Commissioning Plan

Integrated Lifestyle Support Service

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1. Executive Summary

The Health and Care Act (2012) places specific duties on the county council to protect and promote health and reduce health inequalities. Smoking cuts life expectancy by 10 years and is the biggest cause of premature mortality, with around 80,000 deaths in England each year. Smoking reduction services are the single most effective way of discharging the council's duty to tackle poor health.

Alongside smoking, obesity has been identified as the single most significant public health challenge facing society. Being overweight or obese increases the risk of developing chronic diseases such as type 2 diabetes; heart disease; stroke and some cancers with a consequent demand on health and care services.

Nationally the drive is towards preventing illness, tackling unhealthy behaviours and helping people to remain in good health for as long as possible. The unprecedented increase in the demand for health and care services escalates the need to look for prevention opportunities. The Wellbeing Commissioning Strategy sets out the council's intentions to provide interventions which reduce risks to health and tackle the impact of disease across primary, secondary and tertiary levels; an approach supported by the Lincolnshire Joint Health and Wellbeing Strategy which emphasises prevention and early intervention, delivering transformational change by and shifting the focus away from treating ill health and disability towards prevention and self-care.

Lincolnshire County Council currently commissions a range of services supporting prevention and the management of unhealthy lifestyles. These address single lifestyle issues or have a specific focus, such as smoking cessation, NHS Health Checks and alcohol treatment. The need to re-procure the Stop Smoking Service (SSS) provided an opportunity to investigate a more holistic approach to supporting people with multiple unhealthy behaviours through the commissioning of an Integrated Lifestyle Support (ILS) service.

The ILS service will provide adults in Lincolnshire with high quality accessible information and direct support focusing on the four lifestyle behaviours with the greatest impact on health and wellbeing:

- Smoking of tobacco
- Physical inactivity
- Obesity (food, nutrition and a healthy weight) and
- Excess alcohol consumption.

Evidence from the Joint Strategic Needs Assessment shows that:

- The smoking prevalence rate in Lincolnshire is 16.3%, significantly higher than national and regional averages.
- 63.7% of adults in Lincolnshire are estimated to be overweight or obese significantly worse than the average for England though broadly comparable to neighbouring areas in the East Midlands.
- 24.5% of Lincolnshire's adult population were considered physically inactive, significantly higher than nationally, and second highest in the East Midlands.
- Around 21% of adults in Lincolnshire are drinking alcohol at levels that pose some risk to their health.

Evidence suggests an adult in mid-life who smokes, drinks to excess, is inactive and eats unhealthily is four times more likely to die early. In England around 25% are engaged in 3 or more of these behaviours, and only 6% engage in none. The most vulnerable and disadvantaged are more likely to lead an unhealthy lifestyle.

Changing health behaviour requires a range of approaches that combine tiers of interventions addressing the individual, the community and the population. The ILS service will focus on supporting individual behaviour change within this broader context of local communities and the wider population. Evidence shows that people who are motivated to make changes in their behaviour and receive appropriate professional support significantly increase their chances of success.

The countywide ILS service will provide tailored individual support for up to 12 months. The service will promote sustainable lifestyle change and behaviours through access to stop smoking services, brief interventions for alcohol, diet and nutrition, and physical activity. These activities will be provided from within local communities to build community resilience and prevent relapse.

The service will target eligible adults aged 18 and over. They will be referred into the service through a single point of contact via the following pathways:

- People with long term health conditions, will be accepted where their GP or other health or care professional believes a lifestyle change will improve their condition.
- At risk adults who have undertaken a NHS Health Check for CVD Prevention
- People, who might require, in future, support for smoking cessation and/or weight management prior to surgery.
- Eligible carers identified through primary care or a carer's assessment.
- People who smoke and seek help to stop, particularly pregnant women.
- The Lincolnshire County Council workforce with any of the above.

Estimates on the scale of behaviours within the proposed criteria show the potential size of the target group is substantial. Funding for the service is £2,750,000 comprising; £1,249,000 current spend on the stop smoking service, a further £1m from the public health grant and £500,000 from the Lincolnshire Clinical Commissioning Groups through a Section 256 Agreement. The service is looking to deliver 10,000 behavioural change outcomes per year – this can be multiple outcomes for one individual.

The outcomes and measures to be delivered by the service are;

- Reduction in obesity prevalence (measure: 5% weight loss).
- Increased participation in physical activity (measure; moving from inactive to active).
- Reduction in smoking prevalence (measure: 4 weeks quit status).
- Increased number of people drinking sensibly (measure: less than 14 units per week or reduce alcohol consumption by 50%).
- People supported from areas in Lincolnshire that have the greatest need.
- Percentage of people supported to eat five portions of fruit and vegetables on a 'usual' day.
- Percentage improvement in self-reported wellbeing.

Estimation on the potential pool of people in Lincolnshire with unhealthy lifestyle behaviour has been modelled based on a number of assumptions from Public Health England and the Kings Fund. This approach will be tested, as far as possible, as part of the market engagement phase and, if necessary with further benchmarking work with other commissioners. This will include whether there is sufficient funding to deliver 10,000 behavioural change outcomes per year.

Agreement is in place to extend the existing stop smoking service by a further six months to allow sufficient time to procure and mobilise the new ILS service. The contract for the new ILS service is due to be awarded in January 2019, with the new service going live in May 2019.

2. Background and Introduction

The *Health and Care Act (2012)* places specific duties on the county council to promote and improve the health and wellbeing in Lincolnshire as well as taking steps to reduce health inequalities. Health improvement measures could include: giving information and advice, providing services to promote healthy living and incentivising people to live more healthily.

Smoking remains the biggest cause of premature mortality in England, accounting for around 80,000 deaths each year and approximately 1,250 in Lincolnshire. On average a smoker reduces their life expectancy by 10 years and has an increased risk of developing more than 50 health conditions. Therefore reducing smoking prevalence is the single most effective way of discharging the Public Health duty. Alongside smoking, obesity is also a major public health challenge. Being overweight or obese increases the risk of developing chronic disease such as type 2 diabetes, heart disease, stroke, liver disease and some cancers. The burden on the health and care system will only increase unless interventions are put in place to tackle unhealthy behaviours.

The Council currently commissions a local stop smoking service (LSSS). In 2015 the contract for the service was awarded to North51 to provide a smoking cessation service, covering a maximum period of 5 years. Their Quit51 stop smoking service operates a community model of provision encompassing a core service alongside engagement with a network of sub-contracted providers offering behavioural interventions linked with medication to support people to quit smoking. The central functions include:

- Co-ordination, support and administration of core and network activities
- Management and responsibility of a core team of specialist smoking cessation advisors
- Networked smoking cessation with affiliated/contracted providers
- Hub telephone support
- Training – professional development, brief interventions and service awareness
- Promotions and social marketing initiatives.

Smoking cessation services are measured for outcomes based on the level of 4-week smoking quits (Carbon Monoxide validated and non-validated) going through the service, as outlined in the Public Health England guidance. The Lincolnshire's Tobacco Control Strategy 2013 - 2018 included an ambition to secure up to 7,000 4-week smoking quits annually in order to contribute to the reduction in smoking prevalence within the county.

Based on performance for the LSSS in 2017/18, 5,207 people set a quit date, resulting in 2,351 4 week quits, a quit rate of 44.2% (down on the previous year's performance of 48.6%). Performance against the council's 4 week quit maximum capacity of 3,169 quits was 74% for the smoking cessation service.

Bionical, the parent company of North51 have stated that they are exiting from the provision of public health contracts and as such following the end of the current contract will not be submitting a tender for the new service. Agreement has been given to extend the current LSSS contract to 30 June 2019 to allow sufficient time to procure a new integrated lifestyle based service.

In addition, the council also commissions the following services aimed at preventing and managing unhealthy lifestyles; NHS Health Checks and a Substance Misuse Treatment Service, which provides specialist structured interventions to people with higher levels of alcohol dependency. Whilst neither of these services are included within the scope of the

Integrated Lifestyle Support (ILS) service, they will provide referral routes in and out of the ILS and are therefore key dependencies.

The council does not currently commission any services to address weight management, physical inactivity, obesity or lower level excess alcohol consumption.
The need to re-procure the LSSS has provided an opportunity to investigate a more holistic approach which supports people with multiple unhealthy behaviours to improve their health and wellbeing through the commissioning of an ILS service. The introduction of an ILS in Lincolnshire will provide high quality, accessible information and support to adults in Lincolnshire to help them adopt and maintain healthier lifestyles. It will focus on the four lifestyle behaviours that have the greatest impact on health and wellbeing:

- Smoking of tobacco
- Physical activity
- Food, nutrition and a healthy weight
- Excess alcohol consumption.

3. Summary of Requirements

3.1 National Strategies and Policies

Health in all Policies (Public Health England, 2016) advocates a collaborative and systematic approach to ensure health and wellbeing considerations are incorporated into local policy making. The approach is based on the recognition that many of the most pressing health and care challenges, for example the increase in people living with chronic and long term illnesses, an ageing population, and growing health inequalities, are highly complex and often linked to wider social, cultural and economic determinants of health. The ILS will address this through targeting people with multiple behavioural factors which place them at heightened risk of developing long term complex illnesses linked to their lifestyle.

NHS Five Year Forward (NHSE 2014) highlights the current issues faced by the NHS and associated services and promotes the need for greater opportunities for better health through an increased focus on prevention and self-care. The ILS will support this aim by helping people to make healthier lifestyle choices and behavioural changes. The outcome of the approach will be to improve health and wellbeing and reduce health inequalities thereby reducing or delaying the need for costly health and social care services.

Action on cardiovascular disease: getting serious about prevention (PHE, 2016) provides an overview of the impact of CVD and outlines Public Health's role in prevention. As a result of this publication, commitments to CVD prevention have gathered momentum and it has become a priority for the NHS Prevention Board; as a result it features prominently in the *Next Steps on the NHS Five Year Forward View (2017)* and the NHS *RightCare Programme.*

Care Act (2014) emphasises the need for prevention as a way of promoting wellbeing; preventing, reducing or delaying need; providing information and advice where appropriate. The introduction of an ILS service supports the council to meet its duties under the Care Act to prevent, delay or reduce the development of needs for care and support.

Transforming the delivery of Health and Social Care – the case for fundamental change 2012 explains the need to focus on preventing illness, tackling risk factors, helping people remain in good health, supporting people to live in their own homes and integrating care around the needs of people and populations. The ILS supports this through targeting

specific individuals with risk factors that suggest they may be at risk of future need for more costly health and care support.

NICE have published a number of relevant guidance documents which provide information and best practice guidance to inform service design and delivery. This includes:

- NICE Guidance: Behaviour Change – Individual Approaches, 2014 [PH49]
- NICE Guidance; Nutrition Support in Adults, 2012 [QS24]
- NICE Guidance: Alcohol use disorders – prevention, 2010 [PH24]
- NICE Guidance: Weight management – lifestyle services for overweight or obese adults, 2014 [PH53]
- NICE Guidance: Smoking: supporting people to stop, 2013 [QS43]
- NICE Guidance: Smoking Harm Reduction, 2013 [PH45]

3.2 Local Strategies

The *Wellbeing Commissioning Strategy* sets out the council's intention to improve and protect the health and wellbeing of people in Lincolnshire. This can best be achieved when people are supported to be independent, make healthier choices and live healthier lives. The council's approach to prevention and early intervention is illustrated in Figure 1. A key component of the strategy is to work in collaboration with the NHS to address risky lifestyle behaviours. The ILS will support people across the range and levels of prevention set out below. The approach to prevention aims to provide interventions which reduce risks to health and wellbeing and tackle the impacts of disease:

- **Primary prevention** aims to prevent a condition or disease developing e.g. through promoting health behaviours;

- **Secondary prevention** aims to reduce the impact of a condition that already exists – this can include early detection and management, and lifestyle programmes to improve healthier behaviours and slow progression of the condition;

- **Tertiary prevention** aims to reduce the impact of long term illness e.g. through rehabilitation programmes and long term condition management programmes which aim to maximise capacity for living well.

Figure 1: Community Wellbeing Commissioning Strategy, 2017-2020

The new *Joint Health and Wellbeing Strategy (JHWS)* for Lincolnshire, agreed by the Lincolnshire Health and Wellbeing Board in June 2018, has a strong emphasis on prevention and early intervention, with a clear aim to deliver transformational change which shifts the focus from treating ill health and disability to prevention and self-care. The ILS support a number of these themes and priorities and so will be an important part of ensuring the delivery of the aims and objectives of the JHWS. The overarching themes of the JWHS are to:

- embed prevention across all health and care services;
- develop joined up intelligence and research opportunities to improve health and wellbeing;
- support people working in Lincolnshire through workplace wellbeing and support them to recognise opportunities to improve their health and wellbeing;
- harness digital technology to provide people with tools that will support prevention and self-care;
- ensure safeguarding is embedded.

The priorities in the JHWS are focused on the areas identified from the JSNA as being the most important health and wellbeing issues facing the county. These are:

- Carers
- Dementia
- Housing and Health
- Mental Health (Adults)
- Mental Health and Emotional Wellbeing (Children & Young People)
- Physical Activity
- Obesity

3.3 The Level of Need in Lincolnshire

Joint Strategic Needs Assessment (JSNA) for Lincolnshire is an overarching needs assessment for Lincolnshire, detailing key issues for the population and providing the evidence base for service planning and commissioning. Below is a summary of the evidence from the relevant JSNA topics linked to the lifestyle behaviours that will be addressed by the ILS service.

3.4.1 Smoking (JSNA Reduced Smoking in Adults topic)

Tobacco is the single largest cause of preventable ill health and premature death in the UK and smoking increases a person's risk of developing more than 50 serious health conditions. Smoking accounts for over one third (35%) of respiratory deaths; over one quarter (27%) of cancer deaths; and about one seventh (13%) of all cardiovascular disease deaths.

In 2017, the smoking prevalence rate in Lincolnshire was significantly higher than the national and East Midlands average prevalence; 16.3% for Lincolnshire, 15.7% East Midlands and 14.9% England[1].

Because smoking prevalence is based on survey data caution needs to be taken when looking at estimates at district level due to lower numbers of people surveyed. However it would appear from this data that prevalence is likely to be highest in Boston and lowest in South Kesteven.

[1] PHE Local Tobacco Control Profiles

Smoking during pregnancy can have adverse outcomes for maternal and child health, contributing to miscarriage, stillbirth, premature birth, low birth weight, sudden infant death and other chronic conditions which can impact on a child's development.

Smoking at the time of delivery continues to be a challenge for Lincolnshire with historically poor data quality. As of December 2017, the range of smoking in pregnancy across CCGs was 13.8% to 17.7%, in contrast with the national figure of 10.7%.

Smoking remains the leading cause of health inequalities with the most disadvantaged and vulnerable groups within society having the highest smoking rates. This very high smoking rate is one of the most significant causes of the difference in health and life expectancy between areas of high deprivation and areas of low deprivation.

3.4.2 Obesity and Weight Management (JSNA Obesity topic)

Being overweight or obese greatly increases the risk of developing type 2 diabetes, hypertension, cardiovascular disease, liver disease and some forms of cancer. Being overweight or obese is therefore associated with increased disability, reduced quality of life and premature death.

All four of Lincolnshire's Clinical Commissioning Groups (CCG) rank within the top five in the East Midlands for obesity prevalence, with 75,885 people on the obesity register and an estimated 27% (161,931 people) of the population having a BMI over 30. Lincolnshire has a hospital admission rate for obesity of 5 per 100,000 population, similar to the regional average.[2]

The percentage of adults estimated to be overweight or obese in Lincolnshire is 63.7%, significantly worse than the England level and broadly comparable to other neighbouring areas in the East Midlands. However within Lincolnshire this ranges from 60.7% in Lincoln to 67.8% in East Lindsey[3].

The NHS Health Check Programme locally assesses adults aged 40-74 years for cardiovascular disease risk that includes BMI. The assessment has identified, that of the adults screened as part of a health check, 66% have excess weight and 28% are obese.

National estimates for the levels of morbid obesity when applied to Lincolnshire suggest that there may be 11,500 adults with a BMI over 40 and 800 with a BMI over 50.[4]

3.4.3 Physical Activity (JSNA Physical Activity topic)

According to Public Health England, physical inactivity is one of the country's most urgent challenges. Without action the burden upon the health and care sector could destabilise services and have a major impact on people's mental and physical health.

Numerous national policies and NICE guidance evidences the value of regular physical activity. Physical inactivity directly contributes to morbidity and premature mortality, as well as obesity. Regular physical activity can improve health outcomes with or without weight loss. Revised physical activity guidance recommends adults achieve a minimum of 150 minutes of moderate activity, linked with at least two muscle strengthening activities and

[2] Health Survey for England 2017: Adult overweight and obesity, QOF
[3] Public Health Outcomes Framework
[4] Clinical Commissioning Policy: Complex and Specialised Obesity Surgery, NHS Commissioning Board, 2013

efforts to minimise sedentary behaviour every week. Moderate activity can be achieved through brisk walking, cycling, gardening, housework as well as sport and exercise.

In 2016/17, 24.5% (accounting for 146,938 people) of Lincolnshire's adult population were considered physically inactive, significantly higher than nationally (22.2%), the second highest in the East Midlands and the highest amongst Lincolnshire's 16 statistical neighbours. Within Lincolnshire, South Holland has nearly a third (31.9%) of adults considered inactive, the highest in the East Midlands. Boston (28.2%) and East Lindsey (27.1%) are also significantly higher than the national average and in the top 10 highest inactive populations in the East Midlands.[5]

3.4.4 Alcohol (JSNA Substance Misuse topic)

Alcohol consumption can be linked to 60 different medical conditions including liver disease, hypertension, depression, stroke, cardiovascular problems and cancers. It also contains large amounts of sugar which can be linked to weight problems and alcohol related diabetes. It is recommended that no more than 14 units of alcohol are consumed regularly per week which should be spread over 3 or more days with several drink free days per week.

In Lincolnshire, there were 14,398 hospital admissions for alcohol related conditions during 2016/17 which is 1,811 per 100,000 population. Around 22.1% (132,544 people) are drinking at levels that pose some level of risk to their health, with 6,807 of these dependent on alcohol which requires specialist treatment.

In January 2016 the Chief Medical Officer issued revised guidance on alcohol consumption which advises that in order to keep to a low level of risk of alcohol-related harm adults should drink no more than 14 units of alcohol a week. Based on the Health Survey for England, Public Health England estimate that 22.1% of adults in Lincolnshire drink over 14 units of alcohol per week. Whilst this is the second lowest in the region, household surveys are known to under-estimate alcohol consumption and some individuals who don't currently exceed government guidelines might have drunk at risky levels in the past and hence remain at risk of developing alcohol-related conditions.[6]

3.4 Literature Review

In a report commissioned by the Kings Fund*, 'Clustering of unhealthy behaviours over time: implications for policy and practice' (Buck and Frosini, 2012)* evidence suggests that many unhealthy behaviours such as smoking, poor diet, hazardous alcohol use and physical inactivity, tend to cluster together. Yet services and policies designed to help people change their behaviour tend to take a silo approach, addressing these behaviours in isolation, and not recognising that many people experience more than one behaviour simultaneously.

An adult in mid-life who smokes, drinks to excess, is inactive and eats unhealthily is four times likely to die early than someone who does none of these. In England around a quarter of people are engaged in 3 or more of these behaviours, and only around 6% engage in none of them. It is estimated that around 80% of deaths from major diseases, for example cancer and heart disease, are attributable to unhealthy lifestyle risk factors.

According to the World Health Organisation, the eight key risk factors (alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable consumption and physical inactivity) account for as much as 61% of all

[5] Public Health Outcomes Framework
[6] Local Alcohol Profiles for England

cardiovascular deaths and over a quarter of all coronary heart disease (CHD) and is the leading cause of death worldwide.

Research suggests tackling the behaviours and risk factors that contribute to major disease such as cardiovascular disease, metabolic diseases and cancer is possible with a range of primary, secondary and tertiary prevention approaches, including lifestyle programmes, at scale. NICE guidance *PH6 on 'Behaviour change: general approaches' (2007)* points towards there being overwhelming evidence that changing people's health related behaviours can have a major impact on some of the largest causes of mortality and morbidity.

There is strong evidence to show that positive changes to behavioural risk factors during adult life will reduce an individual's risk of early death and ill health, including dementia, disability and frailty in later life. Emotional and mental health is also an important contributing factor to people's overall health and wellbeing.

The greater the number of unhealthy lifestyle behaviours the greater the risk of ill health and early death. Evidence suggests that the most vulnerable and disadvantaged are more likely to lead an unhealthy lifestyle leading to a higher risk of ill health. The strong link between deprivation and ill health underlines the importance of tackling the underlying determinants of unhealthy behaviours as well as the behaviours themselves. Therefore, individual level interventions aimed at changing unhealthy behaviours need to be complemented by interventions at a population, community and organisational level, such as public campaigns to raise awareness and prompt behaviour change.

Alongside this, there is strong evidence relating to the motivation to change (Lai et al. 2010; Ruger et al. 2008), and changing the context in which someone makes a decision – nudge interventions (Thaler and Sunstein, 2008). For any change in behaviour to occur, a person must:

- be physically and psychologically capable of performing the necessary actions;
- have the physical and social opportunity - people may face barriers to change because of their income, ethnicity, social position or other factors. For example, it is more difficult to have a healthy diet in an area with many fast food outlets or no shops selling fresh food;
- be more motivated to adopt the new behaviours, rather than continuing with old habits.

The COM-B Behaviour Change Model, recommended by NICE guidance [PH49] on '*Behaviour Change: individual approaches'* (2014) focuses on:

- goals and planning;
- work with the client to agree goals for behaviour and the resulting outcomes;
- develop action plans and prioritise actions;
- develop coping plans to prevent and manage relapses;
- consider achievement of outcomes and further goals and plans.

In conclusion, research estimates that 25% of the population engages in 3 or more unhealthy behaviours which significantly increases their risk of developing a long term condition(s) or disability. A review of academic literature and best practice suggests that addressing multiple lifestyle behaviours in a holistic way rather than in isolation offers an effective model. However, the greatest impact is achieved when interventions are sequenced; delivered as a plan of interventions developed with the individual seeking behavioural change. Therefore any behavioural change model needs to be flexible to take

account of the overlaps between the issues for individuals and look for opportunities to optimise common management approaches across a period of up to 12 months.

3.5 Engagement

3.5.1 User Engagement

From the evidence provided in section 3.4, there is a compelling case to show that by focusing on interventions that address multiple behavioural risk factors rather than on a single health related lifestyle issue provides a more holistic approach to supporting people identified as being at risk of developing co-morbidities or dying prematurely. Existing examples (see section 3.5) from elsewhere in the county provide a proven model of delivery to inform the development of the ILS in Lincolnshire.

Given this and based on advice from the council's Community Engagement Team (CET), no direct service user engagement has been undertaken to inform the development of the model. However, a recommendation of the CET is that once the contract is awarded, as part of the mobilisation phase, the service provider engages with service users to help inform how the service will be rolled out into different communities across the county.

In addition, once the service is operational, the service provider will also be expected to engage service users in ongoing evaluation of the service and to inform service improvements and developments.

3.5.2 Stakeholder Engagement

As part of developing the Joint Health and Wellbeing Strategy, a series of stakeholder engagement events were held between June to August 2017 to gather views from key stakeholders, partners and public on what the health and wellbeing priorities should be for Lincolnshire, based on the evidence in the JSNA. Over 400 people, representing 80 organisations or groups, took part in the exercise. The clear message from the engagement was the need for preventative action which prevents, reduces or minimises the escalation of health and care needs in the future. Section 3.2 details the Joint Health and Wellbeing Strategy themes and priorities, and a full report on the engagement findings is available to view on the council's website.

Preliminary engagement with key stakeholders, including primary care providers, the Lincolnshire Carers Services and Arden and Gems, was undertaken in June 2018 regarding the referral pathways. The purpose of this exercise was to gather initial feedback on how people identified 'at risk' would be referred into the ILS. Information gathered as part of this process has been used to shape the proposed model and approach. However, following market engagement further engagement and testing may be required with potential referral partners to validate all the assumptions set out in Section 4.

A formal stakeholder engagement exercise, primarily aimed at primary care partners and the Lincolnshire Carers Service, is planned for late summer 2018. The purpose will be to raise awareness of the proposed approach, seek buy-in and support, and further test the assumptions around the eligibility criteria, volume of interventions and referral pathways. A Stakeholder Communication and Engagement Plan is being developed for this phase of engagement.

3.5.3 Market Engagement

Initial market engagement has been undertaken to test whether the service proposed is viable, affordable, deliverable and attractive to potential providers. A PIN notice was published and a questionnaire issued to responders that described the principles of the proposed service, covering scope, structure, demand and budget. Feedback was sought on the market's likely interest and capacity to undertake such a service.

In total fourteen providers responded to the ILS pre-market engagement questionnaire, of which eight appear to operate services linked to both support to stop smoking and wider lifestyle support. Whilst the level of information provided does not allow for detailed evaluation of their capability, it is indicative of a good level of interest in the market and the potential likelihood of a good level of competition in any resulting tender process.

Ten of the fourteen interested providers indicated a preference for a contract with an initial term of 5 years with an option(s) to extend. A question was posed about the viability of a shorter 3+1+1 term, and whilst this was generally acknowledged to be viable, concerns were raised. Ability to offset the costs of set up and mobilisation (including property acquisition, IT and infrastructure, TUPE and recruitment) was the main reason for concerns about a shorter term, but staff stability, service development and innovation in the delivery model, and the development of trusting relationships with other local service providers, including the NHS, and residents were also key factors in the preference for a minimum 5 year term.

Based on information supplied, eight of the fourteen interested providers appear to have the capability to provide the full range of the Integrated Lifestyle Support services; however it's unclear in most cases how countywide coverage would be achieved at this stage. Where providers noted that they are unable to provide the whole range of services themselves, there was an appetite to work as a prime provider and in partnership with specialist providers as sub-contractors to deliver the full scope of services.

In response to a request to identify potential challenges in an integrated delivery model, several key points were identified. These included factors linked to the delivery of a broad range of support that could add cost (such as out of hours coverage, training needs across a range of disciplines and the management of a large number of sub-contractors); and the need to preserve specialisms, such as stop smoking service delivery in line with NCSCT and NICE guidance and the multiple ways in which support for quitting can be utilised.

The market was generally positive about the deliverability of an Integrated Lifestyle support service and the feedback around this question suggested that the annual budget and volumes indicated were achievable. However two providers did raise concerns over viability, suggesting that the funding for the volumes indicated was not viable and would only attract low quality providers who bid on the basis of an intention to challenge/change contract targets. There was an associated suggestion that there are clear fixed costs associated with delivery of individual preventative health services and setting of delivery volumes that are proportionate to the contract budget. Further, letting the market propose delivery volumes within the available budget so that the contract is realistic and achievable would be the best course of action. Further face to face market engagement, to test the volume and cost assumptions, will take place on 15 August 2018 to feed into the finalisation of the specification document.

The preferred model for nine of the fourteen is a block payment model with variations, ranging from total block payment to block for mobilisation and fixed costs based on activity, with supplier's keen to manage their exposure to financial risk by ensuring payments are at a level and frequency to cover their costs of delivery. The majority were also positive about a performance linked payment incentivisation element based on delivery of outcomes. Much of

the feedback requested a shared approach to risk, taking into account the specialist nature of some of the work, and investment required to realise outcomes, particularly for the most vulnerable.

Some helpful feedback was provided about specific measures of quality and performance that could be incorporated. However the most noticeable feature of feedback in this section was the significance of an IT system capable of capturing, monitoring and reporting measures and outcomes from across the range of services and outcomes in scope. This highlights the importance of clearly specifying any system requirements we may have, as well as management information requirements, in the tender documents.

A report on the pre market engagement is shown in Appendix A.

3.5 Review of delivery models in other local authority areas

As part of scoping and developing this commissioning plan, views were sought from other providers and commissioners of similar lifestyle services to learn from their experiences and to inform the development of Lincolnshire's specification. Within the timeframe, interviews were held with four commissioners and one provider (Derby City, Derbyshire, Norfolk and Gloucestershire); however, one of the commissioners was less developed than the Lincolnshire model.

The services reviewed as part of the benchmarking exercise varied in structure, delivery and size. A report on the benchmarking exercise is shown in Appendix B and the key points are summarised below:

3.5.1 Eligibility & Referral pathways:

- All those interviewed use a combination of professional and self-referral.
- 2 providers started with a professional only referral pathway but stated it did not work and strongly advised us not to take this route
- Can take up to 3 years to get all partners on board for a new service and around 6 months for a recommissioned one
- Criteria needs to be well defined

3.5.2 Volume and Demand (modelling/trajectory)

- Provider figures would indicate a budget requirement of £2.7 to £3.5m for 10,000 outcomes depending on model and intensity of the programme
- There was a mix of opinions on smoking groups ranging from 'we are going to run them' to 'they don't work'
- One commissioner was predicting needing 16,000 clients to get 10,000 outcomes
- Some services provided Health Checks and some signposted back to GP's

3.5.3 Delivery Model

- All providers have locality based staff who are generic and can provide multiple services
- There is a mixture of smoking services with some being direct delivery of NRT and some not. Direct delivery was achieving the better outcomes
- Most services have a separate access system for smoking clients
- All services deliver an assessment online
- Physical activity elements are mixed with some being delivered in house and others outsourced, those with outsourced provision are more comprehensive but also more expensive
- Some provided support for up to 12 months

- All providers only allowed each person to access weight management services once
- Most providers use a 8-12 week weight management programme, some more structured and intense than others depending on budget
- Some services use volunteers some do not
- Workplace services vary across each provider, some are comprehensive and have dedicated staff and some smaller or are only in the early stages of development

3.5.4 Relationships (commissioner/provider, provider/primary care etc)

- In house services vary from informal management processes to formal contracts similar to those outsourced
- Making specialist staff generic can be problematic
- Relationships with Primary Care are sensitive and take time to develop

3.5.5 IT Systems and Performance Management

- All services advised to invest in good IT systems
- All services are outcome focussed
- Single case management systems seem to work best although most use a separate one for smoking due to difference in reporting and access for this service. Those who aren't using a single data management system want one
- Smoking systems include Quit Manager and Theseus

3.5.6 Finance and Payment mechanism

- PbR has been used by most commissioners but all scrapped it as unworkable
- Direct supply of NRT works well
- Champix is done both in house or in partnership with primary care

3.5.7 Procurement and mobilisation

- There is a mix of in house and outsourced services, both have advantages and disadvantages
- Two authorities brought services in house to avoid tendering and the third stated a 5+2 contract was the minimum they would consider due to the complexity and long lead in periods
- TUPE eligibility is an issue if changing from specialist roles to generic workers
- Dialogue process may be beneficial during the tender process
- Flexibility is required within the contracts to enable services to adapt and develop as they mature

Although, due to time constraints, it was only possible to contact a limited number of other local authorities there is still valuable learning to be gained from this exercise. A professional referral route only is unlikely to bring the required results as it takes a long time to get a new service fully functional. Investment in a good front facing electronic system is highly recommended. All the areas interviewed use outcomes and generic workers but stated services evolve as the service becomes established and a flexible commissioning approach will therefore provide the best results.

If after the market engagement, further work needs to take place to scope the service there may be a requirement to engage again with other commissioners to help finalise the delivery model. This may include the need for further benchmarking on the level of demand, take up rates, cost and deliverability.

4 Recommended Model for Future Delivery

The case for commissioning an integrated lifestyle support service and the principles of the proposed delivery model were considered by the Commercial Board on 31 May 2018. The evidence presented in the report, alongside the positive market interest demonstrated the strong potential for the service. Following consideration of the options, the Board agreed the option to proceed with the commissioning and procurement of the ILS as a 3+1+1 contract.

4.1 Delivery Model

The countywide ILS will provide a service to an individual for up to 12 months, which may include: information, sign posting, goal setting, action planning and support tailored to the clients needs. The service will be designed to change and promote sustainable lifestyle change and behaviours. This will be enabled through access to stop smoking services, extended brief interventions[7] for alcohol, diet and nutrition, and physical activity. Individuals should be navigated to and/or provided an integrated package of service provision. The service will offer continuation activities from within local communities to build upon community resilience and prevent relapse.

A diagram illustrating the proposed delivery model is shown in Appendix C.

Specifically the model will:

- Deliver a differentiated offer, which encourages people to self-care. This could be based on a digital platform (for example; website based, applications, social media), which could be supplemented with telephone and face to face assistance, where appropriate. This approach is in line with the Customer's IMT Strategy.
- Deliver information advice and support across the range of lifestyle behaviours via a single point of access and assessment, which may include a single telephone number, email and website (aligned and utilising the Library of Information)
- Assess people's level of need and motivation to change their behaviour using an evidence-based approach.
- Provide health coaching and behaviour change support for those in most need, across a number of behaviours.
- Connect people and families to local community assets and services, such as local voluntary programmes, groups and commercial services to support healthier lifestyles, and will provide up to date local information on current activities and events available, to which people can be signposted to support their behaviour change.

The central function of the ILS will be to deliver an evidence based, accessible, needs led integrated behaviour change programme (in line with NICE Guidance PH49) which will include the:

- Provision of enhanced behaviour change support for the targeted population. This support should consider; digital support, face to face, and group work interventions covering a time period that is conducive with long term lifestyle changes or similar to accommodate client based goals.
- Delivery of information and support across the range of lifestyle behaviours via a single point of access which should include digital, telephone and inter-personal interventions

[7] The term 'brief intervention' is defined by NICE in the relevant guidance for each specific behavioural topic area.

- Signposting to existing services and connect people to the use of community assets to support and facilitate self-care and self-management, for both the eligible and those not eligible for direct service provision (see an example model in Appendix C).
- Targeted public health promotion with the customer and partners for public health campaigns, for example PHE's One You campaign.
- Deliver Making Every Contact Count (MECC) training for front-line staff and volunteers involved in supporting healthy lifestyles.

4.2 Referral Pathways

The service will provide referral pathways for eligible adults, aged 18 and over, who are identified as having at risk status with one or more unhealthy behaviours (smoking, obese, inactive, excessive alcohol consumption), following a NHS Health Check (for people aged 40 -74), carers assessment, clinical referral or self-referral. The referrals will be directed through a single point of contact (via website, email or telephone) to ensure ease and parity of access.

Market engagement and any follow up work with stakeholders and potential referral partners will provide an opportunity to test our assumptions about using the following referral pathways:

a) People with long-term health conditions, whose condition is likely to be made worse by unhealthy behaviours, these conditions include; diabetes, cardio vascular disease risk, liver disease, musculoskeletal conditions and coronary heart disease. Referrals for long term conditions clients will be accepted where it is felt (by the treating clinician or similar) that a lifestyle change will improve their condition and unhealthy behaviours.
    i. The provider will be required to establish a referral pathway with Primary and Secondary care services within Lincolnshire to facilitate these referrals through the single assessment point.

b) At-risk adults who have undertaken a NHS Health Check for CVD Prevention, as defined within the NHS health check criteria, enabling primary care staff to refer directly into the ILS.
    ii. The provider will be required to establish a referral pathway between Primary and Secondary care services within Lincolnshire to facilitate referrals through the single assessment point post NHS Health Check.

c) People who are engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and/or weight management prior to surgery.
    iii. The provider will be required to establish a referral pathway from the Clinical Assessment Service (CAS) for the purpose of pre-elective surgery health optimisation through the single assessment point.

d) Carers being supported by Lincolnshire who may be obese, a smoker, inactive or drink to excess. Carers identified through primary care systems, e.g. NHS, Health Checks and carers that are being supported by Lincolnshire Carers Service will have the opportunity to be referred, if eligible through their unhealthy behaviour(s).
    iv. The provider, in conjunction with the Lincolnshire Carers Service, will be required to develop and implement an online self-referral form and telephone contact for this pathway; ensuring carers can access the service

without the need for clinical input and referral through the single assessment point.

e) People who smoke and seek help to stop smoking, particularly pregnant women. A specific referral pathway would need to be established with midwifery services in Lincolnshire to facilitate this component. National and local referral routes exist to refer smokers into a service (e.g. National Quitline and Maternity Services). It is expected that the introduction of CQUIN9 'Risky Behaviours' in 2018 will generate a substantial number of eligible referrals through secondary and primary care; the provider will be required to further develop relationships with the NHS Trusts and CCGs in order to maximise on this potential.
    v. The provider will be required to develop and implement an online self-referral form and telephone contact for this pathway; ensuring people who smoke can access the service without the need for clinical input and referral through the single assessment point.

f) The Lincolnshire County Council workforce with any of the above. The ILS in collaboration with the Customers Occupational Health and staff wellbeing services will develop suitable sign posting routes into the ILS for individuals who display with one or more of the targeted unhealthy behaviours.
    vi. The provider will be required to develop and implement an online self-referral form and telephone contact for this pathway; ensuring LCC staff can access the service without the need for clinical input and referral through the single assessment point.

4.3 Eligibility Criteria

4.3.1 Professional Pathway Criteria

Eligible
Adults aged over 18 who take part in one or more unhealthy behaviour who:

- Are diagnosed with one or more long-term health conditions, including; diabetes, cardio vascular disease risk, liver disease, musculoskeletal conditions and coronary heart disease.
- Are at risk (defined by Q-risk score) adults who have undertaken a NHS Health Check for CVD Prevention.
- Are engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and/or weight management prior to surgery.

Ineligible
If a client fits any of the criteria below they may not join the programme:

- An unstable condition.
- Identified as not motivated to change using an approved assessment tool.
- Any medical problem which severely restricts exercise or compliance with the programme, for example; type of neurological condition.
- Individuals, where upon assessment are deemed to have a level of need significantly in excess of service capabilities, and not ready to change an unhealthy behaviour. These will be reviewed on a case by case basis with clients/or sign posting organisation informed of the rationale, if the referral is

appropriate. This approach will also be in line with motivational interviewing guidance.

4.3.2 Self-Referral

Eligible
Adults aged 18 and over, or who are smokers, who:

- Are carers and registered with the Lincolnshire Carers Service who may be obese, drink beyond recommended limits, a smoker or inactive.
- People who smoke and seek help to stop smoking, particularly pregnant women.
- All smoking adults (16+) that live and/or work in Lincolnshire.
- Smokers under 16 with parental consent or if competent under 'Fraser Guidelines'.
- The LCC workforce with any of the four targeted unhealthy behaviours.

Ineligible
Any person who sits outside of the eligibility criteria.

4.4 Potential scale of behaviours and people within the proposed criteria

The following calculations have been modelled to show the potential pool of people in Lincolnshire with unhealthy lifestyle behaviours. This is potentially an over estimation as actual evidence for the number of multiple behaviours that someone has is not available; therefore it is likely that someone will appear on more than one register. Future monitoring through the ILS service will help to identify the scale of multiple behaviours and enable more accurate estimates of the number of people who can potentially benefit from this service.

Based on these estimates, the potential size of the target group is substantial. Therefore in order to translate the multiple behaviours into the number of potential people that will need to engage with the ILS service further modelling and assumptions have been applied to each priority target group. These are explained in further detail below. Market engagement will need to test if these figures are too large and seek views on how we manage the size of the target group. This will include validating the eligibility criteria in section 4.3 to ensure the service delivers at least 10,000 outcomes per year.

4.4.1 Long Term Conditions

This table is for the Lincolnshire population on selected disease registers (taken from QOF – 2016.17). Each group has then had the general Lincolnshire prevalence of behaviours applied as a proxy for the behaviours which exist within the cohort, as no data is available on the specific behaviours of people on disease registers. This suggests the total estimated number of behaviours that exist within people on each disease register.

	Total people on disease register	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
Atrial Fibrillation	*18,726*	*3,052*	*5,055*	*4,587*	*4,318*	*17,012*
Coronary Heart Disease	*33,424*	*5,448*	*9,024*	*8,189*	*7,386*	*30,047*
Cardiovascular Disease - Primary Prevention	*5,464*	*891*	*1,475*	*1,338*	*1,207*	*4,911*
COPD	*17,487*	*3,052*	*5,056*	*4,588*	*4,138*	*16,834*
Heart Failure	*9,123*	*1,847*	*2,463*	*2,235*	*2,016*	*8,561*
Hypertension	*128,785*	*20,992*	*34,766*	*31,547*	*28,457*	*115,762*
Peripheral Arterial Disease	*5,641*	*919*	*1,523*	*1,382*	*1,246*	*5,070*
Stroke and Transient Ischaemic Attack	*17,607*	*2,870*	*4,753*	*4,313*	*3,891*	*15,827*
Diabetes	*49,386*	*8,050*	*13,334*	*12,099*	*10,914*	*44,397*
Osteoporosis	*2,304*	*376*	*622*	*564*	*509*	*2,071*
Rheumatoid Arthritis	*5,506*	*897*	*1,486*	*1,348*	*1,216*	*4,947*
Total	***293,453***	***48,394***	***79,557***	***72,190***	***65,298***	***265,439***

On the hypertension register alone this suggests over 115,000 behaviours, providing assurance that the criteria would not limit the potential for a provider to access sufficient suitable clients to fulfil outcomes targets. In total there are likely to be around 265,439 behaviours across all registers, however it would be assumed that some people would appear on more than one register which would overestimate the total pool.

In order to estimate the possible number of people on more than one disease register the findings from Public Health England's report into multi-morbidity[8] has been used. Based on this report, the average multi morbidity prevalence across Lincolnshire is 26.2%. Modelling this prevalence rate to the 265,439 behaviours figure means that potentially 69,545 people are likely to have multiple long term conditions and therefore appear on more than one disease register. Assuming these are therefore double entries, the possible total behaviour figure is 195,894. By then applying the Kings Fund's modelling assumption (see section 3.4 – 25% of people are engaged in 3 or more behaviours), the potential number of people in this cohort engaged in 3 or more behaviours is estimated to be 48,973.

4.4.2 Health Checks

Using the most recent data for 2017-18[9], 39,085 people were offered an appointment and 25,023 people received one (64% take up rate, higher than the national average). Applying general population behaviour rates suggests a pool of 22,675 behaviours may exist within the 25,023 clients.

[8] Prevalence of multi-morbidity by local areas in England (derived from observed prevalence estimates provided by Barnett and colleagues) (2017)
[9] https://www.healthcheck.nhs.uk/commissioners_and_providers/data/

	People receiving a health check in 2017/18	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
Health checks	*25,023*	*4,079*	*6,756*	*6,310*	*5,530*	*22,675*

By then applying the Kings Fund modelling assumption (as referenced in section 4.4.1), the potential number of people in this cohort with 3 or more behaviours is estimated to be 5,671.

4.4.3 Health Optimisation

Hospital Episodes Statistics (HES) provide data on the number of people who receive hospital treatment. Based on the inpatient treatment codes which pertain to hip and knee replacements, in Lincolnshire the number of people during 2015/16 who received a hip or knee operation was 1,067. This however is likely to be an over estimation as the HES codes may also take account of more general hip and knee operations which are not covered by the health optimisation policy.

As the health optimisation policy will apply to people requiring support for weight management and/or smoking cessation prior to surgery, the Kings Fund modelling assumption has not been applied to this cohort, therefore estimated number of people is 1,067

4.4.4 Carers

In 2016/17, the number of unpaid adult carers known to the council was 20,300, although only 8,100 received a service[10]. Applying general population behaviour rates suggests a pool of 7,281 behaviours may exist within the 8,100 clients

	Total carers	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
Unpaid Carers receiving a service from the council	*8,100*	*1,320*	*2,187*	*1,984*	*1,790*	*7,281*

By then applying the Kings Fund modelling assumption (as referenced in section 4.4.1), the potential number of people in this cohort with 3 or more behaviours is estimated to be 1,820.

4.4.5 Pregnant Women who smoke

7,302 Lincolnshire women gave birth in 2016. As the criteria is only for smoking in pregnancy, the applied behaviour rate at 17.7% (the smoking prevalence rate for 2016 has been applied rather than the 2017 rate of 16.3%, as it collates with the birth year) would equate to 1,292 potential behaviours. This is likely to be an overestimation as many will give up smoking upon becoming pregnant without the need for supportive services. However, Smoking at Time of Delivery data is only an indicator of those still smoking at the end of pregnancy and therefore underestimates due to all of those for whom service intervention supported them to quit.

[10] Source: JSNA Carers topic

The Kings Fund modelling has not been applied to this cohort as it is only dealing with a single behaviour. Therefore the potential number of people in this cohort is estimated to be 1,292.

4.4.6 Lincolnshire County Council Workforce

Although total employment fluctuates, there are around 4,500 within the LCC workforce. Applying general population behaviour rates suggested an estimated 4,047 behaviours may exist within a cohort of 4500 clients.

	Approximate workforce	*Potential smokers (at 16.3%)*	*Potential obese (at 27%)*	*Potential inactive (at 24.5%)*	*Potential excess alcohol (at 22.1%)*	*Estimated total number of behaviours*
LCC Staff	*4500*	*734*	*1215*	*1103*	*995*	*4047*

By then applying the Kings Fund modelling assumption (as referenced in section 4.4.1), the potential number of people in this cohort with 3 or more behaviours is estimated to be 1,012.

Based on all the modelled assumptions detailed above, the total overall possible behaviour pool is 301,801 of which 59,835 people will potentially have 3 or more behaviours. Based on evidence from the LSSS, a 50% depreciation rate[11] has been applied in order to estimate the potential number of people who will need to engage with the ILS in order to achieve at least 10,000 outcomes.

Target cohort	*Potential population size*	*Number of invitations (if applicable through professional referral pathway) (based on 50% invited)*	*Number of people engaging with the ILS and setting outcome targets (based on a 50% drop off rate)*	*Potential number of people who achieve an outcome (based on a 50% drop off rate)*	*Potential range of outcomes that could be achieved*
Long term conditions	*48,973*	*24,500*	*12,250*	*6,125*	*6,125 – 18,375*
Health checks	*5,671*	*2,800*	*1,400*	*700*	*700 – 2,100*
Health optimisation	*1,067*		*534*	*267*	*267 – 801*
Carers	*1,820*		*910*	*455*	*455 – 1,365*
Pregnant women who smoke	*1,292*		*646*	*323*	*323*
Workforce	*1,012*		*506*	*253*	*253 – 759*
Totals	***59,835***		***16,246***	***8,123***	***8,123 – 23,723***

[11] 50% of people identified as eligible for the service will engage and set an outcome target, of those that set a target only 50% will then go onto achieve it.

From this assumption, an estimated 16,246 people will need to be engaged with the potential of achieving between 8,123 (ie one person achieving one outcome) to 23,723 outcomes (ie one person achieving 3 or more outcomes).

The estimated number of people that will potentially need to be engaged to achieve at least 10,000 outcomes corresponds with feedback from another commissioner which also predicted needing 16,000 clients to achieve the same level of outcomes. Subject to feedback from the market, it may be necessary to do further testing with other commissioners and potential referral partners to validate these assumptions and to test whether the allocated funding will be sufficient to engage enough people to deliver the expected number of outcomes.

4.5 Costs

The table below shows the estimated costs for the ILS service. These figures have been calculated using known information from the existing stop smoking service for the cost and demand of pharmacotherapy treatment. In addition, the unit cost of sending an invitation letter is based on the data from NHS Health Checks. The potential number of letters that may need to be sent is based on the assumptions that 27,300 referrals will be made through the professional pathway as a result of being on a disease register or following a health check (see last table in section 4.4). Taking into account these estimated costs, the amount of potential funding available for delivery the lifestyle behaviour support element of the ILS is £1,565,610. This equates to £156.56 per outcome or £192.74 per individual (based 8,123 people achieving one or more outcomes).

Market engagement, along with any further benchmarking with other commissioners, will provide an opportunity to test the predicted costings set out in the table below. In addition to testing whether there is sufficient funding to deliver at least 10,000 outcomes, the market will be asked to feedback on the potential infrastructure and digital support costs.

Activity	Potential number	Unit Cost	Total
Infrastructure			£100,000
Digital Support			£50,000
Lifestyle Behavioural Support	10,000		£1,565,610
Pharmacotherapy NRT*	3,711	£110	£408,210
Pharmacotherapy – Champix*	2,474	£220	£544,280
Invitations**	27300	£3	£81,900
Total			**£2,750,000**

*****Based on validate data from the current stop smoking service

** Based on current costs for NHS Health Check letters – ie search cost for Arden and Gems and the and cost of sending invite to client

4.6 Funding

The Council currently spends £1,249,000 annually on a stop smoking service, and commits no public health grants towards tackling obesity. We will commit a further £1m from the public health grant (3% of the budget). In addition Lincolnshire Clinical Commissioning Groups (CCGs) have committed to provide a further £500,000 through a Section 256 Agreement. The total budget for an ILS service is therefore £2,750,000 per annum.

4.7 Benefits

A countywide branded ILS approach would:

- Significantly increase activity resulting in substantial behaviour change over the life the contract.
- Improve health and reduce health inequalities.
- Reduce cost to public services.
- Reduce the need for health and care interventions.
- Reduced morbidity and mortality deemed preventable.
- Improve opportunities for engagement within communities, thereby reducing social isolation.
- Improve productivity and reduce absenteeism.
- Offer multiple effects to family members, partners and children of clients through a whole system approach.
- Satisfy obligations within the public health grant to tackle obesity.

4.8 Measures and Outcomes

- Deliver 10,000 outcomes per year – this can be multiple outcomes for one individual.
- Reduction in smoking prevalence (measure: 4 weeks quit status).
- Reduction in obesity prevalence (measure: 5% weight loss).
- Increased participation in physical activity (measure; moving from inactive to active).
- Increased number of people drinking sensibly (measure: less than 14 units per week or reduce alcohol consumption by 50%).
- People supported from areas in Lincolnshire that have the greatest need.
- Increased number of people supported to eat five portions of fruit and vegetables on a 'usual' day.
- Percentage improvement in self-reported wellbeing.

4.9 Key Risks

A full risk register has been developed for the ILS which will be kept under constant review, a copy of the register can be found in Appendix E. Top five risks identified are:

Risk Title	Probability	Impact	Score	Mitigation / Update
Lack of CCG commitment regarding budget	3	3	9	Section 256 agreement drafted. Not yet signed. To be escalated to Project Board
Lack of clarity around Health Optimisation policy and lack of joined up approach with all four CCG's	3	3	9	Contact made with LWCCG. To be escalated to Project Board
Lack of engagement from key referrers	3	3	9	Increase volume of direct engagement with key referrers (e.g. General Practice via LMC, Practice Manager and GP's)
Failure to attract suitable bidders	2	3	6	Further market engagement planned for 15th August 18 following further development of commissioning plan and service specification. Good level of interest.
Failure to accurately cost	2	3	6	Finance are part of the Project

the service				Team. Assumptions to be tested as part of market engagement.

Risk Scoring
Probability: 1 – Hardly ever; 2 – Possible; 3 – Probable; 4 – Almost certain
Impact: 1 – Negligible; 2 – Minor; 3 – Major; 4 - Critical

4.10 Dependencies

4.10.1 Wellbeing Service

Lincolnshire County Council commissions a Wellbeing Service which is designed, following an assessment, to offer a range of services to promote independent living. The service is preventative, enhances wellbeing and aims to reduce or delay escalation into statutory support services. The Wellbeing Service is not a behavioural support service therefore there is no duplication is service provision. However, the Wellbeing Service does report on a number of health and wellbeing outcomes which the ILS will help to deliver.

4.10.2 Substance Misuse Treatment Service

Lincolnshire County Council commissions a specialist community alcohol and drug treatment service which provides a personal recovery plan tailoring treatment to meet individual needs. This work may include brief talking therapies or more complex structured treatment and clinical services such as opiate substitute medication or alcohol/drug detoxification. Whilst the ILS includes providing support and interventions to help people manage their alcohol levels, if the level of support needed is beyond low level support and interventions (ie requiring more than 4 sessions), then individual may need to be referred into the structured treatment service for more specialist support.

4.10.3 NHS Health Checks

The proposed model for the ILS does not include the commissioning of the NHS Health Check programme as this is commissioned separately in line with national guidance. However, the Health Check mechanism will be an important referral route into the ILS service, specifically for adults aged 40-74 who are identified as being at risk as a result of having a health check.

4.10.4 Making Every Contact Count (MECC) (HEE, 2016)

MECC is an approach to behaviour change that utilises the many day to day interactions that organisations and individuals have with other people in order to support them to make positive changes to their physical and mental health and wellbeing. It encourages opportunistic concise healthy lifestyle information which enables people to engage in conversations about their health at scale across organisations and populations. The successful provider will be required to train any front line staff and volunteers in MECC.

4.10.5 Primary Care including Neighbourhood Teams

The professional referral pathways (people with a diagnosed long term condition included on a disease register, following an NHS Health Check or through the Health Optimisation policy) are dependent on GPs/primary care identifying appropriate individuals with risk behaviours and referring them into the ILS service through the single point of contact. The successful provider will be required to establish referral mechanisms to enable primary care professionals to refer into.

4.10.6 Midwifery Service

A specific referral pathway would need to be established with midwifery services in Lincolnshire to facilitate this component. National and local referral routes exist to refer smokers into a service (e.g. National Quitline and Maternity Services). It is expected that the introduction of CQUIN9 'Risky Behaviours' in 2018 will generate a substantial number of eligible referrals through secondary and primary care; the provider will be required to further develop relationships with the NHS Trusts and CCG's in order to maximise on this potential.

4.10.7 Carers First/Lincolnshire Carers Service

The Lincolnshire Carers Service is delivered in partnership by Lincolnshire's Service Centre and Carers FIRST. The Carer's Assessment Tool (Carer's Star) includes a health element which could highlight any specific unhealthy behaviours of the carer. Carers FIRST already have access to Mosaic to enable them to directly refer into the Carer's Service system. The provider will need to work with the Lincolnshire Carers Service to establish an appropriate self-referral mechanism for carers following a carer's assessment.

4.10.8 Diabetes Prevention Programme

The Diabetes Prevention Programme is a primary prevention intervention targeting people who are pre-diabetes and not yet identified on the diabetes disease register. Whereas, the ILS is a secondary prevention intervention which will target people that have already been diagnosed as having diabetes. Following the initial assessment, the ILS will be able to signpost people identified as being pre-diabetic and outside of the scope of the ILS to the Diabetes Prevention Programme but there will be no direct referral route from the Diabetes Prevention Programme into the ILS.

5 Impact Assessment

An initial Impact Assessment has been completed to assess the positive and adverse impacts of the proposed change on people with protected characteristics and identify ways of mitigating or eliminating any adverse impacts. A copy of the Impact Assessment is provided in Appendix F and includes the following key impacts:

Positive impacts:

- The ILS will increase levels of weight loss and physical activity, and as result will reduce the risk of developing long term conditions including type 2 diabetes, CVD, and some cancers for the targeted population.
- People with long term conditions, who have an increased risk of disability, will be supported to make lifestyle changes.
- The ILS will improve health and reduce health inequalities for adults aged 40-74 in Lincolnshire who are identified as 'at risk' following a NHS Health check, social care assessment or other clinical referrals.

Negative impacts:

- Significant proportions of the adult population outside of the target age range for NHS Health Checks (40-74 years) are overweight/obese, inactive or are smokers. Consequently, if the service reaches its capacity within the target age group, younger and old people risk not having their needs adequately addressed.
- People with a learning disability also have complex health needs, co-morbidities, higher rate of premature mortality than the population as a whole and as a result appear on the disease registers. They are also more likely to be inactive and obese.

If the ILS is not targeted appropriately or made accessible to people with a learning disability then the health inequalities may be exacerbated. One of the main referral routes for the ILS will be through the NHS Health Check; these are aligned with the delivery of the personal health checks for people with learning disabilities; however, less than 30% of adults in Lincolnshire with a learning disability currently access their health check.

- Levels of overweight and obesity are higher in men than in women; however, only 14% of referrals to previously commissioned weight management services were for men. If the ILS weight management services are not accessible or attractive to men it is possible that this health inequality may increase.

The Impact Assessment will be kept under review throughout the commissioning process and updated accordingly. Feedback from ongoing engagement with key stakeholders as part of developing the proposed model, as well as market engagement with providers through a Supplier Day in August will be gathered and used to inform any changes.

A Privacy Impact Assessment will also need to be undertaken as part of the mobilisation phase to ensure robust mechanisms are in place to transfer service data from the current stop smoking service to the ILS.

6 Managing the Changes

A Governance Board has been set up to provide overall responsibility and oversight for the commissioning work. Membership includes the Executive Councillor for Adult Care, Heath and Children's Services; Executive Councillor for NHS Liaison and Community Engagement, Director of Public Health and senior officers from Public Health and the Commercial Team – People Services.

An ILS Project Team has been established to oversee the commissioning, pre-procurement, procurement and mobilisation of the new service. This group is made up of representation from Public Health, the Commercial Team – People Services and Finance.

Public Health also continues to be in dialogue with other key stakeholders and referral partners to ensure all the evidence is gathered to inform the development and future delivery of the ILS.

Agreement has been reached to extend the current stop smoking service contract for a further six months, so the service is now due to end on 30 June 2019. This extension builds capacity into the project plan by allowing time for a longer mobilisation period to ensure a smoother transition and hand over between the two services.

7 Key Milestones

Activity/Milestone	Deadline	Progress
Commissioning Plan written	31 July 2018	Completed
First Impact Assessment	31 July 2018	Ongoing
Draft Specification written	31 July 2018	Completed
Market Engagement	15 August 2018	Started
Procurement Plan written	7 September 2018	To commence

Final Specification written	30 September 2018	Started
Adult Care & Community Wellbeing Scrutiny	10 October 2018	To commence
Executive Councillor decision	17 October 2018	To commence
Contract Notice	October 2018	To commence
ITT Period	Oct – Nov 2018	To commence
ITT Evaluation	Nov – Dec 2018	To commence
Award contract	w/c 7 January 2019	To commence
Implementation/Mobilisation	Feb – May 2019	To commence
Go live	May 2019	To commence

8 Appendices

Appendix A – Pre Market Engagement Summary

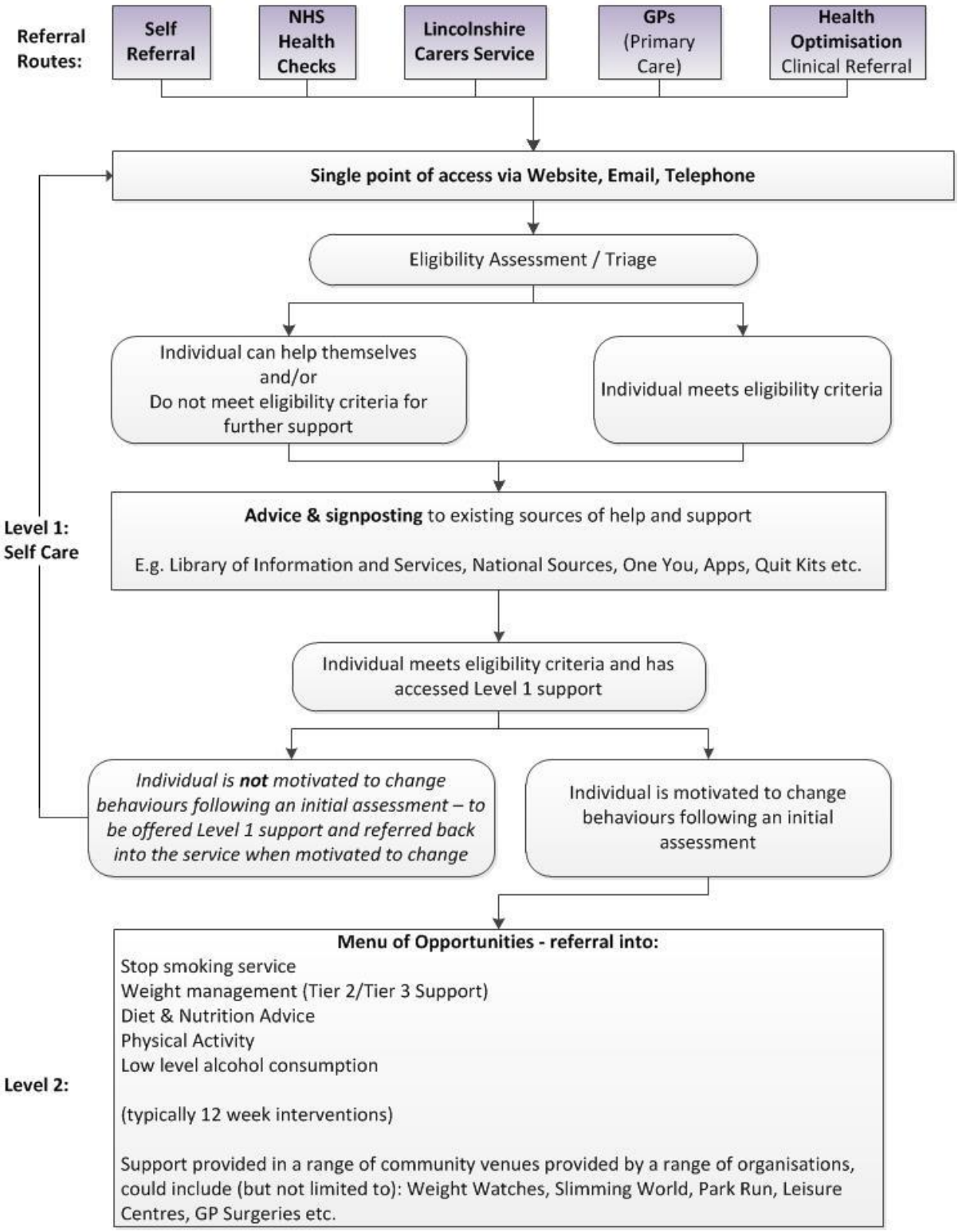
Pre-Market Engagement Summar

Appendix B – Benchmarking Report

ILS Benchmarking Report_Appendix B.d

Appendix C

Lincolnshire's Integrated Lifestyle Support Service



At any point the service can refer out to existing intensive support programmes where clients meet the eligibility criteria, e.g. Substance Misuse Treatment Service, Wellbeing Service

Appendix D – ILS Risk Register

20180813_ILS Risk Log.xls

Appendix E – ILS Equality Impact Assessment

ILS EIA_v0.2_30072018.