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Slough Borough Council Integrated Health and Wellbeing Service

Service Specification

1st April 2025 to 31st March 2030

(5-year inital period with option to extend for up to 2 years until 31st March 2032)

Table of Contents

1. Introduction

The commissioning of the Slough Integrated Health and Wellbeing service provides an opportunity to deliver evidence-based health improvement and behavior change

interventions, designed to address the key health and wellbeing issues that impact our residents and communities.

Through collaboration with stakeholders, the IHWS aims to:

- Enhance the health and wellbeing of Slough residents.
- Empower residents to take control of their health and achieve optimal wellbeing.
- Reduce health inequalities across the population.

1.1 Rationale

Slough Borough Council's corporate plan, 'A Fresh Start' identifies key local priorities which includes making Slough a town where residents can live healthier, safer, and more independent lives. [1] This strategic priority calls for collaboration with partners to target health inequalities, promote wellbeing, support residents to be as independent as possible whilst also providing quality services for the most vulnerable adults, improving community safety and tackling anti-social behaviour. The strategy recognises the importance of using data and insight to effectively address the unfair and avoidable differences in health and wellbeing among residents.

The organisation of health and social care in England has changed and will continue to change, with a focus on forging new levels of partnership across local services to provide better, more joined-up care for patients and users. Alongside the core duties of Slough Borough Council, Slough Place Based Committee, Health and Social Care Partnership Board, Frimley Integrated Care Borad (Frimley ICB) and Primary Care Networks (PCNs) have been working collaboratively to drive the best health and wellbeing outcomes for the population and to support residents in living healthier, safer, and more independent lives.

1.2 National Policy Context

These local-level ambitions contribute towards those set at the national level. In 2019, the NHS Long Term Plan set an ambition to take wider action on preventing ill health and reducing health inequalities.[2] The Department of Health and Social Care (DHSC) recognised the importance of tackling ill health to improve the general health of the population and as part of the prevention agenda, the DHSC states the need for targeted and personalised interventions that can support individuals to understand and manage their health risks. It is therefore an ideal time to update and develop our IHWS to empower residents to change their behavior and their quality of life.

Each year, lifestyle factors such as smoking, poor dietary choices, physical inactivity, and excessive alcohol consumption lead to conditions such as cardiovascular disease (CVD) diabetes, obesity, hypertension, stroke, high cholesterol, respiratory diseases, and a negative impact on mental wellbeing. There is also a significant financial cost to the government and

[1] Slough Borough Council: A fresh start, Corporate Plan 2023 - 2027
[2] The NHS Long Term Plan

local authorities. Obesity alone costs the NHS £6.5 billion per year,[3] with an estimated cost to the economy of £74 billion due to its impact on raising NHS treatment costs and reducing workplace productivity.[4]

Evidence shows that prevention and early intervention represents good value for money and that interventions across a variety of risk factors offers a positive return on investment.[5] A systematic review found that for every for every £1 spend on public health interventions, there was an average of £14 of benefits to wider society.[6] This return on investment includes healthcare savings as well as longer-term gain in health and saving to wider society. Prevention activity is an investment and by acting now, the benefits of improved health and wellbeing as well as reduced costs to health and social care can be realised for years to come.[7]

1.3 Local Context

Slough is a significant commercial centre in the Thames Valley, located in the South East of England in Berkshire and 22 miles west of London. It is served by the Great Western Main railway line and is strategically positioned near the M4 and M25 motorways as well as being in close proximity to Heathrow Airport.

Slough is home to approximately 158,500 residents and is renowned for its cultural diversity, hosting one of the largest multi-ethnic populations outside London,[8] with high migration rates from various parts of the world. In terms of demographics, Slough has an even gender split but a younger population on average in comparison to the South East region and England, with 24% of residents age under 14.[9]

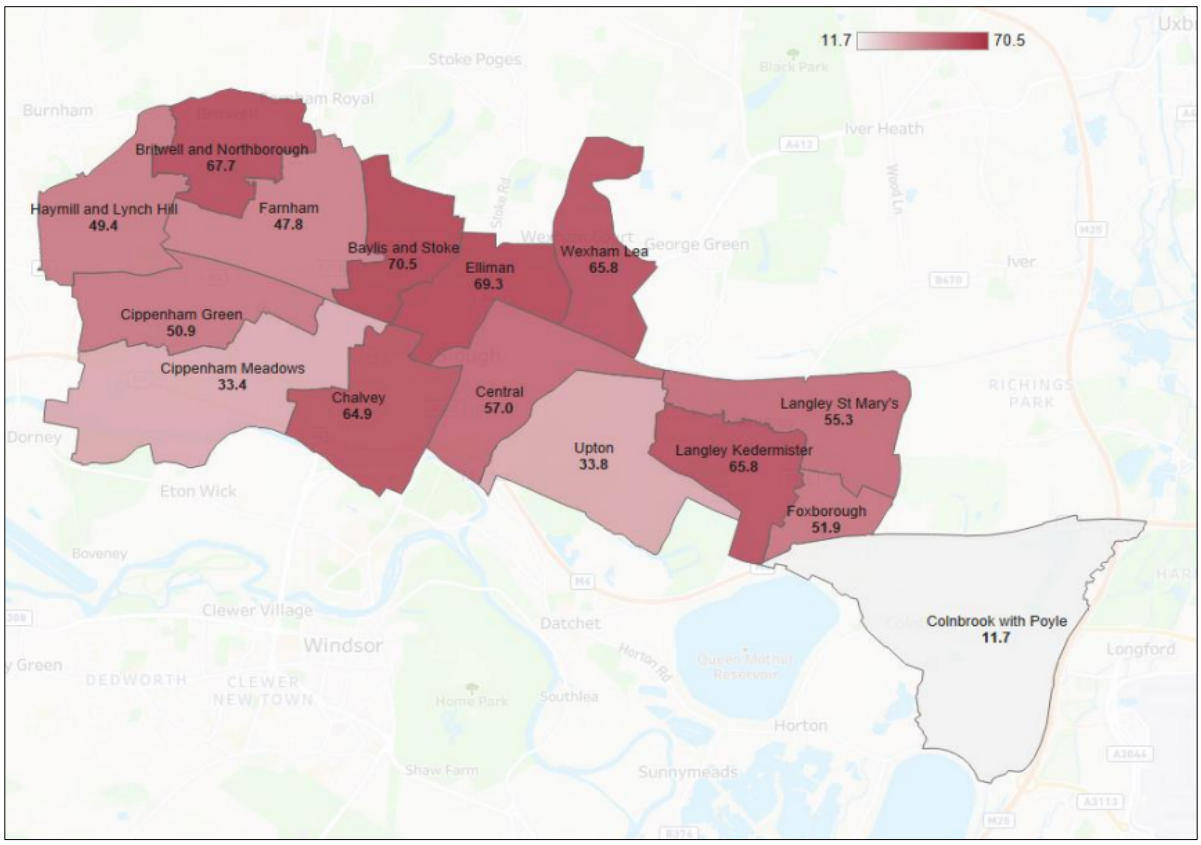
Slough has a younger population and larger family sizes compared to the regional and national averages, with a median age of 34 years, which is younger than the median age for England (40 years) and the South East region (41.9).[10] The age profile in Slough is generally younger compared to England and the South East, with a greater proportion of under 14s and 34 to 44 year olds. Conversely, there is a smaller proportion of people aged 65 and over in Slough compared to these regions.[11]

Residents are more likely to be employed in lower-paid jobs, and there are significant health inequalities and patterns of ill health across the life course, often associated with socioeconomic disadvantages and historically negative attitudes towards ethnicity. Slough

[3] Department of Health Social Care (DHSC) Media – Plan to tackle obesity
[4] Institute for Fiscal Studies – The costs of obesity
[5] Public Health England – Protecting and improving the nation's health (2020-25)
[6] Journal of Epidemiology Community Health – Return on investment of PHI
[7] Department of Health & Social Care – Adults Social Care Reform White Paper
[8] Office for National Statistics – How the population has changed in Slough
[9] Slough Borough Council, Berkshire Observatory – Population Report for Slough
[10] Office for National Statistics – How the population has changes in Slough
[11] Slough Pharmaceutical Needs Assessment 2022-2025
[12] Office for National Statistics – How life has changed in Slough: Census 2021
[13] Office for National Statistics – How life has changed in Slough: Census 2021
[14] Slough Borough Council – Annual Equality and Diversity Report

has higher levels of deprivation than the South East average and life-expectancy is considerable lower than neighbouring areas

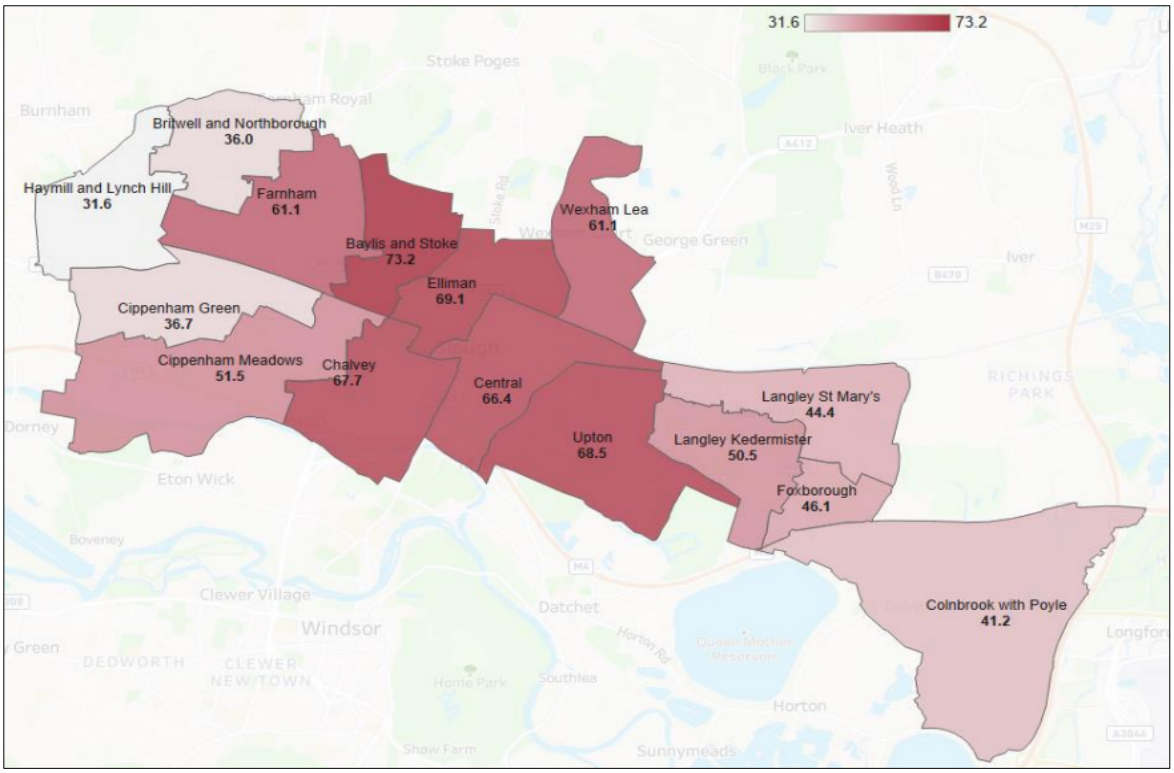
Figure 1: Population density of Slough at ward level



Slough is one of the most diverse areas in the country, with a significant proportion of the population being from ethnic minorities or Eastern Europe. According to the 2021 census,

- 46.7% of residents are from an Asian ethnic background.[12]
- With 11.3% of its residents being Sikhs, Slough has the third highest concentration of this religious group among local authorities in England. [13]
- Over 150 languages are spoken in Slough.[14]

Figure 2: Percentage of ethnic minority groups by wards in Slough



At a ward level, the wards with the highest concentrations of Black, Asian and Minority ethnic groups are Baylis and Stoke ward (73%), Eliman (69%) and Upton (68%).[15]

Table 1: Ethnicity in Slough

Ethnicity	Slough	South East	England
White ethnic group	36.0%	86.0%	81.0%
Asian ethnic group	46.7%	7.0%	9.6%
Black ethnic group	7.6%	2.4%	4.2%
Other	5.7%	1.5%	2.2%
Mixed ethnic group	4.0%	2.8%	3.0%

Nearly 14% of Slough's population live in multigenerational household. The demographic and ethnic diversity emphasises the need for tailored services that address the unique healthcare challenges and needs of Slough's population.

[15] Slough Pharmaceutical Needs Assessment 2022-2025

Table 2: Household English language proficiency – Slough

Can speak English very well	Can speak English Well	Cannot Speak English well	Cannot speak English at all
42.8%	38.2%	16.2%	2.7%

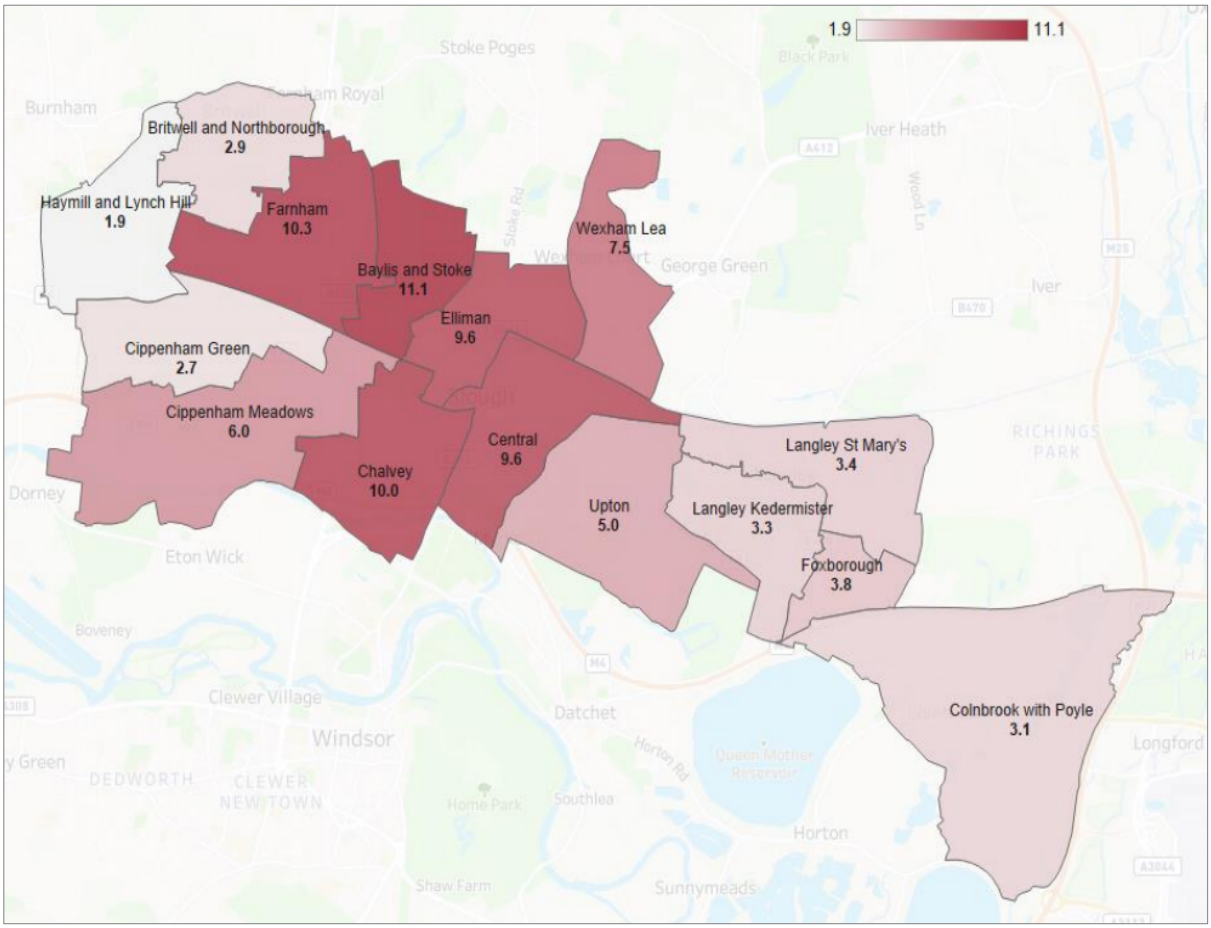
Whilst 81% of Slough's population possess a good level of English language proficiency, 16.2% cannot speak English well and 2.7% cannot speak English at all.[16]

Table 3: Proportion of households that English as a main language

Area	All adults in household have English as the main language	At least one but not all adults in the household have English as a main language	No adults but at least one person aged 3-15 has English as a main language	No household members have English as their main language
Slough	63.2%	15.6%	5.8%	15.4%
South East	91.4%	3.6%	1.2%	3.8%
England	89.2%	4.3%	1.3%	5.0%

[16] Office for National Statistics – Main language, English language proficiency, and household language in England and Wales

Figure 3: Percentage of people that cannot speak English well or at all



There are high concentrations of people that cannot speak English well or at all in the Baylis and Stoke ward (11.1%), Farnham ward (10.3%) and Chalvey ward (10%).

In Slough, the top five languages spoken other than English are Punjabi, Polish and Urdu Romanian and Tamil.[17]

1.3.1 Disease prevalence in Slough

The main cause of early death (under the age of 75 years) in Slough are cancer and cardiovascular diseases. Over half of the deaths caused by cancer and cardiovascular disease are considered preventable with smoking, physical inactivity, obesity, poor diet, and excess alcohol consumption being key underlying preventable factors.

Table 4: PHOF Indicators related to Smoking – Slough

PHOF Indicator	Period	Slough	England
Smokers setting a quit date (16+)	2022/2023	5,078 per 100,000 smokers	2,998 per 100,000 smokers
Smoking prevalence in adults (18+) (GPPS)	2022	17%	13.6%

[17] Slough Borough Council - Insights Data Pack

PHOF Indicator	Period	Slough	England
Smoking prevalence in adults with long term mental condition (18+)	2022/2023	37.7%	25.1%

Even though the data indicates Slough has a higher number of smokers setting quit dates, it has a significantly higher prevalence of smokers, with a prevalence rate of 17% compared to the national rate of 13.6%.[18]

Data from the Annual Population Survey finds that although smoking is reducing nationally, it is becoming increasingly concentrated among more economically disadvantaged communities. For instance:

- 25% of adults classified as routine and manual workers were likely to be smokers in comparison to 10% in managerial and professional occupations.
- 29% of adults unemployed were current smokers compared to 15% of employed adults.
- 29% of adults with no formal qualifications were current smokers in contrast to 7% of adults with a degree. [19]

30.7% of adults aged 19 and over were classified as physically inactive in Slough,[20] and 58.2% of adults aged 18 and above were recorded as obese or overweight.[21]In addition, only 18.9% of adults in Slough were meeting the required five portion of fruit and vegetables per day[22] compared the national average of 31%. Slough also has a higher number of alcohol related mortality with 84.2 per 100,000 mortality rate compared to the national average of 60.3 per 100,000.[23]

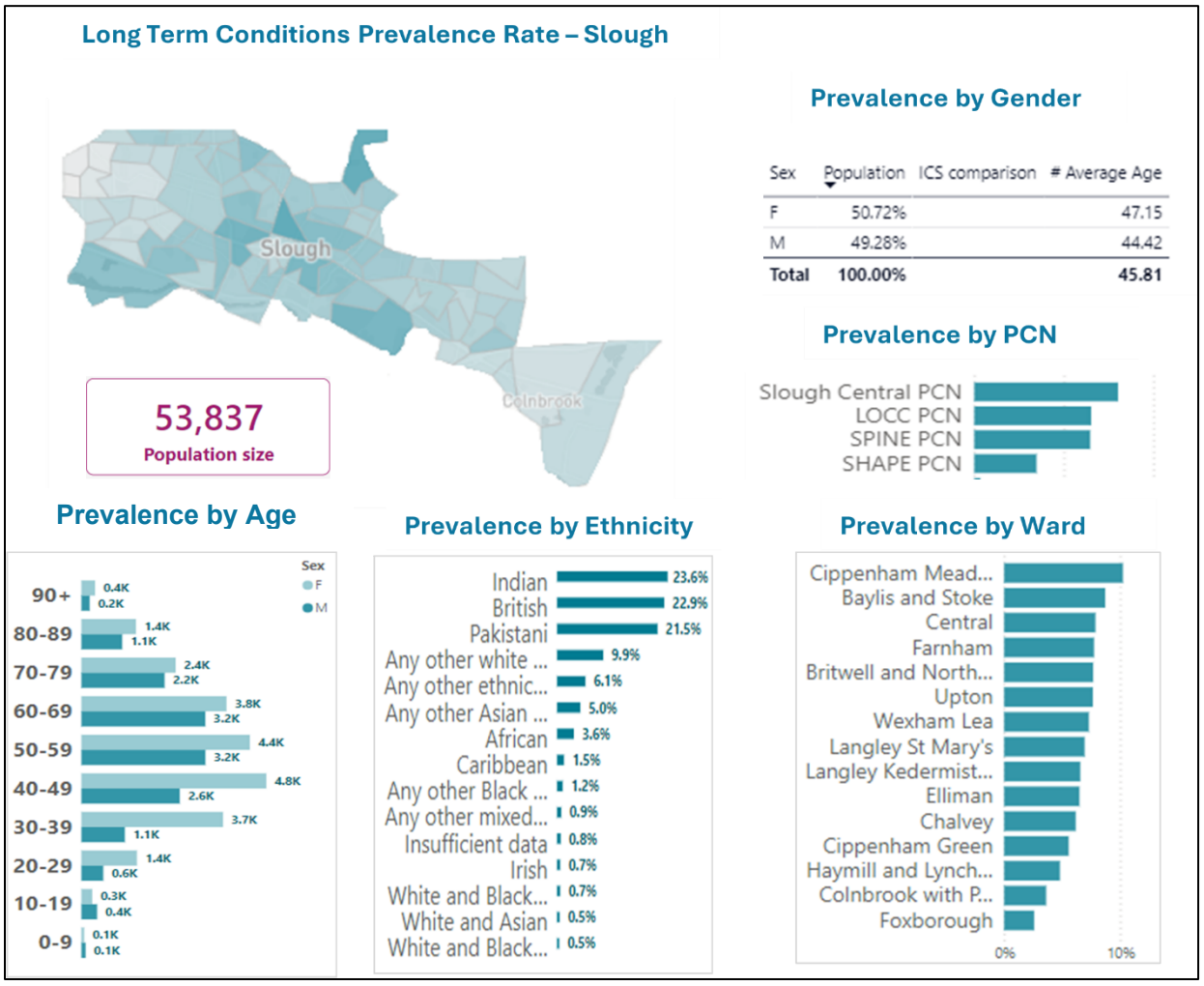
Using detailed data from Connected Care has provided further insights into the current health profile and outcomes of residents in Slough. Figure 4 shows the prevalence of long-term health conditions like cardiovascular disease, diabetes, and hypertension in Slough. One third of residents registered with a Slough GP have or are at risk of developing a long-term health condition due to their lifestyle. The highest prevalence of long-term conditions is in the more deprived wards of Cippenham Meadows and Baylis and Stoke.

The data also reveals that long-term health conditions are unevenly distributed across different demographics and ethnic groups. For instance, the prevalence rate of long-term conditions is 23.6% in the Indian community and 21.5% in the Pakistani community. While long term conditions affect the older population more, they are increasingly impacting

[18] OHID – Public Health Profiles
[19] Office for National Statistics – PAS, Statistics on smoking
[20] OHID – Public Health Profiles
[21] OHID – Public Health Profiles
[22] OHID – Public Health Profiles
[23] OHID – Public Health Profiles

younger and working aged adults aged between 30 to 69. Females are also more impacted than males.

Figure 4: Long terms Conditions Prevalence Rate – Slough



1.3.2 Consultation with residents

As a council, we recognise that the best services are those designed jointly with the people who use them. We developed a consultation to seek the views of our residents, to help us design a service that residents feel appropriately addresses their needs.

Findings from the consultation revealed key areas where residents felt they were having issues in being able to lead a healthier lifestyle: These include:

- Not being aware of what the service offers
- Not knowing how to access the service

The following health topics and services were the most important to service users:

- Exercise and fitness related services
- Healthy eating services

- Mental health
- Weight loss

We have taken into consideration the outcomes of both the survey results and focus group discussions with various groups. This specification has therefore been developed on local evidence and insight.

1.3.3 Integrated Health & Wellbeing Service Review Health

We completed a service review of our current IHWS, identifying the key strengths, successes and areas for improvement. The service review comprised of a health equity audit to assess performance against tackling inequality.

The key recommendations from the service review include:

- **Diversify Referral Pathways:** Promote IHWS in non-primary care settings like drug and alcohol services and secondary care and increase awareness in CVS and midwifery/health visitor services to enhance referral sources.

- **Enhance Digital and Cultural Adaptations:** Reassess digital app reporting and targeting to improve engagement with younger populations and continue cultural adaptation efforts to better serve predominant ethnic groups.

- **Improve Communication and Training:** Collaborate effectively with primary care, clarify referral criteria, and provide staff training on tobacco control and the Make Every Contact Count approach (MECC).

- **Targeted Interventions for High-Risk Groups:** Conduct Health Equity Audits for weight management services, consider inequality groups in future interventions

1.3.4 Local Health Needs Assessment

In 2023, we conducted two Health Needs Assessments which looked at healthy weight and smoking. Both needs assessment examined the prevalence, risk factors, population group affected, access to and use of service and evidence of effective initiatives to promote healthy behaviours. A physical activity and falls prevention needs assessment is ongoing at the time of writing this specification. However, the recommendations form the completed needs assessment are below.

Smoking Cessation Service:

- **Focus on High-Risk Groups:** Prioritise attention to high-risk population groups including routine and manual workers, carers, people with mental health problems, inclusion health groups, pregnant women, young people vaping, and ethnic minorities. Services should be targeted, culturally competent and adapted to engage with key populations

- **De-normalise Smoking:** Implement strategies to de-normalise smoking, including promoting the use of vapes only as a smoking cessation aid for adults, preventing youth influence, and establishing smoke-free policies in public areas frequented by young people, such as school entrances.

- **Training and Information on Tobacco Control:** Ensure that all partners provide comprehensive training and information on tobacco control regulations. Promote opportunistic approaches like the Make Every Contact Count (MECC) strategy to maximise tobacco dependency interventions.

- **Enhance Communication and Public Education:** Develop and evaluate communication plans to educate the public on the dangers of smoking, particularly its effects on young children. Create materials to raise awareness about smoking cessation support and engage the community through informed campaigns

Weight Management:

- **Targeted Interventions:** Implement interventions in specific wards with higher prevalence of excess weight to address localised needs effectively.[24]

- **Consideration of Inequality Groups:** Ensure that future interventions considering inequality groups and make relevant adaptations to engage these groups effectively.

- **Collaboration with NHS Frimley ICB:** Align efforts on CVD and diabetes prevention and management, ensuring a cohesive approach to reducing adult excess weight as a significant modifiable risk factor.

2. Service Aims and Objectives

2.1 Aim of Service

The aim of the Slough Integrated Health and Wellbeing Service (IHWS) is to provide a significant positive health impact on the lives of our residents, particularly targeting those who will benefit the most.

The service seeks to motivate, empower, and enable communities to improve their health and well-being while reducing the widening gap of health inequalities.

This will be achieved by offering a holistic, accessible, and equitable service that addresses both individual and population health needs.

[24] Obesity Health Needs Assessment - recommendations

2.2 Service Objectives

The IHWS objectives strive to achieve:

- **Equitable Access and Seamless Pathways:** Establish a data-driven integrated lifestyle service with universally equitable access, seamless referral pathways, and mechanisms for easy referral, entry, and exit routes.

- **Health Inequality Reduction:** Utilise principles and approaches to address the wider determinants of health, aiming to tackle and reduce health inequalities and ensuring integration with local systems, partnerships, and commissioned services.

- **Comprehensive Health Interventions:** Develop and deliver healthy lifestyle services to address and prevent key health and behavioural risk factors such as smoking, obesity, and inactivity, using evidence-based, co-produced, and needs-led approaches.

- **Promotion and Self-Care Empowerment:** Promote the service as the borough's lead on healthy lifestyle modification and prevention of long-term conditions and develop a suite of universal interventions and digital tools to empower residents in self-care. This will enable our residents develop skills to lead healthier lives and become less reliant on services.

- **High-Quality Behaviour Change Support:** Provide tailored, high-quality, evidence-based behaviour change support services to reduce health inequalities, targeting interventions to meet the individual needs of priority groups and support those with multiple risk factors.

- **Collaborative Partnerships:** Foster collaborative relationships with partners across various sectors to engage priority groups effectively and leverage community assets for place-based service delivery.

- **Continuous Improvement and Monitoring**: Implement a co-design and co-production approach for continuous improvement, involving residents, servicer users, and stakeholders. Continuously monitor and evaluate the service to drive innovation, quality, and responsiveness to community needs.

3. Integrated Health and Wellbeing Service Principles

The IHWS is underpinned by key principles that will drive and contribute to the IHWS goals of improving local health outcomes as well as increasing the overall health and wellbeing of Slough residents. The key principles include:

Digital technologies

The service will leverage digital technologies to effectively engage and support residents in making sustainable health changes. This includes:

- Recruiting and retaining users
- Motivating and supporting behaviour change remotely
- Monitoring engagement
- Facilitating access to local services

Key components include a website, an electronic Customer Relationship Management (eCRM) system in addition to apps for specific elements of the service like smoking cessation and weight management, digital communication channels such as emails and SMS text messages) to reduce missed appointments and provide ongoing motivation.

Marketing and Social Media

The service will maintain a strong marketing, web, and social media presence. A marketing and communications plan will include at least ten social marketing campaigns per year, supporting additional local and national campaigns. Targeted advertising will promote the service to priority groups. Marketing materials will be accessible, easy to read, and disseminated through various media to address digital exclusion. The service provider will involve community leaders, clinicians, and primary care health professionals in the development of targeted and appropriate campaign messaging

Partnership Working

The service will leverage existing community resources and partnerships, working with local services, primary care, VCSE sector, and community organisations. Clear referral pathways will be established for additional support, including social care, housing, and mental health services. Outreach efforts will raise awareness and connect residents to services.

Co-production and community participatory approach

The service will engage with residents and community groups across Slough's diverse population in the co-production, design, and evaluation of services to ensure that services are accessible and culturally appropriate to the communities they serve.

Accessibility

Services will be free at the point of access (with some exceptions) and delivered through a hybrid model (virtual, telephone, face-to-face) in accessible locations. Programs will be available outside normal working hours to meet community needs and address social

isolation.

Inclusion, Diversity and Cultural Competence
The service will adopt anti-stigma, anti-discrimination, and anti-racism principles, ensuring services are relevant, flexible, and culturally appropriate. Reasonable adjustments will be made to accommodate residents with protected characteristics. Information will be available in various formats and languages, and support tailored for specific needs (e.g., pregnant women, people with disabilities).

Quality Assurance
All staff will be qualified, trained, and have relevant DBS checks. The service will ensure high standards through robust feedback systems, safeguarding policies, and continuous professional development. Staff will have recognised behaviour change competencies and knowledge of local services.

Workforce
The service will employ local people who speak local languages and pay at least the national wage. A diverse skill mix will ensure cost-effective service delivery.

Data and follow-up
Data will be collected at service entry and exit, reported monthly, and feedback provided to referring GPs. Regular audits will assess service effectiveness and adherence to principles. Data sharing agreements will ensure secure transfer of information.

Evaluation and Insight
The service will evaluate its provision and gather stakeholder insights through surveys, service user stories, focus groups, and interviews. Learnings will be presented at Partnership Board and contract monitoring meetings.

Innovation
The service will continuously seek ways to innovate and improve delivery based on monitoring, feedback, and evaluation.

Performance Monitoring
Monthly contract monitoring meetings with SBC will review performance and quality data, and recovery plans if necessary. Bi-monthly Partnership Board meetings and quarterly stakeholder meetings will address operational matters, risks, and partnership working.

The service provider will also be expected to develop a service development plan and complete a Health Equity Assessment Tool (Health Equity Audit) annually and identify recommendations on how the service might be improved to reach the most vulnerable communities. The service provider will be expected to work with the provider to develop a serious incident reporting plan.

Equality Monitoring The service will adhere to the Equality Act 2010, collecting data for all nine protected characteristics. Annual reviews will assess needs and participation rates, with action plans to address any issues.

Environmental Sustainability

The service will promote physical activity and active travel, deliver services locally to reduce travel needs, and use recycled materials for publicity and information leaflets.

4. Service Model

The integrated model (see diagram below) will encourage and enable Slough residents to adopt healthier lives, making more effective use of the wealth of available assets and resources within Slough. Although universal in design, the service will tackle health inequalities by targeting residents with the greatest risk of poor healthy life expectancy using a population health management approach informed by data. The CORE 20 Plus 5 model will be used alongside evidence from needs assessment and data segmentation to define the key priority groups

4.1 Core20PLUS5

The Core20

The Core20 component identifies the most deprived 20% of the national population, using the national Index of Multiple Deprivation (IMD) as a criterion. This IMD incorporates seven domains, covering a broad spectrum of social determinants of health, thereby providing a comprehensive view of deprivation.

PLUS

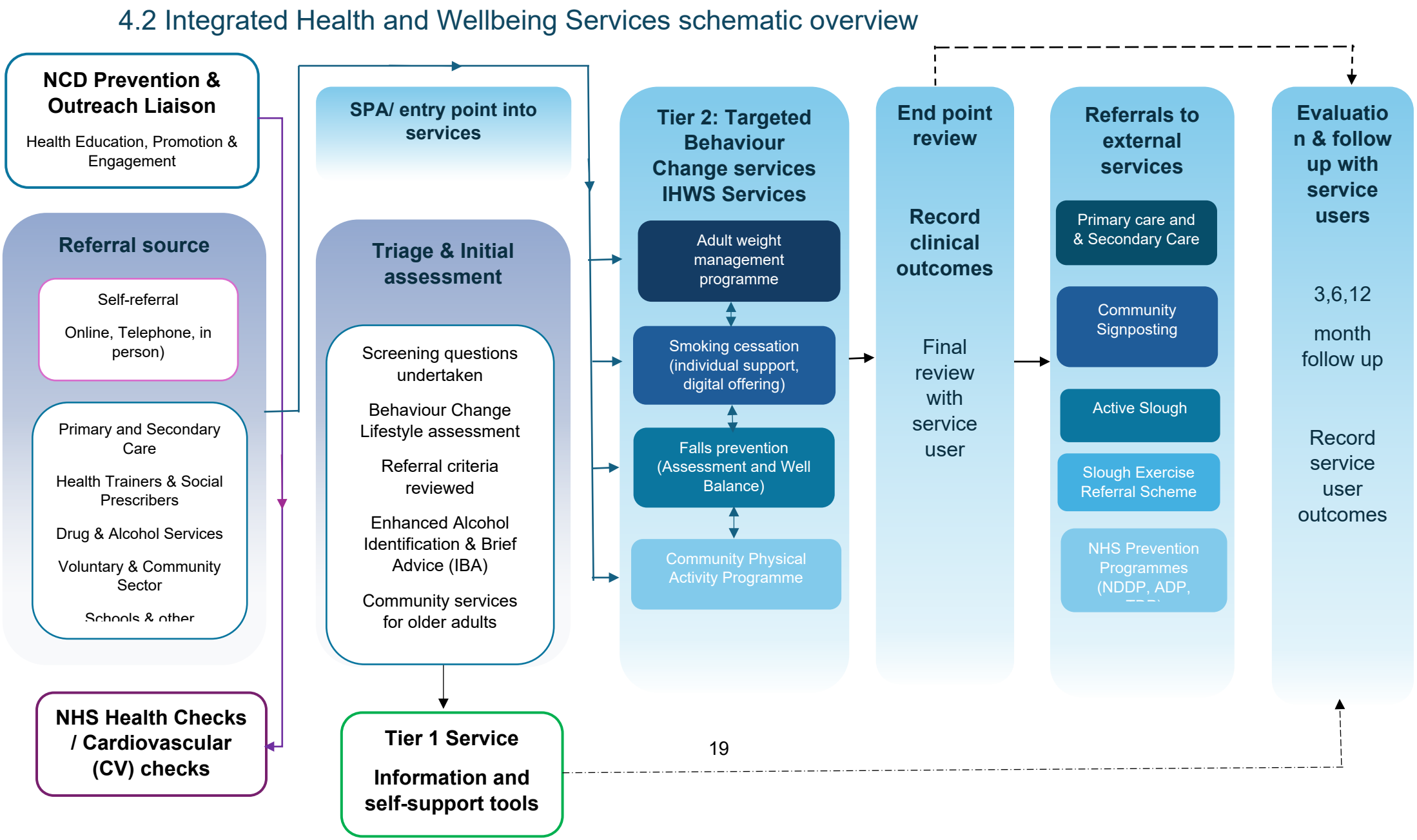
The PLUS element of the approach emphasises tailoring interventions to specific local needs. It calls for the identification of PLUS population groups at a local level, which typically include ethnic minority communities, carers, people with learning disabilities and autism, those with multiple long-term health conditions, and other groups under the Equality Act 2010. Special attention is given to inclusion health groups such as people experiencing homelessness, substance dependence, vulnerable migrants, and other socially excluded categories.

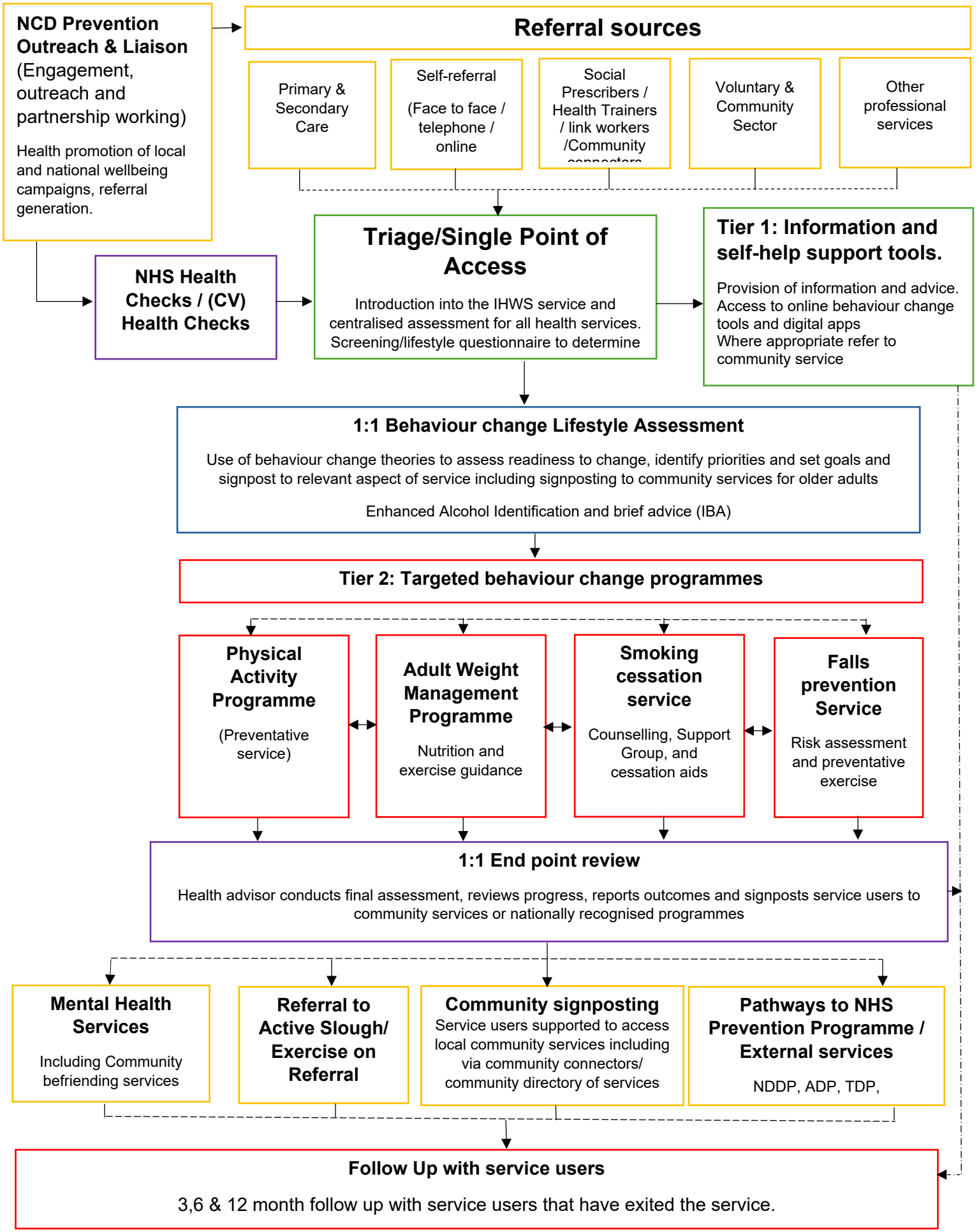
5 Clinical Areas of Focus – Adults

1. Maternity: Focused on ensuring continuity of care for women from deprived and minority backgrounds.
2. Severe Mental Illness (SMI): Emphasising annual physical health checks to meet national targets.

3. Chronic Respiratory Disease: Aiming to increase vaccinations against COVID, flu, and pneumonia to reduce exacerbations and emergency hospital admissions.
4. Early Cancer Diagnosis: Striving for 75% of diagnoses at stages 1 or 2 by 2028.
5. Hypertension and Lipid Management: Optimising management to reduce the risk of myocardial infarction and stroke.

Figure 5: IHWS Service Outline




NCD Prevention Outreach & Liaison (Engagement, outreach and partnership working)
Health promotion of local and national wellbeing campaigns, referral generation.
Referral sources
Primary & Secondary Care
Self-referral
(Face to face / telephone / online
Social Prescribers / Health Trainers / link workers /Community
Voluntary & Community Sector
Other professional services
NHS Health Checks / (CV) Health Checks
Triage/Single Point of Access
Introduction into the IHWS service and centralised assessment for all health services. Screening/lifestyle questionnaire to determine
Tier 1: Information and self-help support tools.
Provision of information and advice.
Access to online behaviour change tools and digital apps
Where appropriate refer to community service
1:1 Behaviour change Lifestyle Assessment
Use of behaviour change theories to assess readiness to change, identify priorities and set goals and signpost to relevant aspect of service including signposting to community services for older adults
Enhanced Alcohol Identification and brief advice (IBA)
Tier 2: Targeted behaviour change programmes
Physical Activity Programme
(Preventative service)
Adult Weight Management Programme
Nutrition and exercise guidance
Smoking cessation service
Counselling, Support Group, and cessation aids
Falls prevention Service
Risk assessment and preventative exercise
1:1 End point review
Health advisor conducts final assessment, reviews progress, reports outcomes and signposts service users to community services or nationally recognised programmes
Mental Health Services
Including Community befriending services
Referral to Active Slough/ Exercise on Referral
Community signposting
Service users supported to access local community services including via community connectors/ community directory of services
Pathways to NHS Prevention Programme / External services
NDDP, ADP, TDP,
Follow Up with service users
3,6 & 12 month follow up with service users that have exited the service.

The SBC IHWS provides a cost-effective, high-quality Healthy Lifestyle Service that encompasses prevention, treatment, and long-term behaviour change. The service is designed to offer a holistic and seamless experience for residents, encouraging and enabling the adoption of healthier lifestyles.

4.3 Service components

The service has various elements and components, and it is essential that they all work seamlessly together to ensure residents have a Healthy Lifestyle Service that best address their needs and meets the aim of the service.

4.3.1 Triage and single point of access

The importance of having a streamlined and efficient triage and single-point-of-access service cannot be overstated. This system ensures that individuals seeking help can be promptly and accurately assessed, directing them to the most appropriate support and resources. It enhances the overall efficiency of the service, reduces delays in receiving care, and improves the experience and outcomes for service users.

Details collected

The service will provide a single point of access for both self and professional referrals, available through multiple channels: telephone, email, in-person clinics, or an online referral form. Referrals will be addressed within 48 hours (2 working days), with at least three attempts to contact the individual, including two telephone calls and a letter, email, or text message. Upon contact, a service user record will be created to track their journey and outcomes.

Information collected at Triage:

- Name
- Date of birth
- Contact details (telephone number, email address)
- Address and postcode
- Biological sex and gender identity
- Ethnicity
- Religion
- Sexual orientation
- Occupation
- Pregnancy/breastfeeding status
- Family details (e.g., children)
- Long-term conditions/disabilities and/or medication
- Any reasonable adjustments required (e.g., interpreter, easy-read resources)

- Lifestyle behaviors (smoking status, physical activity levels, alcohol consumption)
- Height/weight/BMI (if known)
- Other details as appropriate
- Health behaviors the service user is interested in changing or improving

It is noted that service users accessing the service via community outreach NHS health checks will have provided some of the above details. Previously collected data can be transferred to avoid repetition, ensuring a seamless experience for the service user.

Referral sources

- Access routes into the SPA will include self-referral, professional referrals, referrals from community and voluntary sectors and referrals from NCD outreach programmes. Referrals from professional referrals with a primary reason (e.g. smoking cessation or diabetes structured education) must be prioritised for that request. The service user will be asked if they wish to be assessed for other services. Service users must have consented to any referral.

- Primary Care referrals should be efficient and allow GPs to refer and signpost as easily as possible. The Service Provider will need to work with Health Care Professionals and the Integrated Care Board (ICB) to ensure appropriate clinical templates, privacy impact assessments and data sharing agreements are in place. Where servicer users have been referred into the service by primary or secondary care, the referrer should be notified of the outcome of any behaviour change programmes in order to maintain accurate patient records. Feedback to GPs will be built in at the mobilisation period.

- Service users must be contacted within 2 working days of receipt of registration. Service users who contact the service by phone should be offered registration during that call. The registration should be short and simple, reducing opportunities for people to drop out, but to gain enough information for basic servicer user registration on Client Relationship Management (CRM) system and to determine which of the following categories a servicer user would like support with, to ensure they access the correct pathway.

- Service users will be required to give consent for any referrals.

- The Service Provider will set up digital mechanisms, including data sharing agreements, to seamlessly refer servicer users to services. The Service Provider will ensure that the referral form and assessment process collect all information required for onward referral where possible, while ensuring that the amount of information collected from servicer users is kept to a minimum. When collecting required

information, consider the whole servicer user journey and ensure information requested is not duplicated.

Signposting

The Service Provider will signpost to community assets, this could be to local stakeholders, digital assets or to a community directory of resources or agencies. These would include, but are not limited to**:**

- Slough community Connectors
- Slough Job centres
- Self-care resources – NHS choices, One You etc.
- Patient support groups
- Community activities
- Social health services - welfare, employment, housing etc.
- NHS and OHID approved smartphone health apps
- Relevant Frimley ICS Web pages including weight management web page

4.3.2 Behaviour Change Lifestyle Assessment

The Integrated Health and Well-being Service follows the general guidance provided by the National Institute for Health and Care Excellence (NICE) on behaviour change.[21][22][23] This guidance includes recommendations that are applied across a range of interventions to ensure effective behaviour change support.

Key aspects of the approach include:

- Focus on addressing health inequalities: The service will use a proportionate universalism approach, ensuring that interventions are designed to address health inequalities by targeting resources proportionately to those who need them most.

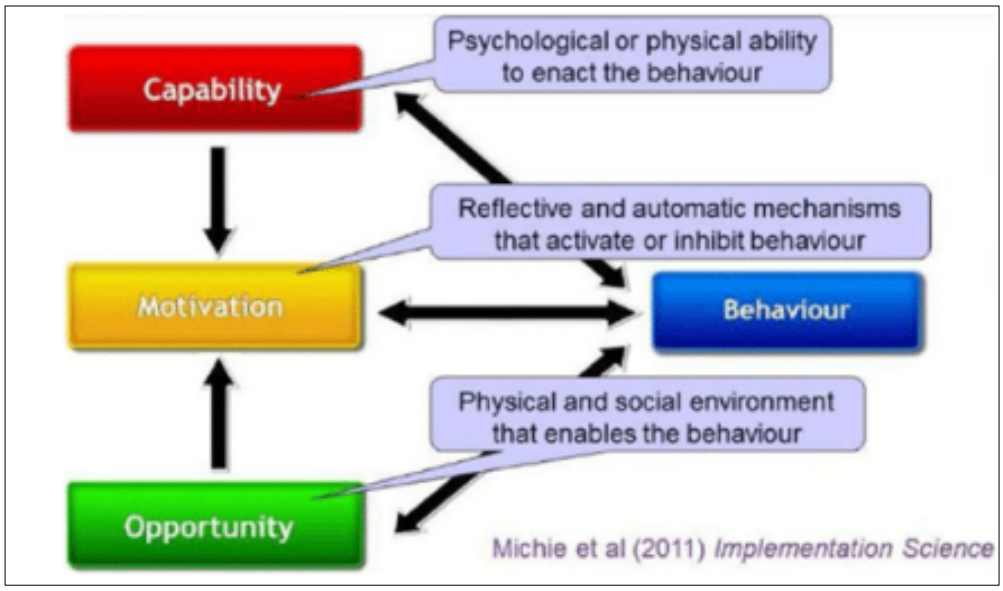
- Referrals to tailored Programmes: All programmes are tailored to individual needs, focusing on initiating and maintaining behaviour change. The personalised approach considers the unique circumstances, motivations, and barriers faced by each service user.

- Regular Monitoring: Service users will be monitored at regular intervals for up to one year after completing an intervention. This long-term follow-up helps to sustain behaviour change and provides ongoing support.

[21] National Institute for Health Care Excellence: PH Guideline [PH6]
[22] National Institute for Health Care Excellence: PH Guideline [PH49]
[23] National Institute for Health Care Excellence: NICE guideline [NG183]

In alignment with these guidelines, the IHWS adopts the COM-B model (Capability, Opportunity, Motivation - Behaviour) to underpin its behaviour change strategies.

The COM-B Framework system: Behaviour occurs as an interaction between three necessary conditions.



Service Providers delivering this service will be required to either use the COM-B model or a similar evidence-based model for behaviour change interventions.

The NICE guidance also recommends Making Every Contact Count (MECC) and other brief interventions designed for all public-facing staff to feel comfortable to hold discussions with people around how they might improve their health by addressing key risk factors like smoking, alcohol, diet, physical activity and mental wellbeing. Staff should adopt a MECC approach when working with servicer users.

Key performance indicators for Triage and Behaviour Change Lifestyle Support

Measure	Annual Target	Reporting Frequency
Single Point of Access		
Number of referrals into the service, with ability to be broken down by primary reason of referral and by source.	100%	Quarterly
Conversion rate of referral to behaviour change screening reported	100%	Quarterly

Number and percentage of referrals contacted within 48 hours	90%	Quarterly
Number of Assessments completed	4000 in yr 1 +5% increase annually	Quarterly
Levels of activity on the website, including visitors, unique visitors, time spent on site, users digital journey reported.	100%	Yearly
Onward referrals and signposting		
Breakdown of specialist behaviour programmes referred to reported: - Smoking Cessation - Adult Weight Management - Enhanced IBA Alcohol Offer - Community NHS Health or Cardiovascular Heath Checks	100%	Quarterly
Breakdown of external services referred to reported e.g. - Diabetes - Drug and Alcohol Treatment Services - Mental health	100%	Quarterly
Number of clients who have completed more than one behaviour change service reported	100%	Quartely

*Please note these KPIs are indicative and can be changed according to the service needs and latest data to align with SBC's Population Health Management Approach.

4.3.2.1 Signposting to community Services for Adults Over 60 at Triage

The community service for adults over 60 aims to assess various needs during the initial triage phase and provides appropriate onward referrals to enhance their independence and mental wellbeing. The service follows relevant guidelines, including NICE Guideline 32 for older people.

During the initial assessment phase, the service provider will assess needs, focusing on identifying older adults who might require one-off task completion or befriending services to alleviate loneliness.

Onward Referrals

- **One-Off Tasks:** Identify vulnerable older adults who need one-off tasks and refer them to relevant community services such as GoodGym and Slough CVS.

- **Befriending Services:** Assess isolated older adults for loneliness and refer them to befriending services aimed at alleviating isolation. The primary providers for these services are GoodGym and Slough CVS.

- **Follow-Up:** Conduct follow-up checks at 7 days to ensure referrals have been actioned and provide additional support if required.

Holistic Approach

Ensure that the assessment identifies all potential support needs, allowing servicer users to focus on one lifestyle initially and return to another later if needed. This includes managing expectations by providing clear, consistent, and timely information about the service and setting realistic goals.

Key Performance Indicators for Signposting to Community Services for Adults aged 60+ at Triage

Performance Measure	Annual Target	Reporting Frequency
Proportion of adults aged 60+ triaged by the service, that may require a one off task being completed e.g. clearing up, moving furniture, offered referral to GoodGym or Slough CVS	100%	Quarterly
Proportion of isolated older adults aged 60+ triaged by the service, that could benefit from a befriending service to relieve the burden of loneliness, offered referred into GoodGym or Slough CVS	100%	Quarterly

4.3.3 Tier 1 Information and self-help support tools

Tier 1 service is designed for users who do not require or are not interested in targeted support, and who are not identified as being at-risk. This tier aims to empower individuals to make positive changes independently by providing them with accessible information and self-help tools.

Key components of the Tier 1 Service

- **Resource and Tools:**
    - Service users will have access to a range of information and online behaviour change tools and apps, all of which will be clearly available on the service website.
    - A comprehensive online resource library will be maintained, featuring

educational materials such as articles, videos, and interactive content covering topics like healthy eating, physical activity, alcohol reduction, and stress management. This could include but not limited to:
        - **Smartphone apps:** Couch to 5k, NHS Food Scanner app, Easy Meals app, Active 10.
        - **Recipes and Tutorials:** Simple, cost-effective, nutritious recipes and video cooking tutorials.
        - **Online Videos:** Activities provided by certified instructors.
    - Self-assessment tools will be available online for users to evaluate their own health behaviours and track their progress over time.

- **Signposting to Community Services**:
    - Where appropriate, users will be made aware of available community services, including the Integrated Health and Wellbeing Service (IHWS), local health and wellbeing groups, fitness classes, or community centres.
    - Information on outdoor gyms, Green Gyms, cycling and running groups, and other outdoor/park activities such as Health Walks.

- **Digital platforms:**
    - The service will utilise digital platforms, including social media, email newsletters, and the service website, to disseminate information and engage users.

- **User Feedback Mechanism:**
    - A feedback mechanism will be established to allow users to provide input on the usefulness of the resources and suggest areas for improvement.

All healthy eating guidance will be in line with government/NHS guidelines, e.g., the Eatwell Guide (including cultural alternatives). Care will be taken not to promote unsustainable fad diets that may be harmful to health.

The service user can opt in for a follow up call in 6 months to assess if their requirement has changed and whether they can re-enter the service. If identified as Tier 2 or 3, the service user will be booked into a 1:1 Behaviour Change Lifestyle Assessment with a Health and Wellbeing Coach.

Key Performance Indicators for Tier 1 Information and self-help support tools

Measure	Annual Target	Reporting Frequency
Number of service users offered Tier 1 service reported	100%	Quarterly
Proportion of tier 1 service users who opted for a follow-up call in 6 months who are contacted in 6 months	100%	Quarterly

4.3.4 NCD Prevention, Outreach and Liaison

Non-communicable diseases (NCDs), such as cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes, are leading causes of global morbidity and mortality, responsible for over 40 million deaths annually.[28]

NCDs are a significant cause of death in England, playing a large role in the burden of mortality across the nation. In 2019, 88.8% of deaths in England were attributable to NCDs.[29] Approximately 14% of people in England live with one or more chronic long terms conditions, highlighting the urgency of addressing these health issues.[30]

In Slough, prevalent long-term conditions include hypertension, diabetes, and coronary heart disease. Additionally, the prevalence of smoking in Slough is 17% % corresponding to 26,945 adult smokers. Approximately 66% of adults are living with excess weight and about a quarter are living with obesity.[31]

In 2022, the under 75 mortality rates from all circulatory diseases in Slough was around 109 per 100,000; considerably higher than the regional average of 63.1 per 100,000 and the England average of 77.8 per 100,000[32] .

In 2020, the incidence of emergency hospital admission for COPD in Slough for adults 35 years and older was 170 per 100,000. This is lower than the South East regional average of 295 per 100,000 and lower than the England average of 415 per 100,000.[33]

In 2022/23, 10.5% of Slough's population aged 17 years and over was registered in primary care as having diabetes. This is higher than the South East average of 6.9% and national average of 7.5%.[34]

Given this context, integrating NCD prevention, community engagement, and outreach into the Slough Integrated Health and Wellbeing Service is crucial. Addressing modifiable risk factors through targeted interventions can significantly reduce NCD prevalence and severity, improve residents' quality of life, and decrease healthcare burdens.

Aim of NCD Prevention, Outreach and Liaison

The aim of the NCD Prevention, Outreach and Liaison element of the Integrated Health and Wellbeing Service is to promote a healthy lifestyle and contribute to the prevention, early detection, and management of long-term conditions among Slough residents. This will be achieved through primordial, primary, and secondary prevention strategies, delivering targeted and accessible educational information, fostering relationships within key communities, and collaborating with local stakeholders to address and meet local health needs.

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[28] World Health Organisation – Noncommunicable diseases key facts
[29] Office for Health Improvement & Disparities – data on the distribution and burden on NCDs
[30] Journal of the Royal Society of Medicine – Prevalence of multiple long term conditions.
[31] Slough Borough Council – Healthy Weight Needs Assessment
[32] Public Health Profiles – Under 75 Mortality Rates, Slough
[33] Public Health Profiles – Emergency hospital admissions for COPD (35+)
[34] Public Health Profiles – Diabetes prevalence

Model of Delivery

Outreach Engagement Plan:

- Develop an outreach engagement plan, agreed upon by The Commissioner, to systematically engage with priority groups throughout the contract duration.

- **Health Education and Awareness Outreach:**
    - Deliver targeted health education and awareness outreach on NCD prevention and management including the prevention of diabetes, and the role of cancer screening early detection and prevention.
    - Deliver targeted health education on the links between CVD and dementia and educate on signs and symptoms of dementia.
    - Utilise various platforms such as video campaigns, workshops, seminars, social media, and community centres.
    - Develop and distribute co-designed culturally appropriate and accessible educational materials.
    - Establish referral pathway from outreach event to NHS and cardiovascular health checks and triage for the IHWS.
    - Provide information and signpost residents to the integrated health and wellbeing service website for further information and self-help tools.
    - The service provider is encouraged to feature Slough residents, community leaders and primary care clinicians in the development of campaign messages such as videos to target and reach underserved communities.

- **Outreach Locations:**
    - Conduct outreach activities and events in locations suitable for recruiting target populations, including faith settings, supermarkets, workplaces, leisure centres, community events, by identifying the location of target high-risk groups through population health management using segmentation data from Frimley ICS.
    - Prioritise community-led events (e.g., fun fairs, faith settings) over health-based events to reach key community groups not typically engaged with health services.

- **Community Connectors:**
    - Identify and build relationships with key community connectors who have existing trust within target community groups to inform and guide outreach offer.
    - Build relationships with trusted community leaders to support and develop community capacity to promote the service.
    - Working collaboratively with SBC community development team and voluntary sector organisations to build community capacity to take action on health by identifying and working with community assets.

- **Partnerships and Referral Pathways:**
    - Establish strong partnerships with local stakeholders, including healthcare providers, community organisations, schools, and businesses.
    - Strengthen referral pathways to external services, including national programmes, specialist medical care, mental health services, community organisations, and social support services.
    - Work with the national screening lead to promote various screening programmes, including Bowel Cancer, Abdominal Aortic Aneurysm (AAA), cervical cancer, and breast cancer screenings.

- **Engagement and Tailoring Services:**
    - Engage and recruit key priority groups using population health management approach informed by the NHS CORE 20 Plus 5.
    - Develop insights to tailor the service to meet the needs of residents from priority groups, ensuring they are aware of the available support to help change their behaviour.

Skills requirements of staff

- Partnership Working: Staff need to have experience in partnership working.

- Training: Staff will be trained in behaviour change models, VBA and the Making Every Contact Count (MECC) approach.

- Personal Attributes: They should be approachable, supportive, and non-judgemental.

- Community Understanding: Staff should understand the needs of the community, with an expectation that this will increase referrals from priority groups into the service, ultimately resulting in improved outcomes for a greater number of residents.

- Promotion and Networking: They should be skilled in promoting services and networking, as well as tailoring the service to the relevant audience.

Key Performance Indicators (KPIs) for NCD Prevention, Outreach and Liaison

KPI Description	Measure	Target Number
Community Outreach	Number of community events and outreach activities delivered per annum	12
Community Collaboration	Percentage of outreach event delivered in collaboration with community connectors, Voluntary sector organisation or healthcare system partner	100%
Reach and Engagement	Total number of people accessing community health education events per annum	1000
Equity and Inclusion	Percentage of high-risk target population reached by health education campaigns (CORE 20 PLUS 5)	50%
Referrals and sign posting	Total number of referrals received into the IHWS from outreach engagement	500
	- Number of individuals signposted to national screening programmes including breast, cervical cancer screening, and AA screening	300
Staff Training and Development	- Number of staff trained in health education and outreach	100%
Programme Evaluation and Satisfaction	- Number of service users invited to complete evaluation survey	100%
	- % of service users completing evaluation survey	50%
	- % of service users who completed the evaluation reporting an increased knowledge, awareness, skills, and capabilities in relation to the outreach topic	75%

Note that the delivery of community awareness events will not substitute the expectation that the service provide will optimise opportunities for residents to access the service in public places via clinics in hot-spot and targeted areas.

4.3.5 Community NHS Health Checks and Cardiovascular Checks

The NHS Health Check is a statutory programme in England that aims to prevent the development of Heart Disease, Stroke, Type 2 Diabetes and Kidney Disease, while also raising awareness of dementia. The programme targets adults aged 40 to 74, with a focus on risk

assessment and provision of support to prevent, reduce and manage risk of cardiovascular disease.

The NHS Health Check is viewed as primarily a preventative service. It is not aimed at people who have already been diagnosed with a cardiovascular disease as it is assumed that these people will already be on a general practice disease register, and therefore will be reviewed regularly and receiving appropriate treatment.

Current evidence suggests that those who are most at risk and potentially with most to benefit from population-level early interventions may be least likely to engage.

Those who are at greater risk of diabetes and stroke compared to the majority population are people from most black and minority ethnic (BAME) populations (people from Black African, African Caribbean and South Asian backgrounds are at risk of developing type 2 diabetes from the age of 25, compared to the age of 40 for the white population72).

Barriers to engage with an NHS Health Check in certain populations have been attributed to institutional and socio-cultural barriers to accessing healthcare, socioeconomic inequalities and the experience of racial discrimination and harassment. Best practice nationally has shown innovative ways of accessing underrepresented high-risk groups by maximising the use of community assets, including the use of community connectors, knowledge, venues, faith groups, voluntary and community organisations.

The programmes have been delivered in community settings such as supermarkets, community venues, faith settings, places of work and leisure centres, using an opportunistic outreach approach. Programmes led by community groups collaborating with health services have been successful in building trust with groups least likely to engage.

Evidence also suggests that a community-based health check can provide a catalyst to accessing further medical advice from mainstream health services. According to the NHS Health Check Delivery Survey, in 2019/20, 27% of Local Authorities used community outreach providers to deliver Community NHS Health Checks (CNHSHC).[35]

As part of the NCD prevention and outreach programme, Community NHS Health Checks (CNHSHC) will complement the current NHS Health Checks delivered by general practice and will not be a replacement or addition to the current service. The service will enable access to residents who have historically not attended health checks, providing early intervention and prevention, and will seek to case-find in younger high-risk age groups.

The service will contribute to the NHS England's Core20Plus5 – reducing health inequalities in hypertension case-finding. The service will also provide a Cardiovascular health check which mirrors the NHS health checks for targeted at risk groups who are not eligible for NHS health checks based on their age. Service users will need to meet all other eligibility criteria for NHS health checks with the only unmet eligibility criteria being aged between 30-39 years.

[35] NHS Health Check Delivery Survey Delivery

Aim of service

The aim of the Community NHS Health Checks and Cardiovascular Health Checks Service is to prevent the development of heart disease, stroke, type 2 diabetes, and kidney disease among adults aged 40 to 74 years including people from minority ethnic groups aged 30-39 years recruited via targeted cardiovascular health checks, by providing targeted risk assessment and support. This service will focus on early intervention and prevention, raising awareness of dementia, and addressing health inequalities by engaging historically underrepresented and high-risk populations through community-based outreach.

By leveraging community assets and collaborating with local groups, the service will enhance access to health checks, contribute to case-finding in younger age groups, and support NHS England's Core20Plus5 initiative to reduce health inequalities in hypertension case-finding.

Model of delivery

- **Invitation and Offer:**
  - The service will provide an 'Invitation and Offer' for a 'Risk Assessment' via a Community NHS Health Check to eligible residents for a minimum duration of 20 minutes.
  - Cardiovascular health checks will be offered to targeted groups, defined as people from minority ethnic groups aged 30-39 years. These checks will deliver the same service as the NHS Health Check to targeted groups at high risk of CVD but not eligible for NHS Health Checks.

- **Referral into IHWS:**
  - Service users identified with risk factors such as smoking, lack of physical activity, obesity, or a Q-risk ≥ 10% will be referred to appropriate services within the Integrated Health and Wellbeing Service (IHWS), with the service user's consent.
  - Data collected will adhere to the national NHS Health Check minimum dataset requirements and will be securely transferred back into the GP practice clinical system. This data will be included in quarterly monitoring reports.

- **High-Risk Referrals:**
  - Service users with a risk score >20% will be referred to primary care for further assessments and treatment according to NICE guidelines.

Risk Assessment

As part of the NHS HC or CV HC, the service provider must conduct a risk assessment for a minimum duration of 20 minutes by collecting the following information if not already collected at triage:

- Age
- Gender
- Ethnicity ('if the Patient declines to reveal his/her ethnicity this matrix must be entered as 'not stated')
- Family history of CHD in first-degree relatives

- If the Patient is diabetic or not
- Smoking status
- Height, weight (BMI)
- Systolic and diastolic blood pressure
- Key points: pulse rhythm should be taken prior to a blood pressure check, in line with NICE Hypertension clinical guideline. Individuals who are found to have an irregular pulse rhythm should be referred to the GP for further investigation of atrial fibrillation.

- if the individual has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg, respectively, the GP would be responsible for further assessments including
    - a non-fasting HbA1c test or a fasting plasma glucose (FPG)
    - an assessment for hypertension including offering ambulatory blood pressure monitoring.
    - an assessment for CKD

- Patients diagnosed with hypertension, atrial fibrillation, or CKD should be managed in line with NICE Clinical Guidance (NICE, 2023) and will exit the Service Pathway, being removed from the eligible population, and should not be recalled for a NHS Health Check

- Total cholesterol and HDL

- Cholesterol must be measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol. A random cholesterol test should be used for this assessment. A fasting sample is not required.

- If a person has recently (less than 12 months) had a blood test for cholesterol, then these results may be used, and new tests do not have to be administered.

- Diabetes risk assessment
    - Individuals who are identified as being at high risk of type 2 diabetes (BMI greater than or equal to 27.5 and from Black, Asian and other MINORITY ethnic groups); or BMI greater than or equal to 30; or Blood pressure at or above 140/90mmHg, or where the systolic or diastolic blood exceeds 140mmHG or 90mmHg, respectively) should also receive a plasma glucose test – either an HbA1c, which is recommended, or a fasting plasma glucose test as part of an NHS Health Check.

- Physical activity levels as per the General Practice Patient Activity Questionnaire (GPPAQ)

- Alcohol Check
    - The service provider need to ensure that everyone having a health check has their Alcohol consumption assessed using the AUDIT C scoring tool.

- Service users whose drinking (AUDIT score) is placing them at increasing or higher risk of future health damage, NICE recommends that NHS Health check provider provide them with brief advice on how alcohol can contribute to health problems and encourage the Patient to reduce their alcohol consumption, as well as referring to local alcohol service provider who is our drugs and alcohol service provider.

- Dementia brief intervention – all Patients aged 40+ receiving an NHS Health Check
  - As part of a health checks, the provider must provide information to all Patients to raise awareness of dementia and the availability of memory services. The intention is to raise awareness only and is not about assessing individuals for memory difficulties at the time of the check. It will, however, help to ensure that people with dementia are diagnosed at an earlier stage by providing them with information.
    - The key messages to be included in the dementia component include.
    - Reducing risk of dementia (Educate people on the link between cardiovascular risk factors and developing vascular dementia).
    - Key signs and symptoms of dementia
    - Reinforcement of behavioral and physiological risk factor management
    - How to access further information and support
    - The NHS Health Check dementia leaflet are available to order in a variety of formats and languages from the NHS, (NHS Health Checks, 2022).

Communication of Risk

- General Health Advice: All individuals, including those with less than a 10% risk, should receive general health advice (MECC conversation).

- Face-to-Face Discussion: A face-to-face discussion should be offered to discuss results and ways to reduce cardiovascular disease risk. Follow-up medical interventions will depend on risk assessment results.

- QRISK Score: To maximise the benefits of the programme, efforts should be made to ensure individuals understand their level of risk and lifestyle modifications necessary. The use of QRISK heart age measurement is encouraged to highlight the patient's current health status by comparing heart age with actual age. The provider would be expected to follow national or clinical guidance on tool updates.

- Results: Provide Patients with a copy of their results, including blood pressure, cholesterol, QRISK score, and other significant findings, either in print or digitally.

- Information Packs: Provide Patients with information packs which details support options for reducing CVD risk via the integrated health and wellbeing service, tailored to individual

lifestyle issues (e.g., smoking cessation support). The provider may draw relevant information from resource available from Frimley Health and Care webpage

- Evidence-Based Information: Advice should be based on the latest Best Practice Guidance, with additional resources from DOH, OHID, NICE, NHS, and BHF.

To assist Providers with the 'Communication of Risk', the NHS Health Checks 'Results Booklet' is available from the national website for Provider's use, (NHS Health Checks, 2016).

Risk Management: Lifestyle interventions

- Those identified with CVD risk of 20% or require additional testing and clinical follow-up for undiagnosed conditions or are at high risk of developing CVD or diabetes should be flagged in communication with their GP for further action in line with NICE Clinical guidance: https://www.nice.org.uk/guidance/ng238.

- Information should be given about reducing modifiable risk factors including discussion on referrals to appropriate T2 lifestyle service. Service users completing a Health Check who need further support should be enrolled on an appropriate T2 lifestyle service one at a time

Equipment

- The Service Provider will arrange their own POCT capability, in line with national best practice guidance standards. An annual submission of evidence of QA compliance will be required which will evidence any equipment is regularly maintained and calibrated.

- The Service Provider will be responsible for the procurement of all equipment and consumables required to deliver Health Checks. This will include calibration, quality control, assurance and maintenance of equipment used (in line with manufacturers' recommendations) in the provision of Health Checks including:
    - Near client testing equipment
    - Weighing scales
    - Tape measures
    - Any other equipment needed including disposable and reagent costs

- The Service Provider should ensure that appropriate protective equipment, including gloves, aprons, and materials to deal with blood spillages, are readily available on the premises where the service is provided.

- The Service Provider should ensure that staff are made aware of the risk associated with the handling of clinical waste and the correct procedures to be used to minimise those risks.

- The Service Provider will follow the guidance and advice relating to point of care testing (POCT) and quality control in Section 4.5 of the NHS Health Check best practice guidance (see also below Standards 3 and 4).

- The Service Provider will source and maintain stock levels of equipment for community NHS or CVD HC, including but not limited to cholesterol kits, HbA1c monitors, blood pressure monitors (Microlife Watch BP Home A), stadiometers, scales, and any associated consumables. ISO standard ISO15197:2013 defines performance standards for self-testing meters. In the absence of a standard for other point- of-care testing devices, this will be considered a minimum performance requirement.

- The cost of consumables must be met at the sole cost and expense of the Service Provider.

- The Service Provider must ensure that effective calibration and quality assurance of equipment is carried out and documented routinely (in line with relevant manufacturer guidelines).

- The Service Provider must ensure that all clinical waste generated via delivery of CNHSHC is managed safely and effectively.

Priority Groups

The service will prioritise the following groups for community NHS Health Checks and CV Health Checks, in alignment with the CORE20PLUS5 initiative to reduce health inequalities:

- The most deprived 20% of the population (CORE20);

- Ethnic minority communities, particularly those of South Asian heritage (PLUS);

- Populations including ethnic minorities (already covered in the second bullet point), people with learning disabilities, carers, people with mental health conditions, people who are homeless, and people with multiple long-term conditions (PLUS);

- Focus on the five clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding;

- Communities and groups with a high prevalence of cardiovascular disease and diabetes;

- Communities with a low response rate to GP invitations for NHS Health Checks (to be agreed in consultation with primary care);

- Men in routine and manual occupations.

Staff Skills Requirements
The Service Provider will ensure that all staff providing community NHS or CV Health Checks are adequately trained and adhere to the NHS Health Check competence framework. Staff must be capable of:

- Explaining the NHS Health Check and its benefits to potential recipients.

- Following the latest NHS Health Check best practice guidance and staying updated with any changes to the programme.

- Undertaking all clinical measures included in an NHS Health Check, including Point of Care Testing (POCT), and calculating cardiovascular risk.

- Communicating the servicer user's risk in accordance with NICE guidance in a way that the individual understands and that motivates them to reduce their risk.

- Providing appropriate advice and making referrals as necessary, including onward referral to GP practices for further investigation.

- Raising awareness of cardiovascular disease and diabetes and emphasising the importance of lifestyle choices in reducing risk (e.g., reduced alcohol consumption, stopping smoking).

- Being aware of the risks associated with handling clinical waste and following correct procedures to minimise those risks.

- Keeping their knowledge and skills up to date by attending annual refresher training as required, provided by the Service Provider.

Referral pathways
- Service users can access an NHS HC or CV HC without having to have an assessment through SPA, however it is also a referral route for those who have been triaged through the SPA.

- It is expected that NCD prevention, outreach and liaison work will support the generation of referrals for the NHS/CV health checks and will enable a focus on

priority groups that may not already be aware of the NHS Health Check Programme.

- The Service Provider can recruit eligible service users through both opportunistic events and through booked appointments.

- The Service Provider will work closely with Public Health to deliver in areas where there has been low or no delivery of GP NHS Health Checks. This might include third party provision to a GP practice/registered population on behalf of the GP.

- The Service Provider must use appropriate marketing and communications to target and engage key priority groups including but not limited to community events, social media. Use should be made of nation and local campaigns including but not limited to CVD campaign.

- The Service Provider will ensure that service users who have completed community NHS or CV HC and would benefit from lifestyle/behavioral support are enrolled on an appropriate T2 lifestyle service one at a time.

Follow up and Maintenance

The Service Provider will need to have fulfilled the following before an individual exits the Outreach NHS Health Check process:

- Their CVD risk score has been given to them and results of their Health Check discussed with them (including discussion around how to reduce risk), including a digital or hard copy for the servicer users to take away with them.

- The Service Provider will ensure that a secure and efficient electronic method of transferring clinical information captured during the check will be used to send back the information to the servicer users GP within 72 hours and within 24 hours for servicer users who receive a high-risk score (QRISK > 20%). This will include all elements of the check as identified in the service model, any advice provided, GP referrals and referrals to lifestyle improvement services, using all elements of the Department for Health and Social Care (DHSC) minimum dataset and relevant read codes. The Service Provider must highlight the importance to GPs of adding the Outreach NHS Health Check information to the patient's data file within the clinical system and not simply scanning it in.

- To refer or signpost individuals at risk or eligible for intervention to appropriate services as required (physical activity, weight management, pre-diabetes, alcohol service, stop smoking service) and encourage them to attend.

- Service users with a CVD risk ≥ 20%, who are not registered with a GP, should be supported to register with a GP and advised to attend their nearest Walk-In Centre in

the interim for further assessment.

- Service users will be offered an evaluation form to give feedback which will be used to inform and improve the service.

Quality Assurance

The provider will adhere to the following quality assurance roles and responsibilities:

- Achieve a high standard of care review and risk assess local pathways against national guidance and standards.

- Work with commissioners to develop, implement, and maintain appropriate risk reduction measures.

- Provide agreed performance data and evidence of quality to the commissioner at agreed intervals.

- Review implementation on a routine basis through audit and ensure appropriate staff training is in place for delivery of the programme. To audit practice, the service will seek the views of patients who attend for an NHS Health Check; asking their experience of, and satisfaction with the NHS Health Check, together with suggestions for service improvement.
- Ensure appropriate links are made with internal governance arrangements, such as risk registers.

- Ensure they meet the Equality Act 2010 requirements, by ensuring reasonable adjustments are made for everyone, but specifically in respect of those who share one of the nine protected characteristics. Community venues need to be fit for purpose and have the equipment and privacy required to conduct an NHS Health Check.

Eligibility criteria

Eligibility criteria for NHS Health Checks

Eligibility Criteria
The patient is between 40 and 74 years old

Exclusion Criteria
Previously had a Health Check under this programme within the last 5 years
Existing diagnosis of diabetes (type I and type II)
Patients with hypertension
Patients with ischaemic heart disease
Patients with chronic kidney disease (stage 3-5)
Patients with Familial hypercholesterolemia
Patients with a previous history of stroke/TIA or heart failure
Patients with peripheral arterial disease

Patients who have already had a formal health check and have been identified as high risk (QRISK > 20%) and placed on a high risk register within the last 10 years
Patients with Atrial fibrillation.
Patients currently on statin treatment

Eligibility criteria for Cardiovascular Checks

Eligibility Criteria
The patient is between 30-39 years old and is from a Black, Asian and Minority ethnic group

Exclusion Criteria
Existing diagnosis of diabetes (type I and type II)
Patients with hypertension
Patients with ischaemic heart disease
Patients with chronic kidney disease (stage 3-5)
Patients with Familial hypercholesterolemia
Patients with a previous history of stroke/TIA or heart failure
Patients with peripheral arterial disease
Patients with Atrial fibrillation.
Patients currently on statin treatment

Key performance Indicators for NHS Health Checks and Cardiovascular Checks

Definition	Annual Target	Reporting frequency
Number of NHS health check offered to those eligible	1500	Quarterly
Number of NHS health check received	1125	Quarterly
Proportion of those who receive a complete NHS Health Check dated with all indicators listed in risk assessment recorded at the time of delivery	100%	Quarterly

% of NHS health check delivered to priority groups	- 30% BAME - 40% Routine and manual workers - 60% from high areas of deprivation IMD 1 and 2	Quarterly
Proportion of NHS Health Checks undertaken where referral to lifestyle/ local services to help reduce risk, (e.g. national diabetes prevention programme, stop smoking service) is made, where appropriate.		
Proportion of staff delivering POCT who have been trained (by a competent trainer) to use the equipment	100%	Annually
Number of CV health checks offered	800	Quarterly
Number of CV health checks delivered	600	Quarterly
Proportion of those who receive a complete CV Health Check dated with all indicators listed in risk assessment recorded at the time of delivery	100%	Quarterly
% of CV health checks delivered to priority group	- 40% Routine and manual workers - 60% Number from high areas of deprivation IMD 1 and 2	Quarterly
Proportion of CV Health Checks undertaken where referral to lifestyle/ local services to help reduce risk, (e.g. national diabetes prevention programme, stop smoking service) is made, where appropriate.		Quarterly
Proportion of staff delivering POCT who have been trained (by a competent trainer) to use the equipment	100%	Annually

4.3.6 Smoking Cessation

Tobacco use remains the single leading cause of preventable deaths in the UK. All tobacco use harms the body, causing damage to nearly every major organ in the body and contributing to chronic diseases such as cardiovascular disease, respiratory disease, and cancer. Smoking is also a major contributor to health inequalities. It accounts for approximately half of the difference in life expectancy between the lowest and highest income groups due to smoking related ill health.[36]

In Slough, it is estimated that 17% of the adult population smoke,[37] but smoking rates are much higher among some groups, particularly those in lower socio-economic and vulnerable communities including those from minority ethnic groups, making smoking a major risk factor for health inequalities.

Local smoking rates are higher among routine and manual workers (22.2%),[38] among people with a serious mental health illness (37.7%) as well as adults suffering from anxiety and depression (20.6%).[39] Higher prevalence is also seen among drug and alcohol users. 54.2% of adults who were admitted to Slough hospitals for non- opiates use and 42.1% admitted for alcohol misuse were smokers.[40]

In recent years, there has been a notable increase in the popularity of vaping among young people. Evidence suggests potential health harms from vaping, including respiratory issues and potential long-term effects that are not yet fully understood. The Association of Directors of Public Health (ADPH) South East Position Statement on Vaping (2024) highlights several key messages relevant to this issue:

- Vapes are an effective aid for adults to quit smoking.
- If you smoke, vaping is safer than smoking.
- Vaping has minimal serious side-effects when used for a short time to stop smoking.
- People who want to quit smoking using vapes should be encouraged to quit smoking and switch to vaping.
- People who do not smoke should not vape.
- We must prevent children from using vapes due to the unknown longer-term harms of vaping and the risk of nicotine addiction.[41]

[36] Action on Smoking and Health (ASH), smoking and health inequalities
[37] Office for Health Improvement & Disparities – Public Health Profiles, Smoking prevalence
[38] Office for Health Improvement & Disparities – Public Health Profiles, Smoking prevalence
[39] Office for Health Improvement & Disparities – Public Health Profiles, Smoking prevalence
[40] OHID Smoking Public Health Profiles
[41] South East of England – Position Statement on Vaping

Slough aligns with this position, emphasising that vapes should only be used by adults as a quit aid to stop smoking and should not be taken up by non-smokers. Preventing non-smokers, especially youth, from initiating vaping is crucial due to its associated risks.

High prevalence of chewing tobacco and shisha among Slough residents

Slough has a high prevalence of chewing tobacco and shisha use. Both practices are popular among some ethnic groups and are often perceived as a safer alternative to cigarette smoking. However, shisha smoking poses significant health risks, including exposure to toxic substances, increased risk of infectious diseases, and similar long-term health consequences as cigarette smoking, such as cardiovascular and respiratory diseases and cancer. Likewise chewing tobacco and other smokeless tobacco products raises the risk of oral health problems as well as long-term conditions including cancer of the mouth, throat and pancreas Raising awareness about the dangers of shisha and chewing tobacco is critical to addressing this public health issue.

Service Description

The aim of the Stop Smoking Service is to reduce smoking prevalence and associated health inequalities in Slough by providing targeted support and resources to help residents quit smoking.

The service focuses on promoting the use of evidence-based cessation aids, such as vapes for adult smokers, while preventing the initiation of vaping among non-smokers and youth. Additionally, the service aims to raise awareness about the dangers of all forms of tobacco use, including cigarettes chewing tobacco and shisha, and to support long-term behaviour change to improve overall health and wellbeing in the community.

The service will provide nationally accredited programme of setting a quit date, structured support, and confirmation of quitting at 4 weeks, including CO (Carbon Monoxide) verification.

Priority Groups

Although the smoking cessation service is universal, priority groups should be actively targeted to ensure they are aware of and utilise the service. These include but are not limited to:

- Ethnic minority communities
- Men in routine and manual occupations
- Smokers who live with children
- The most deprived 20% of the population (CORE20)
- Populations including ethnic minorities (already covered in the first bullet point),

people with learning disabilities, carers, people with mental health conditions, people who are homeless, and people with multiple long-term conditions (PLUS)
- Focus on the five clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding
- The unemployed.

Universal and specialist support

The smoking cessation service will offer both universal and specialist support, providing tailored assistance to meet the diverse needs of service users. The program is designed to support individuals through a structured process to quit smoking, with options for both up to six-week universal support program and a more intensive twelve-week specialist support for priority groups.

Service provision

Universal Support (Four to Six-Week Program):

- **Behavioural Support:** Service users requiring support to quit smoking will receive behavioural support from trained Stop Smoking Advisors. This support will be available via telephone, virtual sessions, or face-to-face meetings in community venues and will apply behavioural support and pharmacotherapy according to NICE guidance and the https://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf with flexibility to tailor quit plans to individual needs.

- Advisors will provide ongoing monitoring and follow-up using behavior change tools, motivational texts, and emails to encourage and support service users in their quit attempts.

- **Carbon Monoxide Validation:** Where possible, quit attempts will be validated through carbon monoxide (CO) testing.

- **Pharmacy Collaboration:** The service will establish service level agreements with pharmacists to deliver smoking cessation support in the community.

- **Relapse Management:** Service users who relapse after completing the six-week program may re-join the service or be referred to a Health and Wellbeing Coach for consideration of enhanced support based on their needs and motivation.

Specialist Support (Twelve-Week Program):

- **Target Groups:** Specialist support will be provided to priority groups, including:

    - Children and young people aged 12 and above.

    - Pregnant women, women who have recently given birth, and other household members who smoke.
    - Individuals with mental health conditions, including dementia and Alzheimer's.
    - Individuals with respiratory conditions, including asthma and COPD.
    - Vulnerable groups linked to PHE Disparities (e.g., those in social housing, frontline workers, homeless individuals, substance misusers, refugees, asylum seekers, routine and manual workers).

- **Targeting and Flexibility:** The targeting of groups will be guided by the latest data and adjusted annually in collaboration with the Public Health team.

- **Behavioural Support:** The service will deliver high-quality stop smoking interventions in line with NICE quality standards and guidelines, extending sessions over a longer period (typically twelve weeks) as preferred by the service user. Options for support include telephone, virtual, or face-to-face sessions, as well as texts and motivational emails.

- **Collaborative Pathways:** The provider will work with local organisations, community groups, and health providers to establish effective referral routes and support networks for these target groups.

- **Holistic Support:** Stop Smoking Specialists will collaborate with carers, health professionals, and social workers to provide comprehensive support tailored to the needs of these service users.

- **Relapse Management:** Service users who relapse after completing the twelve-week program may re-join the program following a review of their needs and motivation.

Training for front line staff:

- **Training on Very Brief Advice for Quit Smoking:** The service will train frontline staff, including health professionals, on delivering very brief advice for quit smoking and the process of making referrals to the service.

- **Training on Very Brief Advice for Quit Vaping for Young People:** The service will also provide training to frontline staff on delivering very brief advice for young people to quit vaping, along with the referral method to appropriate services

Community Awareness and Outreach

- **Public Awareness Campaigns:** The service will raise public awareness by maximising the benefit of national advertising and social marketing campaigns and delivering local campaigns, especially targeting groups in most need. The service will undertake outreach, information, and education sessions on the harms of tobacco in the

community, especially in areas with high prevalence of health inequalities. Participate in national marketing campaigns related to tobacco and smoking cessation.

- **Youth Vaping and Health Harms:** Address the increasing popularity of youth vaping and its potential health harms. Emphasise that vapes should only be used by adults as a quit aid and not by non-smokers, in line with the South East Position Statement on Vaping.

- **Shisha Use:** Contribute to tackling the high prevalence of shisha use among Slough residents by raising awareness about its dangers, including the risks of toxic substance exposure and long-term health consequences similar to cigarette smoking.

- **Workplaces:** Conduct workplace outreach to promote smoking cessation and support smoke-free environments.

- **Smokefree homes, cars, and buildings:** Deliver an evidence based Smokefree Homes and Cars campaign that informs smokers of the risks of second-hand smoke, recruits at least 50 participants per year to pledge not to smoke in their homes or cars, and offers follow-up support.

Appointments should be offered either face to face or remotely (e.g. Zoom, telephone call). Face to face or remote options should be offered equally to servicer users, ensuring that servicer users have a choice. Service users should be able to move between the two options, with the most common method used for reporting purposes.

Face to face appointments should be offered at a range of community locations across the County, at a range of different times including out of standard office hours. This should be developed in line with the servicer user's need.

Skills requirements

All staff delivering smoking cessation support will be appropriately trained in-line with the National Centre for Smoking Cessation Training (NCSCT) requirements, including specialist modules, and will be expected to complete an annual update to retain competency to deliver stop smoking interventions.

Staff must be able to:

- Treat the servicer user holistically whenever possible by offering an internal referral to other lifestyle services offered by The Service Provider e.g. weight management.

- Contribute to the broader tobacco control and prevention agenda by linking in with Public Health initiatives e.g. Tobacco Control Alliance, Trading Standards and stay on top of the latest emerging evidence and literature e.g. e-cigarettes, ASH.

- Keep the wider Healthy Lifestyle Service team updated of national campaigns in their specialist area e.g. Stoptober.

- Have knowledge on the dangers of illegal tobacco and encourage servicer users to report it. [42]

Stop smoking support will be provided universally to all those who live, work, study and/or are registered with a GP in Slough.

As part of a Population Health Management Approach and improving health inequalities, the service will triage and provide an appropriate level of intervention according to the individual's wider determinants and circumstances, where those who are more vulnerable and have a higher risk of health inequality will be provided intensive support.

Approach to working with vulnerable groups

Maternity groups

- Please see NICE guidance NG209, sections 1.18 - 1.20.

- The Service Provider will create an SLA with the local midwifery service to provide onsite stop smoking support for pregnant women and women who have recently given birth and other members of their household.

- In addition to NRT and behavioural support, the provider will offer voucher incentives to support women to stop smoking during pregnancy, aligned with the latest evidence in relation to the requirements for successful design of the offer, implementation, and evaluation. This will be in line with the Smoking in Pregnancy Challenge Group - Supporting smokefree pregnancies through incentive schemes.

- The Service Provider will consider providing voucher incentives jointly to the pregnant woman and to a friend or family member that she has chosen to support her during her quit attempt, aligned with the latest evidence in relation to the requirements for successful design of the offer, implementation, and evaluation. This will be in line with the Smoking in Pregnancy Challenge Group - Supporting smokefree pregnancies through incentive schemes.

- The Service Provider will consider providing voucher incentives jointly to the pregnant woman and to a friend or family member that she has chosen to support her during her quit attempt, aligned with the latest evidence in relation to the requirements for successful design of the offer, implementation, and evaluation.

Children and young people

[42] https://www.stop-illegal-tobacco.co.uk/share-information

- Please see NICE guidance NG209, sections 1.4-1.7. Please note the guidance document covers support to stop smoking for everyone aged 12 years old and over.

- For young people accessing the service who are in care, the carer will also attend sessions. Stop Smoking Specialists will support both the service user and carer, giving advice and guidance to quit smoking and on the supply and use of NRT.

- The service will make and maintain a close working relationship with all local secondary schools, pupil referral units and youth services and ensure that there is a clear referral pathway for young people to access smoking cessation support.

Secondary care

- Please see NICE guidance NG209, section 1.14

- The Service Provider will support delivery of NHS-funded tobacco dependence treatment services (maternity, mental health, and acute inpatient services) in line with the NHS Long Term Plan commitments.

- The service will be required to develop strong partnerships and joint working with inpatient and outpatient services at local hospitals that serve Slough residents and help support staff with training (see Section 5.2.4 Quality assurance and training).

- Health professionals from these settings will be regularly trained to refer into the service.
- The Service Provider will create a pathway for referral and ongoing support for those discharged from hospital.

Pharmacotherapies

- Pharmacotherapy is the provision of pharmaceutical products, medicines, or medicaments. The only types of stop smoking medications currently approved by NICE are: Nicotine Replacement Therapy (NRT), Bupropion (Zyban) and Varenicline (Champix) and nicotine containing e-cigarettes (or vapes). Bupropion (Zyban) and Varenicline (Champix) are contraindicated in pregnancy or those under the age of 18.

- Stop Smoking Advisors will discuss with service users which options to use to stop smoking, considering: their preferences, health, and social circumstances. Any medicines they are taking. Any contraindications and the potential for adverse effects. Their previous experience of stop-smoking aids.

- The Service Provider will have full responsibility for managing the full prescribing budget for smoking cessation which is included within the financial envelope for this contract. The Service Provider will monitor and be accountable for prescribing practice

for Stop Smoking Support.

- All servicer users must be offered the choice of using pharmacotherapy and all pharmacotherapy choices must be available as equal first-line options. Pharmacotherapy support should only be provided alongside motivational and behavioural support and for servicer users who have set a quit date. NRT will be offered free to those who are eligible for free prescriptions.

- The Service Provider will offer NRT for 12 weeks, or as long as needed to help prevent a relapse to smoking. The providers will offer medicinally licensed nicotine-containing products on a long-term basis to help people maintain a lower level of smoking.

- The service user should not be given more pharmacotherapy two weeks past their quit date if they have continued to smoke. Where a servicer user relapses during a quit attempt (and does not wish to begin a new treatment episode), no further pharmacotherapy will be provided until such time as the servicer user is motivated to make another quit attempt.

- All pharmacotherapies will remain available for at least the duration recommended by national guidance (e.g. NICE) and the drug summary of product characteristics. Any new licenced stop smoking medicine that becomes available will need to be assessed and approved by The Commissioner before The Service Provider is able to use this within the smoking cessation offer.

- Quantities prescribed will be in line with national recommendations and the manufactures instructions. Records of pharmacotherapy treatment per servicer user must be kept on servicer users' electronic notes including detail of product prescribed, quantity and duration.

- The Service Provider must follow appropriate guidance when prescribing more than one type of pharmacotherapy such as combination NRT e.g., nicotine patches and another form of NRT (such as gum, inhalator, lozenge, or nasal spray). This should be considered for people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past. No more than two types of pharmacotherapies must be prescribed per servicer user.

- Pharmacotherapies will be available for more than one treatment episode (for example, a servicer user using Varenicline who relapses during a quit attempt will, providing they are committed to attempt to stop again, be able to begin a new course of Varenicline if this is assessed to be the most appropriate medicine for that servicer user) in line with NICE Guidance and the drug summary of product characteristics.

- Any prescribing protocols should be agreed by clinical and pharmacy leads and should be approved by the Authority (e.g., any Patient Group Directions (PGD)). Where clinically appropriate the Service Provider will provide a direct supply of General Sales List (GSL) NRT using a direct supply protocol as the preferred model.

- All service users should be made aware of potential side effects of pharmacological products and any adverse reactions will be reported using the yellow card scheme If the servicer user wishes to use prescribed drugs such as Varenicline or Bupropion it should be provided in line with NICE Guidance and their GP should be informed.

- Follow up consultations should be agreed with the servicer user to include smoking status validation using a CO test. Further supply of treatment could be made at these consultations using the direct supply protocol, up to a maximum of 8 weeks supply for NRT and 12 weeks for Varenicline.

E-Cigarettes

- E-cigarettes provided or recommended by the service will follow the NCSCT OHID guidance on Incorporating e-cigarettes into your Stop Smoking Service: Making the case and addressing concerns (2021).

- The service will maintain regular contact with local approved retailers who sell e-cigarettes in order to promote evidence-based smoking cessation and ensure people who switch from tobacco are counted as quitters if they successfully stop smoking.

- Support will be provided to service users who are not eligible for free e-cigarettes but choose to quit using e-cigarette products. Advice provided will be in line with NICE guidance NG209, sections 1.12.13 - 1.12.17. Advice will be provided about where to buy e-cigarettes to ensure they are safe (and education provided on the dangers of illicit e-cigarettes).

- Given that the landscape around e-cigarettes is evolving The Provider will need to adapt and develop new policies and make changes to services, as agreed with The Commissioner, when new clinical evidence and guidance is acknowledged and introduced.

- The services should be marketed as 'e-cigarette friendly'.

- The Service Provider is not permitted to work with e-cigarette shops or vendors that have investments in the Tobacco Industry as per Article 5.

Carbon monoxide testing

- The Service Provider will source and maintain stock levels of Carbon Monoxide Monitors and associated equipment. The cost of consumables must be met within the contract value.

Partnership working

- The Service Provider will act as the system leader for smoking and tobacco cessation services throughout Slough and will act as a source of expertise, help and guidance to all providers of cessation services in primary care, acute care and the voluntary sector.

- The service will also be required to work in partnership with local services in Slough, including substance misuse services, youth services, schools, pharmacies, LGBT groups/services, VCSE sector, community services and other relevant services; developing robust referral pathways for smoking cessation support.

- The Service Provider will support the work undertaken by the Slough Tobacco Control Network.

- The service will be required to work closely with the SBC Community Enforcement & Regulatory Services team to find opportunities for promoting tobacco cessation support through their enforcement work.

- The service will be a key partner to the Targeted Lung Health Checks and the COPD Hublets as well as other services linked to tobacco and smoking to ensure referral pathways are developed and maintained.

Quality assurance and training

- All stop smoking advisors will be Level 2 trained in smoking cessation with the National Centre for Smoking Cessation Training (NCSCT). Specialist advisors will be Level 3 trained and complete the specialist modules for pregnancy and mental health.

- Service Provider and advisors will attend NCST update webinars, ASH webinars, and other refresher courses to stay up to date with the latest guidance.

- Service Provider and advisors will attend any local or national tobacco cessation meetings, for example the Slough Tobacco Control Network, in order to learn from examples of best practice from other localities.

- The service will provide access to training for all Level 2 stop smoking advisors across the borough. Where appropriately trained staff are available, the service can provide in-house Level 2 and Level 3 training.

- The service will offer and provide Level 1 and Level 2 stop smoking training to staff in pharmacies, housing, midwifery, health visiting, inpatient and outpatient staff at local

hospitals, substance misuse staff, teachers, and any other relevant staff in primary care, acute care, or the voluntary sector.

- The service will ensure that maternity staff are appropriately trained to promote and deliver incentive schemes to pregnant women to stop smoking.

- The Service Provider will undertake campaigns, outreach and awareness raising in the community, working together with other partners such as Community Solutions, social prescribers, and VCSE organisations on the harms of tobacco and smoking.

Data and follow up

- The service will use the NCSCT recommended service user recording template, which includes socioeconomic status. All data must be stored on a secure system in accordance with the Data Protection Act 1998.

- The service will undertake the required national monitoring and reporting to NHS Digital (see here for information and guidance).

Applicable service standards (including but not limited to)

- NG209 Tobacco: preventing uptake, promoting quitting and treating dependence
- QS43 Smoking: supporting people to stop
- QS92 Smoking: harm reduction
- QS82 Smoking: reducing and preventing tobacco use
- TA123 Varenicline for smoking cessation
- NCSCT/PHE. Local Stop Smoking Services: services and delivery guidance (2014)
- NCSCT Training Standard: Learning Outcomes for Training Stop Smoking Practitioners (2018)
- NCSCT. Competences required for delivering a Standard Treatment Programme (2012)
- NCSCT/OHID. Incorporating e-cigarettes into your Stop Smoking Service: Making the case and addressing concerns (2021)

4.3.6.1 Digital smoking cessation application

The digital app-based smoking cessation support is designed to provide accessible and flexible assistance for residents who prefer to manage their quit attempts independently. This app will offer comprehensive resources and tools to help residents quit smoking while integrating seamlessly with the broader smoking cessation service. The app will also serve as a gateway to further support, encouraging users to undergo a triage assessment to review their needs and enhance their quit journey.

Digital Service Description: App Features

1. **Educational Resources:**
    - Provide information on the health risks associated with smoking and the benefits of quitting.
    - Include evidence-based guidelines and tips for quitting smoking.
2. **Personalised Quit Plans:**
    - Allow users to create and customise their quit plans based on individual preferences and needs.
    - Set quit dates, track progress, and identify triggers and coping strategies.
3. **Behavioral Support Tools:**
    - Offer behavior change techniques and motivational content, including daily tips and encouraging messages.
    - Include interactive features such as goal setting, progress tracking, and self-monitoring tools.
4. **Pharmacotherapy Guidance:**
    - Provide information on nicotine replacement therapy (NRT) and other pharmacotherapy options.
    - Signpost to local pharmacies where NRT can be purchased or accessed through prescriptions.
5. **Community and Peer Support:**
    - Facilitate peer support through online forums and chat groups where users can share experiences and advice.
    - Include features for connecting with local support groups and community resources.
6. **Continuous Engagement:**
    - Send regular motivational texts, emails, and push notifications to keep users engaged and motivated.
    - Encourage ongoing interaction with the app to support sustained behavior change.

Integration with Triage and Community Clinics

- **Triage Offer and Needs Review:**
    - All residents accessing the app will receive information encouraging them to take up the triage offer and undergo a needs review. This will help tailor support to their specific requirements and enhance their likelihood of success in quitting smoking.
    - Users will be informed about the benefits of a comprehensive assessment and the additional support available through the service.

- **Option to Decline Triage:**
    - Residents can choose not to attend the triage assessment and continue receiving appropriate support via the app.
    - The app will still provide robust support, ensuring those who prefer independent management are well-equipped to quit smoking.

- **CO Verification Encouragement:**

- The app will encourage users to visit any community clinic for carbon monoxide (CO) verified quit validation.
- Information about the locations and schedules of community clinics will be readily accessible within the app, promoting easy access for users.

Referral pathways

- Smokers in Slough will be able to self-refer or be referred by either a healthcare professional or other stakeholder, where servicer user consent to do so is requested.

- The Service Provider should develop strong relationships with different stakeholders across Slough to ensure that referrals for smoking cessation support are made e.g. GP Practices. Outcomes of the smoking cessation programme should be reported back to the GP, with the servicer user's consent.

- The Service Provider should recruit servicer users through both opportunistic events and booked appointments.

- The Service Provider will work with the local NHS Trusts that are delivering the Long-Term Plan (LTP) Tobacco Dependency treatment services. The Service Provider will ensure that clear and easy pathways are in place for patients that are discharged from NHS Trusts so that they can continue their stop smoking journey in the community. The Provider is expected to share individual patient quit outcomes back with the NHS Trust as required to help the NHS Trusts fulfil their data reporting requirements (e.g. via a data sharing agreement).

Key performance indicators for Smoking Cessation offer

*Please note these KPIs are indicative and can be changed according to the service needs latest data to align with SBC's Population Health Management Approach.

KPI	Measure	Annual Target	Reporting frequency
Smokefree homes, cars, and buildings	Total number of participants having smokefree homes, smoke free cars and smoke free buildings	50	Quarterly
Children and Young People prevention programme	Total number of children and young people reached through the Children and Young People prevention programme	1000	Quarterly

Workplaces	Total number of workplaces updating their healthy workplace and smokefree policy	10	Quarterly
Quit dates and quit rate	Total number setting a quit date	1500	Quarterly
	Total number of 4-week quitters	750	Quarterly
Number of 4-week quitters	a. From most deprived groups, IMD postcodes 1-4	50%	Quarterly
	b. BME in polish	40%	Quarterly
	c. Routine and manual	40%	Quarterly
Number of 12-week quitters	a. Those with respiratory conditions, including asthma and COPD,	5%	Quarterly
	b. Pregnant women stopping by time of delivery	5%	Quarterly
	c. With a mental health condition	5%	Quarterly
	d. From Children and Young people aged 12 and above, women who have recently given birth and other people who smoke in their household,	5%	Quarterly
	e. Other vulnerable groups – linked to PHE Disparities (social housing, frontline workers, homelessness, substance misuse, refuge, and asylum seekers)	5%	Quarterly
CO- Validation	Carbon monoxide validated quits	85%	Quarterly
Evaluation	Undertake evaluation and insight of the service with service users, stakeholders, and health professionals to inform service improvement	Continuous	Quarterly

Key performance indicators (KPIs) for digital smoking cessation offer

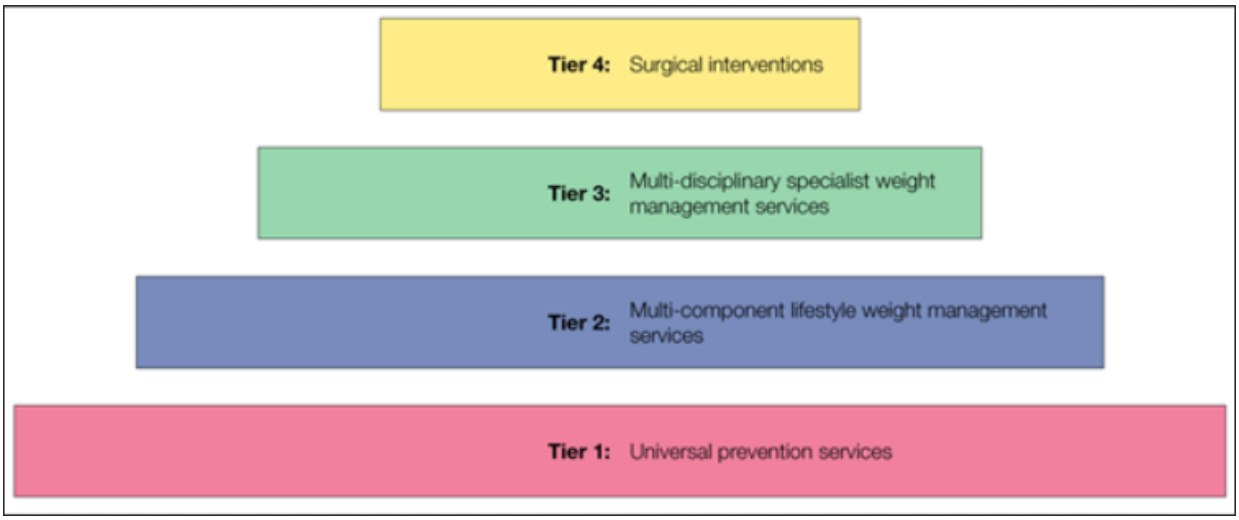
Key Performance Indicator	Annual Target
Number setting a quit date	400
Number of 4-week quitters	200

4.3.7 Adult Weight Management Service

Service description

To deliver an accessible digital and/or face to face tier 2 adult weight management service, which supports overweight and obese adults aged 16 and over to lose weight and learn how to maintain a healthier weight.

The weight management offer needs to interface with existing clinical weight management services at tier 3 and tier 4 which are commissioned separately and are available to support those with greater clinical needs. See below diagram for explanation of the different tiers.



This service must also be suitable for 13–15-year-olds to attend. Parental guidance should be sought, and a parent would be expected to attend alongside the teenager.

Model of delivery

In line with NICE PH53 guidance,[43] the tier 2 adult weight management programme must be developed/designed by a multidisciplinary team. This includes input from a registered dietician, registered behaviour change expert, and qualified physical activity specialist. The service must be multi-component, addressing dietary intake, physical activity levels and

[43] https://www.nice.org.uk/guidance/ph53

behaviour change.

- Programmes should last for at least 12 weeks, and there should be a focus on long-term sustainability of outcomes running through the programme from the outset. Sessions should be offered at least weekly and include a 'weigh-in' at each session. The service must be flexible and offer a variety of elements; from one-to-one, online, hybrid and face-to-face sessions, with additional follow-up support for those who may require it, such as additional support, signposting, and referral to other relevant services.

- The service must aim to support service users to achieve a healthy balanced diet as represented through the Eatwell Guide. As part of this, the service will also support service users to reduce their consumption of foods and drinks high in fat, sugar, and salt

- The service will support service users to achieve the England CMO's physical activity recommendations and a reduction in sedentary behaviour. The service must be designed to enable individuals to lose weight safely. To achieve this, individuals need to reduce their calorie intake to support weight loss at a safe rate of 0.5kg- 1kg each week. Please refer to Public Health England guide to delivering Tier 2 Adult Weight Management Services.[44]

- The Service Provider could consider rolling programmes that allow participants to start at different points and cover the same material but not necessarily in the same order.

- The service will recognise the wider determinants of health in taking part in a weight management programme such as housing, income, and cost of living and therefore will work in partnership with services such as Family Hubs, community solutions, social prescribing and community development teams to support the wider issues for Slough residents.

- Dietary approaches within the weight management service should follow government guidelines on healthy eating as shown in the Eatwell Guide. Where appropriate, The Service Provider will be expected to tailor the dietary component of the service to the cultural needs of the local population.4541

- The service should aim to reduce sedentary behaviour and increase physical activity, supporting individuals to meet physical activity guidelines.

- A variety of face-to-face programmes are to be widely available throughout

[44]Public Health England – Guide to delivering and commissioning Tier 2 AWM services
[45] NHS Eatwell Guide

community-based locations which are accessible and in convenient locations in Slough. Services should be delivered at a range of venues and times to ensure convenience of access to all servicer users. These should be reviewed regularly following user feedback surveys. Services should appeal to different demographics and delivered in locations where there is higher prevalence of obesity, and other associated outcomes.

- All servicer users will have their BMI, and other appropriate anthropometric measurements (e.g., waist circumference when BMI <35), measured at baseline, on programme completion, and at follow up appointments at 6 and 12 months.

- The service must use validated tools when collecting data on lifestyle behaviors such as diet and physical activity on individuals and the service. These tools must be agreed with the Authority prior to commencement of the service. The service will consider individual-level factors such as the person's age, cultural background, and any disabilities they have. The service should not exclude, and should make reasonable adjustments for, individuals with physical or learning disabilities and for individuals with mental ill health.

- Programmes may be delivered by the Service Provider and or through subcontracting with providers who are recognised as providing an effective service, as per the NICE guidance.

- To ensure that the service causes no harm (for example through stigma), The Service Provider will ensure that all equipment and facilities used meet the needs of most adults who are overweight or obese and will respect servicer user's privacy (for example at a weigh-in).

The service will ensure the following core components, developed with input of a multidisciplinary team include:

- Behaviour-change techniques to increase motivation and confidence in the ability to change. This includes strategies to help the individual identify how changes can be implemented and sustained at home.

- Supporting the adult to make sustainable healthier lifestyle decisions with an emphasis on the importance to eat healthily and to be physically active, regardless of their weight.

- A tailored plan to meet individual needs, appropriate to the individual's gender, ethnicity, cultural background, economic and family circumstances, stage of change,

any special needs and how obese or overweight they are. This will include helping them to set goals, monitor progress against them and provide feedback as well as signposting to wider support.

- Information and help to master skills in, for example, how to interpret nutritional labelling and how to modify culturally appropriate recipes on a budget.

- Help to identify opportunities to become less sedentary and to build physical activity into their daily life (for example, by walking or cycling and moving more).

- A range of physical activities that adults can enjoy and that can help them gradually become more active.

Follow up and maintenance

- The programme will be expected to provide a clear, seamless and effective exit strategy from the service so that individuals feel supported to continue making changes to their lifestyle.

- The service will complete a formal maintenance plan for servicer users on completion of the course. This will outline how the servicer user intends to maintain the benefits they have experienced from the tier 2 service. This maintenance plan document will be reviewed with the servicer user at their follow up appointments (6 and 12 months).

- The achievement of long-term success/challenges should be regularly audited against the details in the maintenance plan, to identify themes in those plans that have been successfully implemented, and those that have not.

Inclusion Criteria

- Aged 16 years or over, however the service should be able to accommodate 13 to 16-year-olds with parental agreement.

- Individuals with a BMI* ≥30 or ≥22.5 for black and minority ethnic groups

- Individuals with a BMI ≥28 AND with a co-morbidity that is adversely affected by their weight. Co-morbidities include:
    - Type 2 diabetes;
    - Hypertension;
    - Cardiovascular disease;
    - Osteo arthritis;
    - Dyslipidaemia;
    - COPD; and

- Sleep apnoea

- Not been referred to a weight management service by health professional in the last 6 months

*Capacity for Adult Weight Management will be reviewed on an ongoing basis during quarterly monitoring meetings during the contract. If there is capacity, BMI will reduce to >28 (>22 for black and minority ethnic groups and those with a co-morbidity) in order for service to support overweight people in accordance with NICE recommendations.

Exclusion criteria

Individuals not complying with the criteria will not be eligible to access the service but can access alternative provision through the dietetic service, their GP as appropriate.
Furthermore, the following individuals should be excluded:

- Have an eating disorder
- Are pregnant
- Have an underlying medical cause for obesity and would benefit from more intensive clinical management than a tier 2 service
- Have significant co-morbidity or complex needs as identified by their GP or other healthcare professionals

Service Adaptability and Priority Groups

Services will be adaptable so that they can be tailored and delivered to targeted population groups with the specific aim to reduce health inequalities. Such groups include:

- People from more socioeconomically deprived backgrounds.
- People who may have higher risk of developing long-term conditions such as diabetes and cardiovascular disease.
- People from underrepresented communities.
- Women only.
- Men only.
- Women who have given birth $\geq$ 6 months to two years prior.
- People living with physical and learning disabilities.

Skills requirement for staff

- Staff delivering the tier 2 programme must be adequately trained to do so and they must receive regular professional development sessions to ensure that current best practice is always adhered to. This should include a qualified nutritionist to provide

servicer users with tailored support and guidance.

- Any supervised physical activity sessions must be led by an appropriately qualified physical activity instructor and take into account any medical conditions people may have. Instructors should be on Chartered Institute of Sport and Physical Activity (CIMSPA) (or equivalent) at level 3 or above.

- All staff will be expected to provide a sensitive approach so that individuals accessing the service feel that they are in a safe space and facilitators must offer a non-judgemental, empathetic and non-threatening environment.

- All staff will be expected to have a thorough knowledge and understanding of other services in the community that offer additional support for lifestyle changes, in order to improve weight loss maintenance outcomes. This knowledge will facilitate discussion to occur between the staff members and the servicer users throughout their journey to provide a consistent focus of how to sustain improvements in the long-term.

Referral Pathways

- Referrals will be received from primary care, professional referrals, self-referral, or from other parts of the integrated service.

- Individuals should be given the opportunity for a re-referral after 6 months as necessary, with the understanding that weight management can be a long-term and complex process. Use clinical judgement, considering the person's circumstances, previous experiences of weight management and commitment to change.

- Work within agreed service pathways and ensure service users are appropriately linked to NHS Tier 3 or Tier 4 services in the borough.

- Develop a cross-referral pathway for stopping smoking, healthy eating, MECC+, physical activity and health and wellbeing coaching from the new integrated health and wellbeing service.

Partnership Working

- The provider will work in partnership with SBC healthy weight steering group by providing expertise, help and guidance to all stakeholders in primary care, acute care, and the voluntary sector.

- The service will also be required to work in partnership with local services in Slough, including substance misuse service, youth services, schools, community solutions, social prescribers, pharmacies, LGBT groups/services, VCSE sector, community

services and other relevant services; developing robust referral pathways for weight management support and referring residents into support services where needed.

- The provider will be informed of wider factor support offers including social, financial and employment support.

- The provider will be part of the Whole Systems Approach to Healthy Weight and support the work undertaken by the borough in promoting healthy weight initiatives.

Quality assurance

- The service provider will ensure that the service causes no harm and includes appropriate expertise when designing a weight management service. This may include some of the following experts; a registered nutritionist, dietician, behaviour change expert, physical activity specialist and psychologist.

Data and follow up

- Data will be collected for each service user at the following time points:

- At week 0, as participants start the active intervention.

- At the end of the active intervention (usually week 12 but can vary), or at the last week of attendance for participants who do not complete the active intervention.

- The service will follow up service users at 26 weeks, 6 months and 1 year.

- Please refer to Section 3.3.8 for other data and follow up requirements.

Applicable service standards

The Service Provider will deliver weight management services that are evidence-based and in line with relevant clinical guidance and other national publications, in particular:

- NICE Clinical Guideline 189 Obesity: identification, assessment, and management https://www.nice.org.uk/guidance/cg189
- NICE NG 7 Preventing excess weight gain https://www.nice.org.uk/guidance/ng7
- NICE PH 11 Maternal and child nutrition (2014) https://www.nice.org.uk/guidance/ph11
- NICE PH 42 Obesity: working with local communities (2012) https://www.nice.org.uk/guidance/ph42
- NICE PH 49 Behaviour change: individual approaches (2014) https://www.nice.org.uk/Guidance/PH49

- NICE PH 53 Managing overweight and obesity in adults – lifestyle weight management services (2014) https://www.nice.org.uk/guidance/ph53
- Obesity in adults: prevention and lifestyle weight management programmes (2016) QS111 https://www.nice.org.uk/guidance/qs111/chapter/about-this-quality-standard
- Government dietary guidelines are visually illustrated through the Eatwell Guide (2016): https://www.nhs.uk/live-well/eat-well/the-eatwell-guide/
- England Chief Medical Officer's (CMO) physical activity recommendations guidelines: https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical- officers-report

Additional resource documents

- The NHS Weight Loss Plan https://www.nhs.uk/live-well/healthy-weight/start-the-nhs- weight-loss-plan/
- Adult weight management: key performance indicators https://www.gov.uk/government/publications/adult-weight-management-key-performance- indicators
- Changing Behaviour: Techniques for Adult tier 2 behavioural weight management services: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_ data/file/738214/adult_weight_management_changing_behaviour_techniques.pdf
- PH53 Weight management: lifestyle services for overweight or obese adults
- PH47 Weight management: lifestyle services for overweight or obese children and young people
- QS94 Obesity in children and young people: prevention and lifestyle weight management programmes
- PHE/NICE. A Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services (2017)

Key performance indicators

1. 100% of participants enrolled in the service meet, as a baseline, the eligibility criteria as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services

2. A minimum of 3500 eligible adults are provided a Tier 2 service annually

3. 60% of participants complete the active intervention (where completion is attendance of at least 75% of all sessions during the active intervention. It is recommended that commissioners or service providers do not stipulate that specific sessions must be attended to allow for periods of sickness, holidays, clashes with commitments etc. to occur at any point during the active intervention

4. At least 50% of individuals enrolled in the service are from identified high risk groups including areas of high deprivation, Black and Minority Ethnic communities, individuals with disabilities, individuals with mental health conditions.

5. 75% of participants will have lost weight at the end of the active intervention
    a. 30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention
    b. 50% of completers will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention
    c. 35% of completers provide a weight measure at 6 months
    d. 35% of completers provide a weight measure at 6 months
    e. 20% of completers provide a weight measure at 12 months

4.3.8 Falls Prevention

Service description

The Falls Prevention Service, a crucial component of the Integrated Health and Wellbeing Service (IHWS) in Slough, will aim to mitigate the risk of falls among residents, primarily targeting those aged 60 and above. This service will enhance the safety, independence, and overall well-being of older people through comprehensive assessments, tailored interventions, and community-based support.

The Falls Prevention Service will include a comprehensive assessment process. The provider will undertake a multifactorial falls risk assessment according to the NICE guidance and evaluate the individual's confidence in preventing falls and identify potential risk factors through the Falls Self-Confidence Test and Basic Questionnaire Assessment. Additionally, a Footwear and Foot Care Assessment will assess physical contributors to falls. The provider will use the Quantitative Timed Up and Go (QTUG) Test to determine the individual's risk level and guide the appropriate care pathway. A Home Risk Assessment will identify environmental hazards in the home that may increase the risk of falls. Based on the assessed risk level (low, medium, or high), the provider will direct service users to suitable interventions tailored to their needs.

Public health is in the process of developing a falls prevention needs assessment aiming to better understand the burden of falls and fractures to our older adults (65+), and promote healthier behaviours across our most vulnerable communities locally. The objectives of this work are to (i) provide an overview of the epidemiology of falls in Slough, (ii) review the evidence and recommendations for effective management of falls and quality care services (iii) identify current service provision, and (iv) identify any gaps in current service while propose actions for local planning and strategy formulation.

This needs assessment will also assess the current falls pathway locally and the value of using the electronic frailty index (eFI) collected by our GP practices as an additional tool to identify individuals that are at risk of frailty that will complement the QTUG test use by our provider in the future.

Community Based Support and Well Balance Classes

The Falls Prevention Service will offer a holistic package of community-based support measures to enhance physical health and social well-being:

- **Core Strength and Balance Classes:** Utilising the OTAGO exercise programme, these classes will be designed for individuals assessed as low to medium risk. Conducted over a 12-week period in local community centres, the classes will focus on improving core strength, balance, and overall physical fitness.

- **Specialised Referrals:** For individuals at higher risk, the provider will offer referrals to specialised care, such as falls clinics, vision and hearing assessments, and medication reviews.

- **Social Isolation Interventions:** To address the impact of social isolation, the Service Provider will include befriending services and other social support mechanisms.

- **Home-Based Support:** For those unable to attend community sessions, the provider will offer home visits and chair-based exercises to ensure continued access to strength and balance training.

- **Dementia Awareness and Signposting:** The provider will increase awareness of dementia and its impact on falls risk. This will include training staff to recognize signs of dementia and providing information to service users and their families. The provider will also establish strong referral pathways to dementia services, such as memory clinics and support groups, to ensure comprehensive care.

Referral Pathway and Inclusion Criteria
Referrals to the Falls Prevention Service will be via multiple sources including outreach engagement and referrals to the IHWS via other sources. However, effort will be made to explore more opportunities for referrals to external services. This includes (but is not limited to):

Enhancing Digital Referrals: Developing and promoting online or digital platform referrals to facilitate easier access to the service, considering the increasing reliance on digital means for accessing health services.

- **Strengthening GP and Hospital Collaboration:** Strengthening relationships with GPs and hospitals to improve the number of referrals and engagement with the programme, given the relatively higher conversion rates from these sources.

- **Broadening Outreach to Other Sources:** Actively engaging with schools, drug services, CVS, and midwives/health visitors to diversify referral sources and reach more of the target population.

The service will be inclusive, catering to individuals aged 60 and above without specific exclusion criteria.

Key Performance Indicators for Falls Prevention Service

KPI	Measure	Target Number	Reporting Frequency
Falls Assessment	Number of falls assessments completed	800	Quarterly
Risk Identification	Number of people identified through the assessment as Low risk		Quarterly
	Number of people identified through the assessment as Medium risk		Quarterly
	Number of people identified through the assessment as High risk		Quarterly
Service Offering and Uptake	Number of individuals over 60+ offered the Falls Prevention service		Quarterly
	Number of service users starting the Well-Balance class		Quarterly
	Number of service users completing the Well-Balance class		Quarterly
Outcome and Impact	Percentage of completers with improved wellbeing scores	100%	Quarterly
Referrals and Signposting	Number of people referred to community physical activity programme		Quarterly
	Number of people signposted to organisations memory clinic		Quarterly

Outcome measures

The Falls Prevention Service will aim to achieve the following outcomes (including but not limited to):

- **Enhanced Independence:** By improving physical fitness and confidence, participants will be better able to maintain their independence.
- **Reduced Hospital Admissions:** Effective falls prevention will reduce the incidence of fall-related hospital admissions.
- **Improved Mental Health:** Participation in social and physical activities will contribute to better mental health and reduced feelings of isolation.

4.3.9 Enhanced IBA Alcohol offer

Service description

This element of the service will identify and provide support to those individuals whose alcohol consumption may be putting their health at risk, who want support to reduce their alcohol consumption, and make broader changes to their lifestyle. As part of the assessment process, both digital and phone, the service will offer servicer users the AUDIT tool to identify their score. Anyone with an AUDIT score of 8-15 will be offered Identification and Brief Advice (IBA). They will then be offered the Enhanced Brief Intervention Service. This offer will be available digitally or by telephone support with a member of staff.

Model of delivery

To deliver up to four Enhanced Brief Interventions, using behaviour change techniques and motivational interviewing principles, to adults in Slough whose AUDIT score indicates hazardous or harmful alcohol consumption (see chart below). The Service will assess readiness to change their behaviour and offer enhanced brief interventions to support servicer users to reduce alcohol consumption, including but must not be limited to, a drinking calculator, self-completing drinking diary and a written self-help pack, including a summary of the servicer user's goals and an action plan will be either printed and sent or emailed to the servicer user.

Additional interventions must include the recording of current drinking levels, delivery of evidence based brief advice and information, and recording of drinking levels over time, e.g. 6 months. The follow up method needs to be agreed between the Service Provider and the servicer user.

To develop innovative mechanisms to reach and support people to reduce their drinking to be within UK Chief Medical Officer low risk drinking guidelines.

4.3.9.1 Digital Enhanced IBA Alcohol Offer

The Service Provider will also offer an online Alcohol Identification and Brief Advice service in consultation with the Commissioners. The online tool should include the following:

- A useable, attractive interface that will encourage residents to use the tool
- A drinking assessment based on the validated AUDIT tool
- A drink tracker that builds a picture of individual drinking over time to highlight unhelpful patterns and motivate a change based on their AUDIT score

- Goal setting and sharing to encourage users to use the tool to reduce their alcohol consumption and undertake behaviour change

- Articles and information on the health harms of alcohol misuse

- Data reporting on drinking behaviour, usage levels, changes in alcohol consumption and the demographic profile of users of the tool

- Google analytics of web traffic data

Inclusion Criteria

- Adults aged 18 and above with an audit score of 8-15

Exclusion Criteria

- Adults with an audit score of 0-7

- Adults with an audit score of 16+

- People aged 17 or under should be referred to the young people's substance misuse service.

Audit Score	Category	Service Provider	Service Offered
0-7	Low risk consumption	Healthy Lifestyle Service	Signpost to digital resources if appropriate
8-15	Hazardous or harmful alcohol consumption	Healthy Lifestyle Service	IBA and offer Enhanced IBA either: • Telephone • Digital
16-19	Possible alcohol dependence	Drug and Alcohol Specialist Treatment Service	Tier 2 in line with DOH Model of Care for Alcohol Misusers
20+	Possible alcohol dependence	Drug and Alcohol Specialist Treatment Service	Tier 3 and where appropriate Tier 4 access to rehab/detox -depending on SADQ

Skills Requirement

All staff offering enhanced IBA will complete the service's behavioural change training. They are also required to have the additional training, knowledge, and experience for them to engage and work with this group. They must be able to identify alcohol related harm and be able to deliver evidence-based brief and enhanced interventions. Staff will keep the lifestyle service updated of national campaigns in their specialist area.

Referral pathways

Referrals can be accepted as self-referrals or from a professional. The Service Provider will forge close links with the specialist drug and alcohol treatment service and have recognition that individual alcohol risk levels fluctuate and as such, a servicer user may need to be referred on to specialist support from the treatment provider.

All young people (under 18 years old) should be referred to the young people's drug and alcohol treatment specialist service regardless of risk score.

4.3.10 Community Physical Activity

Service Provision

The community physical activity service will provide both universal and targeted physical activity programmes for those who live, work, study and/or are registered with a GP in Slough.

- The community physical activity offer will:
    - Support people to make incremental and sustainable increases in their physical activity levels, moving them closer to the Chief Medical Officer guidelines.
    - Promote parks and open spaces as places to be active for people and their families.
    - Create effective partnerships with relevant organisations delivering sport and physical activity in the borough to enhance the offer for physical activity.
    - Increase access to sport and physical activity opportunities in the borough.
    - Increase the number of people in the borough who volunteer in roles that promote physical activity and sport.
    - Seek additional external funding to support the delivery of projects e.g., Sport England Get Healthy Get Active.
    - Service users will receive motivational texts and emails to encourage them to continue to be active in the community.

The service will recognise the need to provide community wide opportunities and affordable access to physical activity and sport in the borough. The service will be adaptable and tailored to the local population, considering the diverse cultures and languages spoken in the borough. An essential part of this will be coproduction with the local communities. Within the

duration of the contract the provider will use the Population Health Management approach and work with the commissioners to agree the priority population(s) to be targeted each year ensuring access to physical activity is available to the following, including (but not limited to):

- Residents with activity levels below 150 minutes a week.
- Those from diverse cultural and ethnic backgrounds who are underrepresented and may not access conventional physical activity programmes.
- Those with higher risk of developing long term conditions such as Type 2 diabetes, cardiovascular disease, dementia, and falls.
- Those with excess weight (BMI>30 or >22.5 for Black Asian populations).
- Those with higher risk of developing long term conditions such as Type 2 diabetes, cardiovascular disease, and falls
- Those from LGBQT+ communities
- Those with physical or learning disabilities
- Those from more deprived neighbourhoods
- Shift workers
- Those with behavioural risk factors such as overweight/obesity and sedentary lives
- Those with physical or learning disabilities.

The provider will work collaboratively with get Berkshire active, leisure services in Slough, and any other stakeholder in taking a whole systems approach to addressing physical inactivity. The provider will act as a lead to increase physical activity opportunities in the borough by promoting and signposting accordingly through various channels such as digital platform, stakeholder meetings, resident groups, community champions, business support groups and newsletters. The provider will contribute to the borough's vision on improving the health outcomes of residents in the borough through physical activity.

In agreement with the commissioners, the provider will be allowed to charge a minimal cost to offer the programme universally programme but would ensure that programme will be provided free for individuals who successfully complete the Tier 2 weight management programme and 12-week exercise on referral programme offered by Everyone Active

The provider is expected to deliver a programme of community physical activities at venues such as housing estates, indoor and outdoor community spaces, Health Centres, and libraries,

providing Health Walks, aerobics, yoga and Pilates, chair-based exercise classes and various family/child-parent activities. Activities will be coproduced with communities.

In recognition of the existing and growing demand for community-led physical activity, the provider is expected to work in partnership with other physical activity providers and VCSE groups. The provider will support these groups to deliver physical activity sessions to reach vulnerable communities through governance, qualified instructor support, and seed funding. Additionally, the provider will assist these groups in continuing sessions if there is ongoing demand in the community and will support them in bidding for other funding opportunities.

Activities will be delivered in-person at variety of venues and where appropriate have a virtual offer. The service will be offered at times suitable for service users including evenings and weekends.

Referrals for physical activity

The Service Provider will:

- Accept referrals from the new integrated health and wellbeing service, all healthcare professionals, service users who have completed the exercise on referral programme and relevant stakeholders for the community physical activity element.
- Accept self-referrals.
- Develop a referral pathway for entry and exit and ensure long- term physical activity behaviour change has been embedded.
- Develop a cross-referral pathway for stop smoking, healthy eating, weight management and other T2 services from the new integrated lifestyle service.

Partnership working

- The service will be required to work with local General Practices and other relevant referral sources, including Social Prescribers, Community Solutions, Family Hubs, Housing, Adult Social Care, Homelessness, Independence, and Preventative Services (HIPS), other council commissioned services, to raise awareness of the service and provide referrals into the service.

- The service will also be required to work in partnership with local services in Slough, including substance misuse services, youth services, schools, pharmacies, LGBT groups/services, VCSE sector, community services and other relevant services, developing robust referral pathways and to coproduce the community physical activity programme.

- The Service Provider will act as the system leader for physical activity services throughout Slough and will be a source of expertise, help and guidance to all stakeholders.

- The Service Provider will be part of the Whole Systems Approach to Healthy Weight and support the work undertaken by the borough in promoting physical activity initiatives.

- The service will be required to work closely with other Authority teams, the new integrated health and wellbeing service providers, and a range of stakeholders in the borough.

Professional competencies

- Community physical activity instructors must be appropriately qualified to deliver the activity and, where possible, be qualified in motivational interviewing.

- Exercise on referral instructors will be members of the Professional Register for Exercise Professionals (England) Level 3 minimum.

Data and follow up

- The following measures will be taken at the point of referral to establish baseline, progress at week 12 and at week 24:
    - Qualitative measurements: questionnaires, focus groups, one-on-one interviews, diary logs.
    - Quantitative measurements: BMI, blood pressure, cardiorespiratory fitness, psychological outcomes, waist circumference, body fat.

- The measures will demonstrate social, emotional, and economic as well as health impact.

- Please refer to Section 3.3.8 for other data and follow up requirements.

Education and insight

- The Service Provider will utilise the Standard Evaluation Framework (SEF) for Physical Activity[64] and ensure that they follow at least the essential criteria for provider-led activities. Specifically: programme details, evaluation details, demographics of individual participants, baseline data, follow-up data (impact evaluation) and process evaluation.

- It is required that on at least two interventions per annum the essential, and as much of the desirable, framework will be followed to provide evaluation that has effective evidence-based impact.

- Please refer to Section 3.3.9 for other evaluation and insight requirements.

Applicable service standards

Community physical activity

- QS183 Physical activity: encouraging activity in the community
- NG90 Physical activity and the environment
- PH41 Physical activity: walking and cycling
- PH17 Physical activity for children and young people
- PH16 Mental wellbeing in over 65s: occupational therapy and physical activity intervention
- Department of Health and Social Care. UK Chief Medical Officers' Physical Activity Guidelines (2019)
- Department of Health and Social Care/OHID. Physical activity for general health benefits in disabled children and disabled young people: rapid evidence review (2022)
- Public Health England. Everybody Active, Every day: An evidence-based approach to physical activity (2014)
- Public Health England. Everybody Active, Every day: What works, the evidence (2014)
- Public Health England. Identifying what works for local physical inactivity interventions (2014)

Exercise on referral

- PH54 Physical activity: exercise referral schemes
- NHS. Exercise Referral Systems: A National Quality Assurance Framework (2001)
- SSEHS Active (2020). A Toolkit for the Design, Implementation and Evaluation of Exercise Referral Schemes: https://ncsem-em.org.uk/wp-content/uploads/2020/10/section-7- exercise-referral-scheme-commissioners.pdf

Key performance indicators

The KPIs from the physical activity element of the integrated service will form Slough's quarterly health and wellbeing performance measure. Providers will be required to submit reports on time to ensure the data is submitted.

Tier 2 – Community Physical Activity:

- Deliver community physical activity sessions in blocks of up to 12 weeks to target a minimum of 1000 residents from the priority groups completing at least 50% of the sessions quarterly

- Support a minimum of five VCSE organisations to deliver community physical activity for our priority communities annually

End point review

Upon completion of Tiers 2 or 3 support, service users will undergo a final assessment to review progress and determine any further support needs. This may include referrals to the Support Club for ongoing group support or other community services to support the maintenance of healthy behaviors.

Referral and signposting

Referrals can take place to external agencies and to include but not limited to:

- Exercise on referral
- Live Well
- Pre-diabetes services
- Diabetes education services
- Drug and Alcohol Specialist Treatment Services (Children and Young people and Adult Services)
- Healthy Minds
- Patient support groups

Signposting

The Service Provider will signpost to community assets, this could be to local stakeholders, digital assets or to a community directory of resources or agencies. These would include, but are not limited to**:**

- Online Directories: Slough Family Information Service (BFIS) and Slough Online Directory (BOD)
- Physical activity opportunities including Simply Walks, Nature Alliance
- Self-funded options for weight management
- Self-care resources – NHS choices, One You etc.
- Patient support groups
- Community activities
- Social health services - welfare, employment, housing etc.
- NHS and OHID approved smartphone health apps.

Each signpost service will have its own eligibility criteria which will need to be part of the assessment algorithm to determine which services can be offered to each servicer user.

It is expected the number and variety of signpost services will change and increase throughout the duration of the contract, and The Service Provider will have the capability to develop and keep up to date the menu of options for servicer users alongside this, collaborating with the Commissioner.

Follow up

Service users who have had an assessment and are not eligible for one of the specialist behaviour change programmes should have a contact opportunity at 6 months to re-engage for support, unless the servicer user has specifically said that they do not want to be contacted again.

Follow up all service users who have completed an internal specialist behaviour change

programme (Smoking Cessation, Adult Weight Management, and Enhanced IBA Alcohol offer) at 6 and 12 months. The follow up should comprise of:

- Monitor progress against behaviour change programme (e.g., smoking progress, sustained weight loss)

- Record outcomes (self-reported if service not part of HLS)

- Identify any additional lifestyle behaviour change needs.

- Offer additional support/signposting/referral if appropriate.

- All follow ups should be in a method (email, phone, text) agreed by the Service Provider and the servicer user. A minimum of three attempts to contact at different times of day and day of week should be made at each time point. If no contact can be made, an email/letter should be sent to the servicer user offering for the servicer user to get back in touch.

- All follow up processes delivered by the Service Provider must be integrated to ensure all follow up is seamless and does not result in duplication of contacts with servicer users.

- The follow up system will have the capability to be tailored, to offer additional follow ups if appropriate to the referral source.

- Following a referral, service users will be triaged and directed towards Tiers 1, 2, or 3 support as appropriate. The Health and Wellbeing Coach will take a 'person-centered approach,' listening to the needs and strengths of the resident to ensure the support plan provided has the best chance of success. This approach will consider the wider social, cultural, and economic context, motivation, and skills, including any potential barriers to achieving and maintaining behaviour change.

4.3.11 Service Delivery Process and Workflow

For service users identified for Tier 2 or Tier 3, a Health and Wellbeing Coach will conduct a 1:1 behaviour change lifestyle assessment.

- This assessment will preferably be face-to-face to allow for the collection of anthropometric measurements, but it can also be completed over the phone with self-reported measures if requested. The assessment will take place at a convenient time and location for the service user and will last approximately one hour.

- The assessment includes the collection of height, weight, and other relevant physical

measurements. Lifestyle indicators will be evaluated, such as alcohol use, assessed using the Alcohol Use Disorders Identification Test Consumption (AUDIT-C) tool.

- If the score is ≥5, the full AUDIT will be completed. Service users with a full AUDIT score below 16 will receive brief advice, while those scoring 16 or above will be referred to local alcohol services. Smoking status and frequency will be recorded, and current smokers will be offered support through the Stop Smoking service.

- Mental wellbeing will be assessed using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Depending on the result, the service user may be offered mental wellbeing support through referral to appropriate external mental wellbeing services. A clear mental wellbeing pathway will need to be established so that Health and Wellbeing Coaches can offer appropriate support and escalate when required. Minutes of moderate physical activity per week will be assessed using the General Practice Physical Activity Questionnaire (GPPAQ), along with an evaluation of sleep patterns and quality.

- The assessment will also determine the service user's readiness to change and potential barriers, understanding their capability, opportunity, and motivation to self-manage their behaviour change. Short- and long-term goals will be identified, along with strengths and support systems that could aid in behaviour change, such as social support and community groups.
- The results will form a baseline for the service user, and the assessment will be repeated upon exit from the service to measure outcomes. The Health and Wellbeing Coach will direct the service user to Tier 2 or Tier 3 support based on the assessment results.

- The servicer user's information should move with them through all services delivered as part of this contract, so they should not be asked the same question twice throughout the assessment process and referral pathway (apart from the follow-up process). This particularly applies to servicer users completing a community NHS or CV health check prior to the behavioural assessment.

- A key element of the assessment is the holistic assessment of needs and the opportunity to identify support that might be required in addition to the primary reason for referral. Service users may choose to focus on one lifestyle initially and return to another lifestyle issue at a later point.

- The service must adequately manage an individual's expectations in terms of the aims and outcomes by providing clear, consistent, and timely information once they have been referred. Setting realistic goals is crucial to improve the servicer user experience

as well as programme uptake, adherence, and outcomes.

- Where someone is not registered with a local GP, the Service Provider will encourage them to register and, if necessary, provide information on how to do this.

- The behavioural assessment will refer servicer users to the most appropriate behaviour change programme, utilising current eligibility criteria. Where appropriate, servicer users will be referred to external services, e.g., drug and alcohol specialist treatment service. Service users can also be signposted to community assets, community directories, and digital assets. The range of services the behavioural assessment will signpost or refer servicer users will be agreed with The Commissioner.

- Follow-up with servicer users who have had an assessment will occur at 7 days to check if the signposting or external referral has been actioned. For internal referrals for behaviour change programmes, follow-up will occur at 7 days if the referral has not been actioned. In all follow-ups, the aim is to check if any other support is required at an early stage.

4.3.12 Equipment

- The Service Provider will source and maintain stock levels of equipment for the behaviour change lifestyle assessment, including blood pressure monitors (Microlife Watch BP Home A), stadiometers, scales, and any associated consumables. ISO standard ISO15197:2013 defines performance standards for self-testing meters. In the absence of a standard for other point- of-care testing devices, this will be considered a minimum performance requirement.

- The cost of consumables must be met within the contract value.

- The provider must ensure that effective calibration and quality assurance of equipment is carried out and documented routinely (in line with relevant manufacturer guidelines).

5. Model of delivery

- **Outreach Engagement Plan:** Develop an outreach engagement plan, agreed upon by The Commissioner, to systematically engage with priority groups throughout the contract duration.

- **Health Education and Awareness Outreach:**

- Deliver targeted health education and awareness outreach on NCD prevention and management including the role of cancer screening early detection and prevention and the importance of immunisation.
- Deliver targeted health education on the links between CVD and dementia and educate on signs and symptoms of dementia
- Utilise various platforms such as workshops, seminars, social media, and community centres.
- Develop and distribute culturally appropriate and accessible educational materials.
- Establish referral pathway from outreach event to NHS and cardiovascular health checks and triage for the IHWS
- Provide information and signpost residents to the integrated health and wellbeing service website for further information and self-help tools.

- **Outreach location**
  - Conduct outreach activities and events in locations suitable for recruiting target populations, including faith settings, supermarkets, workplaces, leisure centres, community events, etc.
  - Prioritise community-led events (e.g., fun fairs, faith settings) over health-based events to reach key community groups not typically engaged with health services.

- **Community connectors**
  - Identify and build relationships with key community connectors who have existing trust within target community groups to inform and guide outreach offer.
  - Build relationships with trusted community leaders to support and develop community capacity to promote the service.
  - Working collaboratively with SBC community development team and voluntary sector organisations to build community capacity to take action on health by identifying and working with community assets

- **Targeting High-risk Groups**
  - Identify and target high-risk groups through population health management using segmentation data from Frimley ICS.
  - Refer high-risk individuals to enhanced and targeted tier 2 lifestyle support services, including physical activity, smoking cessation, and falls prevention.

- **Partnership and referral pathways**
  - Establish strong partnerships with local stakeholders, including healthcare providers, community organisations, schools, and businesses.

- Strengthen referral pathways to external services, including national programmes, specialist medical care, mental health services, community organisations, and social support services.
- Work with the national screening leads to promote various screening programmes, including Abdominal Aortic Aneurysm (AAA), cervical cancer, and breast cancer screenings.

- **Engaging and Tailoring Services**
  - Engage and recruit key priority groups using population health management approach informed by the NHS CORE20Plus5.
  - Develop insights to tailor the service to meet the needs of residents from priority groups, ensuring they are aware of the available support to help change their behaviour.

Skills requirements of staff

- Partnership Working: Staff need to have experience in partnership working.
- Training: Staff will be trained in behaviour change models and the Making Every Contact Count (MECC) approach.
- Personal Attributes: They should be approachable, supportive, and non-judgemental.
- Community Understanding: Staff should understand the needs of the community, with an expectation that this will increase referrals from priority groups into the service, ultimately resulting in improved outcomes for a greater number of residents.
- Promotion and Networking: They should be skilled in promoting services and networking, as well as tailoring the service to the relevant audience.

Key Performance Indicators – Annual Targets

KPI Description	Measure	Target Number
Community Outreach	Number of community events and outreach activities delivered	12
Reach and Engagement	Number of people accessing community health education events	1000
Equity and Inclusion	Percentage of high-risk target population reached by health education campaigns (CORE 20 PLUS 5)	50%
Referrals and sign posting	Total number of referrals received into the IHWS from outreach engagement	500
	Number of individuals signposted to national screening programmes including breast, cervical cancer screening, and AA screening	300

Staff Training and Development	Number of staff trained in health education and outreach	100%
Community Collaboration	Number of outreach event delivered in collaboration with community connectors, Voluntary sector organisation or healthcare system	75%
Programme Evaluation and Satisfaction	Number of service users invited to complete evaluation survey	100%
	% of service users completing evaluation survey	50%
	% of service users who completed the evaluation reporting an increased knowledge, awareness, skills, and capabilities in relation to the outreach topic	75%

Note that the delivery of community awareness events will not substitute the expectation that the service provide will optimise opportunities for residents to access the service in public places via clinics in hot-spot and targeted areas.

6. Service Outcomes and Key performance indicators

The key performance indicators for the service per annum are:

Service Area	Key Outcomes	Total
Single Point of Access	Conversion rate of referral rate to behaviour change screening.	80%
	Number and percentage of referrals contacted within 48 hours	90%
NCD Prevention, Outreach and Liaison	Number of community events and outreach activities per annum	12
	Total number of referrals into IHWS from outreach and engagement	500
	Number of individuals signposted to national screening programmes	300
NHS Health Checks	NHS Health Checks Completed	1125

Cardiovascular Checks	CV Checks completed	600
Smoking Cessation	Number setting a quit date	1500
	Number of 4-week quitters	750
Adult Weight Management Service	Total number of eligible adults accessing the Tier 2 Service	3500
Falls Prevention	Number of falls assessments completed	800
	% of completers with improved wellbeing scores	100%

6.1 Quality Measures

The Service Provider is expected to take a partnership approach to monitoring and evaluation and work closely with the Authority to share learning.

The Authority will work with the Service Provider in the first instance of this contract to develop a monitoring system that is fit for purpose, provides the right data, and helps with priority setting for the service. This will be reviewed on an ongoing basis to ensure that the evidence of impact and outcomes from the contract is captured.

The following are minimum requirements that would be expected; however, the Authority will work with the Service Provider during implementation to understand what can be provided and set baseline targets.

Smoking and Adult Weight Management have mandatory reporting into national systems which are detailed in this section. The Service Provider will be responsible for completing these submissions.

KPI description	Measure	Annual Target	Reporting frequency
Triage/Single Point of Access/Behaviour change			
Total number of people accessing IHWS	Number of referrals into the service, with ability to be broken down into primary reason of referral and by source	100%	Quarterly
	Conversion rate of referral to behaviour change screening reported	100%	Quarterly

	Number and percentage of referrals contacted within 48 hours	90%	Quarterly
	Number of assessments completed	4000 in year 1 +5% increase annually	Quarterly
Website Activity	Levels of activity on the website, including visitors, unique visitors, time spent on site and users digital journey.		Yearly
Onward referrals and Signposting			
Breakdown of specialist services referred to:	Number referred to Smoking Cessation services reported	100%	Quarterly
	Number referred to Adult Weight Management services reported	100%	Quarterly
	Number referred to Enhanced IBA Alcohol offer reported	100%	Quarterly
	Number referred to NHS Health Checks or Cardiovascular Health Checks reported	100%	Quarterly
Breakdown of external services referred to:	Number of external services referred to reported: e.g. - National Diabetes Prevention Programme - Drug and Alcohol Treatment Services - Mental Health Services	100%	Quarterly
Service utilisation	Number of clients who have completed more than one behaviour change service reported	100%	Quartely
Signposting to Community Services for Adults over 60 at Triage			
Signposting and onward referrals	Proportion of adults aged 60+ triaged by the service, that may require a one off task being completed, e.g. clearing up, moving furniture, offered referral to GoodGym or Slough CVS	100%	Quarterly
	Proportion of isolated older adults aged 60+ triaged by the service, that could benefit from a befriending service to relieve the burden of loneliness, offered a referral into GoodGym or Slough CVS	100%	Quarterly
Tier 1 Information and self-help support tools			
Total number of services users	Number of service users offered the Tier 1 service reported1	100%	Quarterly

accessing Tier 1 services	Proportion of Tier 1 service users who opted for a follow-up call in 6 months who are contacted in 6 months 1	100%	Quarterly
NCD Prevention, Outreach and Liaison			
Community outreach	Number of community events and outreach activities delivered	12	Quarterly
Community collaboration	Percentage of outreach events delivered in collaboration with community connectors, Voluntary sector organisations or healthcare system partners	100%	Quarterly
Reach and engagement	Total number of people accessing community health education events per annum	1,000	Quarterly
Equity and inclusion	Percentage of high-risk target population reached by health education campaigns (CORE20PLUS5)	50%	Quarterly
Referrals and sign posting	Number of referrals received into the IHWS from outreach engagement	500	Quarterly
	Total number of individuals signposted to national screening programmes including: breast cancer, cervical cancer, bowel cancer, AAA screening and DES screening programmes.	300	Quarterly
Staff training and development	Number of staff trained in health education and outreach	100%	Annually
Programme evaluation and satisfaction	Number of service users invited to complete evaluation survey	100%	Annually
	% of service users completing evaluation survey	50%	Annually
	% of service users who completed evaluation survey reporting an increase in knowledge, awareness, skills and capabilities in relation to the outreach topic	75%	Annually
Community NHS Health Checks			
Total number accessing NHS Health Checks	Number of NHS Health Checks offered to those eligible	1500	Quarterly
	Number of NHS Health Checks completed	1125	Quarterly

	Proportion (%) of those who receive a complete NHS Health Check dated with all indicators listed in risk assessment recorded at the time of delivery	100%	Quarterly
% of NHS Health Checks delivered to priority groups	% of NHS Health Checks delivered to BAME groups	30%	Quarterly
	% of NHS Health Checks delivered to Routine and Manual workers	40%	Quarterly
	% of NHS Health Delivered to individuals from high areas of deprivation (IMD 1 and 2)	60%	Quarterly
Onward referrals to lifestyle services	Proportion (%) of NHS Health Checks undertaken where referral to lifestyle/local services to help reduce risk, (e.g. national diabetes prevention programme, stop smoking service) is made, where appropriate.	100%	Quarterly
POCT trained	Proportion (%) of staff delivering POCT who have been trained (by a competent trainer) to use the equipment	100%	Annually
Cardiovascular Checks (CV)			
Total number of CV checks	Number of CV checks offered	800	Quarterly
	Number of CV checks delivered	600	Quarterly
	Proportion of those who receive a complete CV Health Check dated with all indicators listed in risk assessment recorded at the time of delivery	100%	Quarterly
% of cardiovascular checks delivered to priority groups	% of CV health checks delivered to Routine and Manual Workers	40%	Quarterly
	% of CV health checks delivered to Routine and Manual Workers	60%	Quarterly
	Proportion of CV Checks undertaken where referral to lifestyle/ local services to help reduce risk, (e.g. national diabetes prevention programme, stop smoking service) is made, where appropriate.	100%	Quarterly

POCT Trained	Proportion of staff delivering POCT who have been trained (by a competent trainer) to use the equipment	100%	Annually
Smoking Cessation			
Smokefree homes, cars, and buildings	Total number of participants having smokefree homes, smoke free cars and smoke free buildings	50	Quarterly
Children and Young People prevention programme	Total number of children and young people reached through the Children and Young People prevention programme	1000	Quarterly
Workplaces	Total number of workplaces updating their healthy workplace and smokefree policy	10	Quarterly
Quit dates and quit rate	Total number setting a quit date	1500	Quarterly
	Total number of 4-week quitters	750	Quarterly
Number of 4-week quitters	a. From most deprived groups, IMD postcodes 1-4	50%	Quarterly
	c. BME in polish	40%	Quarterly
	d. Routine and manual	40%	Quarterly
Number of 12-week quitters	a. Those with respiratory conditions, including asthma and COPD,	5%	Quarterly
	b. Pregnant women stopping by time of delivery	5%	Quarterly
	c. With a mental health condition	5%	Quarterly
	d. From Children and Young people aged 12 and above, women who have recently given birth and other people who smoke in their household,	5%	Quarterly
	e. Other vulnerable groups – linked to PHE Disparities (social housing, frontline workers, homelessness, substance misuse, refugee, and asylum seekers)	5%	Quarterly
CO- Validation	Carbon monoxide validated quits	85%	Quarterly
Evaluation	Undertake evaluation and insight of the service with service users, stakeholders, and health professionals to inform service improvement	Continuous	Quarterly
Digital Smoking Cessation			

Triage uptake	% of app users who take up the triage offer and undergo a needs review	50%	Quarterly
4-week quit date	Total number setting a quit date	400	Quarterly
4-week quit rate	Total number of 4-week quitters	200	Quarterly
Adult Weight Management Service			
Total numbers of participants enrolled in service	Participants enrolled in the service meet, as a baseline, the eligibility criteria as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services	100%	Quarterly
	Total number of eligible adults accessing the Tier 2 Adult Weight Management service	3500	Annually
	% of participants complete the active intervention (where completion is attendance of at least 75% of all sessions during the active intervention.)	60%	Quarterly
	% of participants enrolled in service are from identified high risk groups including areas of high deprivation, Black and Minority Ethnic communities, individuals with disabilities and individuals with mental health conditions	50%	Quarterly
Service user weight loss	% of participants that lose weight at the end of the active intervention	75%	Quarterly
	% of participants that lose have lost a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention	30%	Quarterly
	% of completers that lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention	50%	Quarterly

Follow up with service users	% of completers that provide a weight measure at 6 months	35%	Quarterly
	% of completers that provide a weight measure at 12 months	20%	Quarterly
Falls Preventions			
Falls assessments	Number of falls assessments completed	800	Quarterly
Risk identification	Number of people identified through the assessment as low risk reported	100%	Quarterly
	Number of people identified through the assessment as medium risk reported	100%	Quarterly
	Number of people identified through the assessment as high risk reported	100%	Quarterly
Service offering and uptake	Number of eligible individuals over 60+ offered the Falls Prevention Service	800	Quarterly
	Number of service users starting the Well-Balance Class	600	Quarterly
	Number of service users completing the Well-Balance Class	500	Quarterly
Outcome and impact	% of completers with improved wellbeing scores	100%	Quarterly

7. Service Eligibility Criteria and Priority Groups

7.1 Service Eligibility Criteria

The service is universal for Slough residents and/or those registered with a Slough GP practice. However, a proportionate universalism approach should be taken, so that the support given is relevant to the level of need. Specialist Behaviour Change Interventions have eligibility criteria which is detailed in each section, as well as provided in the table below. Where servicer users are not eligible for specialist behaviour change interventions, they should be directed to relevant resources through the universal self- management portal.

Service	Included	Excluded
All Services	Slough resident and/or registered with a Slough GP practice.	
Smoking	All smokers aged 12+.	Children under the age of 12.

		Anyone wishing to only take a Harm Reduction approach to tobacco use e.g., cutting down
Adult Weight Management	• Aged 16 years or over. • Individuals with a BMI* ≥30 or ≥22.5 for black and minority ethnic groups • Individuals with a BMI ≥28 AND with a co-morbidity that is adversely affected by their weight. Co-morbidities include: ◦ Type 2 diabetes; ◦ Hypertension; ◦ Cardiovascular disease; ◦ Osteo arthritis; ◦ Dyslipidaemia; ◦ COPD; and ◦ Sleep apnoea • Not been referred to a weight management service by health professional in the last 6 months Note: Referrals for pregnant women must come from a midwife only	Individuals not complying with these criteria will not be eligible to access the service but can access alternative provision through tier 1 service provision of information, the dietetic service, their GP as appropriate. Furthermore, individuals meeting the following criteria should be excluded from this service: • Have an eating disorder • Have an underlying medical cause for obesity and would benefit from more intensive clinical management than a tier 2 service • Have significant co-morbidity or complex needs as identified by their GP or other healthcare professionals
Alcohol IBA enhanced offer.	• Aged 18 or above. • Anyone with an AUDIT Score of 8 to 15	• Anyone with an AUDIT Score of 7 or below • Anyone of an AUDIT score of 16 or above. They should be referred to Adult Drug and Alcohol specialist treatment service. • Anyone 17 or under should be referred to the young persons Drug and Alcohol specialist treatment service.
NHS Outreach Health Checks	• Between 40 and 74 years of age • Has not had a NHS Health Check in the last 5 years	• Anyone outside of the eligible 40-74 year old age group • Anyone with the following

	• Does not have an existing diagnosis which makes them ineligible (see exclusions list)	conditions: ○ Coronary heart disease ○ Chronic kidney disease ○ Diabetes ○ Previous stroke ○ Hypertension ○ Atrial Fibrillation ○ Transient Ischaemic ○ Attack (TIA) ○ Peripheral Arterial ○ Disease ○ Familial Hypercholesterolemia • Anyone taking statins • Anyone on the High Risk register • Anyone who has had NHS Health Check in the last 5 years
CV Health Checks	• Between 30 and 39 years of age • Has not had a NHS Health Check in the last 5 years • Does not have an existing diagnosis which makes them ineligible (see exclusions list)	• Anyone outside of the eligible 30-39 year old age group • Anyone with the following conditions: ○ Coronary heart disease ○ Chronic kidney disease ○ Diabetes ○ Previous stroke ○ Hypertension ○ Atrial Fibrillation ○ Transient Ischaemic ○ Attack (TIA) ○ Peripheral Arterial ○ Disease ○ Familial Hypercholesterolemia • Anyone taking statins • Anyone on the High Risk register • Anyone who has had NHS Health Check in the last 5 years

*Capacity for Adult Weight Management will be reviewed on an ongoing basis during quarterly monitoring meetings during the contract.
If there is capacity, BMI will reduce to >30 (>22 for Black and minority ethnic groups and those with a co-morbidity) in order for the service to support overweight people in accordance with NICE recommendations.

8. Management of Contract

Expectations

The Public Health and Wellbeing Commissioning Team within Slough Council will lead on the management of this contract. The Council will:

- Identify a Contract Manager to support the Service Provider in meeting its contractual obligations, address and agree actions in response to emerging needs or circumstances and develop links with key stakeholders of the service to assess performance.

- Act in a manner that supports the achievement of the desired outcomes set out above.

- Carry out quarterly contract reviews.
- Agree measures of performance with the Service Provider, set targets and monitor performance against these.

- Carry out an annual evaluation of performance with the Service Provider, which may lead to the agreement of variations in the contract.

The Service Provider shall:

- Appoint a competent Service Manager who will be the Council's main point of contact.

- Act in a manner that supports the achievement of the desired outcomes set out above.

- Develop a standards charter for servicer users that establishes minimum service requirements, including but not limited to, number of days to return telephone calls and respond to emails and letters.

- Provide monitoring data (including backing data) and progress towards outcomes on a quarterly basis as agreed between the Service Provider and Commissioners.

- The Service Provider must be able to evidence that it is meeting the objectives and outcomes of this contract.

- The Service Provider is required to submit data to Commissioners as requested and required as part of its performance management obligations.

9. Communication and Website

Service Description

A communication and website lead will enhance county-wide promotion of the service as well as targeting key demographics. They would be involved in running public facing webinars, both on general areas of healthy lifestyles, but also on healthy lifestyles for people with long term conditions.

There is huge potential for working with health staff and influencing 'patient' information, therefore they will work closely with practices and acute services to make sure self-help preventative messages get to the right people at the right time. They would be responsible for developing a comprehensive resource portal for health professionals to access, and a wealth of opportunities for communities to access.

The aim of this work is to increase wider publicity for the service, increase the number of residents reached and increase referrals, both professional and self-referrals. It will also provide self-management options for those not eligible for services.

Model of Delivery

The Service Provider will develop an annual marketing and communications plan, focusing on all areas of the service for residents, referrers and stakeholders that will be agreed with the Commissioner. Any ad hoc promotions throughout the year will also be agreed with Commissioners and Slough Council Communications team and the annual plan updated.

- The service should be actively marketed to servicer users and professionals across a range of channels including social media, local print and broadcast media, awareness raising via partner organisations' communication channels, and where appropriate ensure this is done jointly with the ICB. A network of local agencies, organisations and facilities should be maintained. Stakeholders, residents, and servicer users should be engaged in developing the communications plan and any marketing material.

- Up to date information about the service, referral pathways, events and access will be available on its own website.

- Develop and maintain a directory of community assets, both physical and digital, that servicer users can be signposted to that links to resources already available through BOD (Slough Online Directory) and BFIS (Slough Family Information Service). This will support servicer user's self-management, as well as compliment servicer users on specialist behaviour change programmes. This would be a holistic directory, relating to services linked to the wider determinants of health in addition to the services directly related to the Healthy Lifestyle Service. This could include but not limited to housing, debt management and drug and alcohol services.

Resources should be in accessible formats.

- Develop and maintain a portal of information for health professionals to access, to help influence patient information, to make sure self-help preventative messages get to the right people at the right time.

- Marketing material should be available for GP practice staff to download from their systems and is also provided in a format to be displayed on waiting room screens. Forge relationships with social prescribing link workers, care coordinators and health coaches to make referrals into services.

- The service will be consistent with and reinforce national messages around physical activity, healthy eating, stop smoking, alcohol reduction, and all information resources provided to servicer users are evidence based and from national guidance provided by a recognised source (e.g., DHSC, NICE, OHID, relevant charity). Where national guidance is updated during the course of the Contract, information given to servicer users must also be updated in line with this guidance within a 3-month period of the change. Information needs to be agreed by The Commissioner in advance of being given to servicer users

Campaigns

As a minimum The Service Provider will:

- Utilise national campaigns to deliver a minimum of three local campaigns that will promote and recruit to the service. These campaigns will be included for agreement with The Commissioner in the annual communications plan.
- Capitalise on and build programmes of work on the 'One You,' Change4Life and other relevant national campaigns e.g., Stoptober, No Smoking Day, and New Year, to locally drive national campaigns.
- Focus on reaching the specified priority groups.
- Using national insight and market segmentation data.
- Work with and through stakeholders and community groups/organisations.
- Feature clinicians where appropriate in video or text-based campaign materials

- Utilise national resources including apps endorsed or developed by OHID for the One You campaigns.

Skills Requirement of Staff

They should have knowledge of communications and marketing, skilled in the promotion of services, networking, as well as being able to tailor the service to the relevant audience.

10. Service Name and Branding

Service Name

On award of the contract the Service Provider and the Commissioner will discuss and agree the Service Name for the Healthy Lifestyle Service. The current name may be kept, or the Service Provider may develop their own. The name and brand must be agreed and signed off by The Commissioner before it is used.

Service Branding

In terms of service branding:

- All marketing collateral must follow Slough Council and NHS Branding Guidance.

- For the NHS Health Check outreach service, national branding guidelines state that in addition to partner branding the NHS lozenge must always be used.

- Staff at events should wear appropriate clothing for the event which could include Service branded clothing.

- The Council will seek formal assurances from the Service Provider that they have taken steps to ensure that any name and branding they may create for the service does not breach intellectual property or copy rights of others.

11. Staff wellbeing and Competence

Strong and Capable Workforce

Competent and happy staff are the cornerstone of an effective service; the Service Provider shall ensure that it actively supports its staff by promoting their wellbeing and by providing a proactive staff support programme and a comprehensive training programme for staff with continuous professional development opportunities.

Staff Wellbeing

There is a positive association between wellbeing, job satisfaction and an employee's job performance and evidence that particular factors within a workplace can positively influence

wellbeing. Workplaces encouraging and facilitating healthy lifestyle choices along with good quality leadership have been found to enable healthy lifestyle choices amongst employees and result in reduced stress, depression and sick leave. Remote working staff should be effectively managed.

Staff training

All staff must be competent, experienced, and qualified to undertake their specific roles. They all need to be skilled in servicer user engagement, trained and competent in COM-B or a similar evidence-based model, and have communication techniques to encourage sustainable health behaviour change. They need appropriate safeguarding training and should be computer literate. The Service Provider shall have robust recruitment and retention procedures. All staff shall be given regular supervision and an annual appraisal, with any development needs.

Skills and knowledge

- Strong interpersonal skills
- Skills in working with people from priority groups
- Working knowledge of lifestyle issues
- Knowledge of long-term conditions, health conditions and medications affecting advice
- Knowledge of local services and clinical pathways that can be referred/signposted to

Training

- Mental Health First Aid (MHFA) – Service Provider to source training or through the Council training provision (provider covers costs)
- Active Medicine non-clinical training
- MECC (delivered by Slough Council)
- IBA (Service Provider to source training and cover costs)
- Behaviour Change – COM-B or equivalent (delivered by Slough Council)
- Basic Domestic Violence, Modern Slavery and Hate Crime Awareness training (delivered by Slough Council)
- Delivering culturally competent services (delivered by Slough Council)
- Motivational interviewing
- Community Engagement
- Universal model of personalised care (delivered by ICB)

Upon request the Service Provider will complete, and submit to the Council, its training needs assessment for this service. The needs assessment will include a competency assessment of all staff skills and qualifications. The Service Provider shall then draw up a staff development and training plan to meet any deficit in staff capabilities.

- The Service Provider will identify a Safeguarding Lead for the service.

- The Service Provider shall also ensure that staff delivering this service including any volunteers undergo the appropriate Disclosure and Barring Services checks (DBS) every 3 years. All costs relating to this shall be met by the Service Provider.

- The Service Provider shall be responsible for ensuring that all staff training is reviewed on an annual basis, and a register of staff training must be kept and made available to the Commissioner when requested. Any qualified health professionals working within the service will have training, professional qualifications and continual professional development (CPD) in line with the national professional body relevant to the profession.

12. Compliance and Quality Standards

The Service Provider must comply with the requirements set out within the 2010 Equality's Act.

12.1 Quality Standards

The Service Provider shall ensure that all services are of good quality. The Service Provider will have a systematic approach to monitoring its delivery standards, and where appropriate will be registered with those recognised bodies that oversee the quality and standards of all applicable areas of service delivery. The Service Provider is required to apply the relevant public health guidance to the delivery of the service, including but not limited to:

- Slough Joint Strategic Needs Assessment
- Slough Joint Health and Wellbeing Strategy https://Slough.moderngov.co.uk/documents/s17933/Joint%20Health%20and%20Wellbeing%20Strategy%202021-2024.pdf
- NICE PH49 Behaviour change in individual
- NICE PH6 Behaviour change: general approaches
- NICE Making Every Contact Count: How NICE resources can support local priorities. https://stpsupport.nice.org.uk/mecc/index.html
- NICE PH1 Brief advice and referral to stop smoking services
- NICE NG92Stop smoking interventions and services.
- NICE PH26 Smoking: stopping in pregnancy and after childbirth.
- NICE QS43 Smoking cessation
- NICE PH10 Smoking Cessation Services
- NICE PH45 Tobacco Harm reduction approaches to smoking
- NICE QS 92 Smoking tobacco harm reduction approaches
- NICE PH53 Guidance on weight management
- NICE QS111 Obesity in adults: prevention and lifestyle weight management programmes.
- NICE PH47 Weight Management - Lifestyle services for overweight or obese children and

young people

- NICE NG7 Preventing excess weight gain.
- NICE PH42 Obesity: working with local communities.
- NICE CG189 Obesity: identification, assessment and management.
- NICE PH44 Brief interventions for physical activity
- NICE PH41 Promoting walking and cycling
- NICE PH24 Guidance on alcohol use disorders / brief interventions
- NICE PH24 Alcohol-use disorders: prevention
- NICE (2010) Alcohol-use disorders: preventing harmful drinking
- NICE PH25 Cardiovascular disease prevention.
- NHS Health Checks https://www.gov.uk/government/publications/nhs-health-checks-applying-all-our-health/nhs-health-checks-applying-all-our-health
- NICE (2019) Evidence standards framework for digital health technologies https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies
- Department of Health and Social Care (2019) Code of conduct for data-driven health and care technology. https://www.gov.uk/government/publications/code-of-conduct-for-data-driven-health-and-care-technology/initial-code-of-conduct-for-data-driven-health-and-care-technology

12.2 Internal Audits of the Service

The Service Provider shall constantly work to improve the service; one mechanism to support this is via audit and review. The Service Provider must actively participate in this process by undertaking internal audits and by making information available to Commissioners for audit purposes. These include:

- Safeguarding audit, including annual completion of the section11 self-audit using the Council's safeguarding self-assessment tool and develop action plans, as necessary.
- Spot checks by Commissioners.

12.3 Complaints, Compliments and Comments

The Service Provider shall have a robust complaints process, ensuring that all who use the service know how to raise concerns and the process the Service Provider uses to review and respond to complaints. The Council must be notified of any complaints.

The Service Provider shall have a mechanism to regularly capture servicer user satisfaction, compliments, and comments. These should be provided to the Council as part of quarterly monitoring meetings.

12.4 Policies and Procedures

The Service Provider must have relevant operational policies and procedures in place to ensure safe working conditions and practice for its employees and people using the service. Policies and procedures will include but not limited to:

- Safeguarding children and safeguarding adults' policies
- Complaints and grievances (staff)
- Equalities and diversity- Promoting diversity.
- Business continuity and emergency planning
- Health and safety
- Induction and staff training
- Recruitment and selection
- Disciplinary/Capability (staff)
- Data Protection, confidentiality, and information security
- Staff code of conduct
- Complaints, comments, and compliments procedures
- Workforce supervision, appraisal, and/or performance management
- Peer support and volunteering
- Bullying and harassment
- Professional boundaries
- Whistleblowing
- Volunteering
- Risk assessment and risk management.

The successful Service Provider will be required to submit copies of all policies to the Commissioner.

12.5 Review and Policies and Procedures

Policies and procedures must be in date. They must have clearly stated objectives and stipulate where responsibilities for implementation, monitoring annual review and development is held.

12.6 Capacity of Service Delivery Issues

- The Service Provider will be required to meet and implement the frontline staffing requirements within the contract and deliver to capacity.

- The Service Provider will alert the Commissioner to any capacity or service delivery issues in a timely and appropriate way.

- Re-routing of resources to other areas within the same contract can only be undertaken with the explicit agreement of the Commissioner.

- The Service Provider must inform the Commissioner of any urgent issues that arise and will work with Commissioners to agree and implement solutions.

12.7 Safer Recruitment

- The Service Provider shall ensure staff delivering this service including volunteers are appropriately DBS checked and complete an appropriate application form and have two satisfactory written references before an individual commences employment delivering this service.

- The Service Provider shall maintain individual staff files, which shall contain all relevant details pertaining to the individual including documentation in relation to the recruitment and selection process, training and induction records, supervisions and appraisals undertaken.

12.8 Review of Service Specification

- Commissioners may review and/or vary this service specification from time to time to ensure maximum benefit for servicer users, residents and stakeholders who are supported by this service. The Service Provider will be closely involved in this process to identify any implications (financial and human resources) for service delivery.

- Commissioners reserve the right to review the content and detail of this service specification on an annual basis to take account of changes in policy and funding. This may also include the inclusion or exclusion of specific elements of the service.

13. Access, Opening Times and Coverage

As a minimum The Service Provider will ensure:

- The website, Single Point of Access Digital Referral & Assessment will be available 24 hours a day, 7 days a week.

- The Single Point of Access phone line will be available Monday to Friday between the hours of 8 am and 8 pm and on Saturday between the hours of 9am and 4pm. The Service Provider will monitor call volume and demand which will be used to review the opening hours of the single point of access. The phone line should be free or charged at the local

rate.

- The Service Provider will offer specialist behaviour change programmes and community NHS and CV health checks during the day and evening during the week and during the day on a Saturday. It is expected that times of sessions will be based on demand and will be regularly reviewed by the Service Provider and the Commissioner.

- The Service Provider should adopt the principles of place-based approaches to face-to-face support at locations/settings across Slough which are convenient/appropriate for the target servicer user group, utilising existing premises and community venues. Services to be offered from joint locations where appropriate i.e., in places where people already go to access other provision. Services must be easily accessible by public transport and must have appropriate access and / or parking facilities.

- The Service Provider shall ensure that the service is available throughout the year at times and in settings that increases its accessibility. The service provided must remain flexible over the contract period to adjust advertised opening hours and staffing, as necessary.

- The Service Provider will address the range of factors that impact on accessibility of the HLS. All servicer users will be treated equally and be given access to the service regardless of gender (including gender reassignment), race, nationality, ethnic or national origin, age, disability, religion, beliefs, or sexual orientation. The service will be flexible and responsive, adapting to the individual needs of servicer users in terms of their circumstances.

- The service must also provide culturally sensitive services and ensure access for people who have a physical or mental impairment. The service must have access to appropriate interpreter services. The Service Provider must ensure that the service complies with the Disability Discrimination Act 1995 and the Equality Act 2010 and would be accessible to wheelchair users and others with a physical disability. It must be available for people will all levels of literacy, sensory impairment, learning disability and be carer friendly.

- Service users whose first language is not English should have access to information and support in their chosen language.

- As there are likely to be numerous interactions over an extended period a flexible scheduling and case management process should ensure the communication with the servicer user is timely and coherent.

- Slough Council will not be responsible for the sourcing, or any costs associated with securing premises; rents, rates and service charges will be the responsibility of the Service Provider.

14. Interdependencies

- Slough Borough Council Directorates
    - Adults and Social Care
    - Leisure
    - Communities
    - Community Engagement
    - Slough Public health 0-19 children services
- Frimley ICS
- GP Practices
- Maternity Services
- Office for Health Improvement and Disparities (OHID)
- Local Pharmaceutical Committee / Pharmacies
- Health Education England
- Fire Service
- Prisons
- Trading Standards
- Libraries
- Community Boards
- Town and Parish Councils
- Primary Care Networks
- Social Prescribers
- Community and Voluntary sector groups
- Adult Drug and Alcohol Specialist Treatment Service
- Young Person Drug and Alcohol Specialist Treatment Service
- Slough MIND
- Citizen Advice
- Housing Associations
- Leisure Providers
- Schools
- Family Centres

15. IT Systems

15.1 Digital Platforms

The service will develop a digital platform that is:

- The digital front door to the service

- Provides active support for universal self-management through a range of digital tools. It needs to appeal to servicer users who are self-motivated, like setting their own goals, use the internet to search for advice and information and use digital technology.
- Can provide digital registration and assessment.
- Central triage referral system for GP, professional referrals, and self-referrals
- The ability for servicer users to book appointments online.
- The digital offer must be available on different platforms e.g., PC, laptop, mobile phones, tablet, etc. It must be accessible, easy to navigate, and the brand must be complimentary to the service provision to attract and engage people and pull them into the digital offer and services when appropriate. Clearly defined user journeys must be provided to ensure that key functions/outcomes of the website are considered and can be reported against.

The digital offer must also provide access to:

- Promotional support for marketing campaigns with clear signposting to campaign specific content or services.
- Up-to-date guidance and information on what health improvement activities are available in the local area (community assets)
- Be able to connect people to these activities through, for example, providing the location, times, information ect for community activities/assets and link to existing Slough Council directories (BOD and BFIS)
- The digital offer must provide access to validated digital tools such as self-monitoring aids to help and motivate servicer users, in a range of different formats e.g., apps. These tools must also have the function to access the digital offer.
- The digital offer will include social media that is relevant to the target audience and supports the communication strategy. All activity coming into the digital offer should be identifiable with the ability to track where visitors go once signposted.
- A digital offer has the potential to support universal self-management where this is servicer user preference and ensure the service reaches as wide an audience as possible but is not a substitute for standard care. In relation to any digital offer, to The Service Provider will:
- Ensure the offer meets the Commissioner's accessibility guidelines and NICE Evidence Standards Framework for Digital Health Technologies, with consideration as appropriate of the effectiveness and incorporation of behaviour change theory into available tools. Compliant with the Government Digital Standards[42] and Slough Council digital standards.

[42] https://www.gov.uk/service-manual/service-standard

- Ability to interface with the CRM system so it links with data capture.
- Regularly review and as necessary update the offer to ensure it remains current, relevant and when appropriate, clinically accurate. As a minimum this should be monthly.
- Maximise existing resources, for example OHID's One You apps to meet servicer users' needs
- Regularly undertake user-testing to review and improve the servicer user's journey. As a minimum this should be 6 monthly.
- Implement best practice efforts to encourage sustained behaviour change and mitigate servicer user disengagement.
- Consider and monitor how the digital offer (and wider digital tools) will reach servicer users who (i) experience barriers to engaging with digital technology and/or support services, or who do not wish to use it for this purpose, and (ii) any groups who may have proportionately higher rates of certain behaviors.
- Ensure systems and processes are in place to capture and respond to any evidence of harms in relation to a digital offer.
- Have a plan in place from the contract start for monitoring and quality improvement including real-world data collection to demonstrate value for money and strengthen the evidence base.
- Any digital solution that is created for the service must be completely portable and not rely on a proprietary software application or Content Management Solution (CMS). A recognised open-source CMS must be used (for example: WordPress, Drupal or equivalent).

15.2 Customer Relationships Management (CRM)

The CRM System represents the operational core, containing the business processes, business rules and data records. The Service Provider's staff are the key users of the system as the system workflows and interface support them in the information capture, decision support, communications, and case management activities the service will deliver. Access can also be extended off-site using mobile applications.

The overarching CRM system must provide:

- Ability to record details of all the services provided to all servicer users regardless of the specialist operational system used to support them.

- Ability to capture details of all the servicer users receiving services including their demographic details, assessment details, their progress through the service(s) and their outcomes.

- Ability to manage a seamless follow up process for the SPA and specialist behaviour change programmes.

- Ability to manage enquiries, comments, complaints, and compliments from the public and servicer users.

- As each servicer user's journey will be a unique sequence of these building blocks it is critical that the technology allows new assessments, activities, and pathways to be defined, developed, and deployed with the sequences of events and the behaviour change indicated by the assessments to be analysed.

- Maintain a secure audit trail of all changes to the database records and records of who has accessed records. A report must be able to be generated if required.

- Consent to "share" information must be captured by the system including any limitations to that consent. The system or supporting processes must ensure the conditions of that consent are applied across all areas of the service.

- Messages can be passed between all parties involved in requesting, delivering, and receiving services.

- Messages can be passed between The Service Provider, NHS, and Slough Council to ensure links can be made with any future digital services.

- Records of existing servicer users in the current service will need to be imported from the current system into the new system.

- Ability to produce reports and analytics that meet the requirements of the Council and to meet national reporting requirements.

- Collaborate with the Commissioner to develop a reporting dashboard capable of presenting accurate and timely activity and outcome data which can be used to inform service development.

- Ideally the data system will be fully interoperable with GP IT systems supporting a seamless referral process and reporting back of servicer user outcomes.

15.3 Data Requirements

The Service Provider must have IT systems in place to gather a minimum data set to:

- Develop IT and data systems to ensure effective performance reporting can be completed from the service start date.

- Establishing and maintaining robust data monitoring and reporting systems.

- Produce regular monitoring, equity, performance and evaluation reports as part of the monthly/quarterly review process.

- Produce OHID/NHS Digital quarterly stop smoking returns, in line with set timescales and templates http://content.digital.nhs.uk/stopsmoking.

- Submit Tier 2 Adult Weight Management data to the National Obesity Audit monthly through the Community Services Data Set (CSDS)

- Deliver outreach NHS Health check data suitable for inclusion into the mandatory DHSC NHS Health Check returns (Public Health complete return)

- Produce ad hoc reports at the request of the Commissioner.

- Produce individual servicer user outcome reports by GP practice on a quarterly basis and disseminate these securely to practices.

- Monitor the servicer users progress over a 6 and 12 month period with the ability to monitor longer term follow up where necessary.

- Monitor the source of referral methods and onward referral information.

- Share data with the Commissioner on all servicer users accessing the Healthy Lifestyle Service (split by type where necessary) on a quarterly basis or at request from the Commissioner. The relevant data sharing agreements will need to be developed and agreed within three months from contract award date.

- Service users identifiable information is only shared with a servicer user's consent.

- The Service Provider will be responsible for developing methods of recording and storing information and data about servicer user progress following their interaction with the SPA (see section 9 for data monitoring requirements).

- The Service Provider must fully meet the data and Information Governance requirements as required for all service areas.

15.4 Data Protection

- The onus is on the Service Provider to collect, store and manage any data in accordance with full terms and principles of the Data Protection Act (2018) and ensure that data security is maintained in accordance with the law and standards set out by the Council

- The Service Provider is required to register with the Information Commissioner's Office.

- All personal data will be treated confidentially, and use of personal data will be made clear by clearly signposted privacy notices.

- The Council and the Service Provider will be joint data controller as defined by law in relation to any information collected, observed or provided by servicer users and will only be used by the Service Provider or its subcontractors as defined by the terms of the contract and any protocols or standards agreed between the Council and The Service Provider.

15.5 Data Validation

- The Service Provider shall ensure that any data being recorded for the service is validated and the process is agreed with the Commissioner.

- The booking, assessment, lifestyle service delivery, and follow up should not all be completed and inputted into the IT system by the same member of staff.

15.6 Audit Recommendations

- The Service Provider will complete two audits per calendar year.

- The Service Provider will agree the topics for audit with The Commissioner before commencing any audit.

15.7 Escalation Procedures

- The Service Provider must ensure that processes are in place for staff to escalate any issues that are raised by servicer users that are a cause for concern.

16. The Approach to Working Together

These principles and values form the basis for partnership working arrangements and will underpin a productive and efficient working alliance with the Service Provider of this service.

- A common purpose approach with good will and trust between partners.
- A 'can do' attitude where partners work collaboratively, adapting to changes in the environment together.
- Development of a culture of partnership, cooperation and recognition of challenges being faced.
- Recognition of challenges that both sectors are operating in a climate of constrained financial resources.
- Recognition that this contract will need to adapt and change and evolve to be responsive to changing circumstances.
- A commitment to jointly resolve any challenges that arise through the delivery of this service and in its monitoring and evaluation.
- Positive promotion of equality and diversity.

16.1 Support from the Commissioner

As a minimum Slough Council and the Integrated Care Board will support the Service Provider in the following ways:

- Proactively use all communications channels available to promote the service.
- Proactively promote the service at any relevant internal and external meetings.
- Facilitate attendance at key meetings e.g., GP locality meetings.
- Function as intermediaries/advisers to problem solve and optimise solutions.
- Facilitate meetings to resolve any issues quickly.
- Facilitate networking for providers to build relationships with partners.
- Support implementation of effective electronic referral using primary care clinical systems.
- Support promotion of staff recruitment to deliver the service where possible.

17. Mobilisation and Implementation

The Service Provider shall ensure that it allocates enough provision from contract award to ensure a smooth transition from current provision to the new service. The Service Provider shall work with the Council and Current Provider to deliver a seamless transition. The Service Provider will nominate a named mobilisation lead within the organisation to manage the mobilisation phase on a day-to-day basis and will ensure that the appropriate resources and skills are allocated to ensure the requirements listed below are delivered. The Service Provider shall attend transition meetings from award of the contract. As part of the transition the Service Provider shall submit to the Council the following:

17.1 Implementation Plan

This must include a detailed project plan covering the key elements for the implementation. The plan must set out the following:

- Details of any personnel who would fill key roles in transition and service delivery, including:
    a) what experience you would ensure they had,
    b) what their roles would be e.g., Project Manager etc.,
    c) when the people assigned to these posts would be identified.
    d) Staffing structure which includes FTE (Full Time Equivalent)

- Transfer of servicer users from Current Provider.

- Timescales

- Provision of building and premises

- Perceived risks and how you will identify and manage risk on an ongoing basis.

- How, and when you will identify any sub-contracting arrangements (if appropriate).

- Details and timescales relating to TUPE, how the TUPE process will be managed, management of TUPE issues and associated risks.

- Strategy for managing identified risks and issues for this contract.

- Outreach engagement plan.

- Communication and marketing.

- Maintaining business continuity.

- Risk and Contingency plans including specifics on managing the clinical transfer of servicer users.

- Completion of Data Protection Impact Assessment

17.2 Risk and Contingency Plans

The Council's transition expectations of the Service Provider are:

a) **A Clear Communication plan**
   The plan shall include clear details of how the Service Provider will ensure that key stakeholders, including servicer users, families and key partner organisations including GP's are kept informed of progress.

b) **Work in partnership with Current Provider**
   The Service Provider shall work in partnership with the current Service Provider to identify and address any gaps in the transition plan.

c) **Provide literature and publicise the new service**
   The Service Provider shall ensure that during the transition period it widely publicises the new service including information about how to access/refer into the service.

17.3 Staff transition

The Service Provider shall work with the incumbent service provider to support the transition process for all staff and recognise the need to be visible and address any anxieties over the TUPE process.

The Service Provider shall:

- Consistently communicate with staff from contract award to allay concerns with the aim of maintaining staff retention.

- Undertake robust TUPE planning and liaison with staff to ensure that the service deliverables can be met.

- Have a workforce development plan in place from service start with the aim of identifying gaps in staff and staff skills.

- Identify process errors and problems early in transition and have mitigation processes in place as soon as possible with the aim of reducing the chances of blockages, poor contractual performance and contractual risk.
- Have a provision of opportunities for staff to input into service development during the implementation phase.

- Ensure the Service Provider has enough visibility to aid service reputation from initiation of the service.

- Recruit and induct appropriately qualified, trained and skilled staff

- These standards and practices shall also apply at the end of the contract if/when there is a transition to another Provider.

17.4 Servicer users

- Managing change effectively to minimise disruption for servicer users and ensure that people receiving support are well informed and proactively supported through the period of transition, minimising disruption and distress caused by changes in service delivery.

- Identify the number of people who use services who will transfer to the new service and obtain consent for any transfer to the new service.

- Communicate with GPs/ primary care in order to keep well informed and to mitigate any concerns about transfer of people with support needs.

- Form a representative user panel that will help shape the new service and provide an advisory role during the transition period.

17.5 Infrastructure

- Ensuring premises planned for use meet the specified standards.

- Working with the key stakeholders to ensure effective joint working and sharing of premises, IT and equipment with relevant data sharing agreements developed and in place.

- Ensure interoperability of systems and put in place standard operating systems for relevant IT systems.

17.6 Service Launch

The Service Provider shall arrange a service launch event, in the appropriate manner, once the service is operational. The Service Provider may also hold further open days. Open days are the responsibility of the Service Provider to lead on, but the Commissioners should be kept informed and can offer input or support from within the Council.

18. Potential Additional Capacity and Roles

- There is potential that over the life of the contract additional capacity or roles may be required to increase the smoking cessation targets.

- There is no guarantee that the service capacity will increase, or roles will be required, and the contract may not be expanded. The following is provided for information only.

- The smoking cessation services are already within the scope of the awarded contract. The additional capacity will be an increase in numbers based on the services described in this specification.

- If additional capacity is required by the Commissioner, and it is permitted under existing Regulations, the Commissioner will vary the contract in line with the change control process set out in the Terms & Conditions.

- The unit prices for the additional capacity may be requested if the need arises

*Please note commissioners may assess the KPI set regularly and work with the provider to adjust as necessary according to the service needs and latest data to align with SBC's Population Health Management Approach.

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