect of compliance with this Service Specification can be considered.

All reviews will consider (not exhaustive):

- Outcomes for service users
- Who gains access to the service

- Quality of service
- Performance against agreed targets
- Service user satisfaction

1.5 The service provider is expected to submit monthly service activity reports detailing achievement of key performance and quality indicators as described in Appendix A.

1.6 The service provider is expected to submit quarterly update reports which include information as set out in section 1.2, achievement of key performance and quality indicators as described in Appendix A, achievement of activities as set out in communications plan and service expenditure. The report should compare local activity with national/regional averages where possible. It should also highlight any service delivery and performance issues including remedial plans to address these.

1.7 The service provider is expected to submit a cumulative annual report which includes all information as set out in section 1.6 together with details of service user feedback and future programme plans.

2 Performance and quality indicators

2.1 Performance and quality indicators (Appendix A) are a measure against which we can judge how well the service is performing. They have been selected to evaluate specified outcomes and requirements and will be reviewed at least quarterly.

2.2 Where underperformance against indicators occurs, the service provider will be expected to produce recovery plan in agreement with the commissioner.

2.3 The targets set will be reviewed with the Provider after the first year of service.

3 Prices and costs

3.1 The total maximum budget available for the delivery of this service will be agreed with the provider for each year during the period of contract delivery.

3.2 Payments will be made as per the terms of the contract.

3.3 The service provider will be responsible for ensuring the cost of securing equipment, facilities and materials necessary to deliver the service is met within the budget available.

Appendix A: Key performance and quality indicators

Performance / Quality Indicator	***Threshold***	***Method of measurement***	***Report Due***
Percentage of health trainers who are qualified to level 3 HT qualification (City and Guilds)	100% of health trainers achieve level 3 qualification before working with clients	An external audit of staff qualifications and competences is completed	At commencement of contract and ongoing as part of recruitment process
The service is delivered in areas/venues which are accessible to target population groups	Services are delivered in high priority areas as agreed with the commissioner	An implementation plan is completed and agreed with the commissioner	At commencement of contract and ongoing subject to change of area/venue
The service is safe, appropriate and complies with legislative requirements	The service has the following in place: • A current health and Safety policy including incident reporting • DBS checks for 100% of staff / volunteers involved in the service • Risk assessments for 100% of service delivery venues • A current information governance / data protection policy • Equality impact assessment is in place for the service	An external audit of policies, protocols and adherence to legal requirements is completed	At commencement of contract and ongoing subject to recruitment or change of venue
Referrals receive a prompt response from the service provider	At least 75% of referrals are contacted by the service provider within one week of receiving the referral	Service activity reports	Monthly

Number of clients accessing service (eligible for assessment)	At least 700 clients are assessed and receive health trainer support during year 1(175 per quarter) At least 900 clients are assessed and receive health trainer support during year 2 (225 per quarter)	Service activity reports	Monthly
Percentage of individuals from the following high priority population groups accessing service: - Deprivation Q1 & Q2 - Healthy Foundations Unconfident Fatalists grouping	At least 65% of service users accessing the service are from deprivation quintiles Q1 and Q2, according to postcode deprivation score At least 50% of service users accessing service are from Healthy Foundations Unconfident Fatalists grouping	Service activity reports	Monthly
Percentage of personal health plans completed	Personal health plans are completed for 100% of new starters	Service activity reports	Monthly
Percentage of service users who successfully achieve primary goal	At least 50% of service users achieve primary goal as set out within their personal health plan	Service activity reports	Monthly
Percentage of service users who successfully achieve secondary goals	At least 85% of service users achieve secondary goals as set out within their personal health plan	Service activity reports	Monthly

Percentage of service users who are able to maintain behaviour changes at: - 3 months - 6 months - 12 months	At least 70% of service users have maintained behaviour changes at 3 months At least 60% of service users have maintained behaviour changes at 6 months At least 40% of service users have maintained behaviour changes at 12 months	Quarterly reports	Quarterly
Percentage of service users who are satisfied with the service they have received	At least 80% of service users who complete the programme rate the following as good or very good: • Service quality • Service accessibility • Health Trainer knowledge and skills • Support received from Health Trainer • Health Trainer friendliness	Service activity reports	Monthly
Promotion of service	Develop a service communications plan, which details the different methods which will be utilised in communications with target audiences and local partners/stakeholders, key messages, outputs, timelines etc, and agree plan with commissioner. Report achievement of	Communications plan developed and agreed with commissioner Achievement of activities	Plan due at beginning of year Quarterly

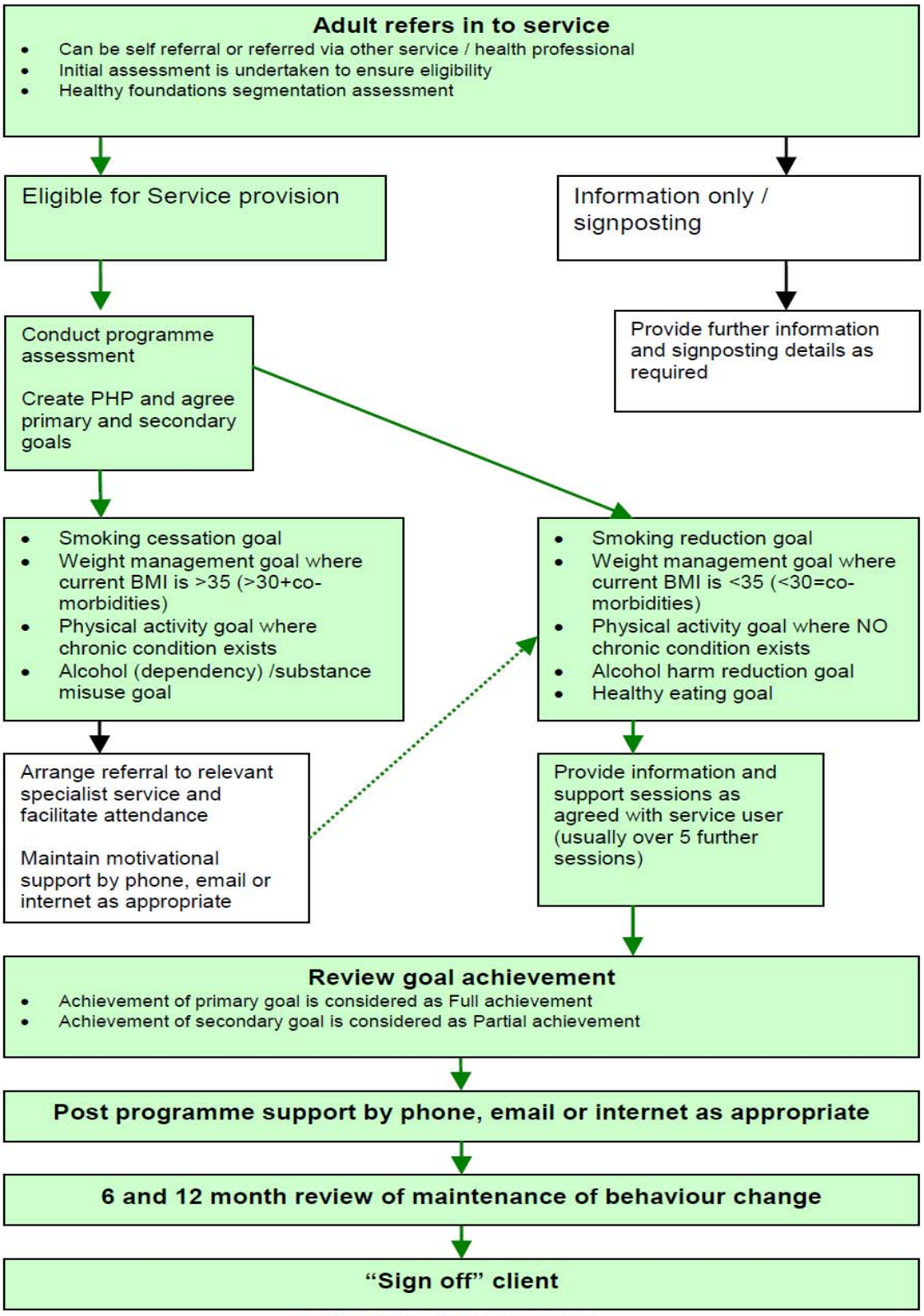
	activities as set out in communications plan, as part of quarterly reporting and annual report	as set out in plan Reports on progress against plan produced and delivered to commissioner	
Engagement with external partners	Engage with partners as appropriate to support referral of clients into the service. This will include attending any public health meetings or fora e.g. Health Improvement Partnerships as requested	Evidence of attendance at meetings and delivery of training events.	Quarterly
	Outward referral pathways also need to be maintained to ensure they remain effective and appropriate. This will require regular meetings with and training updates to local specialist services such as: • Local stop smoking services • Local alcohol treatment services • Weight management services	Details of outward referral pathways agreed with external partners	Quarterly
	Provision of at least 3 RSPH Level 2 Understanding Health Improvement training courses and assessment to partner organisations which contribute to the health trainer care pathway	Numbers and details of partner organisations which receive training and assessment	Quarterly
	At the request of the commissioner,	Number and details of support sessions and	Quarterly

	provision of up to 6 sessions of support to partner organisations and staff, incorporating elements of HT skills into their roles.	organisations supported	
Performance Monitoring	Monthly service activity reports which include information as set out in section 1.5 is produced and delivered to the commissioner ahead of deadline	Monthly service activity reports produced and delivered to commissioner	Monthly
	Quarterly update reports which include information as set out in section 1.6 is produced and delivered to the commissioner ahead of deadline	Quarterly update reports are produced and delivered to commissioner	Quarterly
	Quarterly review meetings are attended to discuss progress of SLA with the commissioner	Quarterly service review meetings are attended	Quarterly
Public Health Network	Ensure that referrals into other specialist services remain effective and appropriate by developing and maintaining relationships through regular meetings, information sharing and training updates	Evidence of attendance at meetings and delivery of training events.	Annually as part of annual report
Annual report	An annual report which includes all information as set out in section 1.6 together with	Annual report is produced and delivered to commissioner	Annually

	details of service user feedback and future programme plans is produced and delivered to the commissioner ahead of deadline.		

Appendix B: Care pathway

Health Trainers service care pathway



Health Trainers service care pathway
Peter Aston July 13

Appendix C: Description of primary and secondary goals

Healthy lifestyle area	**Primary goals** These are goals which are based on national guidance regarding changes in health related behaviour which will result in improved health	**Secondary goals** These are goals which will contribute to the achievement of primary goals
Physical activity, healthy eating and obesity	Weight loss of between 5 & 10 % Agreed cholesterol reduction achieved	• Maintenance or reduction of weight (less than 5%) • Reduction in consumption of fried food • Reduction in consumption of fatty food • Reduction in consumption of sugary food • Reduction in consumption of unhealthy snacks • Reduction in fizzy drink intake • Reduction in consumption of take away food
	Achievement of physical activity levels as set out within Chief Medical Officer (CMO) guidelines: • 150 minutes of moderate intensity activity per week in bouts of 10 minutes or more or • 75 minutes of vigorous activity per week if appropriate (dependant on PA history or existing medical conditions)	• Increase in light intensity activity • Increase in moderate intensity activity • Increase in vigorous activity • Reduction in inactivity • Increase in active travel choices – e.g. walking to work, cycling to college etc • Increase in awareness of the different types of activity which can be included in achievement of CMO guidelines
	Achievement of 5-a-day fruit and vegetable consumption Achievement of balanced diet as described in the ‘eat well plate’	• Increase in consumption of fruit and/or vegetables • Increase in healthy cookery skills • Change in shopping behaviour
Alcohol misuse **(in line with specialist treatment thresholds, as this goal may be more appropriately dealt with through specialist support)**	Reduction of excessive alcohol consumption to safer levels as set out within NHS guidelines: • 2-3 units per day / 14 units per week for	• Reduction in alcohol consumption • Reduction in binge drinking • Change in alcohol purchase • Reduction in frequency of consumption (number of

	women • 3-4 units per day / 21 units per week for men • Reduction in frequency of drinking to achieve at least 2 alcohol free days	days drinking)
Smoking **(Smoking cessation would normally be delivered by LSSS unless agreed with service)**	Smoking cessation for at least four weeks	• Reduction in smoking levels
Mental health	Achievement of 5 ways to well being components for good mental health	• Achievement of 1 or more of 5 ways to well being components

Appendix D: Core Values and Principles

ESCC seeks to ensure that all contracted Providers deliver services, which reflect its core values and principles. In accepting the contract the Provider will be agreeing to these as follows:

- to ensure that Service users and Carers are informed about decisions taken by ESCC and the reasons for them
- to work in partnership with Service users and their Carers
- to target services to those in greatest need
- to value difference and to ensure that services are sensitive to the diversity of need
- to be innovative in seeking to develop flexible and responsive services
- to value staff
- to recognise that all staff are accountable for the delivery of a high quality service that respects the rights of Service users and their Carers
- to focus on the outcomes of interventions to ensure that resources are effecting real change
- to encourage feedback and be open to constructive criticism
- to seek value for money
- to ensure that equal opportunity principles underpin all its services and actions
- to set clear standards for all aspects of service provision

Appendix E: Healthy Foundations Segmentation table

Intervention	Unconfident Fatalists	Live For Today's	Hedonistic Immortals	Balanced Compensators	Health Conscious Realists
Context **Health Motivations**	Low perceived control over health and low self esteem. Health has high value and this group are less likely to feel they are taking risks. Low goal setting behaviour and low intention to lead a healthy lifestyle. Need to address low levels of self-esteem, de-motivation, fatalism, lack of control, and low mood Recognise need for change . Aspire to a healthy lifestyle which is associated with happiness Friends and partner positive influence.	Most resistant to change and segment most likely to defer change. Less likely to be in control of health. Less likely than other segments to feel that their health is at risk if they are not living a healthy lifestyle Live in the present with a fatalistic and short-term outlook. Unhealthy behaviours explained as response to stress, escapism or lack of planning . Triggers for poor health choices emotional (stress, low mood). Lack self reliance Risk perceived only when physical harm explicit Friends positive social influence	Emphasise enjoyment and pleasurable risk over good health . Low value health Anything enjoyable is perceived as healthy regardless of the risk or outcome. Risk perceived as 'enhancing life'. View of health incomplete, includes: fitness, diet avoiding damage and cosmetic factors. Reducing negative risk behaviour must be associated with enjoyable aspects of healthy behaviour e.g. good looks and body and being healthy as fun	Health conscious, take control and value health. Engage in goal setting behaviours and enjoy leading a healthy lifestyle. Learn from mistakes Need to compensate for any health risks with balancing activities e.g. going for a run the morning after excessive drinking alcohol the night before Enhancing health and wellness is important to this group. This segment is aware of multiple health issues and responsive to messages highlighting risky behaviour they sometimes engage in Families reported as strongest positive influence in behaviour, peers strongest negative influencer	In control of health, feel healthy, with high levels of resilience and independence. Perceive no need to compensate for risks, as they do not take them often enough. Set goals, intend to and live a healthy lifestyle.
Intensity Intervention	High	High	Medium	Medium/Low	Low

Required					
Approach	Change presented as worthwhile. Support/hand-holding Small steps Tackle mental health issues	Ongoing Monitoring, mentoring, evaluation Hands-on/ practical approaches best	Tailored information reflecting their priorities 'Sell' positive links between health and their lifestyle	Encouragement to maintain positive behaviour	Non-prescriptive approach 'Maintaining wellness' rather than preventing illness. Primary Care setting preferred.
Personal Interventions	Health check "external trigger/wake up call" e.g. alert to real time health impact and possible LTC. e.g. lung age analyser. Must be presented with behaviour change support package. Presented in a private 1-1 environment. NHS Primary Care Packaged support sensitive to needs: psychological interventions e.g. IAPT Programme, then introduced to lifestyle. This group is timid and may back of from services and may have experienced ineffective CBT. Structured single issue	Health Check – explicit personalised 'real status' (e.g. lung age) away from a health setting to increase personal knowledge. Psychological interventions. Barriers to uptake: convenience, cost and time Psychological interventions e.g. Cognitive Behavioural Therapy (CBT) approaches. This could consider the IAPT Programme Health Trainers: person centred and co-ordinated support access to structured single issue programmes, goal setting, and celebrated successes: e.g. Stop Smoking Services	Not engaged with own health, need a wake up call. "External trigger/wake up call" to balance the enjoyment seeking benefits with actual risk. A diary may assist, this needs to consider motivations; convenience, reward and vanity. Personal and clear advice related to specific need 'Nudge' free gym pass for completion of health diary	Health check available across gyms, primary or secondary care. Mentoring rejected by this group, however welcome advisory roles for behaviour change with their own friends. Supported self Management materials	Wellness health check (outside of medical/ill health context) and/or 'wellness bus, community outreach' Personal and clear advice related to specific need but which allows them to independently select advice where necessary Supported self management materials

	programmes, goal setting, and celebrated successes. Aversive to group programme support 'Nudge' opt out health check				
Format	Person centred Co-ordinated approach to multiple issues, but considering each issue in a staged approach. Each single issue should then be delivered in a structured format	Person centred Co-ordinated approach to multiple issues, but considering each single issue on a stage-by-stage approach. Each single issue should then be delivered in a structured format	Multiple health issues approach understood Individual support to empower and set goals which include rewards, celebration and enjoyment e.g. physical health and good looks	Non-prescriptive approach as segment will be pro active regarding healthy behaviours Facilitative signposting Individual support for lifestyle interventions delivered away from medical settings	Multiple health issues approach Non medical, facilitative approach
Community/ Environmental interventions	Lack of desire to utilise	Not motivated to utilise Identify strongly with local area.	Regeneration and environmental interventions including cycle lanes and parks	Value positive environment, facilities and infrastructure, which support a healthy lifestyle. Regeneration, cycle lanes	Environmental interventions including cycle lanes, parks
Facilities	Lack of desire to utilise	Not motivated to utilise Affordable facilities desirable but require support to plan and structure lifestyle. May be	Gyms and enjoyable activities i.e. dance	Affordable/free gyms Swimming Family/friend fun days Community events e.g. Olympics and health	Activities for the family

		signposted to as part of co-ordinated approach to issues (once addressed need to change)			
Communications	NHS branding Peer testimonials by others who can demonstrate how people ' like us can change'. (Risk message must be supported by intervention offer)	Government/NHS branding . Believe GP best source of health advice Need clear advice delivered to understand need for change. Peer testimonials by others who can demonstrate how people ' like us can change'. Need to clarify behaviour risk levels and need for change before embarking on intervention 'Nudge' Information on short term/current risk. Supported by Opt out gym fitness plan	Government/NHS branding Physical appearance enhancing (e.g. smoking and tooth loss) and messages that stress pleasure in pursuing healthy behaviour More likely than other segments to express a preference for more 'informal' sources of information about health and lifestyle such as family, friends, newspapers, magazines, websites. Services need to be 'sold' to this segment	Government/NHS branding not appropriate and needs to be local Wellness messages Clear signs and information on local facilities are important, as segment will respond once aware of availability	Government/NHS branding not appropriate and needs to be local Information availability rather than prescriptive messages, focusing on control and individual free ability/choice to respond to information and set goals as a result
Engagement	Face to face engagement through known/trusted channels	Won't 'shop around' for information/ advice, so need to go to them	Prefer to be engaged through multiple channels/ influencers	Already engaged with health, so prefer facilitation through a range of sources. In control of own health, prefer to search for own information via	Already engaged with health/ services, so prefer facilitation based approaches 'Nudge' Opt-out Local

				internet, friends and family.	Authority gym annual wellbeing, feedback, and 'my health' pledge service
Service Utilisation and Satisfaction	Heavy utilisation (but least satisfied) service users Highest levels of ill-health/lifestyle illnesses	Low level of service use (despite some health issues). This includes low levels of screening attendance. Average levels of satisfaction.	Average levels of service use and satisfaction	Very low levels of service use (but they are the healthiest) Average levels of satisfaction	Average levels of service use, despite older age Average levels of satisfaction