

**SPECIFICATION  
FOR  
LIVING WELL SERVICE IN  
WORCESTERSHIRE**



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# 1 BACKGROUND AND CONTEXT

## 1.1 General Overview

1.1.1 The Living Well service is a behaviour change, health improvement service, providing:

- 1-2-1 information, advice and support including signposting and support to use on-line self-help materials
- Longer term peer support through community groups

1.1.2 The service is intended to work with individuals from disadvantaged communities (Indices of Multiple Deprivation (IMD) profiles 1 and 2) and those with a BMI of over 30, who require advice and practical support to make healthy lifestyle changes. The service will offer service users targeted and evidenced information, advice and support. The service will also provide follow up monitoring and support, as well as onward referral to specialist services to enable service users to make long term, sustainable healthy lifestyle changes. Access to the service will be through referral to the service from a range of agencies including the NHS and GP practices.

<b>Service user Identified through:</b>	GP; Health Check; School Nurses; Health Professional; Other	
<b>Service user MUST fulfil</b> to be accepted into 1-2-1 service	<b>Either;</b> <b>A.</b> IMD/LSOA Quintile 1or 2 <b>AND</b> <b>B.</b> 16 years of age or over	<b>Or;</b> <b>A.</b> BMI 30 or over  <b>AND</b> <b>B.</b> 16 years and over
<b>Plus 1 or more of the following;</b>	<b>C.</b> Physical Inactivity <b>D.</b> Poor Diet <b>E.</b> Low Mental Health and Well-being Score	
<b>1-2-1 Living Well Advisor</b>		
<ul style="list-style-type: none"> <li>• Brief intervention</li> <li>• Goal identification</li> <li>• Planning for change</li> <li>• Behaviour change</li> <li>• Motivational support</li> <li>• Measurement of progress and outcomes</li> <li>• Signposting and onward referral</li> </ul>		
<b>Outcomes to be recorded and measured throughout contact time</b>		
<ul style="list-style-type: none"> <li>• Onward referral and outcome of referral</li> <li>• Motivation Score (from baseline)</li> </ul>		

<ul style="list-style-type: none"> <li>• Mental Health and Well-Being WEMWBS (from baseline)</li> <li>• 5 a day intake (from baseline)</li> <li>• GPPAQ (modified version) (from baseline)</li> <li>• BMI</li> </ul>			
<b>Exit / Signposting and information</b>			
<b>Service user follow up measurements to be recorded on entry, midway (where appropriate), exit and long term maintenance review(s)</b>	<b>Signposted to Community Lifestyle Club for long term support</b>	<b>Signposted to online tools and local services</b>	<b>Referred to appropriate service</b>
<b>Feedback to referrer where appropriate</b>	<b>Volunteers to support ongoing development of lifestyle clubs</b>	<b>Local and Community services</b>	<b>Feedback to referrer where appropriate</b>
<b>Re-engagement with service applicable after significant time away from the service</b>	<b>Community Development and engagement to build upon community assets</b>	<b>WCC online support tools</b>	<b>Reengagement with service applicable after significant time away from the service</b>
<b>ALL service users must be monitored, recorded and followed up at 1 year from entry date</b>			

1.1.3 The Living Well service will provide an important component for increasing life expectancy in the long term, and the prevention and management of long-term/chronic conditions such as obesity, cardiovascular disease, and diabetes. It is expected that the Living Well service will contribute to changing high level public health outcomes relating to health and health inequalities.

1.1.4 The Living Well service will contribute over the longer term to changing high level public health outcomes relating to health inequalities such as;

<b>Indicator</b>
<b>Outcome 1:</b> Increased healthy life expectancy <i>Taking account of the health quality as well as the length of life</i>
<b>Outcome 2:</b> Reduced differences in life expectancy and healthy life expectancy between communities <i>Through greater improvements in more disadvantaged communities</i>
Life expectancy: Males
Life expectancy: Females
All-age all-cause mortality rate per 100,000 population
<75 CVD mortality rate
<75 Cancer mortality rate
Healthy life expectancy at age 65.
Adult participation in sport
Utilisation of green space for exercise/health reasons

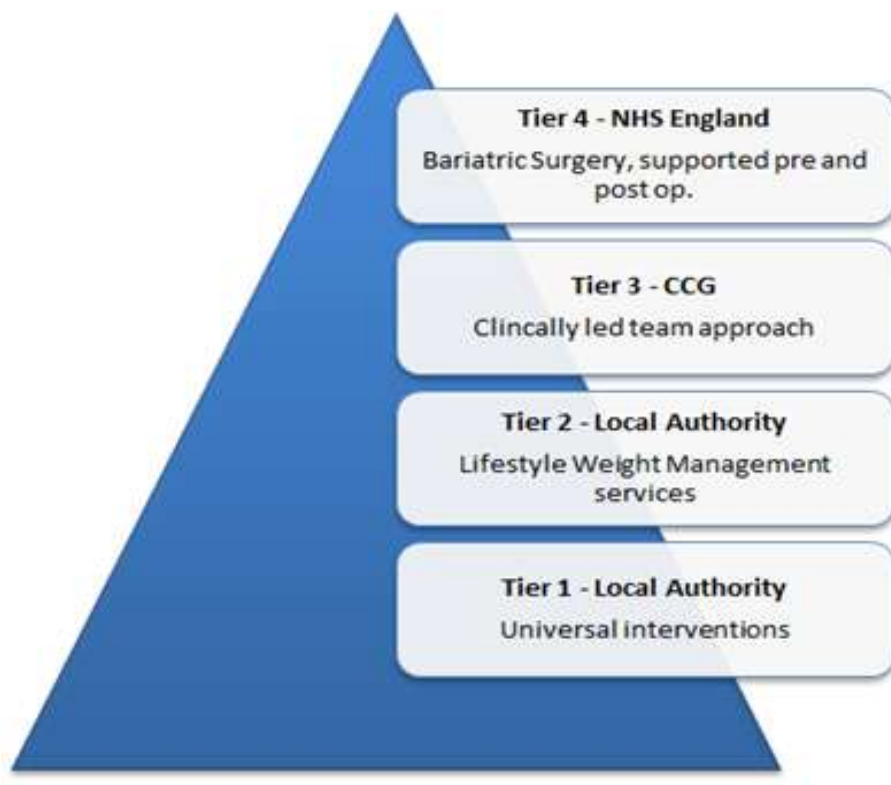
1.1.5 This service will reach and change the behaviour of hard to engage populations using an asset based approach. The method of delivery needs to demonstrably relate to the communities living in the areas it covers and local volunteers, developed as part of the service, will play a key role in supporting this.

1.1.6 The service is also expected to support and facilitate the provision of long term peer support within groups in the local community. Recent NICE guidance (PH47, 2013) has highlighted the positive effects on behaviour change from a group setting, noting that peer and group based settings give participants the opportunity to give and receive support from people facing similar problems, as well as the opportunity to share successes and experiences and build self-belief. Peer support models have been proven successful in various settings including the promotion of breastfeeding with mothers and have been recommended in NICE guidance (2008).

1.1.7 Achieving long term sustained behaviour change is a complex process. It is hoped that this intervention will reach and support service users that previously have been unable to be accessed to achieve in an increase in physical activity and healthy eating, which will in turn have a positive impact upon mental health and well-being.

1.1.8 The Report of the working group into Joined up clinical pathways for obesity demonstrated that Local Authorities, GGC's and Public Health England are responsible for the commissioning of tier services within the bariatric weight management pathway to tackle obesity. Their recommendations are outlined in the diagram below. It shows that local authorities are responsible for commissioning Tier 1 and 2 services within the county. It is intended that this service will be a tier 2 intervention working alongside the CCG who will commission tier 3 services to allow service users movement between the two tiers.

1.1.9 An example structure of the bariatric tier system is below:



## 1.2 Evidence Base

1.2.1 The Living Well service will, through prevention, contribute to tackling chronic diseases such as diabetes, heart disease, stroke and cancer, all of which are major causes of disability and early death. These diseases are closely linked to behaviours and lifestyle factors such as having an unhealthy diet; being physically inactive; being overweight and obese; smoking; and drinking too much. Changing these behaviours will, over time, reduce the risk rates of disability and early death, and therefore reduce demand for health and social care.

1.2.2 The Living Well service has been developed to incorporate NICE guidance (PH49 and PH53) and its principles for designing and delivering a behaviour change and lifestyle weight management service. This document will support the service throughout its development and can be found at <http://guidance.nice.org.uk>

1.2.3 This specification for the Living Well service adheres to and observes the NICE (2007) evidence on behaviour change to reduce health inequalities. The guidance shows that the following principles should be considered when tackling behaviour change in target populations;

- Base interventions on a proper assessment of the target group, where they are located and the behaviour which is to be changed;
- Work with other organisations and the community itself to decide on and develop initiatives;
- Build on the skills and knowledge that already exists in the community, for example, by encouraging networks of people who can support each other;
- Take account of – and resolve – problems that prevent people changing their behaviour (for example, the costs involved in taking part in exercise programmes or buying fresh fruit and vegetables, or lack of knowledge about how to make changes);
- Base all interventions on evidence of what works;
- Train staff to help people change their behaviour.

## 2 PURPOSE

2.1 An essential part of the Worcestershire County Council Future Lives programme and the Keeping Well work stream is to promote health and independence to enable people to keep well and healthy and avoid or delay the need for adult social care. This service has a particular contribution to limiting long term demand amongst those eligible for future adult social care with its emphasis on populations in IMD1 and 2. The Ageing Well needs assessment showed that obesity is a major risk factor for stroke, falls and cardiovascular diseases, and that tackling obesity in earlier life, could have a significant impact upon future care bills.

2.2 In the shorter term it is expected that outcomes will relate to individual behaviour change addressing the presenting problems

2.3 The Living Well service has been designed to focus on those living in more deprived communities, which will help to reduce health inequalities and the burden of future social care demand for those eligible.

2.4 The service will offer a flexible and developmental healthy lifestyle and behaviour change program. The service will focus upon implementation, data collection and ongoing evaluation throughout the first year supported throughout by a Living Well steering group. The steering group will provide ongoing support for the service to review activity and evaluate to inform the service development for years 2 and 3, with the expectation that this may need to be revised in the light of the performance in year 1. The service provider will contribute to and take an active role in the Steering Group.

2.5 The service will work with the most deprived communities (IMD 1 and 2) and with people with a BMI of 30 or over. This reflects evidence which shows that people in different social and geographical groups access support and services in different ways. Generally those in most need of health improvement support are the least likely to access support. The service will spend a significantly greater proportion of time supporting those living in IMD 1 and 2 to live a healthy lifestyle.

2.6 The Living Well service will proactively engage with individuals through a variety of settings specifically including GP practices. The team will motivate, support and encourage people to make healthy lifestyle changes, recording the presenting issue (e.g. physical inactivity), and the progress made against that issue. Advisors will give practical and motivational support to achieve lifestyle modification and identifying barriers to change. The service will act as message bearers between professionals and communities, translating health messages into actions that take account of individual circumstances.

2.7 The service will also build community capacity through the facilitation and provision of long term support groups which include peer support based within the local community, developing a cohort of local volunteers to support the groups.

### **3 AIMS**

3.1 The aim of the service is to reach and change the behaviour of hard to engage populations using an asset based approach. The method of delivery needs to demonstrably relate to the communities living in the areas it covers and local volunteers developed as part of the service will play a key role in supporting this.

3.2 The aims of the Worcestershire Living Well service are to:

- Work directly with individuals in Worcestershire from the most deprived wards to identify and modify health risk related lifestyle behaviour so as to reduce health inequalities and limit longer term demands for adult social care
- Promote independence, self-care and keeping well for life
- Build community capacity through the development of local peer support and volunteering activity
- Promote healthy weight and maintenance of healthy weight

- Bring individuals into more effective contact with mainstream health improvement and other local services - such as smoking cessation, opportunities for exercise, screening, and wider health and social care services

3.3 In order to achieve these aims the Living Well service will;

- Provide an approachable, trained, skilled and flexible workforce
- Offer one to one behaviour change services based within GP practices and community venues
- Support and facilitate community groups and clubs to provide peer led long term support to the community based upon living a healthy lifestyle and maintaining behaviour change
- Offer informed, practical and evidenced support to community groups and clubs
- Train, manage and maintain volunteers to support the development of community groups and clubs and promote healthy lifestyles within their communities
- Develop effective relationships with a wide range of local partners including a referral network of health improvement professionals, as well as non-health services
- Provide accurate information, support and signposting for individuals to enable self-care, including promotion of on-line services
- Ensure a clear referral pathway for referring services
- Collate and maintain accurate data to ensure high quality performance management information is available and engage fully in performance review
- Provide feedback to referring services on the progress of service users
- Contribute fully to an evaluation of the service on request

## **4 SERVICE SCOPE**

### **4.1 Service Description**

4.1.1 The Living Well service should offer support to the population from the most deprived areas or any referred patient with a BMI of 30 or over to identify and adopt healthier lifestyle choices including maintaining a healthy weight. Service users will be offered

4.1.2 1-2-1 and group based support, information and advice at a suitable time from an easily accessible venue, and as well as follow up monitoring and advice to make long term, positive changes to their current lifestyle behaviour.

4.1.3 In line with regional and national targets for health improvement, the main focus of the programme will be on increasing levels of physical activity, adopting a healthier

diet, and promoting mental health and well-being through the '5 ways to well-being'. The Living Well Advisors will promote and support the use of local community groups and activities such as community clubs supported by the service, leisure providers, health walk programmes, cooking clubs and various other activities to achieve this. Smoking cessation and reduction in alcohol consumption will be identified and referrals will be made to the most appropriate services.

4.1.4 The Living Well service, will have high visibility in the most deprived areas of the county identified using the National Deprivation Quintiles and Lower Layer Super Output Areas (LSOAs) (for a list of areas - see 6.1 service model – geographical coverage/boundaries)

## **4.2 Registered patients identified as obese (BMI of 30 or more)**

The service will develop a clear and effective referral pathway for registered patients identified as obese (BMI of 30 or more) by a health professional who require 1-2-1 assistance for behaviour change. The service will support these service users with a specific emphasis on healthy eating, physical activity and mental health and well-being as well as the complexities of diet and behaviour change. The intervention will be proportionate to need and where appropriate, self-help with signposting to online and community support will be provided to service users.

## **4.3 Family Support**

NICE recommendation (PH47) shows that obese children are likely to have obese parents and thus working with parents is the most effective way to support families to lose weight and maintain that weight loss. The service will support the family to achieve healthier lifestyles through healthy eating and increasing physical activity, whilst parents will also access both the 1-2-1 service and community clubs. There will be a pathway developed into the service from school nurses, health visitors, midwifery and the National Child Measurement Programme (NCMP) for parents.

## **4.4 Peer Support/ Community Groups**

4.4.1 The service is expected to promote health and well-being within communities, in particular deprived communities, and offer service users long term, peer led community support by assisting established community groups with evidenced health messages, information and practical support, for example cooking sessions, exercise classes and education sessions.

4.4.2 Where there is no established community group or club provision the service is expected to facilitate the development of a community group based upon the needs of the area and offer the same support listed above.

4.4.3 To support the maintenance of these community groups and promote health and well-being in the community, the service will recruit, train and manage a cohort of volunteers, working closely with existing local services to build upon community assets.

## **4.5 Accessibility/acceptability**

4.5.1 The service is for referred residents aged 16 and over. It will be delivered from visible, easily accessible buildings with disabled access.

4.5.2 The service will endeavour to provide a Living Well Advisor of the same sex when this has been requested by the service user.

4.5.3 The service will be required to provide information and communicate in the most appropriate method including:

- have access to appropriate foreign language translation service
- have access to appropriate sign language translation service and an understanding of deaf culture.

4.5.4 These services must be provided at the cost of the service provider.

4.5.6 The service will conduct appropriate targeted work if specific populations are underrepresented within the service population.

## **4.6 Whole System Relationships**

4.6.1 The Living Well service will work in partnership with a wide range of agencies to ensure the effective delivery of the intervention including, but not restricted to;

- GP practices and Health Centres
- Stop Smoking Services
- Substance Misuse services
- IAPT and other mental health services
- NHS Health Check Programme providers
- Pharmacies
- Leisure Providers
- Lifestyle Clubs in the community
- Community Centres
- Children's Centres
- School Nurses
- Other Health professional(s)

4.6.2 Worcestershire County Council also expects the service to link with other relevant programmes.

4.6.3 The service will establish and optimise referrals with a wide range of partners including GP's, and provide regular feedback to referring health professionals on the progress of their patients/service users through the Living Well pathway.

4.6.4 Partnership links with GPs are essential and it is expected that a large proportion of referrals will be generated from GPs. Any service user referred by any health professional must fulfil the referral criteria set by the service in agreement with the Service Steering Group. The progress of that service user through the service pathway should be fed back to the referral source.

4.6.5 The Living Well service will be supported by, and report to, a Living Well Support Steering Group. Members of the steering group will include key partners and stakeholders including a CCG member from each locality and other NHS representatives, who will oversee and advise the service, supporting evaluation and review to inform year two development. The service provider also will contribute to and take an active role in the Steering Group.

4.6.6 This group will develop an action learning methodology so that lessons learnt in year one can immediately be put into practice by the provider. A longitudinal study to determine the effectiveness and impact of the programme on long term behaviour change and service utilisation will run throughout the life of the contract to include long term follow up of service users.

4.6.7 A Living Well Service Performance Management Group will be convened and supported by the commissioning manager and contracts officer from the Worcestershire County Council Department of Adult Services and Health, with attendance from a Public Health Specialist. The performance management group will report regularly to the steering group.

## 5. SERVICE DELIVERY

### 5.1 Service model

5.1.1 The purpose of the Living Well service elements are to be consistent with current and future NICE guidance (including PH49) and must be updated accordingly;

<p><b>One to one session(s)</b></p>	<ul style="list-style-type: none"> <li>• Establish healthy lifestyle patterns, level of risk and identify potential areas for change through evidenced tools</li> <li>• Review and agree areas for change specifically;             <ul style="list-style-type: none"> <li>○ Diet/ healthy eating</li> <li>○ Exercise</li> <li>○ Mental Health and well-being</li> </ul> </li> <li>• Establish motivation for change</li> <li>• Give brief intervention</li> <li>• Establish the most effective methods for change</li> <li>• Develop SMART goals for change</li> <li>• Measure progress through evidenced tools</li> <li>• Determine level of 1-2-1 support from very brief to high intensity using NICE PH49 tools</li> </ul>
<p><b>Review of progress and provision of support</b></p>	<ul style="list-style-type: none"> <li>• Support the service user through the behaviour change process using evidenced based tools</li> <li>• Record and review progress against service users' personal</li> </ul>

	<p>goals and initial presenting issue</p> <ul style="list-style-type: none"> <li>• Conduct formal reviews and apply evaluation measures at entry, midway (where appropriate), exit and follow up</li> </ul>
<b>Community Groups, Peer Support and Long Term recovery</b>	<ul style="list-style-type: none"> <li>• Promote use of community based support and local assets already established</li> <li>• Build social capital</li> <li>• Promote volunteering in the community and peer support</li> <li>• Provide information and guidance on a range of health topics, to include information from non-health organisations</li> <li>• Practical and applied support</li> <li>• Promote self-esteem, confidence and resilience to empower individuals to be responsible for their own health</li> <li>• Give participants the opportunity to give and receive support</li> <li>• Create a friendly, open environment</li> </ul>
<b>Referral</b>	<ul style="list-style-type: none"> <li>• Identify and signpost service users to other local services as appropriate e.g. Substance Misuse Service, IAPT, Smoking Cessation</li> <li>• Provide and maintain effective referral from and to a wide range of health services.</li> </ul>
<b>Self-Care Service</b>	<ul style="list-style-type: none"> <li>• Signpost and provide support through community clubs, groups and services ordinarily available</li> <li>• Signposting and support to use public and on-line self-help tools, materials and services such as NHS Choices; Change 4 Life</li> </ul>
<b>Sign Off</b>	<ul style="list-style-type: none"> <li>• Review and record service users' achievement against personal goals and presenting issue, including feedback to the referrer where possible.</li> <li>• At the service users request</li> <li>• Following exit interview</li> </ul>

5.1.2 Advisors must use evidenced based tools and techniques for health decision making and goal setting to help service users make informed choices about lifestyle changes. They must also help service users plan for change, and refer them on to specialist health improvement services as appropriate.

5.1.3 Basic evidenced risk assessment tools must be used to support the service user through behaviour change and the evaluation and data collection aspect of the service.

Advisors must record and measure height and weight, calculation of BMI; and assessments of levels of physical activity, food intake, using the GPPAQ and intake of 5 a day. The Warwick and Edinburgh Mental Health and Well-being Scale (WEMWBS) must be used to determine a service user's mental health and well-being. Advisors must give feedback on the information gathered and help their service user to understand how their lifestyle behaviour impacts on their current and long term health.

5.1.4 The service must also monitor the use of primary and social care services for individual service users to demonstrate that the use of services reflects the service user's needs and further evaluate effectiveness of a system wide approach. Further data collection may be requested by the steering group at any time.

5.1.5 The service must ensure the following aspects are considered to ensure maximum benefit for service users: assessment; support; review and sign off. These must include, but is not limited to;

- Evidenced based behaviour change tools and techniques;
- Variety of contact methods with service users to include text, telephone, written and face to face;
- Review of any onward formal referral made;
- Formal feedback to the referrer once exit interview is complete/ or a plan for change has been established;
- Baseline measurement reviews including feedback to service user.
- Yearly follow up including measurements;
- Access to long term community groups and clubs with peer support to promote and maintain healthy lifestyle changes support by trained volunteers.
- Signposting to ongoing, web based or written information and guidance.

## **5.2 Days/hours of operation**

5.2.1 The Living Well service must be highly available and visible including outside of the normal working week i.e. evening and weekend appointments.

5.2.2 Hours of operation may be dependent upon the location from which the advisor is present i.e. GP practice opening times. Accessible and convenient operating hours must be accommodated where possible.

## **5.3 Referral and eligibility criteria and sources**

5.3.1 Service users referred to the Living Well service, through an established referral pathway to be agreed with the Steering Group, must fall into the following categories:

- People living in LSOA quintile 1 or 2
- Patients with a BMI of 30 or more who require 1-2-1 support

- People aged 16 years and over

5.3.2 Appropriate referrals into the service must be generated by working in partnership with a wide range of NHS, public, private and voluntary organisations to ensure the development of a simple and effective referral pathway with those organisations.

#### 5.4 Consent

Written consent must be sought from the service user to share information and feedback with the service user's GP or referring health professional where appropriate (e.g. did not attend/progress made on exit).

#### 5.5 Response times and prioritisation

5.5.1 Of the total number of service users, 70% will be referred from IMD quintiles 1 and 2, and 30% will be referred because they have a BMI of over 30. Service users from IMD 1 and 2 are priority service users over service users with a BMI over 30.

5.5.2 Service users must be contacted within 2 working days of receipt of referral. The service will have a contact number which is staffed or has an answering service that is regularly checked, so that service users are not waiting for long periods for a response. Where an answer machine is in operation service users should always be contacted as soon as possible and within 2 working days.

5.5.3 The provider will deliver services within 2 weeks of the initial eligible referral.

#### 5.6 Geographic coverage/boundaries

5.6.1 The primary focus of delivery must be in the most deprived areas (as identified by the LOSA's). Areas to be covered are:

**Worcester** (Warndon, Gorse Hill, Rainbow Hill, Cathedral, Nunnery and St Johns)

**Bromsgrove** (Charford, Marlbrook and Sidemoor)

**Redditch** (Batchley, Winyates, Greenlands, Abbey, Churchill, Central, Lodge Park, Matchborough, Headless Cross and Oakenshaw)

**Wyre Forest** (Aggborough and Spennells, Areley Kings, Cookley and Broadwaters)

**Wychavon** (Bengeworth, Droitwich Central, Droitwich West, Evesham North, Evesham South, Harvington and Norton)

**Malvern Hills** (Chase, Link and Pickersleigh)

5.6.2 Where priorities change during the life of the Contract, this must be reflected in the location of the delivery of the service and must be discussed with the steering group and the commissioner.

5.6.3 The chosen methods of recruiting service users to the service from IMD 1 and 2 communities will be determined by the service provider, ensuring that they are able to reach and change the behaviour of hard to reach populations to reduce health inequalities.

## **5.7 Locations and Delivery bases**

5.7.1 The service must be accessible to local people who require out of hours provision to include evenings and weekends. The service provider must ensure that the Living Well service operates from visible, accessible locations that have identified rooms for private consultations. All venues must be accessible and be responsive to the ethnic and cultural diversity of local communities in all districts.

5.7.2 GP practice based, central and high street locations in the most deprived areas, ensuring the service is highly visible and easily accessible for the hardest to reach service users, are recommended. The use of home visits is not recommended. The service provider must ensure that the service caters for all eligible service users, and that delivery of sessions in outlying areas is appropriately facilitated where there is demand. All venues must offer a safe and secure working environment and ensure that lone working policies are applied where necessary.

## **5.8 Premises and Facilities**

5.8.1 All resources, equipment and maintenance for the delivery of the respective service remain the responsibility of the service provider.

5.8.2 All premises must meet the requirements of the Disability Discrimination Act.

5.8.3 Services must be easily accessible by public transport and must have appropriate access and/or parking facilities.

## **5.9 Equipment and materials**

5.9.1 The Provider must provide and maintain at its own cost all equipment necessary for the delivery of the services and must ensure that all equipment is fit for the purpose of providing the services. All equipment used must be standardised and calibrated on a regular basis in accordance with manufacturers' recommendations e.g. weighing scales.

5.9.2 Information resources (e.g. leaflets) provided to service users must be evidence based, either from national guidance provided by the National Institute for Health and Clinical Excellence (NICE) or other nationally approved bodies. This information must include healthy eating, physical activity, promoting mental health and well-being and, where applicable, alcohol consumption and stopping smoking.

- Healthy eating information must include promotion of the five a day message on fruit and vegetable intake.
- Physical activity advice must include reference to the guideline of 150 minutes per week for adults.
- Mental health and well-being must include the '5 steps to well-being' programme.
- Alcohol information must include the recommended levels of 14 units per week for women and 21 units per week for men, with reduced tolerance levels for those aged 65 or over.
- Stop smoking information must emphasise the health risks and positive benefit of stopping smoking and congratulations on not smoking.

5.9.3 Where national guidance is updated during the period of the Contract, information given to service users must also be updated in line with this guidance.

5.9.4 Resources and marketing materials may be produced by the service using the nationally recognised Change 4 Life branding and must be designed in conjunction with Worcestershire County Council Brand Guidelines. Resources produced must be approved by the Council's Public Health Team.

5.9.5 Any press releases produced for local media sources must be approved in advance by the Worcestershire County Council Communications Team via the Commissioning Manager.

## **5.10 Signposting**

5.10.1 Service users with identified needs outside the service aims should be considered for signposting or referral to the following services (this list is not exhaustive):

5.10.2 In line with Worcestershire County Council key performance indicators (KPIs), Living Well Advisors must always ascertain the smoking status of each service user. If the service user is a smoker they must offer advice about the benefits of quitting smoking and signpost into local stop smoking services.

5.10.3 The Living Well Service may provide information about the National Chlamydia Screening Programme, and how it can be accessed locally (for service users aged 16 – 24). For further information on Chlamydia screening and other sexual health issues visit: [www.playinitsafe.co.uk](http://www.playinitsafe.co.uk)

5.10.4 Service users should be signposted to specialist local alcohol services for further support if necessary.

5.10.5 Mental Health and Well-being information must include the '5 Ways to Well-being' programme. For further support, service users should be signposted to IAPT (Improving Access to Psychological Therapies) and other mental health services offered in the county.

[www.iapt.nhs.uk/services/services/west-midlands-nhs-iapt-services/](http://www.iapt.nhs.uk/services/services/west-midlands-nhs-iapt-services/)  
[www.comfirst.org.uk/mhnetwork/statutory\\_services](http://www.comfirst.org.uk/mhnetwork/statutory_services)

5.10.6 The service provider must also ensure close liaison with the Living Well Steering Group when developing effective referral and signposting pathways.

5.10.7 The Living Well service is expected to signpost service users to appropriate online support including;

- Change 4 Life
- NHS Choices
- Worcestershire County Council Health and Well-being

## **5.11 Service user discharge**

5.11.1 The service user must be signed off from 1-2-1 support at the latest at 6 months, if the service user is attending a community group provided by the service they may wish to remain an active service user. If the service user is attending an independent community group they no longer need to be an active service user. Sign off from 1-2-1 support should be decided between the advisor and the service user in accordance with need. Sign off from 1-2-1 support can occur once people have determined a long term plan including online or community support if appropriate.

5.11.2 Service users that fail to respond to contact from the Living Well team or are no longer contactable should be signed off from the service after 3 failed contact attempts using different contact methods. These attempts should be recorded and feedback made to the point of referral.

5.11.3 Where possible, all service users signed off from the service should be signposted into a range of local services and activities alongside the self-care pathway, which will enable them to continue to make long term healthier lifestyle choices beyond the support of the Living Well.

5.11.4 The service must review, monitor and record the outcomes for all service users at 1 year from the date the service user commences 1-2-1 support. All service users should receive an exit interview at an agreed date to record their progress, to agree a plan for contact to review and monitor their outcome at 1 year from commencing 1-2-1 support, and to be signposted to on-going support via community or online resources.

## **5.12 Staffing**

5.12.1 The service provider must ensure that all staff are appropriately trained and competent to deliver the service as specified.

5.12.2 The staffing structure of the service must ensure the following key roles are delivered by appropriately qualified staff;

- Performance data, collection, inputting and reporting
- Volunteer recruitment, training and coordination
- Advisor recruitment, training and coordination
- Operational management
- Contract management

5.12.3 The key knowledge and skills required of the provider within the staffing structure include:

- Experience of delivery and management of a 1-2-1 service user focused service in a related field, with a public health/health improvement element;
- Knowledge and understanding of the main public health targets, issues and evidence, particularly with regard to disadvantaged communities.

- Specialist knowledge of community engagement and development work
- Experience of volunteer development
- Experience and delivery of community led groups
- Brief Intervention and motivational interviewing techniques

5.12.4 The provider must ensure an appropriate number of advisors per district and/or LSOA/IMD area dependent on demand and proportion of target audience.

5.12.5 All Living Well Advisors must provide:

- Accurate record of measurements required by the service
- Motivational assessment and support
- The opportunity for an individual to make a realistic and honest assessment of their readiness and personal capacity to make the proposed change;
- Practical ideas and support to encourage an individual in working to achieve their goals
- Detailed knowledge of local support and networks that can offer further help;
- Clear boundaries about the level and length of time that support can be made available - this should be agreed at the first meeting
- Onward referral to specialist lifestyle risk management services as appropriate.
- Leadership and support to a peer support and volunteer pathway and lifestyle club activity.
- Leadership and support for service users to join a peer support and volunteer pathway.

### **5.13 Staff Recruitment**

5.13.1 Where possible, Advisors and volunteers should be recruited from the local communities they serve. The learning and development needs of Advisors, once in post, should be met by the service provider.

5.13.2 The service provider must ensure that staffing levels are flexible so as to sustain appropriate service delivery in accordance with agreed targets and to ensure that service use is determined by service user need not provider convenience.

### **5.14 Staff Training**

5.14.1 All Advisors must undertake a comprehensive training package before any 1-2-1 delivery with any service users. It is the provider's responsibility to find a suitable, comprehensive training package, City and Guilds level 3 or RSPH (Royal Society of Public Health) or equivalent

5.14.2 All advisors must be competent and trained in;

- Motivational Interviewing
- Health Chats (Worcestershire County Council will provide training).
- Mental Health First Aid
- Community Development
- Nutrition and Healthy Eating recommendations
- Physical Activity planning and recommendations

5.14.3 The organisation must provide an appropriate range of mandatory training and ensure all staff complete the programme within the required timescales. The service provider must ensure all members of staff are able to demonstrate their participation in and completion of relevant training. This must include training related to safeguarding for children and vulnerable adults.

## **5.15 Data collection**

5.15.1 The service must have a data collection system and collect the data to meet the monitoring requirements. This includes, but is not limited to:

- Data required for quality and activity performance indicators (see section 8);
- Qualitative data from case studies
- Service user satisfaction reports
- Referral information including regular reports on incorrect referral and action taken;
- Data collection for the whole process of the service user pathway
- Service users' presenting issue and goals, and progress and achievement of those goals;
- Baseline measures for before and after intervention including;
  - 5 a day consumption
  - Physical activity levels (GPPAQ)
  - Mental Health and Well-being score (WEMWEBS)
  - BMI (Height and Weight).
  - Primary issue and progress against that issue

5.15.2 The service must also provide regular feedback to referrers including;

- Service user progress

- Service user satisfaction reports
- Referral information including regular report on incorrect referral and action taken
- Onward referrals made
- Service updates and events
- Opportunity for a referrer to feedback comments and experiences.

5.15.3 Additional data may also be requested as either ad hoc or regular reporting.

5.15.4 An annual report including all of the information listed above must be produced to report on the progress of the service and the service users outcomes. This is to be sent to stakeholders, referrers and Worcestershire County Council, and presented to the Living Well Steering Group.

5.15.5 Worcestershire County Council must be given access to the service data collection system if this is external to the provider e.g. web based, for verification purposes. If the data collection system is internal to the provider spot checks will be taken to monitor data collection and for verification purposes.

5.15.6 All Living Well service activity figures generated by the service provider or Worcestershire County Council may be used by Worcestershire County Council to inform national, regional and local monitoring systems where required.

5.15.7 The service provider is responsible for providing secure internet access on commencement of delivery.

## 5.16 Service Standards

The service provider must deliver services in accordance with best practice in health care and shall comply in all respects with the relevant standards and recommendations contained in National Institute of Health and Clinical Excellence Guidance and the NHS Constitution.

## 6. BASELINE PERFORMANCE INDICATORS - QUALITY, PERFORMANCE & PRODUCTIVITY

### 6.1 Quality and performance indicators

6.1.1 Quality and Activity performance indicators will be monitored by the service provider and reported to Worcestershire County Council on a quarterly and annual basis.

6.1.2 Activity may be monitored by the commissioner on a monthly basis if required.

### 6.2 Quality Performance Indicators

Quality Performance Area	Quality and Performance Indicator(s)	Threshold	Method of Measurement
1.Service User Experience	Service user feedback from	100% of service users asked	Written questionnaire

Quality Performance Area	Quality and Performance Indicator(s)	Threshold	Method of Measurement
	satisfaction survey at a) end of 1-2-1 support and b) at 1 year from commencing support	Of those that respond, 80% must be satisfied or very satisfied	Service provider quarterly report
<b>2.ImprovingService User Experience</b>	Service improvement action plans in place to deal with dissatisfactions expressed in the survey	An action plan as a result of the survey	Documented plan
<b>3.Reducing Inequalities</b>	Referred service users are from a balance (not disproportionate) of deprived areas (IMD quintiles 1 and 2) per district across the county	Proportionate representation of service users maintained by provider	Service provider quarterly and annual report to Commissioner and Steering Group
<b>4.Reducing Barriers</b> <b>Equality monitoring for gender and ethnicity</b>	Equality monitoring for gender and ethnicity (Worcestershire County Council to supply template report and list of ethnicity groups )  Service Improvement Action Plan in place to deal with any measured inequality	Reasonable representation of gender and ethnic groups	Service provider quarterly and annual report to Commissioner and Steering Group
<b>5.Other Lifestyle Services</b>	a) Proportion of service users that smoke that have been given stop smoking advice and signposted to a quit service.  b) Proportion of service users that exceed the government recommendation for safe alcohol consumption who are given alcohol advice and signposted to services.  c) Proportion of service users that require specialist support with mental health issues and are signposted to mental	100% of service users that smoke  100% of service users that exceed the government recommendation  100% of service users that require specialist support with mental health issues  100% of service	Referrals to specialist service and service provider quarterly report  Referrals to specialist service and service provider quarterly report  Referrals to specialist service and service provider quarterly report

Quality Performance Area	Quality and Performance Indicator(s)	Threshold	Method of Measurement
	health and wellbeing services  d) Proportion of service users that require referral to their GP or other specialist services	users that require referral to their GP or other specialist services	Referrals to specialist service and service provider quarterly report
<b>6. Annual report</b>	Annual report delivered to the steering group	Every year	Report presented within 3 months of the end of each year from commencement of Contract

### 6.3 Activity Performance Indicators

6.3.1 Activity performance indicators will be reviewed and agreed with the provider, the steering group and performance management group throughout delivery. In agreement with the Steering Group and service provider the service will follow a learning approach - activity during year one and in years two and three will be determined by progress and outcomes following monitoring and evaluation of year one.

6.3.2 Where activity shows a significant deficit from performance targets across two consecutive months of delivery, an extraordinary review meeting will be called with the service provider by Worcestershire County Council to review performance and identify solutions. Outputs from the meeting will be discussed by the steering group.

Activity Performance Indicators		Annual/Quarter Threshold	Method of Measurement
<b>Overall Service</b>	1. Total number of service users referred to the Living Well service from any agency	No threshold set	Quarterly and End of Year Activity Report
	2. Percentage of service users referred from GP or any NHS Trust (Acute or WHACT)	85%	Quarterly and End of Year Activity Report
	3. Total number of individual service users accessing the 1-2-1 element of the service in each year	4000 (annually)	Quarterly and End of Year Activity Report
	4. Percentage of service users accessing the 1-2-1 service from IMD 1 and 2	70%	Quarterly and End of Year Activity Report
	5. Percentage of service users engaged with the 1-2-1 service with a BMI of 30 from IMD 3, 4	30%	Quarterly and End of Year Activity Report

Activity Performance Indicators		Annual/Quarter Threshold	Method of Measurement
	or 5		
Lifestyle Advisor Caseloads	6. Recording of basic lifestyle measurements including BMI, WEMWEBS, GPPAQ for those who engage in the 1-2-1 service as specified above at entry and exit	100% ALL SERVICE USERS	Quarterly and End of Year Activity Report
	7. Percentage of service users that set personal health goals within one to one advisor sessions	95%	Quarterly and End of Year Activity Report
	8. Percentage completing 1-2-1- and going on to be involved with community clubs	50%	Quarterly and End of Year Activity Report
	9. Percentage <b>achieving improvement</b> against lifestyle measures including BMI, WEMWEBS, GPPAQ, as specified above.	80%	Quarterly and End of Year Activity Report
	10. Percentage of service users who have <b>maintained</b> achievement of goals (including BMI) at 12 months	70%	Quarterly and End of Year Activity Report
Lifestyle Club Engagement	11. Number of service users signposted to lifestyle clubs in the community	No threshold set	Quarterly and End of Year Activity Report
	12. Number of community clubs engaged with Living Well service	Minimum 2 clubs per district	Quarterly and End of Year Activity Report
	13. Numbers of service users engaged with lifestyle clubs	No threshold set	Quarterly and End of Year Activity Report
	14. Number of volunteers recruited and engaged with lifestyle clubs	12, (2 per district)	Quarterly and End of Year Activity Report

## 7. FUNDING INFORMATION AND PAYMENT STRUCTURE

### 7.1 Funding

7.1.1 The budget for the service sits with the Public Health ring fenced grant and is to be capped at £450,000 per annum, initially for up to 3 years. The contract value is £450,000 per annum (i.e. the maximum payment that could be achieved by the provider in any one year).

7.1.2 Cost savings will be explored through the life of the contract and any savings made against the capped spend will be absorbed back into the Worcestershire County Council public health ring fenced grant.

7.1.3 A full data collection system is required throughout the contract period of the service to monitor activity and produce a cost analysis of the service to explore its effectiveness against future estimated health care spend.

7.1.4 The recently developed Economic Assessment Tools will be used at the end of year 1 to predict future potential health care cost savings made as a result in reduction of BMI.

## **7.2 Payment Structure**

7.2.1 There are 2 key elements to the annual payment structure:

1. Block payment (please see Table 1)
2. Payment by result (PbR) related to the Key Performance Indicators (KPIs):
  - a) Incentive payment for overachievement of KPIs (see Table 1 below)
  - b) Withhold of part block payment for underachievement of KPIs: up to 5% of block payment (per annum)

7.2.2 Year 1 KPIs are listed below. These KPIs may change in years 2 and 3 through agreement of the Steering Group.

Year 1 KPIs:

1. Percentage of service users engaged with the 1-2-1 service from IMD 1 and 2 – 70% (Activity Performance Indicator 4)
2. Percentage of service users referred from GP or any NHS Trust (Acute or WHACT) – 85% (Activity Performance Indicator 2)
3. Percentage completing 1-2-1 support phase and going on to be involved with a community club – 50% (Activity Performance Indicator 8)
4. Percentage of service users achieving improvement against one or more lifestyle measures including BMI, GPPAQ, WEMWEBS and 5 a day consumption – 80% (Activity Performance Indicator 9)
5. Number of community clubs engaged with Living Well service (Activity Performance Indicator 12)

## **7.3 Incentive payment for overachievement of KPIs**

7.3.1 In year one 10% of the contract value (i.e. 10% of £450k) will be allocated to the PbR element and 90% to the block payment. This will change in years 2 and 3 as follows:

**Table 1:**

	<b>Block payment allocation</b>	<b>Payment by result allocation</b>
<b>Year 1</b>	90% of contract value/£405k	10% of contract value/£45k
<b>Year 2</b>	80% of contract value/£360k	20% of contract value/£90k
<b>Year 3</b>	70% of contract value/£315k	30% of contract value/£135k

### **7.3.2 Year 1**

The PbR element is offered through incentives of up to a maximum of 10% of the £450k contract value (i.e. £45,000). This is dependent on the provider overachieving the 5 KPIs below. Each KPI can earn up to 2% of the contract value i.e. £9,000 per KPI, per annum. Where a KPI is overachieved in any one quarter, a payment of 0.5% of contract value (£450,000) will be made. Please see Table 2 for Year 1 thresholds

### **7.3.3 Year 2**

The PbR element is offered through incentives of up to a maximum of 20% of the £450k contract value (i.e. £90,000). This is dependent on the provider overachieving the 5 KPIs below. Each KPI can earn up to 4% of the contract value i.e. £18,000 per KPI, per annum. Where a KPI is overachieved in any one quarter, a payment of 1% of contract value (£450,000) will be made. Please see Table 2 for Year 1 thresholds

### **7.3.4 Year 3**

The PbR element is offered through incentives of up to a maximum of 30% of the £450k contract value (i.e. £135,000). This is dependent on the provider overachieving the 5 KPIs below. Each KPI can earn up to 6% of the contract value i.e. £27,000 per KPI, per annum. Where a KPI is overachieved in any one quarter, a payment of 1.5% of contract value (£450,000) will be made. Please see Table 2 for Year 1 thresholds

## **7.4 Withhold of part block payment for underachievement**

7.4.1 Where the service underachieves on any one of the KPIs in any quarter a withhold of payment of 1.25% per quarter of the block budget will be made, continuing for each quarter until the performance returns above minimum standard, thus up to a maximum total withhold of payment of 5% of the block budget per year could be applied.

7.4.2 Withhold of block payment will not apply for the first 2 quarters of the contract in year 1 to allow time for setting up.

Please see Tables 2 and 3 for Year 1 thresholds and incentive payment structures.

**Table 2: Year 1 payment thresholds**

<b>Year 1 KPI's</b>	<b>Underachievement (Part of block payment withheld)</b>	<b>Block payment</b>	<b>Overachievement (Incentive payment)</b>
Percentage of service users engaged with the 1-2-1 service from IMD 1 and 2 – 70% (Activity Performance Indicator 4)	Under 65%	65 – 69%	70% and over (see table 3 below)
Percentage of service users referred from GP or any NHS Trust (Acute or WHACT) – 85% (Activity Performance Indicator 2)	Under 80%	80 -84%	85% and over
Percentage completing 1-2-1 support phase and going on to be involved with a community club – 50% (Activity Performance Indicator 8)	Under 45%	45 – 49%	50% and over (see table 3 below)
Percentage of service users achieving improvement against one or more lifestyle measures including BMI, GPPAQ, WEMWEBS and 5 a day consumption – 80% (Activity Performance Indicator 9)	Under 75%	75 – 79%	80% and over (see table 3 below)
Number of community clubs engaged with Living Well service (Activity Performance Indicator 12 i.e. 2 per district)	0 per district	1 per district	2 and above per district (see table 3 below)



**Table 3: Year 1 incentive payment structure**

Year 1 KPI's	Overachievement (Incentive payments)										
	70%	71%	72%	73%	74%	75%	76%	77%	78%	79%	80%
<b>KPI 1</b> Percentage of service users engaged with the 1-2-1 service from IMD 1 and 2 – 70% and above	70%	71%	72%	73%	74%	75%	76%	77%	78%	79%	80%
Incentive payment per quarter	£12.50	£37.50	£68.75	£113.75	£182.50	£282.50	£432.50	£662.50	£993.75	£1493.75	£2250
<b>KPI 2</b> Percentage of service users referred from GP or any NHS Trust (Acute or WHACT) – 85% and above	85%	86%	87%	88%	89%	90%	91%	92%	93%	94%	95%
Incentive payment per quarter	£12.50	£37.50	£68.75	£113.75	£182.50	£282.50	£432.50	£662.50	£993.75	£1493.75	£2250
<b>KPI 3</b> Percentage of service users completing 1-2-1 support phase and going on to be involved with a community club – 50% and above	50%	51%	52%	53%	54%	55%	56%	57%	58%	59%	60%
Incentive payment per quarter	£12.50	£37.50	£68.75	£113.75	£182.50	£282.50	£432.50	£662.50	£993.75	£1493.75	£2250
<b>KPI 4</b> Percentage of service users achieving improvement against one or more lifestyle measures including BMI, GPPAQ, WEMWEBS and 5 a day consumption – 80% and above	80%	81%	82%	83%	84%	85%	86%	87%	88%	89%	90%
Incentive payment per quarter	£12.50	£37.50	£68.75	£113.75	£182.50	£282.50	£432.50	£662.50	£993.75	£1493.75	£2250
<b>KPI 5</b> Number of community clubs engaged with Living Well - 2 per district	2 per district					3 per district			4 per district		
Incentive payment per quarter	£375					£1,125			£2,250		

**Table 4 – Withhold of payments**

LWS service - payment structure - withhold of payments							
		Quarterly			Annually		
Year		Block payment	Adjustment	Total payment	Block payment	Adjustment	Total payment
		£	£	£	£	£	£
<b>1</b>			<b>1.25%</b>			<b>5%</b>	
	@ 1.25% per quarter / 5% pa	101,250	5,063	96,188	405,000	20,250	384,750
<b>2</b>							
	@ 1.25% per quarter / 5% pa	90,000	4,500	85,500	360,000	18,000	342,000
<b>3</b>							
	@ 1.25% per quarter / 5% pa	78,750	3,938	74,813	315,000	15,750	299,250