MODULE B – PERFORMANCE REQUIREMENTS – SPECIFICATION, QUALITY AND PRODUCTIVITY

SECTION 1 – SPECIFICATION

Care Pathway/Service	**Pre-diabetes Service**
Commissioner Lead	**Dr Veena de Souza and Victoria Sprules**
Provider Lead	**Chiltern Vale Health**
Period	**Dec 2012 to 31st Mar 2013**[1]
Applicability of Module E (*Acute Services Requirements*)	

1. Purpose

1.1 Aims

The aim of the service is to prevent or delay the progression to diabetes in the high risk patient group who are pre-diabetic (impaired fasting glucose (6 – 6.9 mmol/litre) or impaired glucose tolerance (glucose tolerance test between 7.8 – 11 mmol/litre, or have an HbA1c between 6 – 6.4 mmol/litre who are not diabetic).

The service will:

1. Ensure that the target group of patients are correctly identified and referred to the service

2. Educate and inform high-risk patient groups about diabetes, pre-diabetes its definition, complications and associated risks and the important lifestyle changes that can be made in order to reduce their risk of progression to diabetes.

3. Empower and facilitate patients to make their own management plans and to set individual goals to reduce their risk of developing type 2 diabetes. The service will support individuals to make more effective and timely use of health and well being services and to produce their action plans and to set and achieve their goals. This will include referral into appropriate local weight loss and exercise programmes as the patient chooses for example Rosemary Conley/Weight Watchers/Reactivate Bucks.

4. Evaluate the service delivered, reporting to the commissioner, and making changes as required (and agreed with the commissioner) to improve the effectiveness and efficiency of the service.

1.2 Evidence Base

There is good and substantial evidence that diabetes can be prevented in high risk groups with significant and maintained lifestyle interventions that include regular exercise and weight loss.[2]
Any diabetes prevention program needs the following four key components:

[1]Subject to sufficient allocation in the Public Health budget, progress by the provider and agreement by both parties, we would hope that the service continues beyond 31st March 2013. We will attempt to reach agreement regarding this in December 2012. Beyond one year, renegotiation of the agreement will depend on outcomes achieved as well as other issues. A three month notice period will be included in any agreement.

[2] A summary of the evidence with references can be provided on request. Recent NICE guidance should be complied with.

- Education covering diabetes and pre-diabetes, diagnosis, complications and associated risks, the importance of diet, exercise and weight loss.
- Motivational interviewing or similar techniques that allow patient directed goals (weight management and exercise goals) to be set and personal plans to be developed for achieving these goals.
- Achieve and maintain 150mins exercise per week.
- Achieve and maintain healthy diet with 5% weight loss if overweight.

Evidence suggests that positive changes in metabolic parameters can be seen as early as three months and maintained after the intervention with an overall reduction of conversion to diabetes in high-risk groups.
The latest NICE guidance on prevention of diabetes suggests the importance of intervening in high risk groups; this service would form part of this strategy within Buckinghamshire.

1.3 General Overview

Currently in Buckinghamshire there is no county wide systematic approach for pre-diabetic patients, despite the fact that they are regularly picked up, be it at annual review for a chronic condition (e.g. cardiovascular disease, please note practice varies from surgery to surgery) or at NHS Health Checks. The evidence suggests that intervention at this point can be effective and benefits can continue for up to twenty years.
There are a large number of weight loss and exercise programs available in Buckinghamshire including Weight Watchers and Rosemary Conley (both of which are currently commissioned by NHS Buckinghamshire for at risk groups), but no educational and goal-setting sessions for people with pre-diabetes. Other services are available to patients e.g. Reactivate Bucks and exercise on referral, sometimes for a small fee. It is hoped that the pre-diabetes service will encourage and maintain use of these local services in order to provide the key components of the diabetes prevention program.
By basing the prevention program on the evidence, the service provider will deliver a sustained reduction in the number of people with pre-diabetes who go on to develop diabetes.

1.4 Objectives

2. Identify and recruit the target population, meeting agreed activity targets as outlined in section 8.
3. Deliver education on diabetes, prediabetes, definition, risks and complications associated with it.
4. Empower patients in order that they feel enabled with sufficient knowledge and support to embark on sustained lifestyle change programmes that will reduce their risk of developing diabetes, and develop their own plans and goals for doing so. Assist them in developing these.
5. Deliver 2 and 3 through group work, referring patients on to existing weight loss/exercise facilities that are already run in the county to promote healthier lifestyles within the target population.
6. Organise fasting blood glucose test for patients in advance of third group session
7. Provide clear, up to date and quality controlled verbal and written information on diabetes, pre-diabetes, associated risks, definition and complications and lifestyle change options available for service users.
8. Evaluate and monitor the service locally and make changes as required to improve performance
9. Report to the commissioner as detailed in sections 8 and 9.
10. Ensure all groups of individuals from the target population, including men, people of working age, deprived groups, South Asian and other populations at high risk of diabetes and heart disease, are able to access the service by making adjustments to the service as required. Ensure Equality Act compliance by completing an equality impact assessment.
11. Provide appropriate training, supervision and management support for staff within the service (detailed in 3.2) and quality control mechanisms to ensure service standards are maintained.
12. Develop referral flows into the service direct from identified professional groups.
13. Deliver practical behaviour change support for individuals in the target population by providing information and facilitating goal setting and achievement of these goals.
14. Map out local organisations that could support patients attending the pre-diabetes service and signpost patients to these as appropriate.

1.5 Expected Outcomes

The overall aim of the service is to reduce the conversion from pre-diabetes to diabetes in pre-diabetic patients.

Primary outcomes

Reduction in conversion rates from pre-diabetes to diabetes by:

- Improving education and knowledge of diabetes and its risk factors in high risk groups

- Delivering sustained health improvement through behavior change support and facilitated goal setting
- Providing access to and encouraging the appropriate use of relevant NHS and other local services by the target population
- Providing healthy lifestyle information to clients regarding areas relevant to diabetes and cardiovascular disease, both orally and in writing using agreed written material.

Secondary outcomes

- Improve population health
- Reduce the NHS spend on diabetes and cardiovascular disease in Buckinghamshire
- Integration of diabetes prevention with local programmes for weight loss and exercise in Buckinghamshire
- Reduced BMI
- Reduced waist circumference
- Increased levels of physical activity
- Improvement in lipid profile
- Reduction of blood pressure
- Reduction in cardiovascular risk and hence reduction in cardiovascular disease
- Peer support to facilitate and maintain lifestyle change (as a consequence of group-based work).

Outcomes will be evidenced by the production of reports by the provider covering the performance indicators in section 8.

2. Scope

2.1 Service Description

As a minimum the service will include:

- Education for people with pre-diabetes to be delivered in a group setting and to include agreement of patient determined individual goals.
- Referral from education session into appropriate local exercise/diet groups as determined by agreed patient goals and local referral criteria e.g. Weight Watchers. Group work to be encouraged above individual exercise but both to be made available to patients.
- Review of patients in person (groups of around 12 people, maximum 14) at 3 and 6 months. Non-attendees to be telephoned (at least 2 attempts) in order to encourage attendance. If not able or willing to attend to support over the phone and obtain feedback over the phone.
- Some level of support to people who contact the service between groups with difficulties e.g. in accessing their chosen weight management programme or in achieving their goals.
- Referrers to be asked to arrange for fasting glucose prior to first appointment with this service if not already done. Measurement of fasting glucose at 6 months, record of weight changes, waist circumference and amount of exercise per week to be reported back to the commissioner as detailed in section 8.
- Referral form for GP to include fasting glucose blood test request /result – must be less than 3 months old (to be designed by service provider).
- Service infrastructure to support, develop and embed the service.
- Appropriate marketing capability to recruit patients and to encourage attendance.
- Service to be delivered by staff appropriately trained in facilitating groups, diabetes, pre-diabetes its definition and associated risks, lifestyle behaviour change, motivational interviewing and encouraging patients to form own management plans/goals.

2.2 Accessibility/acceptability

This service is available to all people with pre-diabetes, either those with impaired fasting glucose, impaired glucose tolerance or HbA1C between 6 – 6.4 who are not diabetic, who are registered with a GP in Buckinghamshire PCT area and are identified through a **NHS Health Check**. It is estimated that this will amount to approximately 1,000 patients per year. Depending on numbers referred in the first 3 months, the service may be expanded to include some patients who were identified through routes other than NHS Health Checks.

The service needs to be accessible and acceptable to individuals from the target population including men, people of working age, deprived groups, South Asian and other populations at high risk of diabetes and heart disease. This may require adjustments for example to venues, days and times of groups, special groups,

communication materials, etc., learning from best practice elsewhere.

2.3 Whole System Relationships

This service will work collaborating with GP, Hospital, Health Trainers, PCT, Community Nurses, Lifestyle Change supporting programmes and other healthcare workers as necessary but will not require any of them to take on the work of the service.

2.4 Interdependencies

The Pre-diabetes Service will need to work in conjunction with the below groups to ensure the service is targeted at those most in need and delivers a service that is underpinned by the latest available evidence and policy.

- Public Health
- Clinical Commissioning Groups
- Primary Care services
- Community Care services
- Local Authority Health and Well Being groups
- Local Strategic Partnerships
- Third Sector
- Target groups or communities
- Community engagement

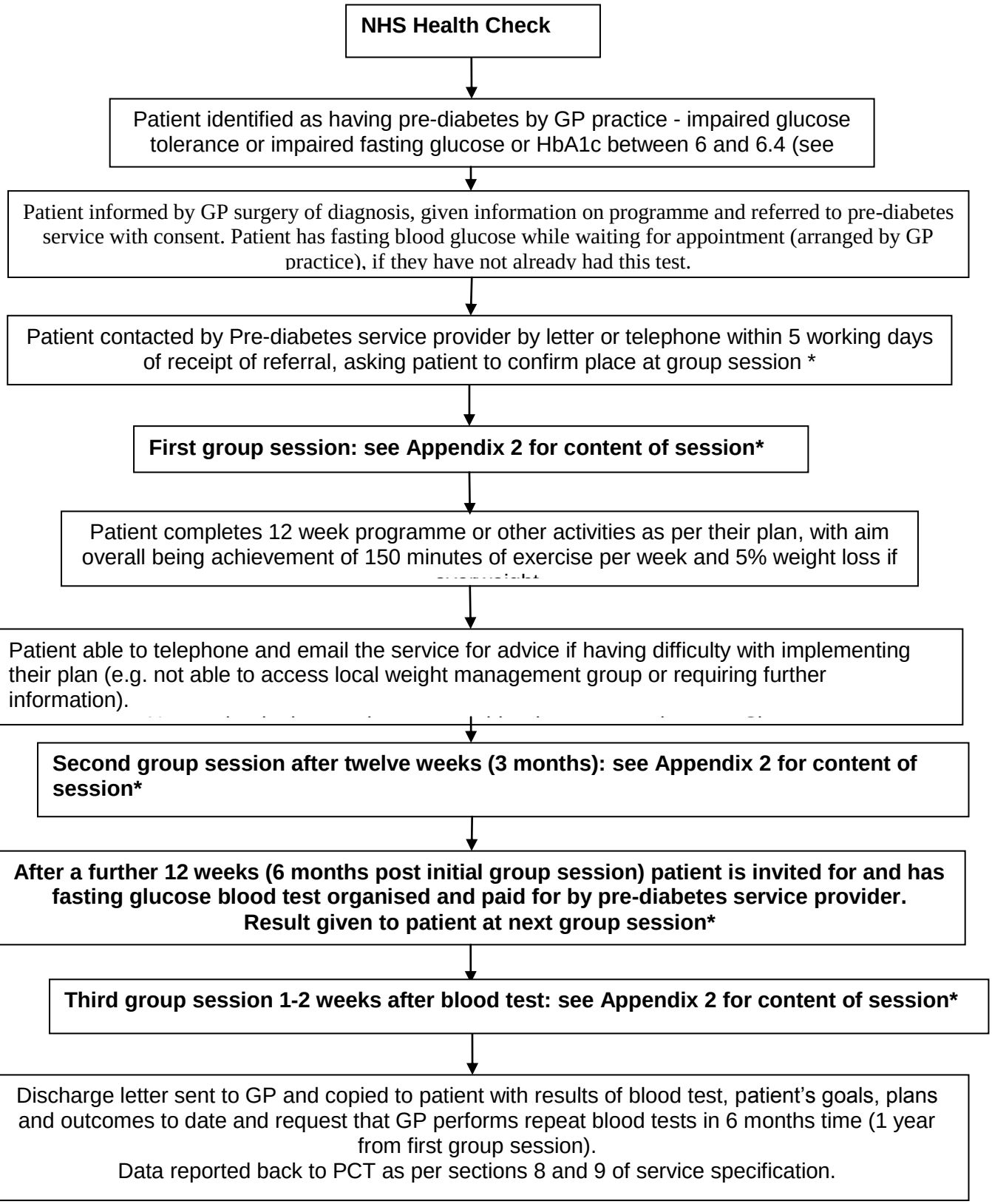
This is not a comprehensive list, but provides the main groups that will link with the service. Additional services will be identified as part of the initial mapping process undertaken by the provider.

2.5 Relevant networks and screening programmes

NHS Health Checks
Cardiovascular disease network

3 Service Delivery

See flow chart overleaf for outline of service plus further details in Appendix 1 and 2.



**Patients who do not respond to invitation or who DNA to be followed up within 2 weeks with letter plus phone calls so that alternative suitable session can be agreed.*
At all points where patient drops out of service reasons for this and outcomes to date to be recorded.

3.1 Service model

See previous flow chart for outline of service. In setting up the service the provider will need to map and make contact with relevant partners with whom it will need to work e.g. local weight management and exercise services, GP practices, etc. This information is available from the commissioner.

Initially the service will only be available to people with pre-diabetes diagnosed as a result of the NHS Health Check unless agreement is reached with commissioner to include other patients, which will depend on referral rates in the initial months. There will be a single referral form that any health care professional can complete for a patient to be referred into the service. Once referred, a member of the administration team will contact the patient to book them into a group session. During the initial group session patients will receive information about pre-diabetes. Patients will be facilitated to identify individual goals and plans as to how they will achieve these goals, with an overall aim of achieving 150 minutes exercise/week and 5% weight loss. They will be encouraged to take part in locally run classes and other services to support weight loss and exercise goals. In Buckinghamshire the PCT currently commissions Weight Watchers and Rosemary Conley for 12 weeks for at risk patients but other services are available to patients e.g. Reactive Bucks and exercise on referral, some at a small fee.

The service will be run by appropriately trained staff with skills in behaviour change. They will have some basic knowledge of diabetes and will understand the importance of lifestyle change to reduce diabetes risk.
Patients should be able to telephone and email the service between group sessions for advice if having difficulty with implementing their plan (e.g. not able to access local weight management group or requiring further information). New technologies that might support patients in achieving their goals should also to be used/made available where appropriate.

Provision will need to be made for disabled people and other people who might have difficulty with access so that the service provides equitable access.

This service and all materials related to it will be free of charge to the clients/patients using this service.

3.2 Supervision and management

The service provider will ensure adequate supervision and management of the service for example cover of sickness, reporting to the commissioner, data collection. This list is not exhaustive.

3.3 Monitoring and evaluation

Expectation for data to be available at 6 months for all patients referred to the service. Reporting will be against the KPIs in sections 8 and 9.

3.4 Care Pathway(s)

Please see section 3, service delivery overleaf.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The target population is people registered with a GP within NHS Buckinghamshire's two Clinical Commissioning Groups. The Public Health Department will inform the provider of any changes to this (likely to be minor), for example when Clinical Commissioning Groups are formalised.

4.2 Location(s) of Service Delivery

The service needs to be accessible locally at venues to suit the needs of target communities. The service will predominantly serve clients from the High Wycombe, Aylesbury and Chesham areas and so an accessible

service must be available in these areas. Any additional areas must be agreed with the commissioner in writing. Specific community settings are to be determined by the provider and must consider the safety of staff and clients.

4.3 Days/Hours of operation

The service needs to have flexible provision that meets the needs of target communities. This will need to include appointments outside of normal working hours.

4.4 Referral criteria & sources

The following referral criteria apply:

- Picked up via the NHS Health Check and found to have pre-diabetes (as defined in Appendix 1)
- Must be over 18 years old
- Buckinghamshire PCT registered patients

Any changes to these criteria will be agreed between the commissioner and provider.

NOTE:

The commissioner reserves the right to change eligibility criteria if numbers referred exceed expectations.
Written consent must be obtained from all clients in order to use their anonymised data for service monitoring, evaluation and improvement.

4.5 Referral route

Service provider to design a referral form that will meet the service needs and complete the care pathway.

4.6 Exclusion criteria

People with diagnosed diabetes are excluded from this service.

4.7 Response time & detail and prioritisation

Patients must be contacted within 5 working days of the service receiving their referral and offered an appointment within six weeks of referral. If not able to make this appointment patient is to be offered a further appointment suitable for them within four weeks of the original appointment. Patients who do not respond to invitation or who DNA to be followed up within 2 weeks with letter plus phone calls so that alternative suitable session can be agreed.

5. Discharge Criteria and Planning

After the third group session the patient will be given a discharge summary and a copy of this sent to the patient's GP. The discharge summary will include blood test results, goals set, progress made, weight, BMI, BP, waist circumference, metabolic parameters at the start and end of the programme and any other relevant data (with the patient's consent) with explanations of results in layman's terms. The discharge letter will also request that the GP does the appropriate follow-up blood test (usually fasting glucose) in 6 months time (which will be approx 1 year after first group session).

6. Prevention, Self-Care and Patient and Carer Information

An Equality Impact Assessment should be undertaken by the pre-diabetes service provider at the outset of the service and for any service changes and should result in the local service adjusting as necessary to meet the needs of all clients.

The service will provide information to all users of the service, in a range of formats depending on need.

DH and DH-approved information (or information agreed with the commissioner) on lifestyle topics should be offered to patients to ensure up-to-date and quality controlled information is used. All information should be given both verbally and in writing, including lifestyle information and all results and patient made plans and goals.

7. Continual Service Improvement/Innovation Plan

The Commissioner will require the Pre-diabetes service to develop throughout the period of the contract to meet the set targets and outcomes, agreed number of clients and projected increases as detailed in this contract.

Senior staff within the provider organisation will be expected to contribute to and support any evaluation of the pre-diabetes service by attending occasional meetings with the commissioner and providing data as per this contract

The service needs to keep up to date with related programmes operating within the Department of health and Public Health England and the PCT area e.g. the NHS Health Check, weight management services, smoking cessation services. This can be undertaken as part of a regular update of the initial mapping exercise and in the contract monitoring meetings.

8. Baseline Performance Targets – Quality, Performance & Productivity

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
1. Service User Experience	**a) Time from referral to attendance at first session b) DNA rate c) Patient feedback**	**a) 90% of first attempt to contact made within 5 working days of receipt of referral b) 90% offered appt that is within 6 wks of referral c) DNA rate to service less than 20%**	**Report to commissioner and review of patient satisfaction and feedback and actions that resulted from this.**	**Monthly for a) and b); Quarterly for c).**
2. Staff satisfaction	**Staff satisfaction survey**	**X**	**Report and actions sent to commissioner**	**one year**
3. Referrals into the service	**Number of referrals by source**	**28 in December 2012, 28 in January 2013 and 56 in each of February and March 2013**	**Report to commissioner**	**Monthly**
4. Reducing Inequalities	**Referral and uptake rates by BME group, different age bands, employed/unemployed, female/male, deprivation quintile**	**Equal representation across demographics so that in no group (e.g. males, Asians, etc) do under 60% of those referred attend**	**Report to commissioner**	**Quarterly**
5. Ensuring access	**Communications with patients and referrers, opening hours and venue flexible to all patient groups**	**DNA rate less than 20% and attendance rate over 80% of those referred overall and over 60% in each group in line with 4 above (e.g. male, Asian, employed, etc.)**	**Report to commissioner – data on attendance and report on publicity, venues, opening hours.**	**Quarterly**
6. Improving Productivity	**Uptake of referrals**	**Over 80% of those referred attend and complete course (3 sessions)**	**Report to commissioner**	**Quarterly**

		At least 14 attend in first month and 56 per month by month 4.		
7. Evaluation	**a) 5% weight loss** **b) 150 mins exercise per week** **c) Reduced BMI, BP, waist circumference** **d) Reduction in fasting glucose** **All above refer to measurement at 3rd session (6 months), where applicable compared to first session or level on referral to service.**	**a) by 3rd group session average weight loss is 3.3kg or more compared to first session or 45% of patients achieve 5% weight loss.** **b) at least 50% of individuals by 3rd group session** **c) overall trend is reduction, target to be set at 3 months** **d) trend is reduction in over 50% of patients, targets to be set at 6 months**	**Report to commissioner**	**Quartley**
8. Data quality	**Data sent to commissioner on excel spreadsheet which will be provided by commissioner**	**95% of KPI data to be complete**	**Report to commissioner**	**Monthly**
9. Audit of operational policies	**Up to date written policies, procedures and certificates as listed in Appendix 3**	**Accessible to commissioner on request**	**View copy of policy**	**Sign off by commissioner**

Monthly data spreadsheets and quarterly reports need to be provided to NHS Buckinghamshire by the 10th day of the following month or quarter, and at least 7 days in advance of the monitoring meetings

9. Activity

9.1 Activity

Activity Performance Indicators	*Method of measurement*	*Baseline Target*	*Frequency of Monitoring*
Number of patients referred	**Report to commissioner**	**17 in first month then 70 per month from month 4**	**Monthly**
Number of new patients seen	**Report to commissioner**	**28 in December 2012, 28 in January 2013 and 56 in each of February and March 2013**	**Monthly**
Number of patients who complete full programme	**Report to commissioner**	**At least 80% of those who attend initial education session**	**Monthly**
Patients to have fasting glucose/BP/weight/BMI/waist circumference/exercise level measured at start and at 6 months	**Report to commissioner**	**At least 80% of patients who attend first session**	**Monthly**

9.2 Activity Plan / Activity Management Plan

As this is a new service, weekly updates are expected until group sessions have started running. After this activity will be sent to commissioner on a monthly basis.

9.3 Capacity Review

As this is a new service, model of delivery and will be reviewed at quarterly intervals and an action plan agreed with the commissioner.

SECTION 2 – SUMMARY OF ACTIVITY, FINANCE AND PAYMENT

2.1 Summary of Activity Plans

The programme for 182 clients will take between 9-12 months to complete and payments will be made upon client course completion.

2.2 Summary of Finance and Payment

The initial contract is for 182 patients attending the programme (at least 2 of the 3 modules) at a total cost of £12,176 for 2012/13, plus set up costs (listed below).

This will include room hire, HCA costs including NI, travel, client costs and six month fasting glucose blood tests, diabetic nurse as clinical lead and for delivery overview, admin including call chasing, data, surveys, letters, etc, management, marketing, purchase of pedometers and Chiltern Health overhead and risk. This amount will be payable as follows: £19.66 per patient attending the first session, £18.68 per patient attending the second session, and £18.68 per patient attending the third session, plus £4.94 for the blood test, up to a total value of £12,176 (£66.90 x 182 patients on the programme). These payments will continue into 13/14 due to the length of the treatment programme for the first 182 patients.

Additionally set up costs will be paid as follows upon contract commencement:

- Projector and LeNovo T430 or equivalent laptop with 3G: £1,100 + £945
- Marketing £1,500
- HCA training: £2,000
- Diabetic nurse training 5 days: £1,000
- Data collection set up: £1,000
- Admin process and service development: £1,000
- Recruitment: £1,500

Total service set-up costs payable in advance £9,845

Budget/funding allocations, service delivery and outcomes, including meeting the activity plan and delivering as per the service specification and other factors will determine whether the service continues beyond the initial 182 patients.

The commissioner will own the intellectual property rights, which will include the course that has been developed and course materials and equipment that have been purchased using set up funds.

Additional information for 13/14:

If a decision is made to renew the contract, and dependant on sufficient funds being available, unless mutually agreed otherwise, the new contract will involve an activity of 57 groups of 14 clients per year (798 new clients in 2012/13) after the 182 already paid for have been seen. This means 4 to 5 new groups per month and at least 6,258 client contacts per month.

If the contract is renewed for 2013/14 it will be paid at £14.04 per patient for the first module, £13.34 for the second module, £4.94 for the blood test and £13.34 for the 3rd module, payable on receipt of data each month, including activity figures and outcomes data as outlined in sections 8 and 9 above. Thus total cost for a client attending all 3 modules plus blood test is £45.66.

If the contract is renewed for 2013/14 bonus payments for performance will be as follows:

1) Payable at the end of the financial year with validated invoice:
   An additional 1% (1% of £45.66) per patient completing the programme* if between 500 and 549 patients complete the programme (*at least modules 1 and 2 completed, but usually all 3 modules, with 95% data completion).
   An additional 2% (2% of £45.66) per patient completing the programme if between 550 and 599 patients

complete the programme as above.
An additional 3% per patient completing the programme if between 600 and 649 complete the programme.
An additional 4% per patient completing the programme if between 650 and 699 patients complete the programme.
An additional 5% per patient completing the programme if more than 700 complete the programme.

2) Payable at the end of each quarter with validated invoice:
An additional 5% per patient completing the programme in that quarter if average weight loss for all those completing is 3.3kg or greater.

3) Payable at the end of each quarter with validated invoice:
An additional 5% per patient completing the programme if at the end of the quarter if 50% or more of patients completing the programme that quarter report doing 150 or more minutes of exercise per week.

These extra payments will apply provided the total contract value for the financial year remains below £48,000.

Payment will be dependent on completed data being returned to the commissioner as detailed in sections 8 and 9 above.

Payment will not be made where data is not complete, patient does not meet criteria for service or patient does not attend session.

Appendix 1: Definitions

Patients are eligible for the pre-diabetes service if they have one of the following:

1. Impaired fasting glucose defined as a fasting glucose level between 6 mmol/l and 6.9 mmol/litre

2. Impaired glucose tolerance (IGT) defined as a glucose level 2 hours post glucose load of between 7.8 mmol/l and 11 mmol/l measured through an oral glucose tolerance test (OGTT)

3. HbA1c between 6 mmol/l and 6.4 mmol/litre and are not diabetic

Appendix 2: Contents of Group Sessions

First Group Session - minimum 2 hours, up to 12 people (plus carers or friend/family member)

Content of initial group session to cover:

1. Diabetes definitions, complications and associated risks
2. Pre-diabetes, definition, complications and associated risks
3. How to reduce the risk of becoming diabetic
4. Measurement / recording of blood pressure, BMI, waist circumference, self reported exercise levels using GPPAQ questionnaire
5. Patient facilitated to make own management plan and set own goals for exercise, weight loss and other lifestyle changes
6. Referral into local services to support and maintain this e.g. PCT funded Weight Watchers or Rosemary Conley, Reactivate Bucks, exercise on referral or self referral to gym. NB Some options may require the patient to pay a small fee
7. Patient's written consent obtained for use of their anonymised data by the service and the commissioner for service monitoring, evaluation and improvement.
8. Depending on evidence to date patients to be given pedometers and advised how to use these. The commissioner will determine, according to most up to date evidence, whether pedometers are to be used and if they are the commissioner will provide the provider with these. Numbers provided will depend on uptake of the service and will assume that they are collected after the 3rd group session and are re-issued.
9. Patient informed of how to make contact if having difficulties between group sessions (e.g. in accessing chosen weight management service) or requiring further information.

Second Group Session - minimum 2 hours, up to 12 people (plus carers or friend/family member)

Content of second group session to cover:

1. Review of goals achieved including, where applicable, pedometer recordings, measurement of weight/BMI and waist circumference and self reported exercise levels
2. Discussion of barriers to change
3. Consolidate knowledge from initial change and motivation to continue and maintain changes
4. Build support networks to maintain change attained
5. Provision for extra support for those struggling e/g referral to Health Trainers

Third Group Session - minimum 2 hours, up to 12 people (plus carers or friend/family member)

Content of third group session to cover:

1. Measurement / recording of blood pressure, BMI, waist circumference, self reported exercise levels using GPPAQ questionnaire and recent pedometer recordings
2. Discussion of blood results (results should be given to each patient at the session). NB The blood test prior to referral will be the responsibility of the referring organisation whereas the provider will be responsible for the blood test at this stage, including costs.
3. Further group work focussing on empowerment and maintenance of lifestyle change and goals.
4. Pedometers collected

After this session:

5. Discharge letter sent to GP and copied to patient with results of blood test, patient's goals, plans and outcomes to date (e.g. weight loss, BMI, waist circumference, blood pressure,

exercise level) and request that GP performs the appropriate repeat blood tests in 6 months time (1 year after first group session).

6. Data reported back to commissioner as per sections 8 and 9 of service specification.

Appendix 3: Written policies, procedures and certificates required

The Provider will have as a minimum, but not without limit, written policies and procedures covering the following:

- Employment Policy
- Disciplinary and Grievance Policy
- Complaints/Disputes Policy
- Health and Safety Policy
- Equality Policy
- User/carer involvement Policy
- Lone working Policy
- Serious Incidents Policy
- Business Continuity Policy
- Information Governance Policy
- Environmental Management Policy

Certificates required, such as professional indemnity certificates, will be listed in the final contract.