**Appendix 1**

**Specification**

**Local Stop Smoking Service (the “Service”)**

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| 1. **Introduction and Context**
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| Our vision: Thriving communities for everyone in Oxfordshire[[1]](#footnote-1)**1.1 National Context**Smoking is the leading cause of preventable ill health and premature mortality in England[[2]](#footnote-2), with about half of all life-long smokers dying prematurely, losing on average about 10 years of life[[3]](#footnote-3). It is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking still accounts for 1 in 6 of all deaths in England, and there are huge inequalities in smoking and smoking related deaths. Reducing smoking rates is the single biggest thing we can do to improve the nation’s health[[4]](#footnote-4).Tobacco use is also one of the largest drivers of health inequality. The difference in life expectancy between the most and least deprived can be as much as nine years, of which approximately half can be attributed to smoking[[5]](#footnote-5). Smoking is much more common among people with lower incomes. The more disadvantaged a person is, the more likely they are to smoke and to suffer from smoking related illness and early death related to smoking. As spending on tobacco consumes a relatively high proportion of the household income for people with low incomes who smoke, smoking can lock people into poverty.Reducing smoking prevalence is important nationally, regionally and locally within the context of improving mortality and morbidity rates for populations in England. There have been concerted efforts to reduce the number of smokers in the population and the increased education of the harm that smoking has on the health of smokers. Whilst there have been considerable reductions in the adult smoking population from 45% in 1974 down to 13.9% in 2019, this still equates to 6,111,270 adults in England who smoke2. Between 2016 and 2018, there were 232,859 deaths attributable to smoking in England2.**1.2 Local Context**Oxfordshire is based in the Thames Valley and is the most rural County in the South East region. The majority (60%) of Oxfordshire’s population are resident in Oxford City and the County's main larger towns. The remaining ~40% live in smaller towns and villages with over 50% of residents living in settlements of <10,000 people. As of mid-2018, Oxfordshire had a population of around 687,500. It is comprised of one Upper Tier Local Authority (Oxfordshire County Council (the “Council”)) and five District and City Local Authorities:* Oxford City Council;
* Cherwell District Council;
* South Oxfordshire District Council;
* Vale of White Horse District Council;
* West Oxfordshire District Council.

The Council housing-led forecasts predict a total population in Oxfordshire of 822,200 by 2027, a growth of 134,800 (+20%) since 2017 with the differences in these estimates particularly apparent for the younger and working age groups. Oxfordshire is broadly comprised of a white British population, with 16% of the total resident population of Oxfordshire from an ethnic minority background, compared with 20% across England. The majority of the ethnic minority population in Oxfordshire is based in urban areas of Oxford City and Banbury town that is within the Cherwell District. The average age of Oxfordshire residents was 40.0 years at mid-2018. A full breakdown of the populations of Oxfordshire is available in the 2020 Joint Strategic Needs Assessment (JSNA)[[6]](#footnote-6). Oxfordshire is one of the leastdeprived Local Authorities in England, but some areas experience high levels of deprivation, with 10 Lower Layer Super Output Area (LSOA) wards that fall within the 20% most deprived LSOA wards in England. There are higher rates of child poverty in parts of Banbury and Oxford City. After housing costs, 1 in 5 children in Oxfordshire are estimated to be living in poverty – within Oxford City, however, this figure rises to almost one-third. These 10 most deprived LSOA wards in Oxfordshire are in Figure 1:*Figure 1. The 10 most deprived LSOA wards in Oxfordshire**[[7]](#footnote-7)*The data in the JSNA6 outlines that priorities for prevention in Oxfordshire need to address the increased likelihood that people who live in more deprived areas, such the 10 LSOA wards outlined in Figure 1, will experience lower life expectancy (with higher rates of death from cardiovascular disease, stroke, lung illness and cancers) and earlier onset of long-term conditions (LTC’s). In Oxfordshire, local organisations and communities are working together to develop a unified approach to prevention to achieve better health for residents. The Oxfordshire Prevention Framework 2019-24[[8]](#footnote-8) outlines the future delivery of a range of initiatives that will PREVENT ill health, REDUCE the need for treatment and DELAY the need for care. To achieve these, the Framework includes smoking as a preventable lifestyle risk factor that needs addressing in Oxfordshire with these types of Services listed as a ‘current asset’. Working collaboratively, the Oxfordshire Prevention Framework 2019-248 will to give practical guidance on how to implement the Oxfordshire Joint Health and Wellbeing Strategy 2018-23[[9]](#footnote-9) for cross cutting priorities of prevention and tackling inequalities. The Oxfordshire Prevention Framework 2019-248 as an approach is not a replacement of the universal offer for health and well-being, however it will be an approach which delivers an increased focus on the neediest communities of Oxfordshire to address inequalities. Using the Oxfordshire Prevention Framework 2019-248, the Council can target the 10 most deprived LSOA wards (Figure 1) and disadvantaged communities across the County when working with partners, residents and communities to support people in adopting healthier lifestyles and to look after their wellbeing.**1.3 The Final Push - Oxfordshire Tobacco Control Strategy 2020-25****[[10]](#footnote-10)**The ‘Towards a Smokefree Generation: A Tobacco Control Plan for England 2017-223 sets a vision to create a smokefree generation by 2030, this will be achieved when smoking prevalence is at 5% or below. To do this it intends to shift emphasis from action at the national level to focused local action, supporting smokers (particularly in disadvantaged groups), to quit. This places significant responsibility on Local Authorities and its partners to contribute towards a reduction in smoking rates. In response to this, the Oxfordshire Tobacco Control Alliance developed an Oxfordshire Tobacco Control Strategy 2020-2510, titled The Final Push, that sets a vision for a wider system approach to eliminating tobacco use and aims to achieve the 5% smoking prevalence target by 2025; five years ahead of the national Tobacco Control Plan for England 2017-223. The Oxfordshire Tobacco Control Strategy 2020-2510 outlines that the ambition to eliminate tobacco use in Oxfordshire cannot be achieved by any one organisation alone with the objectives for reducing tobacco control in Oxfordshire adopting a whole system approach across four pillars as shown in Figure 2.*Figure 2. Four pillars for a whole system approach to tobacco use in Oxfordshire10*The ‘Supporting Smokers to Quit’ pillar of the Oxfordshire Tobacco Control Strategy 2020-2510 includes a commitment for the Council to continue to provide access to these type of Services as these clinically effective interventions can have a positive impact on smoking rates[[11]](#footnote-11). The provision of these Services delivers a cost saving. This can be thought of in terms of providing a return on investment of £10.00 per smoker over the course of a lifetime for every £1 spent[[12]](#footnote-12).The effects of tobacco are not limited to just the mortality and morbidity rates of smokers but has implications for the wider society in which they live. The 2019 Action on Smoking and Health (ASH) Ready Reckoner[[13]](#footnote-13) estimates the costs of smoking tobacco at Local Authority levels. According to ASH, the estimated cost of smoking tobacco to the national and local economy is approximately £12.6 billion and £121.7 million each year respectively (Figure 3). And whilst a large part of this financial burden is placed on the NHS, it has a considerable financial impact upon local governments. For instance, smokers tend to require more support in later life and the resulting cost to social care alone is estimated to be £6 million per year. Smoking also impacts the local economy through smoking breaks, sick days and lost productivity.*Figure 3. Estimated cost of smoking in Oxfordshire*13**1.3.1 Supporting Smokers to Quit**Oxfordshire has a history of delivering the Service to reduce the health and social care burden, as outlined above, that is caused by smoking tobacco. These Services were first established nationally in 2000 in response to recommendations in the 1998 White Paper ‘*Smoking Kills’[[14]](#footnote-14)* and were built around the principle of a universal offer of support available for all smokers, with a combination of behavioural support and pharmacotherapy. Since that time, they have supported an estimated one million smokers to quit tobacco for good[[15]](#footnote-15). Since April 2013, the Health and Social Care Act 2012[[16]](#footnote-16) transferred responsibilities for delivering and commissioning public health services to Local Authorities from the NHS. The Act conferred duties on Local Authorities to improve public health and set conditions to the then ring-fenced Public Health grant provided. These duties may include ‘*providing facilities for the prevention or treatment of illness’;* this would include commissioning these Services that can contribute to reducing local smoking prevalence rates.The provision of an evidence-based Service remains a top priority for the Council as they remain highly effective in both cost and clinical terms[[17]](#footnote-17). However, new approaches are emerging15 and it was time to review the local model of Service delivery from April 2021.With the publication of the Oxfordshire Tobacco Control Strategy 2020-2510, and through the Oxfordshire Tobacco Control Alliance, the Service can now work more closely with the wider system. It is now recognised that this Service alone is **not** the main driver for reducing smoking prevalence and the associated health inequalities in Oxfordshire; national policy and prioritising local tobacco control are more able to achieve this. However, the Service needs to sit within a system-wide collaboration for a strategic approach to tobacco control and form an essential part of a wider action to reduce the smoking prevalence in Oxfordshire to 5% or below by 2025. The Council and five District and City Local Authorities have demonstrated their commitment to a collaborative approach to tobacco control by signing the Local Government Declaration on Tobacco Control[[18]](#footnote-18). Oxfordshire Clinical Commissioning Group, alongside the two NHS Trusts in Oxfordshire (Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust) have signed up to the NHS Smokefree Pledge[[19]](#footnote-19), an equivalent version of the Local Government Declaration on Tobacco Control for the NHS.Both the Tobacco Control Plan for England 2017-223 and Oxfordshire Tobacco Control Strategy 2020-2510 focus on the need to reduce smoking-related inequalities and variation by targeting support to priority groups. Local approaches to engaging and supporting these groups are especially relevant for the Council and NHS, where smokers may have multiple touchpoints with local Council and NHS services. These key documents also marked a shift in focus, identifying the key role the NHS has to play in supporting NHS users to quit smoking tobacco. The Secretary of State for Health and Social Care has set out a commitment to upscaling prevention in NHS Long Term Plan[[20]](#footnote-20). Smoking is a good way for Local Authorities and the NHS to deliver on this. The NHS Long Term Plan prioritises smoking cessation support within secondary care; and as a result, it therefore remains important for Local Authorities and Clinical Commissioning Groups to collaborate and provide sufficient support for smokers at primary care and community levels. The Saving Babies Lives Care Bundle for maternity services[[21]](#footnote-21), as well as the Commissioning for Quality and Innovation (CQUIN)[[22]](#footnote-22) for Secondary Care and Mental Health settings aim to address risky behaviours to deliver Tobacco Dependency services in NHS services, such as through in-patient settings, maternity and mental health. The Council recognises that the implementation of a new Service model will require a shift in current practice (i.e. from a universal specialist service) and an understanding needs to be applied across the whole system, not just certain components of it. It will need to ‘*work together*’ with this system, including the NHS, ‘*in a supportive and honest way*’ to achieve the aims and objectives of this Service.**1.4 Local Needs Assessment** In 2019 an estimated 12% of adults in Oxfordshire were smokers, down from 16.2% in 2011 and lower than the England average of 13.9%; this equates to 65,118 adult smokers in the population. Smoking prevalence in all of Oxfordshire’s five District and City Local Authorities was either below or similar to national and regional averages. While it is encouraging that the population of tobacco smokers in Oxfordshire is less than seen nationally, there is an inequality in who smokes tobacco in the population. In 2020, a Tobacco Health Needs Assessment[[23]](#footnote-23) (HNA) was carried out to assess the current picture of tobacco use in Oxfordshire.  A key recommendation linked to the ‘Supporting Smokers to Quit’ pillar of the Oxfordshire Tobacco Control Strategy 2020-2510 is ‘*to reduce smoking in the higher prevalence populations, a targeted approach is required to help support people to quit*’. This recognises that if a universal approach to policy and delivery of services is maintained in Oxfordshire, there is a risk that any improvements in the average population will not be realised for the most deprived and at worst, may exacerbate and widen the inequalities between the least and most deprived residents of Oxfordshire.A strong relationship exists between tobacco use and local health inequality, as highlighted in Oxfordshire’s Director of Public Health’s Annual Report 2019/207, with smoking rates much higher in those with the lowest incomes[[24]](#footnote-24). To reduce health inequalities, and improve public health, the Council need to help its priority populations to quit[[25]](#footnote-25).The current priority groups in Oxfordshire, for 2021/22, are identified as smokers of tobacco where there is an identified need. These are:* Those living in the 10 most deprived LSOA wards in Oxfordshire (see Figure 1);
* Adults in routine and manual occupations, have never worked or unemployed, sick/disabled and unable return to work and carers;
* Pregnant women;
* Adults with mental ill health (including drug and alcohol misuse); and
* Adults admitted to secondary care settings or living with a LTC.

A full breakdown of the need in Oxfordshire is available in the 2020 Tobacco HNA23. However, to summarise the key findings:* In 2019 an estimated 22.5% of adults in routine and manual occupations in Oxfordshire were smokers, significantly greater than the average for the wider adult population and in parity with England (23.2%).
* The proportion of pregnant women who smoke tobacco at time of delivery (SATOD) in 2018/19 was 7.5% which is lower than the national average (10.6%). Whilst this is encouraging, there remains approximately 484 women SATOD each year and this is not decreasing locally in line with the national trend with SATOD at 8% in 2010/11.
* Approximately 0.8% of residents have a recorded diagnosis of a severe and enduring mental ill health. Data from the GP Patient Survey (GPPS) show that 22.7% adults with a long-term mental health condition in Oxfordshire smoke and is therefore around twice as common among people with mental ill health. Based on national data, prevalence is even greater in those with more severe illnesses (between 37% and 56%)[[26]](#footnote-26). Smoking plays a major role in the 10-20-year gap in life expectancy between those who do and don’t experience mental health problems.
* The smoking prevalence in children and young people is 10.4%, this is equivalent to approximately 2,000 pupils aged 11-15 currently smoking. This is significantly higher compared to England (8.2%) and the South East region (9%). As two thirds of tobacco smokers start before they are 18 years of age, it is a concern that this trend continues for the overall smoking prevalence rate in Oxfordshire in the future.
* People between the ages of 25 and 34 years are the most likely to smoke compared to all other age groups. These are the parents of today and tomorrow and influence the uptake of smoking by young people. In Oxfordshire 895 young people start smoking each year.
* Smoking is the leading cause of preventable ill health and premature mortality in Oxfordshire. In the three-year period 2016-18, there were 2,044 deaths attributable to smoking in Oxfordshire, including 166 deaths from heart disease and 62 deaths from stroke. In the same period, there were 8,176 potential years of life lost due to smoking related illness. As well as dying prematurely, smokers also suffer many years in poor health. Many of the conditions caused by smoking are chronic illnesses which can be debilitating, making it difficult to carry out day to day tasks and engage with society. Smokers are therefore proportionately are less likely to be in work.
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| 1. **Strategic Priorities and Outcomes**
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| * 1. **Local Outcomes**

The Service shall support delivery against the local priorities that have been outlined in Oxfordshire Tobacco Control Strategy 2020-2510:* Reduce the prevalence of smoking in the adult population to below **5% by 2025;**
* Reduce the prevalence of smoking in routine and manual workers to **below 10%;**
* Reduce the prevalence of smoking in those with a serious mental illness to **below 20%;**
* Reduce the prevalence of women who smoke at the time of delivery to **below 4%;** and
* Reduce the prevalence of smoking at age 15 **below 3%.**
	1. **National Outcomes**

The Service shall support delivery against the national ambitions outlined in the Tobacco Control Plan for England 2017-223.The Plan sets out four national ambitions: * The first smoke-free generation;
* A smoke-free pregnancy for all;

People with mental ill health should be given equal priority to those with physical ill health; and* Backing evidence-based innovations to support quitting.

The Plan3 sets out four national targets to achieve by 2022:* Reduce the prevalence of 15-year olds who regularly smoke from 8% to 3% or less;
* Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less;
* Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population; and
* Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.

Additionally, the Service shall support delivery against the national indicators outlined in the Department of Health and Social Care Public Health Outcome Framework (PHOF) for England 2019/20*[[27]](#footnote-27)* (and any future versions). This Service shall specifically contribute to the following PHOFindicators: * C04 - Low birth weight of term babies;
* C06 - Smoking status at time of delivery;
* C13a - Smoking prevalence age 15-year olds – regular smokers;
* C13b - Smoking prevalence age 15-year olds – occasional smokers;
* C18 - Smoking prevalence in adults (18+) – current smokers;
* E03 - Mortality rate from causes considered preventable;
* E04a - Under 75 mortality rate from all cardiovascular diseases;
* E04b - Under 75 mortality rate from cardiovascular diseases considered preventable;
* E05a - Under 75 mortality rate from cancer;
* E05b - Under 75 mortality rate from cancer considered preventable;
* E07a -Under 75 mortality rate from respiratory disease;
* E07b - Under 75 mortality rate from respiratory disease considered preventable;
* E11 - Emergency readmissions within 30 days of discharge from hospital; and
* E12 - Preventable sight loss.
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| **3. Scope and Service Model** |
| **3.1 Aims** **The aims of the Service are to:*** Prevent early death from smoking-related disease and improve quality of life, through delivering a Service that contributes to reducing the smoking prevalence in the geographical area covered by the Council.
* Provide access to a targeted evidence-based specialist Service that includes up to 12 weeks of support to priority Oxfordshire residents, and its employees, to stop smoking for at least four-weeks where there is greatest need due to inequalities in smoking rates or health impacts, with the aspiration of them stopping smoking tobacco for good.
* Provide a universal offer of advice and initial motivation to all Oxfordshire residents that smoke to increase their chances of successfully quitting.
* Deliver the core business of delivering quit support using evidence-based interventions, whilst exploring new methodologies and innovative approaches, grounded in established theories from other appropriate sectors and professions.

**3.2 Objectives** **The objectives of the Service are:*** To provide an easily identifiable Access Point that is the “digital front door” of the Service for potential Service Users and potential referral sources/personnel.
* To work in partnership with a range of referral sources/personnel to develop accessible routes into the Service through referral pathways and systems focussed on the priority groups.
* To provide a highly accessible Service through the provision of three tiers of support according to need, ensuring priority groups are offered the most intensive and effective interventions types.
* To provide a variety of evidenced-based intervention types to priority groups that includes a combination of behavioural support for up to 12-weeks and access to pharmacotherapy. This will meet the needs of the priority Service Users and achieve Service outcomes to help Service Users to stop smoking tobacco for at least four-weeks post setting a quit date (SAQD) and empower them to continue independently well beyond this time frame.
* To proactively target the evidence-based interventions to increase access, motivate and support residents/employees from the priority groups that contributes to reducing the gap in smoking prevalence in Oxfordshire.
* Directly employ Staff, or sub-contract with suitable organisations that employ Staff, with sufficient confidence, competencies and qualifications to an accredited standard.
* Provide appropriate support and advice to other providers that are ‘Supporting Smokers to Quit’ that are not under contract whilst ensuring they have the confidence and competencies to do so; such as primary and secondary care settings where pharmacotherapy is provided alongside very brief advice as per National Centre for Smoking Cessation and Training (NCSCT)[[28]](#footnote-28).
* Use the opportunities presented by Oxfordshire Tobacco Control Alliance, the Oxfordshire Tobacco Control Strategy 2020-2510 (and associated action plans) to encourage and promote smokers of tobacco to use the Service.
* To contribute to the other three pillars in the Oxfordshire Tobacco Control Strategy 2020-2510 by providing advice and guidance to key stakeholders and partners.

**3.3 Service Model Overview**The Service Provider shall consider the entire pathway that smokers follow and develop a clear Service model. The Service will be flexible and responsive that comprises of the three core elements below brought together, under one Service Provider (see Figure 4):* Routes into the Service through developing effective relationships with appropriate stakeholders and partners, to support the referral pathways into the Service of the priority groups.
* Access Point for the Service that is the “digital front door”;
* Accessible three-tiers of interventions through a range of approved types, using the three-tiered approach of levels of intervention initially described in Public Health England’s Models of Delivery for Stop Smoking Services15.

*Figure 4. Oxfordshire Service Model Overview***3.3.1 The Principles of the Service Model**The Service Model will:* Contribute to the reduction in the overall prevalence of tobacco use, and its associated impact, through ‘Supporting Smokers to Quit’ as outlined in the Oxfordshire Tobacco Control Strategy 2020-2510.
* Contribute to the reduction in the socio-economic gap in the prevalence of tobacco use by targeting the Service to priority groups defined as at high risk of tobacco related harm.
* Ensure that it demonstrates compliance with relevant National Institute for Health and Care Excellence (NICE) and NCSCT guidance.
* Include a clear pathway that describes the programme in full and demonstrates how the three-tiers of Services can be accessed.
* Ensure that the intensity of support offered is sufficient to address the needs of the priority groups so as to have the required impact
* Ensure that it can maximise its ability to engage with priority groups and deliver the required outcomes, they will be characterised by the following behaviours:
	+ Well informed;
	+ Well connected; and
	+ Friendly.
* Take an innovative, creative, resourceful and practical approach.
* Ensure all those contacting the Service experience a reliable and efficient process.
* Ensure systems and processes will be simple and clear to all those contacting the Service.
* Be subject to ongoing Service improvements and adjustments to the delivery of the Services throughout the life of the Contract as new evidence emerges from national and international research and local evaluation of the Services.

**3.4. Service Pathway****3.4.1. Access Point**The Service Provider shall:* Develop, implement and manage a central Access Point(s) of the Service that is easily accessible to all smokers and clinical/non-clinical personnel. For example, specialist Stop Smoking Advisors based in communities that serve priority groups and co-located with other services where suitable.
* Provide a “digital front door” that provides access to Tier 1 self-support for those smokers not eligible for the Service or not wanting Tier 2 or 3 support.
* Ensure the “digital front door” can be accessed via appropriate clinical/non-clinical personnel and self-referral.
* Ensure priority groups that self-refer can access the Service using easy and convenient methods that are free including online, sending a text message, e-mailing, a mobile digital application or telephoning the Access Point.
* Ensure smokers understand the difference between each of the three-tiers and the commitment required so they can make an informed choice as to which route to follow (if eligible). If Tier 3, ensure priority groups and professionals understand the types of evidence-based interventions available including the frequency, duration and settings.
* Provide a response to all referrals (regardless of route into the Service) within two Working Days, using more than one contact method if necessary and at different times of the day. If a pregnant woman, this should be within one Working Day and via at least two phone calls and a letter.
* Triage referrals to the appropriate level of support depending on their need, eligibility and preference. This should include an assessment of motivation to quit.
* Triage can be direct (e.g. face-to-face or via telephone) or via electronic forms / self-triage.
* Provide a systematic approach to triaging so priority groups are offered access to the Tier 3 evidence-based interventions with minimal complexity.
* Acknowledge that there is evidence that residents/employees who smoke are open to advice in all healthcare and other appropriately identified settings.
* Act as an expert point of contact for stakeholders on smoking cessation.

The Access Point shall be characterised by offering as a minimum but not limited to:* A predominately online/digital solution.
* Freephone number that is appropriately staffed.
* Provide a function for referral sources/professionals to either e-mail and/or submit referral forms online direct to the Service Provider that is secure and has ease of use. This will be appropriately staffed and regularly checked during working hours.
* Locally branded.
* Links to the Oxfordshire Tobacco Control Strategy 2020-2510 under the #SmokefreeOxon brand.
* Provide access to and information on the approved evidence-based interventions (including self-help).
* Where necessary, provide an interpreter for Service Users whose first language is not English, and where their level of English may restrict their ability to use the Access Point.
* Provide, for the purposes of Tier 1 and Tier 2, expert advice and support information on:
	+ Behavioural Support;
	+ Pharmacotherapy;
	+ Carbon Monoxide (CO) Monitoring;
	+ Harm Reduction Approaches;
	+ Smokefree Homes/Cars;
	+ Smokefree Workplaces; and
	+ Electronic Cigarettes (e-cigarettes), including heat not burn and any future variations) and other Unlicensed Nicotine Containing Products.
* Encourage adopting broader healthier lifestyle choices with links to other Council approved local lifestyle services (e.g. Adult Weight Management Services).
* Supporting local Public Health campaigns, led by the Council and national campaigns; for example, Stoptober, Change4Life and One You.
* Links to nationally approved stop smoking interventions.
* Information shall be made available in various formats and languages, to a variety of audiences, including enquiring smokers and referral sources/professionals.
* Shall be appropriate for use on all mainstream digital formats with the same degree of functionality as the main online/digital source, in particular ensuring webpages are mobile phone friendly.
* Will appear in the top five search results on the top three search engines used in the UK, as defined by the Council, when the search terms “Oxfordshire quit” or “Oxfordshire stop smoking” is used.
* Shall comply with the Accessible Information Standard.[[29]](#footnote-29)
* For those Service Users and/or referral sources/personnel who are unable to access the online/digital solution, there will be an SMS, telephone number and email address available on Working Days.
* Service Users should be able to contact a suitably qualified Staff member from the Service who can provide the same information that is available through the online/digital solution described above. The SMS, telephone number and email address will be:
	+ Publicised in appropriate locations, for example on the online/digital solution, on all printed marketing material that is distributed and in relevant local publications and communications; and
	+ Available at the local rate fee (SMS and telephone).

*The term online/digital used above in relation to the Access Point is in the context of the presentation of information and not an intervention.* **3.4.2 Routes into the Service** The Service Provider shall: * Ensure all smokers are able to self-refer and access the Service using easy and convenient methods by either the online/digital solution, sending an SMS, e-mailing or telephoning the Access Point.
* Acknowledge that there is evidence that residents/employees who smoke are open to advice in all healthcare and other appropriately identified settings[[30]](#footnote-30). The Service Provider shall ensure a referral pathway is in place from these personnel, particularly those personnel closely associated to the priority groups.
* Build and maintain a database of suitable referral sources/professionals and make it available to the Council upon request.
* Work in partnership with a range of clinical and non-clinical personnel to ensure they’re confident and competent in providing very brief advice as per NCSCT28 in stopping smoking tobacco and directing smokers to the Access Point.
* Accept referrals from providers of primary and secondary care.
* Accept referrals from providers of NHS Health Check Programme where the smoker is a resident in Oxfordshire.
* Develop clear and robust referral pathways in collaboration with key health partners that are maintained by the Service Provider in agreement with the Council. These will be simple and seamless, making use of automated forms embedded in clinical systems.
* Ensure referral sources and systems include those outlined in Section 6.2.
* Use a community development approach in areas of higher smoking prevalence, seeking to normalise smokefree status, and to develop and utilise community volunteers and champions to both promote and support the Service. Some of those volunteers might support group delivery and go on to train as local stop smoking practitioners themselves.
* Where the mechanism exists, give named referrers (i.e. a healthcare professional) the option to receive information on the outcome of the Service Users outcomes at discharge. At a minimum provide an annual summary report to named referrers on the activity of the Service.
* Provide referral and signposting to NCSCT very brief advice training28 and support that enables all appropriate and relevant clinical and non-clinical personnel, whose main job is not stop smoking provision, to possess the confidence and skills to initiate conversations about smoking habits and inform local tobacco smokers as to where and how to get support (often referred to as Level 1).
* Provide referral and signposting to annual Level 2 training[[31]](#footnote-31) (including updates) to enable maintenance and/or compliance with the NCSCT Standard Treatment Programme[[32]](#footnote-32) for accredited Level 2 Stop Smoking Advisors not employed by the Service Provider. This is particularly applicable to primary and secondary care settings where pharmacotherapy maybe provided directly.

**3.5 Service Interventions** The Service Provider needs to take a flexible approach to the delivery of the Service to ensure it can meet needs of the population taking a proportionate universal approach based on adapted principals of the three-tiered Stop Smoking Plus model15.**3.5.1 Targeted Tier 3 Intervention for Priority Groups** The Service Provider shall:* Provide a range of evidence-based intervention types through a combination of specialist behavioural support and pharmacotherapy for up to a 12-week period to support priority Service Users to quit.
* Tailor the length and type of evidence-based intervention to the needs of the priority Service Users by using a Continual Improvement and Innovation Plan approach:
	+ Working with a priority Service User to understand their personal strengths e.g. positive motivations;
	+ Focus on community assets e.g. can someone benefit from a local green space or joining a volunteer led walking group;
	+ Looking at social or circumstantial factors e.g. having a supportive partner or a healthy workplace ethos that allows breaks for phone calls to smoking cessation support;
	+ Using peer led approaches – look to develop volunteer or peer led schemes or champions if there is a need or opportunity that would deliver the service outcomes; and
	+ Promote mental wellbeing and support priority Service Users to engage in activities which will keep them well.
* Ensure all outcomes from evidenced-based interventions conform to the Russell Standard[[33]](#footnote-33).
* Ensure all evidenced-based interventions include a combination of behavioural support over multiple weekly sessions, a structured approach and the offer of pharmacotherapy that is in line with the NCSCT Standard Treatment Programme30.
* Where necessary, provide an interpreter for priority Service Users whose first language is not English, and where their level of English may restrict their ability to succeed.
* Work with the Council to shape the Service delivery model to address any identified inequity in access to, or outcomes within the Service through Health Equity Audits.

**3.5.2 Universal Tier 2 Intervention** The Service Provider shall:* Provide a universal one-off brief behavioural support session for those Service Users who contact the Service for support but are not eligible or do not want Tier 3 support. The one-off behavioural support session can be provided through a range of intervention types.
* Provide no more than one one-off behavioural support session every 12-weeks.
* Signpost the Service User to access self-funded pharmacotherapy.
* Encourage Service Users to sign up to the free online NHS Smoke Free 28 day personalised quit plan, to receive additional motivational support to maintain their quit attempt.

**3.5.3 Universal Tier 1 Intervention** The Service Provider shall:* Provide universal access, through the Access Point, to self-support for those Service Users who contact the Service for support but are not eligible or do not want Tier 2 or Tier 3 support
* Signpost the Service User to access self-funded pharmacotherapy.
* Encourage Service Users to sign up to the free online NHS Smoke Free 28 day personalised quit plan, to receive additional motivational support to maintain their quit attempt.

**3.6 Behavioural Support** Behavioural support for those Service Users in priority groups will be more intensive, supportive and tailored. The support involves delivering evidence-based behaviour change techniques. A combination of behavioural support from an accredited Stop Smoking Advisor, alongside pharmacotherapy, can increase a Service Users chances of stopping smoking by up to three times compared to independent attempts (‘cold turkey’). The Service Provider shall: * Help Service Users to avoid, escape from or cope with urges to smoke and to manage withdrawal symptoms.
* Maximise motivation to remain abstinent and achieve the goal of permanent cessation.
* Boost self-confidence.
* Maximise self-control.
* Optimise the use of the pharmacotherapy.
* For Tier 2 and 3, use face-to-face (either one-to-one or group), digital and telephone as primary intervention delivery channels based on Service User capability and preference.
* For Tier 3 only, use rapid, proactive and reactive text messaging, online and mobile digital applications (local or national) for additional adjacent secondary behavioural support between primary intervention sessions.
* For Tier 3 only, provide evidence-based interventions through both group and individual sessions in line with the NCSCT Standard Treatment Programme

**3.6.1 Tier 3 Community Outreach (Face-to-Face);**The Service Provider shall:* Provide face-to-face a combination of behavioural support and access to pharmacotherapy through group and individual sessions.
* Be expected to develop and support access to Service Users from priority groups in settings, deemed appropriate with the Council, that ensure that barriers to accessing the Service are minimised. This may include, but is not limited to:
	+ Workplaces where adults from routine and manual occupations are employed;
	+ Community settings within the 10 most deprived LSOA wards in Oxfordshire (See Figure 1);
	+ Maternity settings;
	+ Mental Health settings;
	+ Drug and Alcohol Service settings;
	+ Primary Care settings (GP Practices / Community Pharmacies); and
	+ Secondary Care settings (Hospitals).
* Ensure settings are selected based on accessibility and acceptability for priority groups.
* Provide support by an accredited Stop Smoking Advisor in line with the NCSCT Standard Treatment Programme30 at times/locations that meet priority Service User’s needs, as agreed with the Council.
* Ensure 85% of priority Service Users that stop smoking through Community Outreach settings have their smoking status verified four-weeks post SAQD, if using CO verification this is defined as less than 10 parts per million (PPM).
* Ensure telephone, digital, text messaging, online and mobile digital applications interventions can be incorporated into this type of evidence-based intervention as an adjunct to offer the priority Service User additional support and/or contact between face-to-face sessions.
* Ensure the venue and facilities used for the Service in the Community Outreach Setting will provide a sufficient level of privacy and safety to both Staff and priority Service Users.
* Meet all Community Outreach Setting costs of using venues and facilities required for delivery against this Specification, ensuring they are fit for purpose and have adequate insurance, liability cover and are compliant with The Equality Act[[34]](#footnote-34).
* Ensure that all Community Outreach Settings are geographically accessible for priority Service User’s arriving by public transport, by car, on foot or bike.
* There will be circumstances where the benefit of a face-to-face intervention to the priority Service User will be significant. This could include instances such as pregnant women, learning disability diagnosis, limited mobility, carer responsibilities, hearing or language impairment etc. The Service Provider is able to determine their own criteria in relation to access to home visits for priority Service Users. This must be resourced from within the price of this Contract.
* Consider accredited sub-contractors from within the settings outlined above that increases access to the priority groups.

*The term online/digital used above in relation to evidence-based interventions is in the context of the provision of a stop smoking intervention.* **3.6.2 Tier 3 Remote Support** The Service Provider shall:* Ensure a proactive and reactive telephone and digital intervention is delivered by an accredited Stop Smoking Advisor in line with the NCSCT Standard Treatment Programme30.
* Enable priority Service Users using remote support to self-declare their smoking status at four-weeks and 12-weeks.
* Ensure face-to-face, text messaging, online and mobile digital application interventions can be incorporated into this type of evidence-based intervention as an adjunct to offer the priority Service User additional support and/or contact between telephone/digital sessions.
* Ensure the full range of remote platforms the Service will provide has a sufficient level of privacy and safety to both Staff and priority Service Users.
* Meet all costs of using remote platforms required for delivery against this Specification, ensuring they are fit for purpose and are compliant with the spirit of The Equality Act32.
* Give consideration to digital poverty when designing the remote interventions for priority Service Users, such as signposting to accessing data bundles, location of public wi-fi hotspots.
* Depending on priority Service User demand include the use of emergent and innovative technologies and digital applications that arise during the life of the Contract, for example live chat and video calling.
* Provide innovative solutions to:
	+ Provide pharmacotherapy to priority Service Users who prefer remote support as the primary mode of intervention; and
	+ Enable 10% of priority Service Users, who prefer remote support as the primary mode of intervention, to have their smoking status verified at four-weeks post SAQD (if using CO verification this is defined as less than 10 PPM).

*The term online/digital used above in relation to evidence-based interventions is in the context of the provision of a stop smoking intervention.* **3.6.3 Tier 3 Follow-up**The Service Provider shall:* Ensure all priority Service Users (Community Outreach and Remote) are followed up at four-weeks (conforming to the Russell Standard31) and 12-weeks and these contacts are recorded.
* Where a priority Service User is deemed lost to follow-up, document as a minimum at least three contact attempts at different times of day using the most appropriate means, as agreed with the Service Users.
* Ensure that at point of discharge, the priority Service User is equipped with relapse prevention strategies.
* Signpost or refer priority Service Users to other Council approved local lifestyle services (e.g. Adult Weight Management Services).

**3.6.4 CO Monitoring (and other means of verifying four-week status)** The Service Provider shall: * Be responsible for providing (including all costs) and maintaining CO monitoring equipment and the associated consumables, including sub-contractors, used in the delivery of the Service.
* Where appropriate, and in agreement with the Council, use other innovative means to verify a successful quit where CO verification is not an option. For example, saliva cotinine tests or urine tests.

**3.7 Pharmacotherapy (Tier 3 only) and Management**The Service Provider shall:* In combination with the behavioural support outlined above, offer priority Service Users access to all the following pharmacotherapy (as specified in NICE Guidance (NG92[[35]](#footnote-35))) as first line interventions:
	+ Varenicline (Champix);
	+ Short-acting Nicotine Replacement Therapy (NRT);
	+ Long-acting NRT; and
	+ Any other pharmacotherapy that becomes licensed for smoking cessation during the life of the Contract and with agreement of the Council.
* Be responsible for the associated costs of all pharmacotherapy incurred by the Service, and any sub-contractors, which is included in the Contract Price as per Schedule 2 (Finance). This includes, but is not limited to, budget management, continued protocol development, budgets and establishing appropriate governance arrangements for short and long-acting NRT and Varenicline (Champix).
* Adhere to the frequency and duration of pharmacotherapy as per NICE Guidance (NG9233).
* Be responsible for either the direct supply of short and long-acting NRT or available under letters of recommendation.
* Offer priority Service Users single or a combination of a maximum of two pharmacotherapy products (often referred to as ‘combination’ or ‘dual’ therapy) based on the priority Service Users preferences and the likelihood that they would follow the full course of treatment.
* Be responsible for evolving and implementing required documents and policies (i.e. letters of recommendation or a Patient Group Directive (PGD)) and evidence-based delivery methods for prescribing Varenicline (Champix)).
* Ensure the availability and accessibility of Varenicline (Champix) that is on a par with short and long-acting NRT (i.e. first line treatment) and in line with NICE Guidance (NG9233).
* Ensure access to priority Service Users to their preferred choice of pharmacotherapy within three Working Days in the case of short and long-acting NRT and within five Working Days in the case Varenicline (Champix).
* Ensure Staff providing pharmacotherapy either directly, or as part of a sub-contract, have the appropriate training, competency and lines of accountability.

**3.7.1 E-Cigarettes and other Unlicensed Nicotine Containing Products**At the time of writing the Specification, e-cigarettes were not licensed for use in England. It is anticipated that such products may be licensed before the end of Contract however the Service Provider and Council will seek to develop, within 18 months of Contract Commencement Date, access for priority Service Users to regulated e-cigarettes that adheres to Article 5.3 of the World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC)[[36]](#footnote-36).The Service Provider shall:* Be expected to keep up to date with the emerging clinical evidence on e-cigarettes and adapt the Service as appropriate, as agreed with the Council.
* Provide behavioural support, in line with the evidence-based interventions, to priority Service Users who are using, or wish to use e-cigarettes and other unlicensed nicotine containing products to support them to quit smoking provided the product does not contain tobacco.
* Be open to the use of e-cigarettes, and other unlicensed nicotine containing products, by priority Service Users who wish to do so and offer access to the licensed pharmacotherapy.
* Ensure e-cigarettes, and other unlicensed nicotine containing products, that are not licensed for smoking cessation are purchased at the expense of the priority Service User and not via the Services pharmacotherapy budget (subject to change during the life of the Contract).
* Enable access to information for priority Service Users and all Oxfordshire residents regarding e-cigarettes, and other unlicensed nicotine containing products currently not licensed, through the Access Point.
* Work with reputable vape shops in Oxfordshire to support those who wish to quit, are not connected to the tobacco industry and whose business model is not to sustain ongoing vaping.
* Explore and report to the Council the most effective way of implementing and issuing e-cigarette starter packs along with behavioural support to those priority Service Users who wish to quit using this method within 18 months of Contract Commencement Date. This will be delivered using the latest evidence and best practice from national programmes and pilots and the South East Region Position Statement on E-Cigarettes (once published).
* Fund any e-cigarettes issued as part of the Service during the life of the Contract within the Contract Price as per Schedule 2 (Finance).

**3.8 Priority Groups**These priority groups have been identified to help reduce the impact of smoking on health inequalities. These groups will be reviewed annually and at least three months prior to the start of each Contract year with the Service Provider to respond to changes in local epidemiology, national and local policy and the evidence base.The Service Provider shall: * Adhere to the relevant NICE Guidance including new guidance released during the life of the Contract.
* Use the following eligibility criteria:
	+ Living or working in the 10 most deprived LSOA wards in Oxfordshire (see Figure 1).
	+ Adults in routine and manual occupations, have never worked or unemployed, sick/disabled and unable return to work and carers: aged 16 years of age and over and as defined by occupation status (according to the Standard Occupational Classification[[37]](#footnote-37)).
	+ Pregnant women: Defined as a woman who is pregnant at the time of accessing the Service.
	+ Adults with mental ill health aged 16 years of age and over (including Drug and Alcohol Misuse): Defined as residents/employees who at the time of accessing the Service are diagnosed with a mental health condition, in contact with (now or in the previous 12 months) a Mental Health service and/or Drug and Alcohol Treatment Service.
	+ Adults admitted to secondary care settings or living with an LTC aged 16 years of age and over: Defined as residents/employees who have been referred from a secondary care or primary care setting with a LTC, as defined by Quality and Outcomes Framework. This includes, but is not limited to, residents/employees diagnosed with a respiratory condition (asthma or COPD), a circulatory disease, a metabolic disease or cancer.
* Note that priority Service Users can only be assigned to one group for the purpose of Contract Monitoring as per Schedule 3 (Monitoring and Review). During the Implementation and Transition Period, the Service Provider and Council will agree primacy for where priority Service Users fall into more than one priority group.
* With the support of the Council, undertake a Health Equity Audit within 18 months of Contract Commencement Date to ensure the Service is reaching the priority groups and attaining good outcomes. The Health Equity Audit will compare the characteristics of people entering the Service and attaining outcomes with the characteristics of the population of Oxfordshire. The Council will advise on data requirements for this element.

**3.9 Staffing**The Service Provider shall: * Deliver the Service flexibly using skill mixed teams that are appropriately trained, competent and supervised.
* Ensure there is clear, visible leadership, strategic vision and relevant multi-sectorial professional expertise to ensure every aspect of the Services are delivered in a safe, efficient and evidence-based manner.
* Have clearly articulated values and an ethos and ways of working to ensure Staff are engaged and committed to deliver high quality care in a supportive organisational environment.
* Ensure all staff have clear roles and responsibilities.
* Have a full-time equivalent Service Manager with up-to-date knowledge and experience of providing the evidenced-based interventions outlined in the Service model.
* Ensure all Stop Smoking Advisors employed directly, or work for a sub-contractor, are trained in line with the NCSCT Training Standard[[38]](#footnote-38) and accredited before providing an evidence-based intervention to the appropriate standard including any specific work with the priority groups and the relevant NCSCT speciality modules[[39]](#footnote-39).
* Ensure there are human resources in place (which follow legislative requirements) and ensure all Staff working with Service Users are suitable to do so.
* Ensure that all Staff receive mandatory training on safeguarding adults and children, information governance, infection control, health and safety, risk management and equality and diversity.
* Ensure that all Staff receive regular line management, supervision and appraisal processes.
* Ensure all Staff will have personal development plans and opportunities for appropriate continuous professional development.
* Ensure Staff feel and work as part of a team, there are clear goals and performance feedback for all, Staff are part of a learning environment and they have the resources to do their job.
* Ensure there is a focus on improving Staff health and wellbeing.

**3.10 Co-Production** **and Service User Engagement**The Service Provider shall:* Demonstrate an understanding of the priority groups, including demographic and social characteristics, attitudes to smoking, opportunities and barriers to change and preferences for the delivery of behaviour change services.
* Ensure appropriate and effective Service User and public involvement in the development and tailoring of Service delivery and be responsive to the changing patterns of need.
* Work with Service User representation groups such as Healthwatch Oxfordshire and Patient Participation Groups.
* In partnership with the Council, routinely review levels of Service User satisfaction through a variety of methods, sharing the information and any lessons learned with the Council in an Annual Service Improvement Report. The report will help facilitate any necessary service improvement activities and evidence that appropriate Service development suggestions have been implemented where possible using the principles of co-production.
* Have a clear compliments and complaints procedure.

**3.11 Service Activity Levels**The Council shall not guarantee any minimum or maximum volume of referrals to the Service Provider under this Contract.The Service Provider shall: * Provide an Annual Service Improvement Report to the Council which should be agreed with the Council six weeks prior to the start of the year.
* Be expected to provide an Activity Plan, as part of the Annual Service Improvement Report, each year which should be agreed with the Council six weeks prior to the start of the year. This should account for any seasonal variation in demand and the impact of national campaigns i.e. Stoptober.
* Accept all referrals, subject to the exclusion criteria or prior agreement with the Council and comply with all reasonable requests of the Council in understanding and managing referral activity.
* Provide at least one session of support at Tier 2.
* Provide at least six sessions of support at Tier 3 to each priority Service User who SAQD up to and including the four-week post-SAQD session.
* Provide at least two additional sessions of support at Tier 3 after the four-week post-SAQD quit session to each priority Service User for up to 12-weeks post-SAQD.
* Achieve a four-week quit rate of ≥50% from the priority Service Users at Tier 3.
* Achieve ≥30% of priority Service Users at Tier 3, that were successful four-week Quits, to remain quit at 12-weeks post-SAQD.
* Expect the minimum acceptable Tier 3 activity levels for the four-week quit will be ≥750 per year.
* Expect the minimum acceptable Tier 2 activity levels to be in excess of 1750 per year but subject to change annually as determined by the Council\*.
* Participate in at least one review during the life of the Contract via self-assessment of the NCSCT Approved Provider Status[[40]](#footnote-40) and do so within 18 months of Contract Commencement Date.
* Report to the Council the most effective way of implementing and issuing e-cigarette starter packs along with behavioural support to those priority Service Users who wish to quit using this method within 18 months of Contract Commencement Date.
* Undertake a Health Equity Audit within 18 months of the Contract Commencement Date.
* Accommodate any growth in activity throughout the duration of the Contract, in agreement with the Council.
* Have appropriate capacity or mechanisms in place to handle enquires to the Access Point via online, digital, telephone calls, text messages and emails from Service Users.
* Expect that referral sources/personnel will contact the Service for advice and information which must be facilitated.

\**Assuming the Service Provider achieves a successful four-week quit rate of ≥50% from the priority Service Users at Tier 3, it is assumed by the Council that at least 1500 priority Service Users will SAQD at Tier 3 each year. For 2020/21, the minimum acceptable Tier 2 activity levels is projected to be in excess of 1755 per year. Combined across the two Tiers, this equates to 3255 Service Users treated by the Service. This equates to ~5% of the estimated local population (65,118) who smoke each year being treated by the Service as per NICE Guidance (NG92)33.* **3.12 Service User Eligibility**The following Service Users in Oxfordshire are eligible for this Service:* Any Oxfordshire resident or employee working in Oxfordshire aged 13 years and over that smokes a tobacco product and who wishes to quit.
	+ For universal Tier 1 support – All Oxfordshire residents and employees
	+ For universal Tier 2 support – All Oxfordshire residents and employees
	+ For targeted Tier 3 support – Oxfordshire residents and employees who are agreed to be in the priority groups in Section 3.8 (subject to change annually).
* For adults, a smoker is defined in terms of daily use, whereas for children and young people it is defined in terms of weekly use.
* Confirmation of an Oxfordshire postcode for resident or employee workplace is based on the given postcode.

The following are ineligible for this Service:* Any Oxfordshire resident aged under 13 years.
* Not an Oxfordshire resident or employed within Oxfordshire. The Service Provider is to refer those person’s ineligible for this service based on residency or employment to a suitable service local to their home and/or working address.
* Does not smoke tobacco i.e. someone who wishes to stop using an e-cigarette.
* If not agreed to be in the priority groups outlined in Section 3.8 (Tier 3 only).

**4. Working Days and Hours of Operation** **4.1 Working Days and Hours of Operation**The Service Provider shall:* Ensure Tier 3 evidence-based interventions are available to priority Service Users 8am to 8pm Monday to Friday, 9am to 4pm on a Saturday, 52 weeks a year (excluding Bank Holidays).
* Ensure Tier 2 and 3 Service Users have a maximum wait for a first contact and offer of a first session no longer than two Working Days from date of receiving a referral or self-referral into the Access Point.
* Ensure that outside these Hours of Operation, smokers are directed to national resources and the Service Provider’s website for more information.
* For administrative functions, ensure the Service shall be contactable by online, telephone, text messages and email 9am to 5pm Monday to Thursday, 9am to 4pm on a Friday for 52 weeks a year (excluding Bank Holidays).
* For all hours outside these opening times, including weekends and bank holidays, the Service Provider shall ensure an answerphone system / out of office response directing Service Users to relevant alternate sources of information. This shall include national resources and the Access Point.
* All online, voice, text and email messages shall be responded to within one Working Day.

**5****. Data Collection and Management****5.1 Data Collection and Management**The Service Provider shall:* Be responsible for the collation, monitoring, analysis and reporting of data to the Council as per Schedule 3 (Monitoring and Review) of the Contract and in the agreed timeframes and data reporting templates.
* Ensure all data provided to the Council will be anonymised.
* Provide, manage and fund a suitable web-based Information and Communication Technologies (ICT) system that shall support data collection of all Tier 2 and 3 Service Users that register with the Service and meets the national data set reporting requirements for NHS Digital, with the capacity to transmit data securely. It shall also ensure secure storage of confidential Service Users’ notes using a computerised system and be registered with the Information Commissioners Office.
* Accept that additions may be made, in agreement with the Council, to the dataset.
* Anticipate that the Council’s requirements shall vary from time to time and the Council may also request additional data from the Service Provider for local Public Health analysis that is over and above what is outlined in Schedule 3 (Monitoring and Review) of the Contract.
* Collate data in-line with the Russell Standard and as per the Stop Smoking Services Quarterly Return[[41]](#footnote-41), from all Stop Smoking Advisors and any sub-contractor.
* Send the data, as per Stop Smoking Services Quarterly Return39, to the Council for sight and agreement no later 10 Working Days before the NHS Digital deadlines.
* Comply with Schedule 5 (Information Governance).
* In all processing of Service User data, comply with the requirements of the Data Protection Legislation including the Data Protection Act 2018, the General Data Protection Regulation 2016 and any subordinate legislation made under such Acts
* Report any breaches of Data Protection Legislation to the Council immediately;
* Liaise with the Council on matters relating to the Access Point, data transfer and data recording.
* Ensure all Service Users give consent for their data to be accessed by the Service Provider and shared with the Council. This includes providing details of what will happen to it, who will see it, how long it will be retained and who to speak to in order to get access to it.
* Comply with the duties in relation to The Equity Act 201032.
* Be responsible for ensuring that software systems driven by databases are able to efficiently exchange information between relevant systems.
* Be Level 1 Information Governance Toolkit compliant[[42]](#footnote-42).
* Ensure that, if they maintain clinical ICT systems, that records are accurate and up to date.

**5.2 Social Media Requirements**For the purpose of this Specification, “Social Media” refers to websites and online/digital services that allow users to publicly interact with each other including, but not limited to, Instagram, Facebook and Twitter.The Service Provider shall: * Only publish material on Social Media which aligns with the requirements of this Specification.
* Act with integrity.
* Ensure that everything posted is accurate, based on evidence and posted in plain English.
* Remove any posts which are not relevant to the particular local health campaign and/or which are unlawful, defamatory, abusive, threatening, harmful, obscene, profane, sexually orientated or racially offensive or otherwise damaging to the Council’s reputation or that of its employees, officers or Councillors.
* Ensure no confidential, sensitive or personal data shall be shared or published, nor any material which is not owned by a third party who has not given consent or licence for such material to be posted.

**6. Sub-Contracting, Partnerships and Interdependencies****6.1 Sub-Contracting** Where it is proposed that the Service Provider shall use a sub-contractor for the provision of elements of the Services outlined in this Specification, the Service Provider is required to demonstrate a management structure and processes that underpin the way the organisations will work together effectively to ensure efficient delivery of all elements of the Services. Where the Service Provider uses a sub-contractor to deliver a Tier 3 evidence-based intervention, the Service Provider is responsible for ensuring these are of equally high quality, delivered by an accredited Stop Smoking Advisor in line with the NCSCT Standard Treatment Programme with regular monitoring and mentoring.**6.2 Partnerships and Interdependencies**The reduction of smoking prevalence, using this Service, requires working with a range of other services, agencies and stakeholders across the County. The Service Provider must work in partnership with these other services, agencies and stakeholders to ensure the delivery of a seamless identification of smokers and routes into the Service. The Service will maintain efficient working relationships with allied services, agencies and stakeholders to enhance the quality of Service delivered and ensure the holistic nature of the Services. Specifically, partnerships and referral sources will be developed and maintained with: * GP Practices, Primary Care Networks, GP Federations and Local Medical Committee;
* Community Pharmacies and the Local Pharmaceutical Committee;
* Dentistry and Oral Health Promotion services;
* Optometry services;
* Maternity services;
* Oxfordshire Clinical Commissioning Group;
* Secondary Care (e.g. Respiratory, Diabetes, Cardiovascular Disease services and the Here for Health service)
* Health Visitors, School Health Nurses and Further Education Colleges;
* Mental Health services;
* Drug and Alcohol Misuse services;
* Other Lifestyle services (Active Oxfordshire, Weight Management and local National Diabetes Prevention Programme (NDPP))
* Social Care services;
* Fire services;
* Local employers of routine and manual occupations;
* District/City Councils and Town/Parish Councils;
* Commercial and Private Organisations;
* VCSE or Organisations, such as Citizen Advice Bureau and others sourced through the Oxfordshire Community and Voluntary Action group.

The Service will also ensure the following referral systems are used to drive routes into the Service: * NHS Health Check Programme;
* QoF;
* CQUINs;
* NDPP.

**6.3 Oxfordshire Tobacco Control Alliance**Reducing the use of tobacco in our communities is everyone’s business and together we can deliver positive results. The Oxfordshire Tobacco Control Alliance, reformed in 2018, is a partnership of local organisations who are working together to end the use of tobacco in Oxfordshire and reports to the Oxfordshire Health Improvement Board[[43]](#footnote-43). The Service Provider will be a core member of the Oxfordshire Tobacco Control Alliance and be expected to attend meetings and contribute to the development and delivery of annual action plans that underpin the Oxfordshire Tobacco Control Strategy 2020-2510.The Service Provider shall:* Act as a partner to any organisation assigned to areas within the Oxfordshire Tobacco Control Strategy 2020-2510 and any future annual action plans produced from it.
* Support the Council and stakeholders to undertake CLeaR assessments[[44]](#footnote-44) to review and improve its tobacco control work.
* Direct and encourage those it is has relationships with for referral pathways and marketing of the Service to undertake very brief advice training as per NCSCT28 or access smoking and tobacco control related training courses and information sources.

The Council, working in partnership with the Oxfordshire Tobacco Control Alliance (and therefore the Service Provider) will be responsible for: * Funding additional online, social and mass media campaigns that promotes making an annual quit attempt across Oxfordshire.
* Funding very brief advice and NCSCT Level 2 training31 for clinical/non-clinical personnel working in a variety of settings across Oxfordshire.
* Funding Service User satisfaction surveys.
* Engaging with smokers in the Oxfordshire through harm reduction approaches that:
	+ May not be able (or do not want) to stop smoking tobacco in one step;
	+ May not be ready to stop smoking, but want to reduce the amount they smoke;
	+ Are cutting down prior to stopping smoking tobacco.
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| **7. Applicable Service Standards**  |
| **7.1 Applicable National Standards**The Service Provider shall remain up to date with national standards and guidance and will ensure that the Service is reflective of these, this includes NICE Guidance (NG92)33.Other NICE Guidance relevant to the Service includes: * NICE Public Health Guidance 5 (2007) Workplace interventions to promote smoking cessation[[45]](#footnote-45).
* NICE Public Health Guidance 14. (2008). Preventing the uptake of smoking by Children and Young People[[46]](#footnote-46).
* NICE Public Health Guidance 23. (2010). School-based interventions to prevent smoking[[47]](#footnote-47).
* NICE Public Health Guidance 26. (2010). Quitting smoking in pregnancy and following childbirth[[48]](#footnote-48).
* NICE Public Health Guidance 39. (2012). Smokeless tobacco cessation - South Asian communities[[49]](#footnote-49).
* NICE Public Health Guidance 45. (2013). Tobacco harm reduction[[50]](#footnote-50).
* NICE Public Health Guidance 48. (2013). Smoking cessation in secondary care: acute, maternity and mental health services[[51]](#footnote-51).
* NICE Quality Standard 43. (2013). Smoking: supporting people to stop smoking[[52]](#footnote-52).
* NICE Technology Appraisal Guidance 123. (2007). Varenicline for smoking cessation[[53]](#footnote-53).
* NICE Technology Appraisal Guidance 39. (2002). The clinical effectiveness and cost effectiveness of bupropion (Zyban) and Nicotine Replacement Therapy for smoking cessation[[54]](#footnote-54).

The provision of the Service is governed by the latest Department of Health and Social Care Best Practice Guidance and all subsequent updates: * Local Stop Smoking Services Service and Delivery Guidance **(**2014)[[55]](#footnote-55)

All Tier 3 evidence-based interventions to adhere to:* NCSCT Training Standard36.
* NCSCT Standard Treatment Programme30.

The Service will be reviewed against the standard to achieve: * NCSCT Approved Provider Status40.

The Service will promote:* NCSCT very brief advice on smoking training[[56]](#footnote-56).
* NCSCT very brief advice on second-hand smoke training[[57]](#footnote-57).

**7.2 Applicable Local Standards**The Service Provider shall:* Comply with the following local standards:
* Oxfordshire Safeguarding Children Procedures[[58]](#footnote-58)
* Oxfordshire Safeguarding Adult Board Procedures[[59]](#footnote-59)
* Have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and assure themselves, regulators and the Council that these are working.
* Comply with Schedule 4 (Safeguarding Policies and Procedures).
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| 8. Sustainability, Equalities and Social Value |
| **8.1 Sustainability**The Service will have a positive social impact on the lives of the people using the Service whilst supporting them to attain a successful quit attempt. The social benefits for Service Users include improved health, employment outcomes and quality of life, increased engagement with appropriate services, reduced anti-social behaviour and acquisition of key life skills. The service should build individual resilience to sustain positive behaviour change beyond the intervention period. The Service will provide support at local community venues wherever possible, reducing travel and minimising the carbon footprint of the Service.**8.2 Equalities**The Service will respond positively to the needs of diverse individuals, specifically needs relating to the characteristics protected by the Equalities Act 2010. These are age, ethnicity, religion or belief, disability, gender, gender reassignment, sexual orientation, marriage and civil partnerships.  This applies to information about the Service being made available in such a way that promotes equality of access and to the quality of Service delivery across all Service User groups and individuals.The Tier 1 and 2 Services are available to all smokers in Oxfordshire but by targeting the Tier 3 Service to specific priority groups at high risk of tobacco-related diseases the Service will contribute to a reduction in health inequalities.The Service Provider shall:* Comply with current equality law and fulfil duties under the Equality Act, 2010, for people with protected characteristics described above
* Respect the diversity of local communities by providing Services in a safe environment free from discrimination where all individuals are treated fairly, with the dignity and respect appropriate to their needs
* Ensure that the Service is culturally sensitive, non-discriminatory and promotes social inclusion, dignity and respect

**8.3 Social Value**Social value has been defined as ‘the additional benefit to the community from a commissioning and procurement process over and above the direct purchasing of goods, services and outcomes’. Council services have a social purpose and therefore the Council will require services to determine social value working within the commissioning process. This will include measures to report on achievement. The Social Value Act includes: * **Local Employment**: creation of local employment and training opportunities
* **Buy Oxfordshire First**: buying locally where possible to reduce unemployment and raise local skills.
* **Community Development**: development of resilient local community and community support organisations, especially in those areas and communities with the greatest need
* **Good Employer**: support for staff development and welfare within Services’ own organisations and within their supply chain.
* **Green and Sustainable**: protecting the environment, minimising waste and energy consumption and using other resources efficiently, within Services’ own organisations and within their supply chain, including active travel
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1. <https://www.oxfordshire.gov.uk/sites/default/files/file/about-council/CorporatePlan2020.pdf> [↑](#footnote-ref-1)
2. <https://fingertips.phe.org.uk/profile/tobacco-control> [↑](#footnote-ref-2)
3. <https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england> [↑](#footnote-ref-3)
4. <https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works> [↑](#footnote-ref-4)
5. <https://ash.org.uk/wp-content/uploads/2019/09/ASH-Briefing_Health-Inequalities.pdf> [↑](#footnote-ref-5)
6. <http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment> [↑](#footnote-ref-6)
7. <https://www.oxfordshire.gov.uk/sites/default/files/file/public-health/PublicHealthAnnualReportMay2020.pdf> [↑](#footnote-ref-7)
8. <https://www.oxfordshire.gov.uk/sites/default/files/file/plans-performance-policy/OxfordshirePreventionFramework_.pdf> [↑](#footnote-ref-8)
9. <https://www.oxfordshire.gov.uk/sites/default/files/file/constitution/oxfordshirejointhwbstrategy.pdf> [↑](#footnote-ref-9)
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