Request

I would be most grateful if you would provide me, under the Freedom of Information Act, details in respect to the contract below.

246 — Specialist Clinical and Community Lifestyle Services:

https://clicktime.symantec.com/15siFBV4YcDuFYWWjpN3q?h=eje5uZXrUWdsMw7Vcn9z87DqGPZ0Eis3-XjrIG99jaY=&u=http://ted.europa.eu/udl?uri%3DTED:NOTICE:561236-2018:TEXT:EN:HTML

1) What are the contractual performance KPI's for this contract?

2) Suppliers who applied for inclusion on each framework/contract and were successful & not successful at the PQQ & ITT stages

3) Actual spend on this contract/framework (and any sub lots), from the start of the contract to the current date

4) Start date & duration of framework/contract?

5) Could you please provide a copy of the service/product specification given to all bidders for when this contract was last advertised?

6) Is there an extension clause in the framework(s)/contract(s) and, if so, the duration of the extension?

7) Has a decision been made yet on whether the framework(s)/contract(s) are being either extended or renewed?

8) Who is the senior officer (outside of procurement) responsible for this contract?

Response

Answer 1: These are included within the attached service specifications for the advertised contracts. This information is in the public domain as was advertised within the tender pack.

Answer 2: We are unable to disclose the names of the organisations that bid for these contracts as they were submitted in confidence and are therefore exempt under section 41 of the Freedom of Information Act 2000.

Answer 3: The total value of this contracts across the 3 Lots (each Lot being a contract) is £12,350,000.

Indicative budget – Lot 1: Health Improvement Service = £1,300,000 per annum.

Potential full contract value (5 yrs) – Lot 1 £6,500,000.

Indicative budget – Lot 2: Specialist Weight Management Service = £660,000 per annum.

Potential full contract value (5 yrs) – Lot 2 £3,300,000.

Indicative budget – Lot 3: Community Link Worker Service
= £510,000 per annum
Potential full contract value (5 yrs) – Lot 3 £2,550,000.

The reason why contract for Lots 1 and 3 are no longer on the Council's published contract register (available from the Council's website) is that these were internalised and are now delivered by Council teams.

Answer 4: The contract duration is for 3 years commencing on 1 July 2019 to 30 June 2022 with options to extend annually for two further years to 30 June 2024.

Answer 5: Please find attached.

Answer 6: Please see 'Answer 4'.

Answer 7: Lot 1 and Lot 3 of this contract have subsequently been internalised. Lot 2 was formally extended on 9th March 2023, using the final 1-year (optional) extension.

Answer 8: Laura Wharton, Assistant Director, Public Health

APPENDIX A

SERVICE SPECIFICATION – Lot 1 Health Improvement Service

Service Specification No.	**LOT 1**
Service	**Health Improvement Service**
Authority Lead	**Lynne Calvert / Ian Riding**
Provider Lead	
Period	1st July 2019 to 30 June 2022 + extension options annually of 1yr + 1yr
Date of Review	**Annual next review 1st July 2020**

1. The Deal for the Future

By 2020 Wigan Council will have a new operating model that focuses on place leadership and enabling growth and reform:

Confident Places:

- There is a regeneration plan which focuses on making Wigan a destination of choice
- Our environment services have a new delivery model to ensure the best value for money
- More services and facilities are run by the community

Confident People:

- Services are integrated, seamless and wrapped around people and families
- Front line agencies are working together to improve outcomes within a wellness partnership delivered on a common spatial footprint.
- There is joint investment in prevention and early intervention through a robust evidence base.
- A multi-skilled workforce performs numerous roles flexibly, placing people and families at the heart
- There is a mixed economy of free schools and academies; schools are a local strategic partner investing jointly to improve outcomes

Confident Council:

- The council delivers fewer services but has a key role as commissioner and broker
- There is a professional core of staff providing strategic corporate and enabling support functions.
- Comprehensive information, advice and self-help are available online.
- Many services will be accessed digitally through a single customer account and residents will have access to open data.
- Many more buildings have been transferred to the community or sold for capital receipt.

Building on from the success of The Deal for the Future Wigan Council is now developing the Deal for 2030. The aim of this strategy will be to develop a borough-wide vision, setting out where we want to be by 2030. This vision will be co-designed with partners and communities to jointly develop and own the strategy, making the Deal 2030 a plan for the place.

The service will align as the local care organisation (Healthier Wigan Partnership) is embedded across the system.

2. National / Regional Context

2.1 National Context

Recent publications, including the Department of Health's *Healthy Lives, Healthy People* and Marmot's *Fair Society, Healthy Lives* review (2010), emphasise the importance of prevention in helping to improve population health and reduce health inequalities.

Behaviour change interventions (such as raising people's awareness through providing brief advice) are one example of a preventative strategy which can help to improve health and quality of life outcomes, in both the shorter and longer term. Behaviour change interventions also have the potential to impact upon wider public health outcomes such as encouraging healthier lifestyle behaviours and supporting people in maintaining their own health. Many people have multiple lifestyle issues that they may need appropriate information, advice and support to help address (The Kings Fund, Clustering of unhealthy behaviours over time, 2012).

Current statistics make a strong case for improving the health behaviours of individuals across England.

Wigan is above the England average for deprivation, smoking prevalence, early deaths from cardiovascular disease and cancer, hospital stays for alcohol related harm, physical inactivity and adult obesity.

The health of people in Wigan is varied compared with the England average.
Life expectancy for both men and women is lower than the England average with life expectancy 12.0 years lower for men and 9.8 years lower for women in the most deprived areas of Wigan than in the least deprived areas.

Smoking at time of delivery are worse than the England average.

The rate of alcohol-related harm hospital stays worse than the average for England. Estimated levels of adult excess weight are worse than the England average.

Within Wigan we are seeing positive trends, with the rate of deaths in people aged under 75 from cardiovascular disease considered preventable has decreased by 26% since 2009-11, while England overall has seen a 19% decrease. Plus Wigan's Healthy Life Expectancy, while significantly lower than England, has improved at a much faster rate since 2009-11 than seen nationally – by 25 months for males (England 4 months) and 26 months for females (England 2 months decrease)

2.2 Evidence Base

In 2004 the Health Trainer workforce was developed to provide targeted support for improving health and reducing health inequalities.

The Health Trainer model is a national model that is based upon a process of behavioural change to implement healthier lifestyles. The Health Trainer is identified as a person who will work with individuals from particularly disadvantaged communities in order to encourage and enable those individuals to make healthier choices. Unhealthy behaviours are a major cause of ill health and premature death. For example, unhealthy eating habits, physical inactivity, smoking, alcohol consumption, however, by setting personal goals to change behaviours and using learning strategies to achieve these, people can develop a greater sense of control to improve their health and wellbeing.

The Health Trainer Service delivery model is grounded in psychological theory and the 1-2-1 element of the programme with key guidance that has been developed to shape how the service should be delivered e.g. NICE Public Health Guidance 6 on 'Behaviour Change: the principles for effective interventions'.

Challenges around public health lifestyle issues continue. Both the Government and independent scientific bodies have emphasised the necessity to improve the health and well-being of the general population. This greater awareness is borne from the growing realisation that the health of the UK population is deteriorating in many fundamental areas while the cost of providing appropriate medical care is increasing relentlessly.

3. Local Context

3.1 The Wigan Picture

Public Health England's latest health profiles outline that:

- % of adults classed as physically active in Wigan is 63.4% which is lower than the England average of 66% [2016/17]
- % of adults in Wigan Borough classified as excess weight is 71.2% compared to the England Average of 61.3% [2016/17]
- Wigan rate for alcohol related admissions is 693 per 100,000 compared to England which is 636 per 100,000 [2016/17]
- Alcohol related mortality in Wigan is 15.2 per 100,000 compared to England average of 10.4 per 100,000 [2014/16]
- 15.6% of the adult population smoke compared to the England average of 15.9% [2017]. Although there has been a welcome reduction in smoking prevalence over recent years smoking remains one of the biggest contributing factors to local health inequalities and premature death
- 13.4% of women are Smoking At the Time Of Delivery (SATOD) compared to the England average of 10.7% [2016/17]
- Smoking related deaths (Directly age standardised rate per 100,000 population aged 35 and over) account for 344.2 deaths per 100,000 compared to the England average of 272 deaths per 100,000 [2014/16]
- 25% of routine and manual workers (18 and over) are smoking compared to the England average of 25.7% [2017]

We know that reducing smoking rates, alcohol consumption, improving diet and encouraging people to take up more exercise would have major positive impacts on people's health. Behaviour change advisors, provide a crucial role in supporting people to make healthier lifestyle choices, particularly those people who we know are at greater risk of developing serious diseases; by providing information and practical support to get people motivated and improve knowledge of, and access to, services and activities to ensure that people are empowered to better manage their health and well-being.

3.2 Deal for Adult Social Care and Health

The Deal for Adult Social Care and Health underpins the council's Deal for the Future. This pioneering approach to delivering care and support services is transforming individual resident's experiences from a traditional limited menu of services to infinite opportunities which build self-reliance, confidence, strengthening communities, taking an innovative approach to ensuring better outcomes for residents of Wigan.

As described in detail the key features of the Deal for Adult Social Care and Health include;

- Different conversations with residents to better understand individual assets, recognising strengths, gifts and talents, valuing the person and rejecting the deficit based approach to traditional assessment methods.
- Connecting people with community solutions delivered and facilitated by local organisations and support networks.
- Supporting the development of community capacity which responds to people's wishes, aspirations and expectations.
- Developing new ways of working by liberating the workforce and provider organisations to deliver creative and innovative options which enable people to live enjoyable and fulfilled lives.

This new operating model is helping us to manage increasing demand by putting a greater focus on a preventative approach, developing more resilience with individuals and communities so that crisis management and support is required less often and people are able to get help when they need it. To support individuals and families closer to home, we are also investing in our communities to help build capacity and infrastructure, through the Community Investment Fund, and enabling Wigan residents to connect with community resources and activities that appeal to them. We want providers to encourage people to become champions of their own health and to access a wide range of support services both

formal and informal as independently as they can, to help people retain or regain their skills and confidence, prevent need, and delay deterioration.

3.3 The Deal for Providers

The Deal for Providers outlines the informal contract between the council and providers who deliver adult social care services, the deal establishes a reciprocal relationship, with clear expectations of each other in the delivery of excellent services and high quality life opportunities and experiences for customers.

4. Key Service Outcomes

4.1 Expected Outcomes including improving prevention

Contribution to Public Health Outcomes Framework

The Health Improvement Service will contribute to a number of performance indicators included within the Public Health Outcomes Framework (PHOF). In particular, the service will contribute to the objectives:

- 'People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities'
    - Alcohol-related admissions to hospital
    - Smoking prevalence
    - Proportion of physically active adults
    - Excess weight in adults
- 'Reduce numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities'
    - Mortality from causes considered preventable
    - Mortality from all cardiovascular diseases
    - Mortality from cancer
    - Morality from liver disease

The Stop Smoking delivery element of the service will contribute more specifically to the following indicators:

- Reduction in the prevalence of smoking in both those over 18 year and those under 18 years of age within the population
- Reduction in the percentage of pregnant women smoking at time of delivery

- Reduction in the smoking prevalence - routine & manual socioeconomic group

4.2 Service Quality

The provider will have in place a system for assuring that the quality of the service provided is based on the principles of:

- Value for Money
- Continuous Improvement
- Self-assessment, ensuring that day-to-day responsibility for the quality of the service is managed primarily by the provider, but with review and engagement with Wigan Council.

4.3 Quality Assurance

The Provider will:

- Demonstrate positive outcomes for individuals by providing regular intelligence, key outcomes and performance data to Wigan Council as detailed in this specification.
- Arrange regular service user groups which focus on service users' satisfaction. Wigan Council may wish to have discussions with the service users which should be facilitated by the service.
- Enable the commissioners to have access to raw data set for quality assurance and service improvement as required for auditing purposes. Processes to be agreed between commissioner and provider eg, data sharing agreements

The Council will;

- Convene quarterly and annual formal contract monitoring meetings with the provider to consider performance monitoring, annual report, and progress on previous service delivery.
- Specify additional; action points, targets and reporting arrangement proportionate to any underperformance.
- Conduct periodic and comprehensive service reviews involving interviews with service users (where appropriate), managers and support workers and have access to service files and other records concerning service users and staff.

The provider will ensure that all necessary consents are in place to ensure that the above information can be made available to Wigan Council when requested.

5. Scope

5.1 Aims and objectives of service

5.1.1 Aims

- Impact positively on identifiable health and social care targets over the long term
- Reduce health inequalities, increase efficiency and improve health outcomes
- To go beyond looking at single-issued healthy lifestyle service with a focus on illness, and instead aim to take a whole-person and community approach to improving health
- Provide access to information, advice, activities and services to enable individuals to remain healthy and independent in their own homes through having an asset based conversation
- To change the relationship between service users/residents and Wigan Council (plus other key stakeholders e.g. health service) by empowering individuals to maintain and improve their own health in line with the 'Deal for Health and Wellbeing'
- Make savings in care costs, improve quality of life and enable individuals to live independently for longer
- The Service Provider is capable of providing flexible and adaptable interventions in a variety of different settings, clinical pathways and use of digital and online solutions
- The Service Provider should have a preventative offer in place to help reduce the uptake of smoking in children and young people
- The Service Provider is responsible for any accredited Level 2 smoking cessation provider (i.e. Pharmacy, GP Practice), including management of the Level 2 provider to ensure that they are competent and confident to deliver and contribute to achieving smoking reduction outcomes

- The Service Provider will ensure that the service offer is evidenced based and in line with national and local service standards and policies.
- Demonstrate health improvement of individuals and families

5.1.2 Objectives

Behaviour change

- Provide clear information for Clients (clients and the referral network) to ensure that the Health Improvement Service is used to optimum effect
- Perform basic tests where appropriate such as Body Mass Index, to identify key health measures
- Motivate and empower individuals to make changes in their behaviour to achieve a positive impact on their health and to monitor health outcomes
- Clients should through an holistic approach be encouraged to negotiate goals (SMART goals) with clear time scales at the first appointment
- Support harm reduction and temporary abstinence principles
- Offer clients individual behaviour change support. This will include delivering core stop smoking support by behavioural change advisors
- Refer where appropriate to the breadth of local services and community assets that support a person to improve their health and wellbeing e.g. opportunities for exercise, improve their mental wellbeing, build resilience, more specialist drug & alcohol services and wider health, social care services and community activities. This aspect should be undertaken at any appropriate or opportunistic time during client contact
- Enable individuals to maintain lifestyle changes they have achieved as a result of taking part in other health improvement initiatives
- Support and facilitate community approaches to health improvement through working in communities and with community services provided by partners (this can include secondment of behaviour change advisors into partner agencies)
- Develop effective and positive relationships with partners with a clear agreed referral pathway into appropriate local services and activities
- Use agreed health outcome monitoring tools to assess, monitor progress and achievement as well as maintenance of goals
- Ensure all practitioners delivering stop smoking interventions or level 2 advisors are in line with best practice, relevant NICE Guidance, the Russell Standard and be compliant with the Gold Standard Stop Smoking Monitoring requirements
- Undertake any additional training on programmes that will enhance the service and meet the requirements of the commissioner e.g. be clear on cancer
- Undertake the Department of Health Smoking return requirements
- Participate in public and community events, adopt/adapt national and other campaign material, provide up to date publicity materials for the service

5.2 Service description/pathway

Wigan Council's vision is to move towards establishing an 'Integrated Health Improvement Service that can address a broad range of factors that impact on people's capability to improve and manage their health and well-being with shared outcomes across providers. Helping to move away from organisations working on single lifestyle issues, such as smoking, to a more holistic approach to living well and tackling the broader determinants of health. For the purpose of:- improving outcomes, improving quality, service integration, stakeholder engagement and whole system fit, efficiency improvements and sustainability. The Provider of this service will be integral to establishing this approach.

The uptake of the service should be supported by raising the public's awareness of the Health Improvement Service and the importance of well-being. It will be essential that the service

provider involves health and social care workforce to help make this happen. The provider will be required to develop local approaches that be tailored to reach key target groups that are more likely to have risky lifestyle behaviours, to ensure that the service is providing support to those most in need to reduce the boroughs internal health inequalities. The service provider will need to be innovative in their approach and be able to devise effective solutions for and with commissioners and communities to increase referrals into service. The service should continue to transform, innovate and look at new solutions to improve health outcomes through the duration of the contract.

The service provider will be required to have appropriately trained staff delivering to an agreed competency framework. The service provider will be expected to input and utilise the existing Councils client management system (Mosaic) or any subsequent appropriate system identified by the commissioner.

The current agreed data collection and monitoring process is as follows:

- Receive referrals from the said 'Wellbeing Hub'
- To obtain consent from client for information to be shared with said 'Wellbeing Hub' to support and facilitate 6 month and 12 month follow up post intervention
- Record client outcomes/outputs in line with national guidance on agreed client management system (or any subsequent system identified by the commissioner). Plus any other additional locally agreed data set request by the commissioner. This must be used in accordance with the necessary Data Security Policy and Operational Schedule. The additional data set requirements may change over time
- To collect and maintain accurate records and ensure high quality performance management information is available
- The Service Provider at 4 weeks post intervention will follow up clients to ascertain maintenance of goal and discuss alternative support available in the event of relapse
- Support and monitor client exit routes into community activity
- To respond to the reporting requirements of the Commissioner in a timely manner on any other information deemed necessary including quarterly reporting on work areas specific to Health improvement intervention
- The Service Provider will provide commissioners with demographic breakdown of clients accessing the service as part of the quarterly reporting procedure
- The Service will provide clients with options to provide and measure customer satisfaction at the end of their Personal Health Plan to identify where possible areas for improvement. This should be collated and shared with the Commissioner
- The Service Provider will have systems in place for effective measurement of individual client performance through tracking and adherence
- The Service Provider will provide a quarterly report which will be sent to the commissioner of all complaints and the actions taken as a result of each investigation. The report will identify changes to practice and policy

The Health Improvement service intervention core function will be to:

- Provide One to One Behaviour Change Interventions including delivering of core stop smoking function. Providing motivational support and signposting
- Provide Group based interventions (where these are deemed appropriate)
- Target people in areas and settings where health inequalities are likely to be higher and those identified as at risk of developing poor health
- Proactively work with community groups, agencies and organisations to establish referral pathways to reach targeted clients
- Aim to recruit people from local communities with a good understanding of local issues who can offer tailored advice
- Help to increase uptake of preventative and lifestyle services and activities

- Support as many smokers who wish to become smoke-free and to achieve the agreed annual targets for smoking quitters
- Following contact with the service, the client will be allocated an appropriate Health Advisor or refer/signpost to an appropriate service
- Where clients wish to work towards specific behavioural change goals with the support of a Behaviour Change Advisor, they will be offered bespoke interventions over an appropriate period to develop and encourage behaviour change. Advisors will support clients to access appropriate support and information relevant to the needs identified within the initial assessment
- Provide a review of progress against client's goal(s) and lifestyle change
- Support the maintenance of healthy behaviour, individually or in a group setting
- Empower individuals to take greater control over self-care and build resilience
- Contribute to local, national and regional programmes and campaigns that seek to promote health and well-being
- To showcase positive individual and system change outcomes via creative case studies and infographics
- Deliver a Smoking Cessation Maternity Intervention Pathway, which actively contributes to the Smoking At the Time Of Delivery (SATOD) targets.
- The service will provide both a smoking cessation and prevention offer for children & young people
- Manage and facilitate a network of smoking cessation Level 2 providers to support the service in achieving greater outcomes in relation to smoking quits; and allow a wider access offer for residents across localities. The provider will be responsible for the training, management, quality assurance and compliance of the smoking cessation Level 2 advisers across various settings. The provider would fund and manage any local incentivisation scheme with Level 2 advisors.

Discharge and planning

The 'Wellbeing Hub' will make contact with all individuals who set a PHP at 6 months and 12 months after exit from the Health Improvement Service. A record of their progress will be made to enable monitoring of the service activity and outcomes, and to ensure that individuals are offered appropriate further support if required.

5.3 Population covered

The Service will work within the boundaries of Wigan Borough and will be open to anyone who lives, works, studies within the Wigan Borough or is registered with a Wigan Borough GP.The Service will target communities and people in areas and settings where health inequalities are likely to be higher and those identified as at risk of developing poor health, aligning delivery to the 7 Service Delivery Footprints (SDFs).

5.4 Location(s) of Service Delivery

The service will be delivered in Place across the 7 SDFs across a range of community organisations in order to facilitate access by a wide range of clients, particularly those living in the most deprived areas. The service should incorporate home, out of hours hubs and digital services to maximise engagement.

5.5 Days/Hours of operation

The service will be delivered at times which ensure maximum accessibility for residents. This will require sessions to be held outside normal working hours of 9am-5pm. Early morning, evening sessions and weekends should be made available.

5.6 Referral Criteria and sources

Referrals will be managed and co-ordinated by the 'Wellbeing Hub' via the publicised telephone number and web address.

Clients can be referred through a number of services/pathways (with client consent) including self referral. However, if a client does not provide consent they cannot be referred using this service. Digital and online referral solutions should be available.

5.7 Response time and prioritisation

Clients will be offered an appointment were possible within 2 weeks of referral into the service or 1 week for individuals requesting stop smoking support.
Follow up appointments will be arranged according to client needs.
Provider will make reasonable efforts to follow-up individuals who DNA.

The Service Provider must be willing to work collaboratively with the Commissioners and be responsive to population need and adapt and redeploy efforts were deemed necessary. The Provider will embrace the Deal for Health and Wellness and its core principles.

5.8 Accessibility/acceptability:

The Health Improvement Service is open to anyone over the age of 16 (12 + Stop smoking prescribing interventions) living in the borough of Wigan (includes patients of Wigan based GPs) and those working, studying in the Borough. Young People age 12 and above who are deemed Fraser Competent who require Stop Smoking Prescribing Interventions will also be eligible for the Service.

The Service will operate an open referral system.

The Service should treat all clients and make reasonable efforts to accommodate the needs of clients, culture, disability, sexual orientation and gender issues within the service and in accordance with equality legislation and discrimination law. The service should proactively seek solutions to engage cohorts who are not accessing the service.

The Service Provider should make reasonable efforts to follow up Clients who Did Not Attend (DNA) their appointment.

The service should have a client outreach and maximise collaborative marketing and behavioural insight activity to improve client engagement. The approach should be intelligence and needs led.

5.9 Exclusion Criteria

Individuals under the age of 16 Health Improvement Advisor elements.
Individuals under the age of 12 (must be Fraser competent) Stop Smoking prescribing intervention.

5.10 Interdependencies with other services

5.10.1 Whole Systems Approach

The Service Provider will liaise with the lead commissioner in Public Health.
The service provider will work closely with the Public Health Officers across the life course to improve targeting, engagement and access.

The Service Provider will employ a collaborative approach with other local health and wellbeing providers, ensuring cross-referral systems are in place to ensure that through asset based conversation the client is accessing the most appropriate service to support and benefit that individual's needs.

There will be a move towards agreeing shared outcomes across lifestyle providers.

The Service Provider will develop and maintain partnerships in order to increase the effectiveness and reach of the service and to establish the position of the team within a network of services. There is an expectation that there will be a move to greater integration across and beyond lifestyle services (this could include secondments and coproduction with other organisations).

The Service will operate as part of a range of identified care pathways in order to support the integration of behavioural change and preventative approaches to health improvement.

The Service will operate as a key element with 'integrated wellbeing service' and will work closely with the Wellbeing Hub.

The Service provider will attend relevant meetings as required to report upon progress of the service.

The service will support the delivery of relevant GM programmes e.g. GM transformation programmes.

5.10.1 Interdependences

Access to support for universal services is vital and underpins the Health Improvement Service. Whilst stakeholders and interdependencies may vary, for example: - General Public, Other lifestyle services, Healthier Wigan Partnership. Primary Care, Secondary Care, Community Sector/Third Sector/Voluntary Sector, Public Sector, Private Sector.

The Service will operate as part of the Weight Management pathway for managing excess weight in adults.

5.11 Medicines Management

The Prescribing budget sits with the commissioning organisation (Wigan Council). The Service Provider must have systems in place to recharge Wigan Council on a monthly basis for any Level 2 associated costs with regards to prescription and NRT provision.

Agreed prescription/product costs must be used in accordance with the approved Stop Smoking Scheme Price list as part of the SLA with Level 2 providers, as approved by Medicines Management

The Service Provider will only recommend treatments which have been licenced for smoking cessation and in line with guidance from Wigan Borough CCG Medicines Management e.g. NRT.

E-cigs/ENDs (Electronic Nicotine Delivery Systems) are not supported or endorsed in Wigan as a smoking cessation product. The service should support any individual who accesses the services already using an END product in their quit attempt. The service should have an agreed pathway to support any individual wanting to quit their END use.

5.12 Relevant Networks and Screening Programme

The provider will ensure that the Health Improvement Service is represented and engaged at relevant National, Regional, Greater Manchester and Local Networks and share learning with partners.

6. Applicable Service Standards

6.1 Applicable National standards e.g. NICE;

The Service Provider will ensure that all service offers are in line with applicable national standards, including but not exclusive to:

- Relevant Nice Guidance
- Compliant with GDPR
- Public Sector Equality Duties and Assessable Information Standards
- Service must be compliant with The National Centre for Smoking Cessation and Training Standard, Gold Standard Stop Smoking Monitoring requirements and Russel Standards

6.2 Applicable local standards;

The Service Provider will ensure that all service offers are in line with applicable local standards, including but not exclusive to:

- Delivery approach should be grounded in the Deal for Health and Social Care
- Asset based delivery and a commitment to working to the Deal Behaviours
- Local Safeguarding policies and procedures including staff training and include safeguarding audit
- Comply with all relevant information governance, GDPR and data sharing agreements
- Local Protocols and Referral Pathways for Lifestyle Services should be followed
- The service will provide service information to all users of the service, in a range of formats depending on need. The service will ensure that service users are able to access appropriate interpretation and translation support services such as face to face or telephone interpretation, and including British Sign Language
- The service will ensure that all interventions will promote self-care/management
- Ensure that staff providing interventions have the necessary equipment to undertake the holistic assessment and that this equipment is maintained, replaced and calibrated etc. to the required standards
- Appropriate lifestyle resources used or provided to the Client must be updated regularly and the provider must maintain adequate supplies as necessary
- Staff should respect the confidentiality of all Clients
- The service should continually strive to innovate and shape, to achieve best outcomes in their delivery approach, to meet the needs of an ever evolving environment
- The Service Provider will ensure that all staff involved in the provision of this service has the appropriate skills, experience, qualifications, training and competence as is necessary to enable them to provide the Services. Working to an agreed competency framework.
- The Service Provider shall ensure that they provide reasonable evidence of on going training and development, particularly focused on the requirements of the Services or new protocol requirements
- All staff receive regularly monitored to establish and maintain a level of competency ensuring a level of acceptable service delivery is maintained
- The Service will provide trained staff who are able to widen the reach of the service through SDFs and its efficacy to service users through events, workshops and integration into existing and emerging multi-disciplinary teams and pathways

7. Location of Provider Premises

No Premises will be provided by the commissioner. It is expected that the Provider will identify a base and outreach delivery hubs.

8. Required Insurances

The provider must, at its own cost effect and maintain with a reputable insurance company the required insurances listed below

- Public Liability Insurance – minimum £5million
- Employers Liability Insurance – minimum £5million
- Professional Indemnity – minimum £2million

APPENDIX B

CONDITIONS PRECEDENT

Provide the Authority with a copy of the Provider's registration with the CQC where the Provider must be so registered under the Law

APPENDIX C

QUALITY OUTCOME INDICATORS

Service Specific KPIs – Health Improvement Service

Quality Outcomes Indicators	**Threshold**	**Method of Measurement**	**Consequence of Breach**
Access Client Appointments	100% of Clients offered face to face confidential appointments within 2 weeks of the referral being received from the HUB (one week for Clients requesting stop smoking support)	Mosaic Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Quality – Overall Health Improvement Achievement No. of Clients commencing a health improvement	min No. 3600 clients	Mosaic Monthly Monitoring	The provider shall provide exception report to the commissioner

intervention per annum Intervention refers to client commencing a stop smoking, harm reduction, physical activity, weight management, alcohol reduction or mental wellbeing intervention.	Number to be broken down into (for monitoring purposes only): • number of 'new' clients (i.e. previously not know to the service) • number of 'known' clients re-entering the service • number of existing clients starting a new intervention	Provider reporting to contract meeting - Quarterly Report	
Access – reducing health inequalities No. of Clients commencing a health improvement intervention from the 20% most deprived areas of the borough per annum	Minimum 60% (min 2160)	Mosaic Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner

Quality Outcomes Indicators	**Threshold**	**Method of Measurement**	**Consequence of Breach**
Access - Referral Route Monitor and provide detailed breakdown of referral source and 'how heard' into service	Monitoring requirement only	Mosaic Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcomes – Deal Conversation (Clients who do not go onto support provided by the service) No. of Clients enabled to access alternative community assets (e.g. service, organisation, group) breakdown by referrals per annum	Monitoring requirement only	Mosaic Monitoring Only Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcomes - Deal Conversation Number of Clients with an intervention enabled to access alternative	Monitoring requirement only	Mosaic	The provider shall provide exception report to the commissioner

community assets (e.g. service, organisation, group) from initial appointment or during intervention including breakdown of referrals per annum		Provider reporting to contract meeting - Quarterly Report	
Outcomes – wellbeing measure Number of clients improving their overall wellbeing per annum as a result of their health improvement plan(s)	Monitoring requirement only Wellbeing measure to be agreed	Mosaic Pre and post wellbeing scores Provider reporting to contract meeting – Quarterly Report	The provider shall provide exception report to the commissioner
Outcome – Smoking Prevalence Continual reduction in the Boroughs overall adult smoking prevalence	Min of 1% reduction in overall adult smoking prevalence per annum (current baseline 15.6%)	Public Health Profiles Provider reporting to contract meeting – Quarterly Report	The provider shall provide exception report to the commissioner
Outcome – Smoking Cessation Achievement No. Clients setting a quit date and % supported to achieve 4 week smoking quit per annum Min % CO validated	Setting quit date Quit at 4 weeks min 50% CO validated min 85% Breakdown by service delivery	Mosaic CO validation Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcome – Smoking Cessation Maintenance (Core Service) % of Clients setting a quit date and maintaining smoke free status -breakdown at 4 weeks post intervention per annum	Min of 85% followed up at 4 weeks post intervention	Mosaic Self-reported Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner

		Intelligence report into reasons for relapse	
Outcome – Smoking Harm Reduction % of clients accessing Healthy Routes for smoking harm reduction.	Monitor No. of clients who following harm reduction intervention(s) go on to set a quit date	Mosaic Self-reported Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcome - Nicotine Vaporisers No. of Clients supported with behaviour change intervention within service to become nicotine free who are using nicotine vaporisers (who are aiming to stop smoking/reduce harm) to stop	Monitoring only	Mosaic Self-Reported Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcome –Weight Loss Achievement No. of Clients undertaking an intervention for weight loss and % achieving at least - 3-5% weight loss - >5 % weight loss Within their intervention per annum	Min 50% achieve 3-5% weight loss Min 38% achieve >5% Weight loss Ambition to move to shared outcomes across providers	Mosaic Weight measurements Analysis of pre and post weight measure to show changes in BMI weight classification Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Outcome –Weight Loss Maintenance % of Clients undertaking an intervention for weight loss maintaining 3-5% and >5% weight loss - breakdown at 4 weeks	Min of 85% followed up at 4 weeks post intervention Min 90% of those followed up maintaining or improving on weight	Mosaic Self-reported Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner

	loss at 4 weeks post intervention	- Infographics Intelligence report into reasons for relapse	
Outcome – Physical Activity Achievement No. of Clients undertaking an intervention to improve their physical activity levels and % improving their physical activity category from baseline within their intervention per annum	75% increasing their physical activity category (SIQ) 60% of those meeting the national recommendations for physical activity to 150mins or more (per week). Target the most inactive residents Ambition to move to shared outcomes across providers	Mosaic Single Item Questionnaire (SIQ) – pre and post score +/- total minutes weekly exercise – pre and post Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Outcome – Physical Activity Maintenance % of Clients undertaking an intervention to improve their physical activity levels maintaining their physical activity levels score breakdown at 4 weeks post intervention per annum	Min of 85% followed up at 4 weeks post intervention Min 90% of those followed up maintaining or improving on goal at 4 weeks post intervention	Mosaic Self-reported Provider reporting to contract meeting - Quarterly Report - Infographics Intelligence report into reasons for relapse	The provider shall provide exception report to the commissioner
Outcome – Alcohol Reduction Achievement No. of Clients undertaking an intervention for alcohol reduction and % reducing their alcohol consumption from baseline within their intervention per annum	90% reducing their weekly alcohol consumption 50% of clients meeting the national guidelines for alcohol (14 units and below per week with at least a minimum of 3 alcohol free days)	Mosaic Template to be agreed regarding low, medium and high risk Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Outcome – Alcohol Reduction Maintenance			

% of Clients undertaking an intervention for alcohol reduction maintaining their alcohol consumption breakdown at 4 weeks	Min of 85% followed up at 4 weeks post intervention Min 90% of those followed up maintaining at 4 weeks post intervention	Mosaic Provider reporting to contract meeting - Quarterly Report - Infographics Intelligence report into reasons for relapse	The provider shall provide exception report to the commissioner
Outcome –Improving Self-Reported Mental Wellbeing Achievement No. of Clients wanting to improve their mental wellbeing and % improving their mental wellbeing from baseline within their PHP per annum	Min of 90% of clients seeing an improvement in their mental wellbeing	Mosaic Agreed mental wellbeing measure Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Outcome –Improving Self-Reported Mental Wellbeing Maintenance % of Clients who wanted to improve their mental wellbeing maintaining their wellbeing score breakdown at 4 post intervention per annum	Min of 85% followed up at 4 weeks post intervention Min 90% of those followed up maintaining at 4 weeks post intervention	Mosaic Agreed mental wellbeing measure Provider reporting to contract meeting - Quarterly Report - Infographics Intelligence report into reasons for relapse	The provider shall provide exception report to the commissioner
Qualitative – Deal Evidence Ensuring that Clients have a positive experience and made behaviour change using the Deal behaviours and principles	Min of 3 qualitative client case studies per quarter Min of 3 service or delivery examples per quarter	Case study e.g. Paper, Video, photo etc (Alternative format where suitable) Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner

Quality – Client experience Ensure that Clients have a positive experience of support	Min 25% response rate from clients completing PHP	An agreed client satisfaction questionnaire Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Access – Equality/Reducing barriers Client equality data to be collected based on the protected characteristics under the Equality Act 2010 - Age, Disability, Race, Sex, Sexual Orientation, Religion or belief, Gender identity, Marriage and Civil partnership, Pregnancy and Maternity and breakdown provided Monitoring should also include the following additional characteristics:- veteran and carers	Demographic Breakdown 100% completed – compliance with accessible information standards	Mosaic Provider reporting to contract meeting - Quarterly Report Other relevant evidence , e.g. information requested and provided in alternative formats, number of appointments requiring an interpreter Breakdown of clients preferred method of contact.	The provider shall provide exception report to the commissioner
Outcome – Smoking Prevalence (SATOD) **Continual reduction in the Boroughs overall SATOD rate**	Min of 1.25% reduction in overall SATOD rate per annum (current baseline 15.5%)	Public Health Profiles NHS Digital return on Smoking Status At Time of delivery (SATOD) Provider reporting to contract meeting – Quarterly Report	The provider shall provide exception report to the commissioner

Quality Outcomes Indicators	**Threshold**	**Method of Measurement**	**Consequence of Breach**
Referral access - Pregnancy	Monitor the number of referrals received from	Mosaic	**The provider shall provide exception**

	Maternity Services / Start Well Services	Monitoring Only	**report to the commissioner**
Outcome –Smoking Cessation in Pregnancy Maintenance % of pregnant smokers maintaining smoke free status breakdown at 4 weeks post intervention	Min of 85% followed up at 4 weeks	Mosaic CO validation / self-reported Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	**The provider shall provide exception report to the commissioner**
Outcome –Smoking Cessation in Pregnancy Harm Reduction Monitor and capture harm reduction achievements for pregnant women who do not wish to quit	Monitor only	Mosaic Self-Reported e.g. smoke free family pledges, reduction in tobacco use, temporary abstinence etc Provider reporting to contract meeting - Quarterly Report	**The provider shall provide exception report to the commissioner**
Outcome – Mental Health Service Users Smoking Cessation Achievement No. Mental Health Service Users smokers setting a quit date and % supported to achieve 4 week smoking quit per annum Min % CO Validated	Monitor only Min 40% quit at 4 weeks Min 85% CO validated	Mosaic CO validation Provider reporting to contract meeting - Quarterly Report	**The provider shall provide exception report to the commissioner**
Outcome – Mental Health Service Users Smoking Cessation Maintenance % of Mental Health Service Users maintaining smoke	Min of 85% followed up at 4 weeks	Mosaic	**The provider shall provide exception**

free status breakdown at 4 weeks post intervention		CO validation / self-reported Provider reporting to contract meeting - Quarterly Report	**report to the commissioner**
Outcome – Protecting children from harm: Smoke Free Families No. of families recruited to the local smoke free families initiative per annum	Min 300 per annum	Mosaic Provider reporting to contract meeting - Quarterly Report	**The provider shall provide exception report to the commissioner**
Capacity Building - Training Capture activity levels and details of Smoking Cessation Level 1, Level 2, and update training delivered including breakdown by staff group	Monitoring only	Provider reporting to contract meeting - Quarterly Report	**The provider shall provide exception report to the commissioner**
Mandatory Reporting Requirements Compile and submit the mandatory DoH /PHE Smoking Quarterly and Annual Returns	Quarterly returns submitted Annual return submitted	Provider reporting to contract meeting - Quarterly Report End of Year Report	**The provider shall provide exception report to the commissioner**

SERVICE SPECIFICATION – Lot 2 Specialist Weight Management Service

All subheadings for local determination and agreement.

Service Specification No.	**LOT 2**
Service	**Specialist Weight Management Service**
Authority Lead	**Emma McNamara**
Provider Lead	
Period	1st July 2019 to 30 June 2022 + extension options annually of 1yr + 1yr
Date of Review	

1. The Deal for the Future

By 2020 Wigan Council will have a new operating model that focuses on place leadership and enabling growth and reform:

Confident Places:

- There is a regeneration plan which focuses on making Wigan a destination of choice.
- Our environment services have a new delivery model to ensure the best value for money.
- More services and facilities are run by the community.

Confident People:

- Services are integrated, seamless and wrapped around people and families.
- Front line agencies are working together to improve outcomes within a wellness partnership delivered on a common spatial footprint.
- There is joint investment in prevention and early intervention through a robust evidence base.
- A multi-skilled workforce performs numerous roles flexibly, placing people and families at the heart.
- There is a mixed economy of free schools and academies; schools are a local strategic partner investing jointly to improve outcomes.

Confident Council:

- The council delivers fewer services but has a key role as commissioner and broker.
- There is a professional core of staff providing strategic corporate and enabling support functions.
- Comprehensive information, advice and self-help are available online.
- Many services will be accessed digitally through a single customer account and residents will have access to open data.
- Many more buildings have been transferred to the community or sold for capital receipt.

Building on from the success of The Deal for the Future Wigan Council is now developing the Deal for 2030. The aim of this strategy will be to develop a borough-wide vision, setting out where we want to be by 2030. This vision will be co-designed with partners and communities to jointly develop and own the strategy, making the Deal 2030 a plan for the place.

The service will align as the local care organisation (Healthier Wigan Partnership) is embedded across the system.

2. National / Regional Context

2.1 National Context

Recent publications, including the Department of Health's Healthy Lives, Healthy People and Marmot's Fair Society, Healthy Lives review (2010), emphasise the importance of prevention in helping to improve population health and reduce health inequalities.

Behaviour change interventions have the potential to impact upon wider outcomes such as encouraging healthier lifestyles and supporting people in maintaining their own health and wellbeing, and many people have multiple lifestyle issues that they may need appropriate information, advice and support to help address (The Kings Fund, Clustering of unhealthy behaviours over time, 2012).

Improving the health outcomes of the most vulnerable remains a priority at national, regional and local levels. Services for local communities should be designed with a strong preventative emphasis to promote positive health and wellbeing, and tackle inequalities.

Nationally 61.3% adults (aged 16 and over) are classified as overweight or obese (Active People Survey, 2016/17). By helping people to manage their weight as part of their overall health and wellbeing, we can enable people to live healthier, happier lives and reduce the illnesses including cardiovascular diseases (mainly heart disease and stroke), diabetes, musculoskeletal disorders, reproductive disorders, social and psychological problems and some cancers (including endometrial, breast, ovarian, prostate, liver, gallbladder, kidney, and colon). Overall health problems associated with being overweight or obese cost the NHS over £5 billion each year.

NICE published a full Clinical Guideline (CG 43) reviewed in March 2015 which set out guidance on the prevention and management of overweight and obese adults which has been considered in the development of this service specification.

Adult Obesity: 'Applying All Our Health' is a resource which helps health professionals prevent ill health and promote health and wellbeing as part of their everyday practice utilising their trusted relationships with patients, families and communities to promote the benefits of achieving and maintaining a healthy weight.

Managing overweight and obesity and their associated health problems can have a positive economic impact on the Public Sector and the wider economy through, increased productivity and a reduction in benefit payments. A whole systems approach to tackling obesity – delivering benefits for the whole local system will be published in 2019 to accomplish transformational change as to how obesity is tackled at a local level.

3. Local Context

3.1 The Wigan Picture

The health of people in Wigan is varied compared with the England average. Life expectancy for both men and women is lower than the England average with life expectancy 12.0 years lower for men and 9.8 years lower for women in the most deprived areas of Wigan than in the least deprived areas.

Healthy life expectancy has improved and we are keen to drive this forward but we still have a challenge regarding overweight and obesity and the associated health and wellbeing impacts and we are determined to address this across the system.

Current estimates show that 71.2% of the adult population in Wigan are classified as overweight or obese (Active Lives Survey, 2016/17), greater than the North West average of 63.3% and the England average 61.3%.

63.4% of adults achieving at least 150 minutes of physical activity a week in Wigan is lower than the England average of 66% (2016/17) but has increased from 54.6% in 2015/16 (Active Lives Survey). In 2017/18 33 service users were approved for bariatric surgery which has reduced from 40 in 2016/17. An effective and efficient Specialist Weight Management Service is key to managing eligible service users who choose the surgical route but also supporting and enabling those who would benefit more from a non-surgical route.

3.2 Deal for Adult Social Care and Health

The Deal for Adult Social Care and Health underpins the council's Deal for the Future. This pioneering approach to delivering care and support services is transforming individual resident's experiences from a traditional limited menu of services to infinite opportunities which build self-reliance, confidence, strengthening communities, taking an innovative approach to ensuring better outcomes for residents of Wigan.

As described in detail the key features of the Deal for Adult Social Care and Health include;

- Different conversations with residents to better understand individual assets, recognising strengths, gifts and talents, valuing the person and rejecting the deficit based approach to traditional assessment methods.
- Connecting people with community solutions delivered and facilitated by local organisations and support networks.
- Supporting the development of community capacity which responds to people's wishes, aspirations and expectations.
- Developing new ways of working by liberating the workforce and provider organisations to deliver creative and innovative options which enable people to live enjoyable and fulfilled lives.

This new operating model is helping us to manage increasing demand by putting a greater focus on a preventative approach, developing more resilience with individuals and communities so that crisis management and support is required less often and people are able to get help when they need it. To support individuals and families closer to home, we are also investing in our communities to help build capacity and infrastructure, through the Community Investment Fund, and enabling Wigan residents to connect with community resources and activities that appeal to them. We want providers to encourage people to become champions of their own health and to access a wide range of support services both formal and informal as independently as they can, to help people retain or regain their skills and confidence, prevent need, and delay deterioration.

3.3 The Deal for Providers

The Deal for Providers outlines the informal contract between the council and providers who deliver adult social care services, the deal establishes a reciprocal relationship, with clear expectations of each other in the delivery of excellent services and high quality life opportunities and experiences for customers.

4. Key Service Outcomes

Specialist Weight Management Service

4.1 Service Values and Principles

The following service values, in relation to service user involvement, will underpin all activities undertaken by the provider:

- Service users should retain the greatest possible control over their lives.
- Service users should be treated with courtesy, respect and dignity.
- Services users should be personally involved in any decision making that impacts on their lives or have the benefit of access to a trained advocate.
- Service users' views will be sought on the quality of the service provided.
- The diverse needs of service users will be respected.
- Wellbeing is at the heart of service provision.

The following service principles will be observed by the service provider in its work:

- Utilise an asset-based approach and undertake wider conversations with service users in order to ensure people are fully supported and connected with their local community.
- The provider will take a flexible approach to service delivery in line with on-going developments and new ways of working in Adult Social Care and Health.
- Collaborate with other lifestyle providers.

4.2 Expected Outcomes including improving prevention

The Provider shall ensure service users will meet the following outcomes:

- Improvement in physical activity.
- Reduction in weight or other measurements of obesity/overweight.
- Improvement in physical health and if applicable co morbidities.
- Improvement in self-esteem, wellbeing and psychological health.
- Improvements in nutrition.

Expected outcomes for Commissioner's population:

- Reduction in complications relating to obesity.
- Reduction in the requirements for bariatric surgery intervention.
- Reduction in the population experiencing significant obesity.

4.3 Service Quality

The provider will have in place a system for assuring that the quality of the service provided is based on the principles of:

- Value for Money
- Continuous Improvement
- Self-assessment, ensuring that day-to-day responsibility for the quality of the service is managed primarily by the provider, but with review and engagement with Wigan Council.

4.4 Quality Assurance

The Provider will:

- Demonstrate positive outcomes for individuals by providing regular intelligence, key outcomes and performance data to Wigan Council as detailed in this specification.
- Arrange regular service user groups which focus on service users' satisfaction. Wigan Council may wish to have discussions with the service users which should be facilitated by the service.
- Enable the commissioners to have access to raw data set for quality assurance and service improvement as required for auditing purposes. Processes to be agreed between commissioner and provider eg, data sharing agreements.

The Council will;

- Convene quarterly and annual formal contract monitoring meetings with the provider to consider performance monitoring, annual report, and progress on previous service delivery.

- Specify additional; action points, targets and reporting arrangement proportionate to any underperformance.
- Conduct periodic and comprehensive service reviews involving interviews with service users (where appropriate), managers and support workers and have access to service files and other records concerning service users and staff.

The provider will ensure that all necessary consents are in place to ensure that the above information can be made available to Wigan Council when requested.

5. Scope

5.1 Aims and objectives of service

5.1.1 Aims

The primary aim of the service is to achieve the best health and well-being outcomes for service users by:

- Improving the health outcomes for individuals who are overweight and obese and who often have significant co-morbidities, and/or pregnancy.
- Motivate, empower and support individuals to make healthy lifestyle changes, which result in weight loss, increase self-confidence and self-efficacy and improve wellbeing.
- Offer support for individuals who are prescribed anti-obesity drugs by their GP.
- Reduce the need for bariatric surgery intervention.
- Provide effective post intervention follow up support to sustain longer term health and wellbeing outcomes.

5.1.2 Objectives

The Specialist Weight Management Service has the following objectives:

- Provide a service that reduces barriers in accessing health care and strive to use an asset based approach to support an individual's aspirations and goals.
- Improve the partnership working between primary and secondary care services embedding the service within key clinical pathways.
- Ensure a smooth transition for young people with additional needs into the Specialist Weight Management Service.
- Develop a service that can be flexible across the weight management pathway as systems change.
- Utilise the availability of digital and technological advancements.
- To proactively seek and integrate individual service user and carer comments in the design, delivery and evaluation process to ensure the service is service user centred, personalised and reflective of the target audiences circumstances and needs.
- To actively contribute to promoting and marketing the service as part of the overall 'LWFG' brand and pathway.
- To actively contribute to promoting and marketing wider lifestyle and Public Health commissioned services, community book, wider community assets, green spaces etc
- Increase the number of individuals accessing the service through innovation, redesign, evaluation, social marketing, audience segmentation and insight data.
- Undertake any additional training on programmes that will enhance the service and meet the requirements of the commissioner e.g. The Deal for Adult Social Care and Health

5.2 Service description/pathway

5.2.1 Service model

The Provider shall have a different conversation with service users to identify their aspirations and goals. The approach will be one of motivation, empowerment and self-management supported by specialist advice, education and treatment from a range of professionals, including allied health professionals and local community provision and assets.

The Provider will ensure that service users access the most appropriate expertise as required utilising a flexible, multi-disciplinary approach.

The Specialist Weight Management Service will have a core set of competences around overall health improvement to address the multiple issues service users present with. Reducing smoking rates, alcohol consumption, improving diet and encouraging people to take up more exercise would have major positive impacts on people's health. Service users will be supported to make healthier lifestyle choices, particularly those people who we know are at greater risk of developing serious diseases; by providing information and practical support to get people motivated and improve knowledge of, and access to, services and activities to ensure that people are empowered to better manage their health and well-being.

Introduce the service user, where appropriate, to the breadth of local services and community assets that support a person to improve their health and wellbeing e.g. opportunities for exercise, improve their mental wellbeing, build resilience, more specialist drug & alcohol services and wider health, social care services and community activities. This aspect should be undertaken at any appropriate or opportunistic time during service user contact.

The Provider shall ensure all members of the team are suitably qualified and registered with the appropriate professional regulatory body and have specialist experience or post-qualification education and training to deliver their particular aspects of the pathway.

The SWMS service will also:

- Provide a range of interventions tailored to suit the individual needs of the service user including psychological support, domiciliary support, pharmacotherapy and a maternity programme.
- Be innovative in their approach and be able to devise effective solutions for and with commissioners and communities to increase referrals into service.
- Work with service users to set realistic personal goals.
- Draw on customer insight research, which highlights how to engage effectively with different consumer groups, based on their behaviours, attitudes and beliefs.
- Monitor progress and key outcomes over the 6/12/ 24 month programme, however, this is dependent on patients aspirations and goals.
- Ensure the workforce is informed and kept up to date about local referral options, services and sources of support.
- Be required to work collaboratively with other local lifestyle and wellbeing providers.
- Work in partnership with other service providers and organisations as appropriate to provide open access to service users who can self refer from targeted geographical areas.
- Participate in public and community events, adopt/adapt national and other campaign material, provide up to date publicity materials for the service.
- Offer a service which is culturally appropriate and accessible to all local communities including learning disability and autism in proportion to the demographics and the health needs of the local population.
- On completion of the programme or where a service user does not wish to continue with the programme the provider shall explore the reasons why and encourage the service user back into the programme or shall assess other suitable options that may be available eg alternative LWFG services, universal services, local community assets, community book, green spaces etc that will support them to continue and maintain their weight loss.
- The service will ensure that all interventions will promote self-care/management.

Bariatric Surgery Assessment – an Multi Disciplinary Team assessment should be undertaken for those who are eligible for bariatric surgery and wish to proceed with surgical intervention in line with the new bariatric referral criteria detailed in 'Clinical commissioning policy: complex and specialised obesity surgery' (December 2012, NHS Commissioning Board). This sets out the eligibility criteria that the Specialist weight management service must adhere to when referring service users for bariatric surgery. Criteria are outlined in 5.7.2 Referral criteria.

5.2.2 Service Pathway

In line with the integration of Health and Social Care the service will use a blended, flexible response model. The core element will be specialist delivery with peripheral elements of opt in / opt out components for and from other service provision / activities eg, outreach - another providers service

user accessing elements of psychological support, in reach – using a physical activity offer from the wider leisure provision.

5.3 Data Collection and Monitoring

The provider will:

- Receive referrals from the 'Access Hub', text message or other agreed route.
- Collect and maintain accurate records and ensure high quality performance management information is available.
- Have mechanisms in place to accurately assess service user satisfaction. This should be collated and shared with the Commissioner and be used for service improvement.
- Provide information in relation to relevant national and local performance indicators, quality standards and customer satisfaction information.
- Have systems in place for effective measurement of individual service user performance through tracking and adherence.
- Support and monitor service user exit routes into community activity eg, community groups / assets, community book, green spaces, volunteering etc.
- The provider may be required to utilise Council data collection systems eg, Mosaic as agreed between the Commissioner and provider.
- The provider will ensure that the data collected fulfils the criteria of the Public Health England economic assessment tool and will support the commissioner to develop case studies that demonstrate cost benefits to the wider system.

5.4 Population covered

The SWMS should be provided for all the adult population who live or work within the Wigan Borough or is registered with a Wigan Borough GP.

5.5 Location(s) of Service Delivery

The Council will ensure that the service is available and accessible at a suitable location across the Borough at a range of times including daytime, evenings and weekends, dependant on demand to accommodate different needs. The service will be aligned to a place based approach and will have links with the 7 Service Delivery Footprints.

The Provider shall at all times ensure that the Location of service delivery:

- Is suitable for the delivery of the Service
- Conforms to health and safety standards; and
- Is sufficient to enable the service to be provided at all times and in accordance with this contract.

5.6 Days/Hours of operation

The service should provide a range of days and times for individual and group work to provide as broad a range of choices as possible including evenings and weekends. Access to the service should be evaluated as part of the feedback of the service.

5.7 Referral Criteria and sources

The Service will operate an open referral system.

Services users accessing the service shall be within the following groups:

- Individuals with a Body Mass Index (BMI) 40kg/m2 or greater.
- Individuals with a Body Mass Index 35kg/m2 or greater who also have co-morbidities (as listed below).
- Individuals who are overweight with a Body Mass Index below 35kg/m2 who are not suitable for primary care or community weight management programmes. This may be due to a lack of previous success in these services or who are unsuitable for less specialist interventions e.g. serious back problems or cardiac conditions which lead to fainting during activity.
- Pregnant women with a Body Mass Index greater than 35kg/m^2.

Consideration should be given to the management of ethnic minorities as risk factors may be of concern at a lower BMI and older people, where risk factors may become more important at a higher BMI.

A range of co-morbidities should be considered when a service user with a BMI of 35kg/m2 is referred to the service. The following key co morbidities will be used for initial assessment into the programme:

- Type 1, 2 and gestational Diabetes
- Sleep apnoea
- Cardiovascular Disease
- Hypertension
- Osteoarthritis
- Dyslipidaemia
- MSK
- Renal disease
- Patients awaiting elective non-bariatric operations such as joint replacements who need to lose weight intensively to reduce their anaesthetic and surgical risks.
- Women who are infertile who need to lose weight to facilitate fertility assistance

The service provider should ensure that it is safe and appropriate for all service users to participate and liaison with a service user's GP may be necessary for those with underlying medical problems/co morbidities.

Referrals for the SWMS service will come from a variety of routes including:

- General Practice – GPs & Practice Nurses.
- Primary Care Professionals – such as Nurses, Health Visitors, Dietitians.
- Secondary Care Professionals – such as Consultants, Specialist Nurses, Dietitians.
- Adult Social Care.
- Inspiring Health Lifestyles.
- Self referral via the LWFG access hub.
- Healthy Routes.

Protocols will need to be in place to ensure service users consent to sharing personal data and that it can be disclosed to LWFG providers, Commissioners and the referral source should feedback be required.

The service will explore the development of technological solutions to feedback to key referrers eg, GP's.

5.7.1 Response time and prioritisation

The timely management of the administrative process is essential to support the volume of services users accessing the service and also to maintain the motivation to engage in the service by a complex service user group.

5.7.2 Bariatric surgery assessment

Specialist Weight Management Service will be responsible for assessing service users for eligibility for bariatric surgery.

The service users should be assessed against the bariatric referral criteria detailed in 'Clinical commissioning policy: complex and specialised obesity surgery' (December 2012, NHS Commissioning Board). This sets out the eligibility criteria that the Specialist weight management service must adhere to when referring service users for bariatric surgery. Criteria are outlined below:

- The service user must have a BMI of 40kg/ m2 or between 35 kg/m2 and 40kg/m2 or greater in the presence of other significant disease.

- The service user must have attended and complied with Specialist Weight Management Service for a minimum of 6 months.
- The service user must have attended a minimum of two service user support group meetings for bariatric surgery (service user to provide dates and locations for meetings attended as evidence).
- The service user is aged 18 years or over, generally fit for anaesthesia/surgery, free from any specific clinical/psychological contraindications for this type of surgery.
- The service user must be prepared for the life-long commitment required for successful bariatric surgery.
- Provider must present a feedback report at quarter meetings with numbers being referred for surgery, number of interventions, venue chosen for surgery and key outcomes (format to be agreed).

5.8 Accessibility/acceptability:

The Service should treat all service users and make reasonable efforts to accommodate the needs of service users, culture, disability, sexual orientation and gender issues within the service and in accordance with equality legislation and discrimination law.

The Service Provider should make reasonable efforts to follow up Service users who Did Not Attend (DNA) their appointment.

The service will target individuals living in the most deprived parts of the borough who are the most likely to experience the greatest health inequalities. The Service will work with key organisations such as Wigan Council Officers, other LWFG providers, GP practices, community groups, and key professionals to encourage service uptake from target areas and population groups.

The service shall be accessible by a range of public and private transport that can be supported by local community or NHS based transport services for eligible individuals.

5.9 Exclusion Criteria

Service users within the following groups would be unsuitable for the Specialist Weight Management Service until confirmation has been received from an appropriate clinician that the necessary issues had been effectively managed to the extent the service users would be suitable to engage in the Specialist Weight Management Service programme.

Obese adults with:

- Iatrogenic weight gain – likely due to drug/medicine management. The service users should be referred back to the specialist initiating the drug treatment.
- Uncontrolled alcohol or drug dependency.
- Poorly controlled major mental health illness, such as psychosis, severe depression, bulimia nervosa.
- Newly diagnosed or uncontrolled hypothyroidism.
- Cushing's Syndrome – A referral should be made via the GP to endocrinology.
- Chronic Kidney disease stage 4+ requiring specialist renal advice.
- Decompensated liver disease requiring specialist hepatic advice.

In all cases if the service user does not meet the access criteria, they will be passed back to the original referrer with appropriate supporting information.

For service users who have been referred through a bariatric provider, the service will engage with the appropriate clinician to agree an appropriate package of support and information sharing.

5.10 Interdependencies with other services

5.10.1 Interdependences

The main interdependencies include, Community Weight Management, Men's Weight Management, Health Improvement Service, the voluntary and community sector.

Other partners may include General practice, Community health care services, Acute care and Healthier Wigan Partnership.

5.10.2 Whole Systems Approach

The Service Provider will liaise with the lead commissioner and will work closely with Wigan Council Officers to improve targeting, quality, engagement and access.

The Service Provider will employ a directly collaborative approach with other local health and wellbeing providers, local community assets / groups etc ensuring cross-referral systems and connections are in place to support and benefit the service user.

There is an expectation that there will be a move to greater integration across and beyond lifestyle services (this could include secondments into other organisations).

The service may enter into arrangements to base staff in host organisations in order to meet specific performance targets and to reach particular population groups who are at risk of developing poor health due to lifestyle factors.

The Service provider will attend relevant meetings as required to share learning, good practice and report upon progress of the service.

The Service provider may be required to attend relevant meetings eg, Service Delivery Footprint huddles, Community Services and integrated and place based working.

5.10.3 Any activity planning assumptions

The provider will be expected to offer a full service and on-going support for current service users who are still within their weight management programme in accordance with their specified plan, when the new contract commences.

The provider will inform the Commissioner when capacity is within 10% of targeted capacity in order to assess the feasibility of funding further Specialist Weight Management Service places if required.

5.11 Funding of this Service Element

The provision of SWMS will be funded to a maximum of £660k per annum through this Agreement.

6. Applicable Service Standards

6.1 Applicable National standards e.g. NICE;

The provider must demonstrate the ability to deliver against the national guidelines eg NICE, NHS Commissioning Board, etc.

The provider is required to have regard to the Equality Act 2010, which means that it must understand who uses the service in terms of protected characteristics and improve the way it does business to ensure that they are able to access services.

7. Location of Provider Premises

Currently the service is delivered across 2 locations, however, this is subject to change.

1. **Leigh LIFT**
   Leigh Health Centre
   The Avenue
   Leigh
   WN7 1HR

2. **Claire House**

Lower Ince health Centre
Phoenix way
Lower Ince
Wigan
WN3 4NW

8. Required Insurances

8.1 The provider must, at its own cost effect and maintain with a reputable insurance company the required insurances listed below:

- Public Liability Insurance – minimum £5million
- Employers Liability Insurance – minimum £5million
- Professional Indemnity – minimum £2million

All quality outcomes indicators will be reviewed on an annual basis.

Quality Outcomes Indicators	Threshold	Method of Measurement	Consequence of Breach
Access Service user Appointments	100% of Service users offered an initial assessment appointment within 4 weeks of the referral being received.	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Quality – Overall Health Improvement Achievement No. of service users commencing SWMS per annum	min No. 575 service users Number to be broken down into (for monitoring purposes only): • number of new service users for the standard pathway	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner

	• number of service users who access a specific element of the service via a different weight management pathway		
Completion The number of service users engaged in the service who complete. Completion defined as attending at least 75% of the programme (based on clinical judgement as time spent within the service varies) and service users outcome data is collected.	Min 65% completion rate	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Access – Maternity Pathway Offer specialist sessions to pregnant women	Minimum 50 pregnant women accessing the service (in additional to the 575 for the standard pathway).	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Access – Domiciliary Pathway A domiciliary service is available for all service users who are clinically unable to attend clinic appointments.	Monitoring purposes only	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	Monitoring purposes only
Access – Bariatric Surgery Number of service users who are assessed and put forward for bariatric surgery.	Monitoring purposes only	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	Monitoring purposes only
The number of service users who undertake bariatric surgery.	Monitoring purposes only	Provider reporting annually	Monitoring purposes only

Outcomes report for service having bariatric surgery.	Monitoring purposes only	Provider reporting annually	Monitoring purposes only
Access – reducing health inequalities No. of Service users commencing a health improvement intervention from the 20% most deprived areas of the borough per annum	Minimum 40%	Monthly Monitoring Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Access - Referral Route Monitor and provide detailed breakdown of the number of referrals, referral source and 'how heard' into service	Monitoring requirement only	Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcomes – Deal Conversation (Service users who do not go onto support provided by the service) No. of Service users enabled to access alternative community assets (e.g. service, organisation, group) breakdown by referrals per annum	Monitoring requirement only	Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcomes - Deal Conversation Number of service users with an intervention enabled to access alternative community assets (e.g. service, organisation, group) from initial appointment, during intervention or upon completion including breakdown of referrals per annum	Monitoring requirement only	Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Outcomes – wellbeing measure Number of service improving their overall wellbeing as a result of their intervention	Monitoring requirement only	Pre and post wellbeing scores	The provider shall provide exception report to the commissioner

	Wellbeing measure to be agreed	Provider reporting to contract meeting – Quarterly Report	
Outcome –Weight Loss Achievement No. of service users undertaking an intervention for weight loss and % achieving at least - 3-5% weight loss - >5 % weight loss Within their intervention, the duration of which is determined by the service users aspirations, goals and clinical support requirements.	**6 months** % achieve 3-5% weight loss % achieve >5% weight loss **12 months** Min 65% achieve 3-5% weight loss Min 45% achieve >5% weight loss **24 months** Min 75% achieve 3-5% weight loss Min 55% achieve >5% weight loss Ambition to move to shared outcomes across providers	6 months for monitoring purposes only Weight measurements Analysis of pre and post weight measure to show changes in BMI weight classification Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Outcome –Weight Loss Achievement % of starters who have maintained or lost weight **plus:** Have achieved two or more of the individual Physiotherapy, Occupational Therapy and Quality of Life outcome measures (to be taken at baseline and repeated at 6 months and 12 months)	70% of all starters Physiotherapy, Occupational Therapy and Quality of Life measures to be agreed	Analysis of pre and post data Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Outcome – Personalised Care Planning Service users to have initial weight, blood pressure and BMI recorded at initial appointment and upon completion of the programme	98% of service users	Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner

Outcome –Improving Self-Reported Mental Wellbeing Achievement No. of service users wanting to improve their mental wellbeing and % improving their mental wellbeing from baseline	Min of 90% of service users seeing an improvement in their mental wellbeing	Mental wellbeing measure and time frame to be agreed Provider reporting to contract meeting - Quarterly Report - Infographics	The provider shall provide exception report to the commissioner
Qualitative – Deal Evidence Ensuring that service users have a positive experience and made behaviour change using the Deal behaviours and principles.	Min of 3 qualitative service user case studies per quarter including cost benefit analysis where feasible. Min of 3 service or delivery examples per quarter	Case study e.g. Paper, Video, photo etc (Alternative format where suitable) Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Quality – Service user experience Ensure that service users have a positive experience of support	Min 25% response rate from service users completing SWMS	An agreed service user satisfaction questionnaire Provider reporting to contract meeting - Quarterly Report	The provider shall provide exception report to the commissioner
Access – Equality/Reducing barriers Service users equality data to be collected based on the protected characteristics under the Equality Act 2010 - Age, Disability, Race, Sex, Sexual Orientation, Religion or belief, Gender identity, Marriage and Civil partnership, Pregnancy and Maternity and breakdown provided	Demographic Breakdown 100% completed – compliance with accessible information standards	Provider reporting to contract meeting - Quarterly Report Other relevant evidence , e.g. information requested and provided in alternative formats, number of appointments requiring an interpreter	The provider shall provide exception report to the commissioner

Monitoring should also include the following additional characteristics:- veteran and carers		Breakdown of service users preferred method of contact.	

APPENDIX A

SERVICE SPECIFICATION – LOT 3 Community Link Workers

Service Specification No.	LOT 3
Service	Community Link Workers
Commissioner Leads	Claire Roberts, Strategic Lead, Primary Care & Place Based Working, Wigan Borough CCG/ Healthier Wigan Partnership Lynne Calvert, Public Health, Wigan Council
Provider Lead	
Period	1st July 2019 to 30 June 2022 + extension options annually of 1yr + 1yr
Date of Review	Annual next review 1st July 2020

1. Population Needs

1.1 National context and evidence base

We have jointly defined a model for Wigan Borough which promotes integrated care, place based working, early intervention and prevention and which supports people to access activities and support in their communities. The Community Link Worker service provides an important part of the infrastructure which enables these approaches to be realised and to deliver the anticipated improvements and efficiency savings to the system.
There is an emerging evidence base that highlights the importance of investing in services that support people to manage their own health and enabling patients to take advantage of non-traditional support and activities in order to improve their health & wellbeing.

A recent report published by Citizens Advice [1] estimates that GPs are spending nearly a fifth of their consultation time dealing with non-medical issues such as housing, unemployment and debt problems. The report also indicated that three quarters of GPs said that the proportion of time they spend dealing with non-health issues as part of consultations had increased over the past year. 80% of GPs responding to a national Citizens Advice survey felt that dealing with non-health queries resulted in decreased time available to treat other patients' health issues.

Locally many of our primary care clinicians report that up to 40% of the appointments that are made with them on a daily basis are for issues that do not require a clinical intervention. Relatively short consultation times and a lack of knowledge or awareness within the practice about local services and community support means that GPs are not always best placed to deal with issues raised by patients. When issues aren't addressed and patients are unable to find the necessary support, they are more likely to eventually rely on more costly, specialist services. More support is required for patients with complex health conditions and social situations, who have difficulty accessing community support systems.

[1] 'A very general practice: How much time do GPs spend on issues other than health?' Citizens Advice, Policy Briefing, May 2015

Similar situations are reported in secondary care settings where the involvement of non-traditional services can support the timely and safe discharge of many patients.

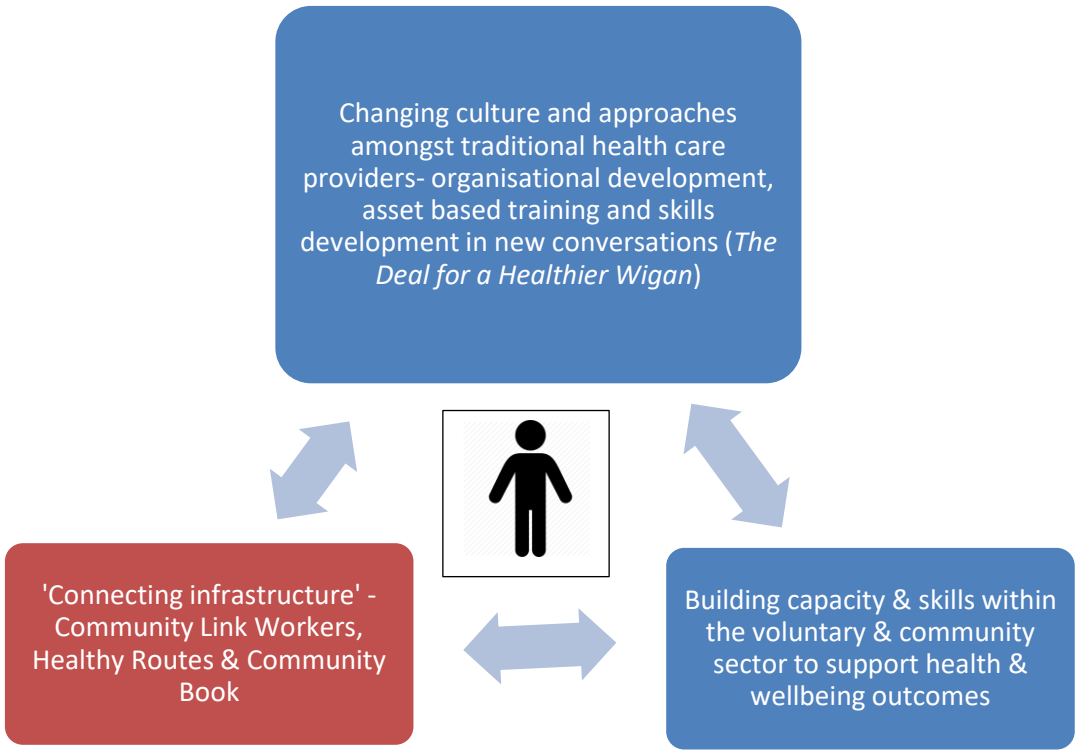
The Community Link Worker service contributes to the implementation of transformational changes outlined in a number of key national, regional and local strategies including:

- The NHS 5 Year Forward View
- GP Five Year Forward View (including the high impact actions)
- Wigan Borough Locality Plan (refreshed August 2018)
- Primary Care Strategy (vision for general practice)
- Wigan Borough Mental Health Strategy
- The Deal for Health & Wellness

1.2 Local Context

There is currently a renewed focus on a system wide approach to organisational development and culture change in Wigan Borough which places asset based working at the centre of all that we do. Community Link Workers form an essential part of the infrastructure to enable health and care staff to operate within the context of a 'social model of health' rather than deliver a traditional medical model.

There are three main 'spokes' to our local approach to asset based working in health care services which are illustrated in Fig.1. Community Link Workers form one part of the model. The three spokes work inter-dependently to deliver system wide change.



Deal for Health & Wellness

The Deal for Health & Wellness underpins a new approach to delivering care and support services. The Deal is transforming individual resident's experiences from a traditional limited menu of services to infinite opportunities which build self-reliance,

confidence, strengthening communities, taking an innovative approach to ensuring better outcomes for residents of Wigan.
The key features of the Deal include;

- Different conversations with residents to better understand individual assets, recognising strengths, gifts and talents, valuing the person and rejecting the deficit based approach to traditional assessment methods.
- Connecting people with community solutions delivered and facilitated by local organisations and support networks.
- Supporting the development of community capacity which responds to people's wishes, aspirations and expectations.
- Developing new ways of working by liberating the workforce and provider organisations to deliver creative and innovative options which enable people to live enjoyable and fulfilled lives.

This new operating model is helping us to manage increasing demand by putting a greater focus on a preventative approach, developing more resilience with individuals and communities so that crisis management and support is required less often and people are able to get help when they need it. To support individuals and families closer to home, we are also investing in our communities to help build capacity and infrastructure, through the Community Investment Fund, and enabling Wigan residents to connect with community resources and activities that appeal to them. We want providers to encourage people to become champions of their own health and to access a wide range of support services both formal and informal as independently as they can, to help people retain or regain their skills and confidence, prevent need, and delay deterioration.

Healthier Wigan Partnership

Healthier Wigan Partnership (HWP) is an alliance of health and social care providers in the borough with an ambition to integrate the way we deliver services. HWP seeks to improve services for local people, support people to be independent, to be in control of their own lives, and ensure the sustainability and affordability of the local health and care system for the future. The focus of HWP is primarily out of hospital care with an aim to ensure high quality, flexible services are delivered close to where people can easily access them. The Partnership is bringing staff from across our organisations to work together around the needs of local people.

This will be a dynamic contract and as such will be subject to change during the lifetime of the contract in line with continual improvement and the development of integrated working through Healthier Wigan Partnership. The provider is expected to work closely with the commissioners to develop the evidence base for Community Link Workers and support on-going quality improvements which meet the needs of local populations.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Wigan Borough System Wide Outcomes

Young People: All children and young people will be treated equally, feel safe and care about their education, health and future employment.

Wellbeing: Enable physical and emotional wellbeing, increase independence and reduce reliance on health and social care services.

Resources: Orientated towards early intervention, with access to timely/responsive services.

Delivery: To deliver more coordinated, integrated and informed personalised care, in the most appropriate community setting.

Life Expectancy: Increase the number of years that people are healthy and reduce the difference in life expectancy between communities

Care: To reduce the need for institutionalised care/avoiding re-admittance.

Quality: A good experience of care and enhanced quality of life

2.3 Local defined outcomes

The service will deliver a number of outcomes and benefits which include system wide and organisational benefits as well as benefits to individuals:

Organisational & System wide benefits

- Providing early intervention and preventative approaches that reduce hospital utilisation and reliance on specialist & targeted services.
- More effective use of primary care and community health and care resources thus enabling improved access for those patients who require clinical intervention
- Strengthening and transforming the role of GP services as a community resource that connects people to appropriate support and activities
- Developing a skill mix in primary and community care which meets the needs of patients
- Building strong and effective relationships with the local voluntary and community sector and making better use of existing community resources and assets
- Tapping into community assets and increasing the number of volunteers and those who are active in their communities

Individual Benefits

- Person centred support that enables individuals to access community activities and a broad range of support to keep them independent and connected to their communities.
- Individuals able to take greater control of their own health and lives
- Improvements in physical and emotional wellbeing
- Access to peer support

2.4 Data Collection Requirements

The provider will be required to record demographic data for all individuals supported through the Community Link Worker service including:

- Age
- Gender
- Pseudonomysed NHS No.
- GP practice registered with
- All protected characteristics must be captured (age, disability, gender reassignment, marriage & civil partnership, pregnancy & maternity, race, religion or belief, sex, sexual orientation)
- Carer responsibilities
- Record if individual is/ was member of armed forces or reservist
- Employment status

The data will be used on an aggregated basis by the commissioner to understand the cohort of patients most likely to access the service, to identify any groups who are less likely to access the service and to enable targeted work to support access by under-represented groups that we would expect to benefit from the service.

The provider will be expected to work with local Business Intelligence teams to help the commissioners to understand how Community Link Workers operate within the local health and care system and the contribution of the service to demand management (e.g. in admission avoidance and reduced re-admissions). We will want to explore jointly how the service is continuing to develop; the benefits and impacts accruing to individuals, organisation and the system; and any gaps in provision or unmet needs. Therefore the following data will be recorded and shared with the commissioners:

- Source of referral (e.g. GP, Practice Manager, staff nurse, other organisation etc)
- Referrals by practice
- Presenting issue (e.g. social isolation, bereavement, low level anxiety, debt)
- Time spent with individual patient
- Services/ activities individuals supported to access (including breakdown of type of organisation)
- Any gaps in provision identified
- Any financial impact the service has had on the health and social care system e.g. reduction in re-admissions, reduction in GP appointments, reduction in presentations to A&E, reduction in prescribing costs (where this is available).

It will be important to understand and assess impacts and ‘distance travelled’ by individuals. Detailed notes should be taken by the Community Link Workers to record conversations, issues raised and feedback. Case studies will be used to understand impacts from a range of perspectives including patients, practice staff, clinicians and the voluntary & community sector.

Quarterly reports including the following data will be provided to Healthier Wigan Partnership via Wigan Borough CCG:

- No. of new referrals received (in the quarter & cumulative contacts over the year)
- Source of referral (including breakdown by GP practice)
- No. of first appointments/ initial patient contacts
- Proportion of DNAs (in order to understand conversion of referral to uptake of the service)
- No of patient contacts
- No of individuals supported by Community Link Worker
- Cumulative number of individuals supported
- Breakdown of referrals per practice
- Breakdown of individuals supported by age, gender etc.
- Summary of presenting issues
- Summary of activities/ services individuals supported to access
- Gaps in provision identified
- Case study examples

Community Link Workers will be expected to participate in multi-disciplinary action learning meetings in order to develop the service; identify and resolve any challenges and to share learning across settings and organisations

The service will also be expected to contribute/input to primary & community care and acute trusts data collection and inputting requirements as part of embedding the service within the settings, and comply with information governance standards.

3. Scope

3.1 Aims and objectives of service

Community Link Workers have become an essential component in the operating model for Service Delivery Footprints (SDFs), which are the defined geographical areas in Wigan Borough covering populations of 30,000- 50,000. The service plays a key role in connecting general practice and other health providers to wider community based support and other public sector providers.

The Community Link Worker service has a number of core objectives:

- To address non-clinical demands on primary, community and acute health care services by delivering a tested intervention that uses 'health coaching', asset based approaches and community knowledge to connect people to sources of support within their community.
- To make effective use of voluntary and community sector assets by improving connections and relationships between local communities & voluntary sector organisations and traditional providers of health and social care.
- To improve the health and well-being of local people by connecting them to community based activities which support their independence and reduce reliance on acute or specialist services, with a focus on early intervention and prevention.

- To support transformational changes to the way we deliver health and social care through a new model that focuses on individual assets and community resources and which challenges the traditional medical model of health.

The service will extend the delivery of asset based models of care to all GP practices in the Wigan borough by aligning teams to clusters of GP practices within the 7 SDFs .

3.2 Service description/care pathway

Community Link Workers will facilitate access to non- clinical services, voluntary and community based activities using motivational interviewing and coaching approaches. Within a GP practice setting, referrals will be received from GPs, Practice Nurses and other practice staff, but also from other teams working as part of the integrated care team within a service delivery footprint. Community Link Workers will be aligned to GP Clusters within the service delivery footprints and will work as part of the 'Enhanced Primary Care Team'.

Community Link Workers based at the Royal Albert Edward Infirmary will work as part of the Integrated Discharge Team. They will receive referrals from any member of the clinical team to support safe and timely discharge with appropriate follow on support to enable people to remain independent and in a community setting.

Community Link Workers will develop an in-depth knowledge of services, activities and assets within the local community which they regularly update by connecting and building relationships with groups and organisations. They will liaise with relevant teams in the SDFs and staff within local Business Intelligence Teams to ensure this knowledge is shared across the health and social care system.

The service is expected to be proactive in managing referrals and able to respond according to the needs of individuals. Referrals made within the Integrated Discharge Team will require an immediate response with longer term support provided through the SDF Team where appropriate. Appointments for referrals made via primary and community care or through SDF Huddles should be provided within one week. Appointments can be delivered face to face or by telephone, depending on the needs of the individual and their circumstances.

The duration and intensity of the intervention delivered by Community Link Workers will be dependent on the needs of the individual and their levels of activation. Input from the Community Link Worker will vary from simple interventions to connect people to appropriate support/ activities in their community to longer term support (usually no more than 6 months) where individuals' needs are more complex. Community Link Workers will operate within place-based teams to access appropriate support and specialist services. Where appropriate Community Link Workers will work alongside clinical staff such as community nurses, mental health teams and social workers to facilitate access to non-clinical support. Current caseloads indicate that the breakdown of simple, intermediate and complex cases is around 60%, 25% and 15% respectively.

The service will ensure data is shared with referring agencies and relevant partners, subject to data sharing agreements and patient consent.

3.3 Population covered

The service will be available to individuals over the age of 18 years who are registered with a GP in the Wigan Borough

The Community Link Worker service will be available to those individuals who need additional support to access community based, non-medical services that will benefit their health and wellbeing. Evidence from the pilot stage indicates that the key reason for referrals to the service are for individuals who are socially isolated, people with low

level mental health problems and people experiencing a life change such as bereavement, unemployment/redundancy. Community Link Workers have played an increasingly important role in supporting those individuals who are high users of health and care services through local complex care pilots. The commissioner envisages that this role for Community Link Workers will continue.
There should be a focus on individuals who require specialist triage and practical support to access services. These may be people who are reluctant to access services or activities due to entrenched, costly behaviours (e.g. people with alcohol and drug problems), because they have been isolated from their communities or because they have mild to moderate mental health problems. Community Link Workers do not deliver the intervention required by such individuals, but they offer support and motivation for people to find and access the right services.

The service will work with carers and support family based approaches.

The service is expected to work with approximately 3,000- 3,500 individuals per annum based on current referral rates. Currently, the majority of referrals (approx. 70%) come from general practice.

3.4 Any acceptance and exclusion criteria and thresholds

1. All patients registered with a GP within the area covered by NHS Wigan Borough Clinical Commissioning Group;
2. Individuals aged 18+ years;
3. Carers and families where this would benefit individual outcomes

3.5 Interdependence with other services/providers

The Community Link Worker service will provide an important contribution to new models of integrated care that are being developed within the health & social care economy of Wigan Borough. The delivery of the service will require strong input from commissioners and a range of providers who will support development and implementation. Community Link Workers will operate as part of practice teams and General Practice Clusters and will attend relevant planning and care meetings. As such it is essential that representatives from general practice continue to be fully engaged in the development of the service and receive feedback on progress and patient outcomes.

The Community Link Worker service will operate as part of an integrated care team within the service delivery footprints. The service will receive referrals from partner organisations where this is deemed appropriate. The key service links and pathways that the service will work within include:

- General Practice
- Integrated Community Services (community nursing, therapies & adult social care)
- Start Well (early intervention for children & families)
- Specialist mental health services (early intervention and support for individuals with long term mental health problems who are managed through primary care)
- Integrated working with Mental Health Link Workers (subject to current business case being approved)
- Employment and health programmes
- Integrated discharge teams

- SDF Huddles and close working with SDF Managers

Wigan Council and Wigan Borough CCG, as commissioners of the service, will support and facilitate partnership meetings through Healthier Wigan Partnership to enable the service to be implemented as part of system wide transformational programmes.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Service Provider will ensure that all service offers are in line with applicable national standards, including but not exclusive to:

- Relevant Nice Guidance
- Compliant with GDPR
- Public Sector Equality Duties and Assessable Information Standards

4.2 Applicable local standards;

The Service Provider will ensure that all service offers are in line with applicable local standards, including but not exclusive to:

- Delivery approach should be grounded in the Deal for Health and Social Care
- Asset based delivery and a commitment to working to the Deal Behaviours
- Local Safeguarding policies and procedures including staff training and include safeguarding audit
- Comply with all relevant information governance, GDPR and data sharing agreements
- The service will provide service information to all users of the service, in a range of formats depending on need. The service will ensure that service users are able to access appropriate interpretation and translation support services such as face to face or telephone interpretation, and including British Sign Language
- Staff should respect the confidentiality of all Clients
- The service should continually strive to innovate and shape, to achieve best outcomes in their delivery approach, to meet the needs of an ever evolving environment
- The Service Provider will ensure that all staff involved in the provision of this service has the appropriate skills, experience, qualifications, training and competence as is necessary to enable them to provide the Services.
- The provider will ensure that staff attend learning and development sessions as identified by the commissioner where this will support development of the service and integrated delivery as part of the care model.
- The service Provider must have appropriate arrangements in place for reporting of incidents/ Serious and Untoward Incidents (SUIs)/complaints/recording patient experience and issuing alerts.
- The Provider must meet all applicable Health and Safety legislation.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements N/A

5.2 Applicable CQUIN goals N/A

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

Community Link Workers will be aligned to the 7 service delivery footprints (SDFs) in Wigan Borough. Where possible, it is expected that staff will be co-located in buildings with integrated teams in the SDFs. Wigan Borough CCG and Wigan Council will work with the provider and local practices to identify suitable accommodation for Community Link Workers. The service should also have allocated resources to deliver the intervention within the Integrated Discharge Team based at the Royal Albert Edward Infirmary.

6.2 Days/Hours of Operation

The service will be delivered at times which ensure there is delivery outside traditional 9-5, and will include weekend and evening operation dependent upon need and demand in each setting.

8. Required Insurances

The provider must, at its own cost, effect and maintain with a reputable insurance company, the required insurances listed below

- Public Liability Insurance – minimum £5million
- Employers Liability Insurance – minimum £5million
- Professional Indemnity – minimum £2million