**One You Cheshire East
(Integrated Lifestyle Service)**

**Performance Monitoring Framework**

**Contract Management and Quality Assurance Schedule**

**Performance and Quality Assurance Standards**

Providers will be monitored against a number of predetermined performance and quality standards which are highlighted in the Schedule.

The objectives of the Key Performance Indicators and Quality Assurance standards are to:

* ensure that the Services are of a consistently high quality and meet the requirements of the Council;
* provide a mechanism whereby the Council can attain meaningful recognition of inconvenience and/or loss resulting from the Provider’s failure to deliver the level of service for which it has contracted to deliver; and
* Incentivise the Provider to comply with and to expeditiously remedy any failure to comply with the Key Performance Indicators.

The Provider shall, at all times, provide the Services in such a manner that the Key Performance Indicators are achieved.

**1.1 Quality Specific Standards**

The Provider is expected to have in place robust governance framework and supporting processes, which ensure that it is compliant with appropriate legal requirements and standards. We would expect the governance framework to include but not be limited to the following:

* Communication between service users, families, parents, carers and staff (including managers and clinicians);
* Communication between staff across wider services, including clinicians and managerial staff;
* Effective reporting and monitoring mechanisms for issues of concern whether relating to the service users, or people connected or employees;
* Service user recording;
* Working with families and carers;
* Service IT / data recording and storage systems;
* Incident reporting and health and safety matters;
* Child Protection & Adult Protection – Safeguarding;
* Reporting and monitoring of incidents and accidents to staff, volunteers and service users [including the management of violence and domestic violence];
* Health & Safety Inspection, and fire safety;
* Clinical Governance;
* Infection Control;
* Inspections by Commissioners;
* Complaints and Compliments management for paid staff, volunteers and service users;
* Service user engagement and co-production;
* Records Management;
* Equality of opportunity in service provision, recruitment and employment;
* Occupational health;
* Information sharing and Information Security;
* Policies relating to confidentiality of information;
* Codes of conduct for staff and service users;

All appropriate policies and protocols must be in place following contract award and prior to the service mobilisation phase being completed. The Commissioner would expect to receive information and assurance that these are current and in place [including with sub contracted services]. Clear and routine review arrangements to maintain effective governance would also be expected. Service users must be made aware of the range of policies which may impact upon their support and be given access to them should they wish.

**1.1.2 Quality Assurance**

The Provider is required to complete quality assurance checks in relation to Service delivery to ensure that outcomes are being met and that contract compliance is achieved.

1. The Provider will have quality assurance processes which clearly includes the standards and indicators to be achieved and monitored on a continuous basis by the Provider to ensure that the Service is delivered in accordance with the best interests of the Service User
2. The quality assurance processes will include the standards required, the method of attaining the standards and the audit procedure
3. The quality assurance processes will analyse feedback and measure the success of the Service in meeting the requirements set out in this Service Specification and the Monitoring Schedule
4. A quality assurance report summary will be made available to Service Users and the Council upon request
5. There must be various means for Service Users to supply feedback with regards to Service delivery and outcomes being met. These methods need to take into account Service Users and their preferences as to the mechanism of feedback (questionnaire, interview, phone call, Service review etc.) and the most appropriate format (i.e. language, pictorial, font size)
6. When negative written feedback is received by the Provider, either formally or informally, a formal written response from the Provider will be supplied noting its receipt and the action that will follow. This feedback will be copied to the Council
7. The Provider will be committed to continuous Service development

**2.1 Performance Management**

**2.1.1 Performance Management Reporting**

The Provider must ensure that a dedicated ‘Performance Management Function’ is established as part of the contract to provide system wide reporting across all of the One You Lifestyle programmes. The Provider will ensure the effectiveness of such reporting, demonstrating assurance processes for systems and procedures to commissioners and other key stakeholders, and support the continued development of both output and outcome monitoring for the service.

The Provider is required to complete performance checks in relation to Service delivery to ensure that outcomes and contract compliance are being met.

1. The Provider is responsible for having performance and quality assurance processes that are capable of providing evidence of achieving outcomes, quality of Service and Key Performance Indicators
2. It is the Providers’ responsibility to submit performance and quality information as per the schedule and failure to complete and return the required information will be dealt with under Service failure and contractual action
3. The Council may choose to further verify submitted claims through feedback from Service Users, Council Staff, Provider staff interviews and/or feedback as required
4. The Provider must have robust business continuity and contingency plans in place with regards to all levels of Service interruption or disruption. If Service interruption or disruption occurs, the Provider is to notify the Council immediately and ensure that alternative provision is sought
5. The Provider will need to evidence ongoing business viability in order that risks or threats to Service delivery are minimised and any threat to the Service User, the local branch, the overall organisation or the Council is highlighted well in advance to the Council of any potential or actual incident
6. The Provider will allow inspection (insofar as it is relevant to the services delivered and the financial stability of the Provider) of financial records upon being given reasonable notice in writing. This shall include details of rates of pay for care staff to ensure legal compliance and any other information deemed necessary by the Council to ascertain the stability of The Provider workforce or business
7. The Provider must ensure that their nominated managers appropriate meetings and submit monitoring information to The Council
8. The Council reserves the right to review or amend the contract management and quality assurance process during the contract term with one months’ notice

Reporting requirements may change over the lifetime of this contract to embrace any wider governance reporting structure requirements.

The Commissioner will hold quarterly contract monitoring meetings with annual performance reviews.

The Provider will attend quarterly review meetings to support the on-going collaborative links that will ensure that the Service is successful.

Through the contract management process we are looking to drive forward innovative ideas and improve working practices.

The Council will work with the Provider to target resources more effectively and to make sure all resources continue to be focused on agreed priorities.

**2.2 Performance Indicators**

**2.2.1 Key performance Indicators (KPI’s)**

The Council has set in Appendix 1 the Key Performance Indicators (KPI’s) and targets which will be used as part of the Service evaluation. Providers must submit their KPIs in their Monthly Monitoring Returns and the Council will conduct various validation spot checks to determine the accuracy of the data submitted and the quality of the service delivered to Service Users.

(See appendix 1 for detail of KPI requirements).

Providers which fail to reach the relevant KPI targets, or do not adhere to specified timescales for submitting KPI information, will be subject to performance improvement measures.

**2.2.2 Critical Performance Indicators/ Incentivised Performance Indicators**

**Incentivised Performance Indicators**

Incentivised key performance indicators are detailed below (annual targets) and are based on the number of participants starting on the programmes, with additional payments to the Provider dependent on their fulfilment.

There will be a guaranteed block payment calculated at 80% of the annual contract value related to the Core Service (not including tariff payment for NRT or Varenicline prescriptions).

20% of the contract value per year is incentivised; this is split over each of the Lifestyle Programme indicators and paid annually.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Lifestyle Programmes/ Smoking Cessation**  | **Critical Failure KPI** | **Baseline Target** | **Max limit of 20% for incentivised payments** | **10% Target** | **Incentivised payment**  | **20% Target** | **Incentivised payment** |
| Physical Activity | 1200 | 1800 | 2200 | 2000 | +2% | 2200 | +2% |
| Weight Management | 450 | 600 | 900 | 750 | +2% | 900 | +2% |
| Falls Prevention | 340 | 570 | 800 | 685 | +2% | 800 | +2% |
| Smoking Specialist | 120 | 160 | 200 | 180 | +2% | 200 | +2% |
| Smoking Community | 180 | 250 | 400 | 325 | +2% | 400 | +2% |
| TOTAL | 2290 | 3340 | 4500 | 3920 |  | 4500 |  |

**Critical Performance Indicators**

A Critical Performance Failure shall include:

* 1. any failure to attain as a minimum the critical failure KPI target set in the above table
	2. a refusal or non-delivery of the Services by the Provider
	3. in the opinion of the Authority the provider is persistently inputting the incorrect data/ submitting inaccurate data as evidenced
	4. any other delay on the part of the Provider without good cause in delivering the Services that could reasonably be considered by the Council as being inconsistent with the Provider performing its obligations under the contract agreement and in accordance with the service specification

**2.3 Outcomes**

Outcomes can be defined as what a person wishes to achieve in order to lead their day-to-day life in a way that maintains or improves their health and wellbeing. These outcomes will vary from one person to another because each individual Service User will have different interests, preferences, relationships, demands and circumstances within their lives.

The Provider must deliver a Service to meet individual Service User Outcomes and the service is to be delivered in line with the ethos and standards as detailed in the Service Specification.

**2.3.1 High Level Service Outcomes**

High level Outcomes are represented in the diagram below:

* + 1. **Individual Service user Outcomes**

Individual Service User Outcomes may be associated with multiple of the high level Service User Outcomes listed above.

The Provider is required to meet individual Service User outcomes using a person centred assessment, support planning and service delivery approach. Every Service User should have their own outcomes documented and delivered in relation to their own personal needs, preferences, likes, dislikes and choices.

Examples of Outcomes and how Providers can document and meet those Outcomes are as follows:

|  |  |
| --- | --- |
| **Service User Outcomes** | **Quality Measures**  |
| 1. **Reduced Rate and Fear of Falling**
 | Individuals undergo exercise for 3 hours a week and that exercises consist of a high challenge to balance. OTAGO or FaME approach.Improvement in strength and balance. Fear of falling score, timed up and go assessment, Berg & balance scale, stand on one foot. |
| 1. **Improved Physical Activity**
 | Moving from inactive to active in line with Chief Medical Officer guidance. Improvement in physical measurements ie Weight, BMI, Waist circumference, resting heart rateImprovement in physical strength by undertaking muscle strength activities twice per week |
| 1. **Improved Mental Health & Wellbeing**
 | Showing improvement in wellbeing through the use of Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS).Information and advices to reduction in alcohol consumption. |
| 1. **Smoking Quits**
 | Supporting individuals to stop smoking through specialist services and community interventions ie relationship building and Nicotine Replacement Therapy. Providing timely information and advice to household members |
| 1. **Reduced excess weight in Children & Adults**
 | Individuals achieving a weight loss through improved diets, physical activities that leads to improvements in Weight, BMI, Waist circumference, resting heart rate, blood pressure |
| 1. **Maternal Physical Health**
 | Increased levels of Physical activity measured by a validated tool such as GPPAQ, using CMO guidelines. |
| 1. **Access to Information to Improve Dietary Habits**
 | Delivering advice on how to achieve behaviour change and advice on calorific balance. Promote healthy eating as shown in the Eat well Guide and government guidance. |

**2.3.3 Outcome Reviews**

It is the Provider’s responsibility to identify and develop individual Service User outcomes through face to face discussions directly with the Service User (and /or their representatives where appropriate).

It is the Provider’s responsibility to measure and present outcomes to Service Users and the Council. It is a requirement of the Provider to do this via Outcome Reviews which should be completed at the commencement and exit of the relevant programme or intervention. This will ensure that all Service Users have a face to face discussion with their Provider regarding their personal outcomes, following access to the service. Any discussion with Service Users regarding their outcomes should be done during face to face reviews, unless the Service User requests otherwise.

Providers are also required to follow up with Service Users providing they are in agreement, at an interval of 6 month after exiting the service in order to evaluate the longer term Outcomes for the individual and give additional information or guidance if required. These may be done face to face or via text/email or phone call.

Where only information, advice and guidance has been provided to individuals following screening, this should be recorded and reviewed in 6 months to see if their personal Outcomes have bene achieved.

The format and method for conducting each Outcomes Review will be in accordance with the Service Specification; however the Council reserves the right to request the Provider to alter the format, method or content of the Outcomes Reviews in order to ensure that the relevant information is obtained and documented.

Following the completion of each Outcome Review the Provider shall record its results and details of action taken in response to the review to evidence Service User Outcomes.

The Council retain the right to verify or validate whether outcomes have been effectively developed, documented, delivered and reviewed via any route that the Council deems appropriate, i.e. by speaking to Service Users, viewing Outcome Reviews, auditing documentation or Service User Satisfaction Surveys.

The Provider will submit detailed monitoring returns to the Council in relation both the high level outcomes and individual Service User outcomes as detailed within this Monitoring Schedule.

The Provider will present performance and quality information as per the schedule and failure to complete and return the required information will be dealt with under Service failure and contractual action will be taken.

**2.3.4 Service User Satisfaction Surveys**

This is one way of the Provider determining and evidencing that outcomes have been supported and achieved.

The Provider will collate all feedback centred around Service Users detailing information on Service improvements, the quality of provision and whether outcomes are being achieved, and report/make this available to The Council upon request as specified within the monitoring schedule.

As a minimum the annual satisfaction survey will measure the following outcomes:

* If Service Users have enjoyed the activities
* How the Service Users rate the programme
* If Service Users feel that activities were at an appropriate level
* If Service Users feel that there have been improvements to their health
* If Service Users feel that staff have the correct skills and training to meet their needs
* If Service Users are satisfied with the information, advise and guidance provided
* If Service Users feel that exercise, smoking cessation or weight loss has improved their fitness
* If Service Users feel they are able to cope better with stress
* If the Service User feels that they are more confident in everyday life
* If the Service User feels safe and free from harm or risk of harm
* If the Service User feels as a result of the intervention they are less likely to visit a GP or Health Professional
* If the Service Users has reduced or changed their medication as a result of the intervention

In order for the Council to ensure that the Provider is actively seeking Service User feedback and to identify areas of good practice, the Provider shall conduct a Service User satisfaction survey each calendar year.

The Council may also conduct routine Service User satisfaction surveys to directly obtain thoughts and views about the Service delivered by the Provider. These satisfaction surveys by the Council have no minimum or maximum frequency and can be completed at any time during the duration of the Agreement.

The format and method for conducting each satisfaction survey will be at the discretion of the Provider; however the Council reserves the right to request the Provider to alter the format, method or content of the Satisfaction surveys in order to ensure that the relevant information is obtained.

As soon as possible following the completion of each satisfaction survey and in any event within one (1) month of completing each satisfaction survey, the Provider shall make available the survey, its results and details of action taken in response to the survey.

The Provider shall permit the Council to use the information which is generated by the satisfaction surveys to assist it in future commissioning and procurement activities.

The Council may at its discretion gather Service User insight information. The Council may ask the Provider to address any issues which are highlighted through this insight information. The Provider will take steps to address the issues raised by the Council within the timescales set out.

The results must be available to the Council by 30th April every year. Failure to comply will result in Service failure and will be dealt with via contractual action.

**2.4 Monitoring Returns**

The Provider is required to collate and return monitoring information to the Council using the templates provided by the Council or in an agreed format from the Provider. The Council retains the right to amend or update the templates if required, and Providers will be notified if any changes are made.

The Provider will strictly adhere to the timescales set out in this Schedule for returning monitoring information and failure to do so will result in service failure and / or contractual action being taken.

The Provider will comply with contract monitoring arrangements including sample checks of monitoring record (electronic or otherwise) and monitoring return validation. The Provider will be informed and consulted on changes to contract management arrangements as and when they occur.

The Council reserves the right to conduct random checks on Service User and Staff documentation and any other files or records in relation to the services delivered to Service Users.

**2.4.1 Quarterly Monitoring Return**

The Provider shall provide a quarterly return to the Council in relation to the reporting periods highlighted below.

|  |  |  |
| --- | --- | --- |
| Reporting Period | Report submitted by | Quarterly Performance Meeting |
| Quarterly monitoring returns ie Q1-Nov to Jan | 15th of the month directly after the reporting period ie 15th February for Q1 | To be arrange for the end of the month of the monitoring return ie end of February for Q1 |

2.4.2 Annual Monitoring Return

The Provider shall make an annual return to the Council which shall provide evidence of each of the areas identified in the table below. This information is to be submitted annually by no later than 30 April.

|  |  |
| --- | --- |
| **Area** | **Information Required** |
| Financial and Insurance | * Evidence of insurance certificate
 |
| Workforce Development | * Workforce development plan
* Staff turnover/ retention
* Recruitment plans and proposals
* Vacancy levels
* Training matrix for staff
 |
| Service Delivery (across each of the Lifestyle Programmes and Smoking Cessation) | * Results from Service User Survey
* Details of safeguarding enquiries
* Numbers of safeguarding referrals (with data available for individual safeguarding cases upon request by the Council)
* Numbers of complaints/comments (with data available for individual complaints upon request by the Council)
* Number of new referrals commenced
* Total number of referrals:

(a) Number starting(b) Number of taster sessions(c) Number leaving early (%)(d) Geographic locations(e) Referral pathway(f) Signposting to(g) Numbers achieving desired outcomes(h) Number of Service Users followed up on* Reviews planned and undertaken
* Any partnership work undertaken with organisations and any community based activity completed
 |
| Health and Safety | * Health and Safety incidents
* Any changes to health and Safety policies or procedures
 |
| Policies and Procedures | * All new or updated policies and procedures to be submitted, as detailed in Section 7.7 the Specification
 |

2.4.3 Submission of Returns

The Council is committed to simplifying the collection and analysis of monitoring information and will implement a process which will require submission of information electronically either by email or a secure portal. The Provider is required to have the facility to undertake this.

In the event that the Provider fails to submit accurate monitoring information in accordance with this schedule, this shall constitute a Service Failure.

2.4.4 Low Level Concerns

Any comment or concern made by a Service User to the Council on the quality and delivery of the service will be recorded as a ‘’low level concern’’. These are defined as issues or concerns, which are not being treated as a formal complaint.

Providers will respond to and resolve any incidents to the satisfaction of the Service User and the Council within the timescale stipulated by the Council.

Any concerns or comments being made in relation to the quality of the service can result in increased monitoring of the Provider, either with regards to individual Service Users or to evaluate themes and trends which have developed.

**2.5 Data Submission KPI’s**

The below KPI’s are relevant to any information or data which the Provider is contractually obliged to submit to the Council, including finance data, monitoring returns and any other information as detailed within the Monitoring Schedule or Service Specification.

1. **Timeliness of data and information submissions**

Providers are to submit the required data and information to the Council as per the stated timescales e.g. quarterly.

**Target: 95%**

1. **Accuracy of data and information submissions**

Providers are to submit accurate data and information to the Council (and are to ensure that any checking processes put in place by the Council is adhered to prior to submitting the data or information)

**Target: 95%**

If data or information is not submitted to the Council as per the required timescales for three consecutive periods, then this will result in service failure and contractual or improvement action being taken.

The three periods are proportionate to the set timescales in place within this agreement, e.g. if a data submission is required on a weekly basis and the data has not been submitted for three weeks this will result in service failure.

The accuracy of data may be spot checked and verified by the Council using various methods including checks of documentation.

**2.6 Inspection Reports**

The Provider shall provide the Council with copies of any inspection reports (including regulatory feedback reports) affecting the Service on request within 2 working days.

**2.7 Underperformance by Provider**

Should the Council identify that a Provider is underperforming against the terms of the Agreement:

1. the Council may without prejudice to its other rights and remedies including initiate one or more of the following: a Quality Assurance Form, Quality Assurance Visit or Contract Review Meeting
2. The Provider must produce a Service Improvement Action Plan which will be agreed with the Council and the Council may specify additional actions or requirements proportionate to any underperformance
3. Suspension of referrals to the Provider will be initiated where any monitoring or feedback obtained exposes performance issues or incidents relating to breaches in Service delivery, which may also include safeguarding incidents
4. Suspension of referrals to the Provider will be initiated whereby an active informal Improvement Notice or formal Default Notice is in place or the Provider is under Large Scale Safeguarding Enquiry (LSE) procedures
5. Exercise its right to make a payment pricing adjustment for Critical Performance Failure in accordance with Schedules 4 & 5 of the contract
6. Where there has been a serious breach or multiples breaches which may affect Service User safety and wellbeing, the Council retains the right to move existing Provider business to alternative Providers. This may be via a staggered approach or moving the business as a whole and is at the Councils discretion

Where improvements are evidenced and the required standard reached, referrals will be resumed to The Provider, initially with a phased approach which will be decided by the Council

**2.7.1 Underperformance of critical performance indicators**

If the level of any and all Critical Performance indicators identified are breached during the contract term, the Provider shall immediately notify the Council in writing and the Council, in its absolute discretion and without prejudice to any other of its rights to Service under this Schedule howsoever arising, may:

1. require the Provider to immediately take all remedial action that is reasonable to mitigate the impact on the Contracting Body and to rectify or prevent a Performance Failure or a Critical Performance Failure from taking place or recurring; and
2. if the action taken above has not already prevented or remedied the Performance Failure or Critical Performance Failure, the Council shall be entitled to instruct the Provider to comply with the Improvement Plan Process; or
3. if a Critical Performance Failure has occurred, exercise its right to make a pricing adjustment for Critical Performance Failure in accordance with Schedules 4 & 5 of the contract (the Council will undertake due diligence around why failure has occurred prior to any decision to penalise the Provider)
4. the Council may without prejudice to its other rights and remedies including initiate one or more of the following: a Quality Assurance Form, Quality Assurance Visit or Contract Review Meeting.

**2.7.2 Implementation of Improvement Action Plan**

Approval and implementation by the Council of any Improvement Action Plan shall not relieve the Provider of any continuing responsibility to achieve the Key Performance Indicators, or remedy any failure to do so, and no estoppels or waiver shall arise from any such Approval and/or implementation by the Council.

**3. Contract Management and Quality Assurance Governance and Validation**

**3.1 Contract Management and Quality Assurance Meetings**

The Provider will be required to attend regular contract management and quality assurance meetings chaired by representatives of the Council. These meetings will be set by the Council from the Commencement Date and will usually be in three monthly intervals.

The Council will arrange to meet with the Provider at least every quarter to review its performance against the provisions of this Specification and to discuss its plans for Service improvement. The Council reserves the right to alter the frequency of these meetings. Wherever possible, the meetings will be arranged by the Council in such a way that they do not impede the Provider in the delivery of the Service.

From time to time, officers from the Council may visit the Provider to verify evidence of service activity and compliance with the requirements of the Agreement and the Specification.

The Council will decide which Council representatives are to be in attendance at the meetings which may include Council staff from teams other than commissioning/ Contract Management and Quality Assurance.

**3.2 Monitoring and Quality Assurance Visits / Audits**

Monitoring, quality assurance, inspection or audit visits can be announced or unannounced and will be carried out by Council representatives. Monitoring and quality assurance visits can be carried out as part of a routine monitoring schedule for Providers to ascertain contract compliance or in response to general or specific concerns. The visits have no set duration and will depend on what aspects of the service are being monitored and quality assured.

The Provider may be subject to monitoring, quality assurance or audit visits and service reviews by the Council at any time during the duration of the Agreement.

The visits or audits can include on-site visits to the Providers offices and Council representatives have the right to access all information in relation to the interventions provided to Service Users, including:

1. Full Staff records (including DBS checks, insurance details, references, application forms, supervisions / appraisal records, disciplinary records, training records)
2. Full Service User records (screening, risk assessments, reviews, referrals to other professionals)
3. Full complaints records (including details of complaints, investigation, responses to complainants, actions taken)
4. Full safeguarding Records (including details of safeguarding alerts and concerns, enquiries, responses to safeguarding allegations, actions taken
5. Full Staff rota schedules, or any other system or format which evidences or details how activities are planned or delivered
6. Full documentation and certificates, including copies of notifications and pending applications
7. All levels of insurance certificates
8. Any other documentation deemed relevant by the Council to a Service Users’ needs, support delivery, wellbeing or health

The Council may also undertake spot checks to satisfy itself as to the ongoing quality of service delivery and to validate performance data. Should any issues be identified, the Provider will ensure that remedial action is taken as per the Councils feedback and within the timescale specified at the time of notification or discussion.

Additional or more in-depth inspections or monitoring will be triggered by any of the following:

1. Whereby an active informal Improvement Notice or formal Default Notice is in place
2. An increase in Safeguarding incidents, or receipt of a serious safeguarding referral which may indicate risk to Service Users
3. Failure to meet required Key Performance Indicators or Best Practice elements
4. Contract Monitoring non-compliance
5. Concerns arising from previous inspections and reviews
6. Concerns arising from Service User or representative feedback
7. Statutory Notices or intelligence shared with the Council
8. Complaints (including verbal, written, formal and informal)
9. Whistle blowing
10. Changes in local branch / local management for this contract without adequate contingencies, handover or not informing the Council
11. Any other issues deemed to be a risk

**Quality and Performance Monitoring Frameworks**

**Key Performance Indicator Framework** (Baseline information will be used to establish KPI’s in year 2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lifestyle Programme** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Physical Activity | All residents 18+ who are regularly undertaking less than half an hours physical activity per week or a relevant medical condition | Numbers of Participation in programme (Incentivised). Recording age, gender, ethnicity, sexuality, faith, disability, employment status, any medical conditions relevant to exercise. GP details. | 1800  | 1200 | Quarterly & Annually |
|  | Conversion rate of a referral leading to programme participation | Percentage of referrals that result in people starting on a programme | 50-75% | N/A | Quarterly & Annually |
| Individuals attending taster sessions  | Numbers accessing taster sessions and how many continue to access the programme | For information only | N/A | Quarterly & Annually |
| Record and report on locations of participants | Location where participants live and the corresponding deprivation level  | As outlined in the service specification | N/A | Quarterly & Annually |
| User feedback score on completion of the programme (or when leaves) | User satisfaction with programme on a Scale 1-10 | Minimum average8.5 | Minimum averageBelow 7.0 | Quarterly & Annually |
| Percentage of the numbers leaving a programme early  | Attrition rate for each programme and reason for leaving early | Less than 40 % | Higher than 55% leaving early | Quarterly & Annually |
| Record the referral source or where signposted on (if applicable) | Record the referral source and signposting on | For information only | Data accuracy  | Quarterly & Annually |
| Outcomes achieved at end of a programme. | Number of participants who have achieved their desired outcomes | For baseline information  | N/A | Annually |
| Provide Information, advice and guidance for individuals on the benefits of physical activity | The numbers of individuals provided with information, advice & guidance, but are not ready or able to access the service. | For baseline information | N/A | Quarterly & Annually |
| Longer term outcomes achieved by participants | Number of follow up reviews 6 months after completing a programme. Including but not limited to: How many individuals access follow on courses or activities in the community | For baseline information  | N/A | Annually |
| Evidence of Partnership working in the delivery of the service | The number of organisations worked with to support programmes and projects | For baseline information | N/A | Quarterly & Annually |
| Evidence of Outreach in promoting the service  | The number and location of places/events in the community Outreach has been provided | For baseline information | N/A | Quarterly & Annually |
| Evidence of an effective and measureable Communication & Marketing Plan | Targeted approach, experienced staff, promotional materials, self referrals, feedback, social media, national campaigns, stakeholders | For baseline information | N/A  | Quarterly & Annually |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lifestyle Programme** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Falls Prevention | For those 65+ (exceptions can be made for those with relevant health conditions)1. Has an individual had 2 or more falls?2. Presented with an acute fall within the last 12 months?3. Has difficulty walking or with balance?TUG and Berg Balance Scale. | Numbers of Participation in programme (Incentivised).Recording age, gender, ethnicity, sexuality, faith, disability, employment status, any relevant medical conditions.GP details. | 570 | 340 | Quarterly & Annually |
|  | Conversion rate of a referral leading to programme participation | Percentage of referrals that result in people starting on a programme | 50-75% | N/A | Quarterly & Annually |
| Individuals attending taster sessions  | Numbers accessing taster sessions and how many continue to access the programme | For information only | N/A | Quarterly & Annually |
| Record and report on locations of participants | Location where participants live and the corresponding deprivation level  | As outlined in the service specification | N/A | Quarterly & Annually |
| User feedback score on completion of the programme (or when leaves) | User satisfaction with programme on a Scale 1-10 | Minimum average8.5 | Minimum averageBelow 7.0 | Quarterly & Annually |
| Percentage of the numbers leaving a programme early  | Attrition rate for each programme and reason for leaving early | Less than 30 % | Higher than 40% leaving early | Quarterly & Annually |
| Record the referral source or where signposted on (if applicable) | Referral source and signposting on | For information only | Data accuracy  | Quarterly & Annually |
| Outcomes achieved at end of a programme | Number of participants who have achieved their desired outcomes | For baseline information  | N/A | Annually |
| Longer term outcomes achieved by participants | Number of follow up reviews 6 months after completing a programme. Including but not limited to: How many individuals access follow on courses or activities in the community | For information only | Data accuracy  | Annually |
| Evidence of Partnership working in the delivery of the service | The number of organisations worked with to support programmes and projects | For baseline information | N/A | Quarterly & Annually |
| Evidence of Outreach in promoting the service  | The number and location of places/events in the community Outreach has been provided | For baseline information | N/A | Quarterly & Annually |
| Evidence of an effective and measureable Communication & Marketing Plan | Targeted approach, experienced staff, promotional materials, self referrals, feedback, social media, national campaigns, stakeholders | For baseline information | N/A  | Quarterly & Annually |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lifestyle Programme** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Weight Management including Family Weight Management | Participants BMI should be 25 or over (over 23 for some BME groups).<18 years, 1 child in family must be above a healthy weight, Children identified through NCMP as overweight or obese | Numbers of Participation in programme (Incentivised)Recording age, gender, ethnicity, sexuality, faith, disability, employment status, any relevant medical conditions. GP details. | 600 | 450 | Quarterly & Annually |
|  | Conversion rate of a referral leading to programme participation | Percentage of referrals that result in people starting on a programme | 50-75% | N/A | Quarterly & Annually |
| Record and report on locations of participants | Location where participants live and the corresponding deprivation level  | As outlined in the service specification | N/A | Quarterly & Annually |
| Individuals attending taster sessions  | Numbers accessing taster sessions and how many continue to access the programme | For information only | N/A | Quarterly & Annually |
| User feedback score on completion of the programme (or when leaves) | User satisfaction with programme on a Scale 1-10 | Minimum average8.5 | Minimum averageBelow 7.0 | Quarterly & Annually |
| Percentage of the numbers leaving a programme early  | Attrition rate for each programme and reason for leaving early | Less than 40 % | Higher than 50% leaving early | Quarterly & Annually |
| Record the referral source or where signposted on (if applicable) | Referral source and signposting on | For information only | Data accuracy  | Quarterly & Annually |
| Outcomes achieved at end of a programme | Number of participants who have achieved their desired outcomes  | For baseline information  | N/A | Annually |
| Longer term outcomes achieved by participants | Number of follow up reviews 6 months after completing a programme. Including but not limited to: How many individuals access follow on courses or activities in the community | For information only | Data accuracy  | Annually |
| Evidence of Partnership working in the delivery of the service | The number of organisations worked with to support programmes and projects | For baseline information | N/A | Quarterly & Annually |
| Evidence of Outreach in promoting the service  | The number and location of places/events in the community Outreach has been provided | For baseline information | N/A | Quarterly & Annually |
| Evidence of an effective and measureable Communication & Marketing Plan | Targeted approach, experienced staff, promotional materials, self referrals, feedback, social media, national campaigns, stakeholders | For baseline information | N/A  | Quarterly & Annually |

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| **Lifestyle Programme** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Maternal Health | Women who are pregnant and for those up to 12 months after giving birth who Smoke, Drink alcohol (whilst pregnant), Are physically inactive (conducting less than half an hour’s exercise a week), Whose BMI is 25 or above | Numbers of Participation in programme (Incentivised)Recording age, gender, ethnicity, sexuality, faith, disability, employment status, any relevant medical conditions. GP details.Record the type of intervention or support provided for each individual | Numbers Included in either Smoking Cessation or Physical Activity target | Numbers Included in either Smoking Cessation or Physical Activity target | Quarterly & Annually |
|  | Conversion rate of a referral leading to programme participation | Percentage of referrals that result in people starting on a programme | 50-75% | N/A | Quarterly & Annually |
| Individuals attending taster sessions  | Numbers accessing taster sessions and how many continue to access the programme | For information only | N/A | Quarterly & Annually |
| Record and report on locations of participants | Location where participants live and the corresponding deprivation level  | As outlined in the service specification | N/A | Quarterly & Annually |
| User feedback score on completion of the programme (or when leaves) | User satisfaction with programme (Scale 1-10) | Minimum average8.5 | Minimum averageBelow 7.0 | Quarterly & Annually |
| Percentage of the numbers leaving a programme early  | Attrition rate for each programme | Less than 20 % | Higher than 30% leaving early | Quarterly & Annually |
| Record the referral source or where signposted on (if applicable) | Referral source and signposting on | For information only | Data accuracy  | Quarterly & Annually |
| Longer term outcomes achieved by participants  | Number of follow up reviews 6 months after completing a programme. Including but not limited to: How many individuals access follow on courses or activities in the community | For baseline information  | N/A | Annually |
| Outcomes achieved at end of a programme. | Number of participants who have achieved their desired outcomes | For baseline information  | N/A | Annually |
| Evidence of Partnership working in the delivery of the service | The number of organisations worked with to support programmes and projects | For baseline information | N/A | Quarterly & Annually |
| Evidence of Outreach in promoting the service  | The number and location of places/events in the community Outreach has been provided | For baseline information | N/A | Quarterly & Annually |
| Evidence of an effective and measureable Communication & Marketing Plan | Targeted approach, experienced staff, promotional materials, self referrals, feedback, social media, national campaigns, stakeholders | For baseline information | N/A  | Quarterly & Annually |

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| **Lifestyle Programme** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Specialist Stop Smoking | Individuals who are pregnant and those with mental health conditions.Quit dates set. | Numbers of Participation in programme (Incentivised)Recording age, gender, ethnicity, sexuality, faith, disability, employment status, any relevant medical conditions. GP details.Record the intervention setting and type of intervention.  | 160 | 120 | Quarterly & Annually |
|  | Smoking Status at time of Delivery (SATOD) for pregnant mothers | Number of mothers who continue to smoke at the time of delivery. Record data for Crewe and Macclesfield Hospitals | For baseline information | N/A | Quarterly & Annually |
| Conversion rate of a referral leading to programme participation | Percentage of referrals that result in people starting on a programme | For baseline information | N/A | Quarterly & Annually |
| Smoking quits achieved for those accessing the service | The number of participants that have quit smoking. Recorded for pregnant mothers and those with mental health conditions | For baseline information | N/A | Quarterly & Annually |
| Information, advice and guidance provided to others in the family household | The number of people offered support and advice  | For baseline information | N/A | Quarterly & Annually |
| Record and report on locations of participants | Location where participants live and the corresponding deprivation level  | As outlined in the service specification | N/A | Quarterly & Annually |
| User feedback score on completion of the programme (or when leaves) | User satisfaction with programme (Scale 1-10) | Minimum average8.5 | Minimum averageBelow 7.0 | Quarterly & Annually |
| Attrition rate for participants not completing the smoking intervention | Percentage of the numbers leaving early | For baseline information | N/A | Quarterly & Annually |
| Record the referral source or where signposted on (if applicable) | Referral source and signposting on | For information only | Data accuracy  | Quarterly & Annually |
| Longer term outcomes achieved by participants  | Number of follow up reviews 6 months after completing a programme. Including but not limited to: How many individuals access follow on courses or activities in the community | For baseline information  | N/A | Annually |
| Evidence of Partnership working in the delivery of the service | The number of organisations worked with to support the tobacco control agenda | For baseline information | N/A | Quarterly & Annually |
| Evidence of Outreach in promoting the service  | The number and location of places/events in the community Outreach has been provided | For baseline information | N/A | Quarterly & Annually |
| Evidence of an effective and measureable Communication & Marketing Plan | Targeted approach, experienced staff, promotional materials, self referrals, feedback, social media, national campaigns, stakeholders | For baseline information | N/A  | Quarterly & Annually |

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| **Lifestyle Programme** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Community Stop Smoking | Any resident who is a smoker and motivated to quit/reduce harm caused by cigarettes. In addition to this, smokers from the age of 12 upwards who wish to stop will be offered medicinal and behavioural support. Quit dates set. | Numbers of Participation in programme (Incentivised)Recording age, gender, ethnicity, sexuality, faith, disability, employment status, any relevant medical conditions. GP details.Record the intervention setting and type of intervention. | 250 | 180 | Quarterly & Annually |
|  | Support via an Intervention. Weekly support for at least the first 4 weeks. Should follow the format suggested by the NCSCT | Numbers provided with an Intervention.  | For baseline information  | N/A | Quarterly & Annually |
|  | Brief advice and medication to individuals who prefer to self-help. Use of the ‘Every Contact Counts’ approach | Numbers provided with medication and self help | For baseline information  | N/A | Quarterly & Annually |
|  | Advice and interventions to those not ready. As above approach, consider Harm Reduction or use of NRT.See NICE Guidance PH45 | Numbers not yet ready to quit. | For baseline information  | N/A | Quarterly & Annually |
|  | Conversion rate of a referral leading to programme participation | Percentage of referrals that result in people starting on a programme | For baseline information | N/A | Quarterly & Annually |
| Record and report on locations of participants | Location where participants live and the corresponding deprivation level  | As outlined in the service specification | N/A | Quarterly & Annually |
| User feedback score on completion of the programme (or when leaves) | User satisfaction with programme (Scale 1-10) | Minimum average8.5 | Minimum averageBelow 7.0 | Quarterly & Annually |
|  | The number of quits  | 35% minimum  |  |  |
| Attrition rate for participants not completing the smoking intervention | Percentage of the numbers leaving early | For baseline information  | N/A | Quarterly & Annually |
| Record the referral source or where signposted on (if applicable) | Referral source and signposting on | For information only | Data accuracy  | Quarterly & Annually |
| Alternative therapies and interventions used to reduce smoking | Record the number and type of therapy provided to an individual ie NRT, Varenicline, e-cigarettes  | For information only | N/A | Quarterly & Annually |
| Evidence of Partnership working in the delivery of the service | The number of organisations worked with to support the tobacco control agenda | For baseline information | N/A | Quarterly & Annually |
| Evidence of Outreach in promoting the service  | The number and location of places/events in the community Outreach has been provided | For baseline information | N/A | Quarterly & Annually |
| Evidence of an effective and measureable Communication & Marketing Plan | Targeted approach, experienced staff, promotional materials, self referrals, feedback, social media, national campaigns, stakeholders | For baseline information | N/A  | Quarterly & Annually |

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| **Innovation****Programmes** | **Criteria** | **KPI** | **Baseline Target** | **Critical Failure** | **Reporting Frequency** |
| Projects identified to be delivered through the Innovation Fund | To be agreed by commissioners. | KPI’s will be set and agreed by commissioners for each project. |  |  |  |

 **Outcomes Framework**

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| **Lifestyle Programme**  | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Physical Activity | Moving from inactive to active. Including proportion of participants achieving recommended levels. | Chief Medical Officer guidelines.Public Health England – SEF for Physical Activity interventions | 50-75% | Quarterly & Annually |
|  | Showing improvement in wellbeing | SWEMWBSAdvice should be based on the ‘5 ways to wellbeing’ model | For information and baselining | Quarterly & Annually |
| Reduction in alcohol consumption  | The number of people provided with information and advise to reduce alcohol intake and the number signposted onto the specialist substance misuse service (CGL) | For information and baselining | Quarterly & Annually |
| Improvement in physical strength  | Undertake physical activity to improve muscle strength at least twice per week | For information and baselining | Quarterly & Annually |
| Improvement in physical measurements | Weight, BMI, Waist circumference, resting heart rate | For information and baselining | Quarterly & Annually |
| Improvement in blood pressure | Hypertensive (>140/90) or normal reading | For information and baselining | Quarterly & Annually |

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| **Lifestyle Programme**  | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Fall Prevention | Improvement in strength and balance | Fear of falling score, timed up and go assessment, Berg Balance Scale alsostand on one foot | 60-100% | Quarterly & Annually |
|  | Individuals undergo exercise for 3 hours a week and that exercises consist of a high challenge to balance | OTAGO or FaME approach | For information and baselining | Quarterly & Annually |
| Showing improvement in wellbeing | SWEMWBSAdvice should be based on the ‘5 ways to wellbeing’ model | For information and baselining | Quarterly & Annually |
| Reduction in alcohol consumption  | The number of people provided with information and advise to reduce alcohol intake and the number signposted onto the specialist substance misuse service (CGL) | For information and baselining | Quarterly & Annually |
| Falls/ hospital admissions/ fractures that an individual experiences prior, during and after the programme | Record of falls or other related hospital admissions | For information and baselining | Quarterly & Annually |

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| **Lifestyle Programme**  | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Weight Management including Family Weight Management | Participants achieving a weight loss | Over 3% and 5% reduction in weight | 30%+ with 5%50%+ with 3% | Quarterly & Annually |
|  | Improvement in physical measurements | Weight, BMI, Waist circumference, resting heart rate, blood pressure | 60-100% | Quarterly & Annually |
| Showing improvement in wellbeing including children | SWEMWBSAdvice should be based on the ‘5 ways to wellbeing’ model | For information | Quarterly & Annually |
| Showing a change in physical activity levels including children | International Physical Activity Questionnaire(IPAQ) | For information | Quarterly & Annually |
| Children showing improvement in physical measurements | Centile decrease | For information | Quarterly & Annually |
| Reduction in alcohol consumption  | The number of people provided with information and advise to reduce alcohol intake and the number signposted onto the specialist substance misuse service (CGL) | For information and baselining | Quarterly & Annually |
| Healthy diet | Behaviour change and advice on calorific balance.Measure the change in diet using the ‘24 hour dietary recall profile’ tool.Promote healthy eating as shown in the Eatwell Guide and government guidance | For information | Quarterly & Annually |

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| **Lifestyle Programme**  | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Maternal Health | Increased level of Physical activity | Validated tool such as GPPAQ, using CMO guidelines  | 60-100%For information and baselining | Quarterly & Annually |
|  | Quit smoking whilst pregnant | The number of participants that quit smoking | For information and baselining  | Quarterly & Annually |
| Showing improvement in wellbeing | SWEMWBSAdvice should be based on the ‘5 ways to wellbeing’ model | For information | Quarterly & Annually |
| Reduction in alcohol consumption  | The number of people provided with information and advise to reduce alcohol intake and the number signposted onto the specialist substance misuse service (CGL) | For information and baselining | Quarterly & Annually |

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| **Lifestyle Programme**  | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Specialist Stop Smoking | Quit smoking whilst pregnant. Recorded for Macclesfield and Leighton hospitals | The number of participants that quit smoking. In line with Public Health indicators. | For information and baselining  | Quarterly & Annually |
| Delivered in line with NICE Guidance | Mental health smoking quits. | The number of participants that quit smoking. In line with Public Health indicators. | For information and baselining  | Quarterly & Annually |
| Showing improvement in wellbeing | SWEMWBSAdvice should be based on the ‘5 ways to wellbeing’ model | For information | Quarterly & Annually |
| Reduction in alcohol consumption  | The number of people provided with information and advise to reduce alcohol intake and the number signposted onto the specialist substance misuse service (CGL) | For information and baselining | Quarterly & Annually |
| Identifying individuals who have health conditions that are caused or made worse by smoking | A regular presence in appropriate settings for timely support | For information | Quarterly & Annually |

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| **Lifestyle Programme**  | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Community Stop Smoking | Individuals who wish to stop smoking | The number of participants that quit smoking and recorded on PharmOutcomes | 35% minimum conversion rate for quits | Quarterly & Annually |
| Delivered in line with NICE Guidance | Support for individuals to stop smoking | The number of NRT vouchers issued | For information and baselining  | Quarterly & Annually |
| Showing improvement in wellbeing | SWEMWBSAdvice should be based on the ‘5 ways to wellbeing’ model | For information | Quarterly & Annually |
| Reduction in alcohol consumption  | The number of people provided with information and advise to reduce alcohol intake and the number signposted onto the specialist substance misuse service (CGL) | For information and baselining | Quarterly & Annually |
| Identifying individuals who have health conditions that are caused or made worse by smoking | A regular presence in appropriate settings for timely support | For information | Quarterly & Annually |

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| **Innovation****Programmes** | **Individual level outcome**  | **Outcome Indicators / Tools/ measure** | **Target**  | **Reporting Frequency** |
| Projects identified to be delivered through the Innovation Fund | To be agreed by commissioners. | To be agreed by commissioners. |  |  |

**Social Value Measures**

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| **Objective** | **Outcomes** | **Measure** |
| 1. Promote Employment & Economic Sustainability
 | Outcome 1: More local people in work | Number of local people employed through the Service |
| Outcome 2: Thriving local businesses | Local businesses are sustainable and there is evidence of business growth and partnership working e.g increase in people accessing services, joint ventures, shared assets (Connected Communities) |
| Outcome 3: Responsible businesses that do their bit for the local community | Engagement and support with local communities, business plans are reflective of an asset based approach to support |
| 1. Raise the living standard of local residents
 | Outcome 4: A Local workforce which is fairly paid and positively supported by employers | Appropriate market salary for staff. Employees are supported to develop professionally through access to training and support. Policies and procedures in place to safeguard staff, including supporting their wellbeing. |
| 1. Promote Participation and Citizen Engagement
 | Outcome 5: Individuals and communities enabled and supported to help themselves | Engagement with local communities |
| 1. Build capacity and sustainability of the Voluntary and Community Sector
 | Outcome 6: An effective and resilient third sector | Partnership approach building on local assets. Use of effective sub-contracting/ partner provider relationships |
| 1. Promote Equity and Fairness
 | Outcome 7: A reduction in poverty, health and education inequalities.  | Multi-agency approach to intervention and support,adopting a holistic asset based approach.Whole family holistic approach |
| Outcome 8: Acute problems are avoided and costs are reduced by investing in prevention. | People have their needs identified early. Organisations and communities report on increased awareness of DA and are able to prevent needs escalating to reduce the number of people entering acute services |
| 1. Promote Environmental Sustainability
 | Outcome 8: We are protecting our physical environment and contributing to climate change reduction. | Re-cycling, reduced carbon footprint |