The following organisations mentioned in this document no longer exist - NHS England & Improvement (NHSE&I) and Public Health England. On the 1st July 2022, NHS England and NHS Improvement merged to become one single organisation. On 1st October 2021 Public Health England was replaced by UK Health Security Agency and Office for Health Improvement and Disparities.

Service Specification

[These provisions may be subject to further amendment and/or refinement prior to contract award, as appropriate].

All defined terms set out in this document reflect the definitions contained within the Call-off Contract unless defined in this document

Service Specification No.	1
Service	Provision of behavioural interventions for people with non-diabetic hyperglycaemia or people with normoglycaemia with a previous history of gestational diabetes
Commissioner Lead	NHS England
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National / local context and evidence base

1.1.1 Introduction to the NHS Diabetes Prevention Programme

The Healthier You NHS Diabetes Prevention Programme (NDPP) is a joint initiative between NHS England & Improvement (NHSE&I), Public Health England and Diabetes UK. It delivers services across the whole of England for people with non-diabetic hyperglycaemia or women with a previous history of gestational diabetes and normoglycaemia, who are at high risk of developing Type 2 diabetes. Eligible individuals are offered a behavioural intervention which will continue for a period of 9 months ('the "**Service**") to support and motivate them to reduce their risk of developing Type 2 diabetes through weight loss and/or a reduction in their blood glucose parameters, as a result of improved diet and increased levels of physical activity.

Diabetes constitutes a major burden on public health and preventative action is necessary to prevent the onset of the condition for those at high risk. A recent report published by Diabetes UK (2021)[1] estimates that the number of individuals at increased risk of type 2 diabetes could

[1] Diabetes UK. 2021. Diabetes Can't Wait.

now be as high as 13.6 million people across the whole of the UK; a report published by the National Cardiovascular Intelligence Network (NCVIN)[2] suggests that the average prevalence of non-diabetic hyperglycaemia in England is 10.7%, which equates to approximately five million people. The report describes how prevalence is higher among Black, Asian and Minority Ethnic groups (and onset is often at a younger age in these groups), and that prevalence increases with age and obesity.

The NDPP is modelled on proven UK and international models. The first NDPP Framework Agreement was implemented in 2016 becoming the first national evidence-based diabetes prevention programme. By 2018 in-person group-based services were being offered across the whole of England and in 2019 the second NDPP Framework Agreement, comprising of improved in-person services and new digital services, was implemented and rolled out across England by 2020. The NHS Long Term Plan, published in 2019, made a commitment to double the size of the NDPP to support 200,000 people every year by 2023/24.

In January 2020 early outcomes from the NDPP were published in Diabetes Care (American Diabetes Association)[3]. Reductions in weight and HbA1c compare favourably to those reported in recent meta-analyses of pragmatic studies and suggest likely future reductions in participant type 2 diabetes incidence.

NDPP services are procured under the NDPP Framework Agreement by the Commissioner for local health economies, and the geographical scope of the Services under individual call-off contracts are based on Integrated Care System (**"ICS"**) areas. ICS partnerships and primary care are responsible for identifying and referring eligible participants and until March 2020 successfully generated sufficient referrals to meet Long Term Plan targets. In 2019/20 this resulted in 170,000 referrals and circa.120,000 people supported on the NDPP.

In March 2020 in response to the COVID-19 pandemic, all in-person delivery was paused and the NDPP converted to remote video and teleconference delivery to continue to support those already participating in the NDPP, as well as continuing to accept new referrals for those at risk of developing Type 2 diabetes.

The Commissioner has expanded the scale of the NDPP following the first two NDPP Framework Agreements and is building on learning in order to offer improved in-person group-based services (the **"Face to Face Service"**) and online and app based digital services (the **"Digital Service"**) as the primary intervention offer, along with tailored remote group-based sessions for those cohorts of Service Users that are more likely to experience health inequalities (the **"Tailored Remote Service"**). Remote sessions will also be available for participants in the Face to Face Service who require a remote catch-up in place of a missed in-person session.

For the avoidance of doubt, in this Service Specification references to the delivery of "remote" sessions means with Service Users and the Staff delivering the sessions not being physically present at the same location but having face to face contact through a suitable videoconferencing and/or teleconferencing platform such as MS Teams, Zoom or Skype or other similar platform.

Analysis undertaken on the NDPP minimum dataset has concluded that where an element of choice had been offered to participants with regards to delivery channels, uptake rates for the NDPP were evidently higher for both younger and older age groups. Similarly, the analysis also detailed good completion rates and outcomes across digital, remote and face to face delivery channels with regards to the mean weight change, with an average of 3.2kg weight loss amongst participants who went on to complete the NDPP.

Evidence from diabetes structured education management shows that people learn in different ways and offering more flexible ways to learn has been shown to increase engagement in self-management and to deliver increased knowledge and confidence (Kings Fund level 2 review, Diabetes UK 2016).

[2] National Cardiovascular Intelligence Network. 2015. NHS Diabetes Prevention Programme (NDPP) Non-diabetic hyperglycaemia. Public Health England.

[3] Diabetes Care. 2019. Early Outcomes From the English National Health Service Diabetes Prevention Program. https://care.diabetesjournals.org/content/early/2019/11/11/dc19-1425

In line with NICE guidance (NG183, October 2020) and based on analysis of previous delivery of the NDPP, and in order to support Service User choice and widened access, the overriding principle of the Service will be that all Service Users must be given unconstrained choice between the Face to Face Service and Digital Service, with a remote service offered to Service Users in the Face to Face Service who miss a session and require a catch-up on content prior to their next scheduled in-person group meeting.

The Tailored Remote Service must also be offered to Service Users upfront as an alternative to the Face to Face Service and the Digital Service but only to particular cohorts or groups who are at higher risk of experiencing health inequalities as set out in this Service Specification, paragraph 3.2.6.

Where the Provider is not providing the Digital Service, the term "Service" relates only to the Face to Face Service and Tailored Remote Service.

2. Outcomes

2.1 Expected outcomes of the NDPP

- Reduction in incidence of Type 2 diabetes among Service Users as a result of the intervention;
- Reduction in weight of Service Users where they are overweight or obese, and the maintenance of a healthy weight; and
- To reduce blood glucose parameters (HbA1c or Fasting Plasma Glucose (FPG)) in Service Users at 12 months from referral and beyond.

3. Scope

3.1 Aims of the Service

The primary aim of the Service is to prevent Type 2 diabetes. All aspects of the Service must be delivered by the Provider in accordance with the NDPP outcomes and with the aim of achieving three core aims:

- Support people to achieve or maintain a healthy body weight, having appropriate regard to achievement of UK dietary recommendations related to fibre, fruit and vegetables, oily fish, saturated fat, salt and free sugars;[4]
- Support people to increase their physical activity and reduce sedentary behavior, and wherever appropriate achieve the England Chief Medical Officer's (CMO) physical activity recommendations;
- To maximise completion rates of Service Users, including across groups that share a protected characteristic.

The above goals are for the Service as a whole, and at an individual Service User level goals must be tailored to suit individual Service User requirements.

A secondary aim of the Service is to establish sound data collection mechanisms to ensure that the effectiveness of the Service in reducing the long term microvascular and cardiovascular complications of Type 2 diabetes, as well as to reduce the associated higher mortality risk, can be assessed over time. It is also to establish the evidence base for the effectiveness of the Service in delivering outcomes.

The tertiary aims of the Service are to continue to build the evidence base around the effectiveness of remote or digital approaches to diabetes prevention and to develop and build an evidence base around the effectiveness of tailored approaches for harder to reach cohorts and other specific groups.

[4] Full references for government dietary guidelines are provided in Annex 1

3.2 Service description / care pathway

3.2.1 Principles

The Provider will deliver the Services in accordance with the following principles:

- The Provider must provide the Services in accordance with this Schedule 2A and the Annexes and Appendices to this Schedule 2A;
- The content of the sessions must aim to empower people at risk of Type 2 diabetes to take a leading role in establishing and maintaining long-term behaviour changes;
- Delivery of the Services will be tailored to the individual circumstances of all Service Users, including age, physical wellbeing or frailty, weight, personal goals, cultural considerations and culinary traditions;
- The Service must aim to ensure equal access by all Service User groups, reduce health inequalities and promote inclusion, tailoring the Services to support and target those with greatest need through a proportionate universalism approach and equality of access for people with protected characteristics under the Equality Act 2010;
- Access to Services will accommodate the diverse needs of the target population in terms of availability (including any out of hours provision), accessibility, customs and location (where relevant), as far as possible;
- The Provider must build effective working relationships with relevant local stakeholders (including local health economies and community sector organisations) to plan and support referral generation and deliver an inclusive programme;
- The Provider must maximise the flexibility of their offering in order to increase reach for all, including communities who face the most barriers to access;
- The Provider must ensure Service User involvement in the co-production/co-design of the Service;
- The Provider must ensure Service User involvement and engagement in the evaluation and improvement of Services;
- The Service interventions must be developed in consultation with behaviour change specialists;
- The Provider must engage proactively with primary care services whilst ensuring that the impact on workload for existing providers of primary care services is minimised;
- All individuals must be treated with courtesy, respect and an understanding of their needs;
- All individuals invited to participate in the Service must be offered the Face to Face Service in line with NICE Guideline NG183 (October 2020);
- All individuals invited to participate in Services must be provided with adequate information and full transparency on the delivery channels available and their associated benefits and risks, in a format which is accessible to them. This information must allow an informed decision to be made by the individual on which delivery intervention is most appropriate to their personal circumstances and preference, in order to maximise NDPP uptake.
- Ongoing improvements and adjustments will be made to the delivery of the Services as new evidence, standards and/or guidance emerges. The Provider acknowledges and agrees that the Services may be adjusted to respond to best available evidence, including (by way of example only) as a result of planned innovation-testing evaluation (e.g. a research project or time-limited pilot of an innovation to improve the Services). Any such adjustments would be effected as a variation to this Contract in accordance with the variation procedure set out in General Condition 13 (Variations).

Subject to the bullet point immediately below, in the event and to the extent only of a conflict between any of the provisions of this Service Specification and Appendix 1 (Tender Response Document) and/or Appendix 2 (Local Service Requirements) of this Schedule 2A, the conflict shall be resolved in accordance with the following descending order of precedence:

- this Service Specification;
- Appendix 1 of Schedule 2A (Tender Response Document);
- Appendix 2 of Schedule 2A (Local Service Requirements).

Where Appendix 1 of Schedule 2A (Tender Response Document) or Appendix 2 of Schedule 2A (Local Service Requirements) contains provisions which are more favourable to the Commissioner in relation to the Service Specification and/or Appendix 1 of Schedule 2A (Tender Response Document) as relevant, such provisions of Appendix 1 of Schedule 2A (Tender Response Document) or Appendix 2 of Schedule 2A (Local Service Requirements) shall prevail.

The Commissioner shall in its absolute and sole discretion determine whether any provision in Appendix 1 of Schedule 2A (Tender Response Document) or Appendix 2 of Schedule 2A (Local Service Requirements) is more favourable to it in relation to the Service Specifications and/or Appendix 1 of Schedule 2A (Tender Response Document) as relevant.

3.2.2 Eligibility

The Services are available to the following:

- individuals aged 18 years or over, up to and including eighty years old. Individuals who are over eighty years old are eligible to access the Service if their GP provides written confirmation to the Provider that the GP perceives the benefits of the NDPP to outweigh any potential risks of participating in a weight loss programme for that individual;
- individuals who have 'non-diabetic hyperglycaemia', defined as having an HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) or an FPG of 5.5 – 6.9 mmol/l within the 12 months prior to the date of referral into the Service. This excludes individuals with a previous diagnosis of Type 2 diabetes from any time in the past, regardless of whether their latest blood reading is within the non-diabetic hyperglycaemic range;
- individuals who have a previous history of Gestational Diabetes Mellitus (GDM) and 'normoglycaemia', defined as having an HbA1c lower than 42 mmol/mol or an FPG of less than 5.5 mmol/l within the 12 months prior to date of referral into the Service.
- where an additional self-referral pathway is required in accordance with paragraph 3.2.5, individuals who achieve a qualifying risk score [to be defined by the Commissioner] when completing the Know Your Risk assessment tool will be eligible for the NDPP.

Where both HbA1c and FPG blood readings are provided on referral, if all readings are NDH (or normal for women with previous GDM) the individual is eligible for the NDPP. Where any reading is in the diabetic range (HBA1c ≥48 mmol/mol or FPG ≥7 mmol/l) the individual is not eligible for the NDPP and must be referred back to their GP for further diagnostic clarification. Where one reading is normal and the other is in the non-diabetic hyperglycaemic range the individual is eligible for the Service.

Oral Glucose Tolerance Testing (OGTT) is rarely used now clinically for diagnosis of hyperglycaemia outside pregnancy; in pregnancy it is used to assess for gestational diabetes. However, it is acknowledged that there may be circumstances where impaired glucose tolerance has been identified in an individual through OGTT (2 hour post 75 gram glucose load glucose value ≥7.8 and <11.1 mmol/l), and such individuals are eligible for the Service.

3.2.3 Exclusion criteria

The following individuals must be excluded from the Service:

- Individuals with an existing or previous diagnosis of Type 2 diabetes at any time in the past;
- Individuals with an active eating disorder;
- Individuals on referral who do not meet the eligibility criteria as defined in paragraph 3.2.2 above;
- Individuals with severe/moderate frailty as recorded on a frailty register;
- Individuals who have undergone bariatric surgery in the last two years;
- Individuals aged under 18 years; and/or
- Pregnant women.

If a Service User becomes pregnant whilst participating in the Service, the Provider must tailor the Service accordingly, following the specification set out in NICE Guideline PH27, for example adjusting any weight loss goals. This guidance stipulates recommendations for diet, physical activity and weight management during pregnancy.

3.2.4 Referral pathway

The principal referral routes into the Service will be through General Practice and Health Checks. For General Practice these include identification of eligible Service Users and referral via opportunistic direct referrals of patients, centralised searches of GP systems or through annual glycaemic reviews for eligible cohorts.

The Provider must be able to receive and accept eligible referrals from all agreed pathways and will collaborate with local health economies to develop and agree additional referral routes in to the NDPP and associated protocols.

3.2.5 Self-referral pathway

The Commissioner may require the Provider to implement a self-referral pathway as part of the Service to widen access to the NDPP, improve equity of access and increase referral volumes. If the Commissioner so requires, it shall notify the Provider and will indicate from when, for how long, and for whom self-referrals must be accepted alongside any additional financial arrangements.

This referral route into the Service will be additional to, and will not replace the principal referral routes through GP Practices and Health Checks listed in paragraph 3.2.4.

Eligibility for self-referral will be based upon a threshold score generated through completion of an online 'Know Your Risk' tool by potential Service Users. The Commissioner may require the Provider to embed a version of this tool upon their website or to accept self-referrals directed to the Provider via an NHS operated or NHS commissioned online 'Know Your Risk' tool host.

The 'Know Your Risk' tool, which is currently available at https://riskscore.diabetes.org.uk/start, asks a series of basic questions including: age, weight, Body Mass Index (BMI), family history of diabetes and ethnicity to generate a risk score. The Commissioner may require the Provider to accept referrals based on any risk score and will notify the Provider what risk score to use as the basis for eligibility to the NDPP.

Self-referrals will not require a blood test eligibility as described in paragraph 3.2.2, but all Service Users must be informed of the importance of seeking a blood test from their GP. All other eligibility criteria described in paragraph 3.2.2 and exclusion criteria described in paragraph 3.2.3 will apply to self-referrals.

The Commissioner may market the self-referral pathway nationally through online and other means to promote uptake of the service (subject always to the Intervention Cap, as defined in paragraph 3.11). The Commissioner reserves the right to require the Provider to undertake additional marketing of the self-referral pathway and this must be delivered as described in paragraph 3.3.

Where the Commissioner requires the Provider to implement a self-referral pathway, the Provider must put in place arrangements to invite eligible participants that are self-referred via the self-referral pathway to participate in the Service as described in paragraph 3.2.6.

3.2.6 Invitation to participate

Subject to the Intervention Cap and Intervention Period (referred to in paragraph 3.11 of this Service Specification), the Provider will invite all referred individuals to participate in the Face to Face or Digital Service. The Provider will initiate contact with all individuals referred to them in accordance with paragraphs 3.2.4 or 3.2.5, within 5 Operational Days of receipt of the referral, inviting them to participate in either the Face to Face Service or the Digital Service and the individual will be entitled to choose whether to participate in the Face to Face Service or the Digital Service.

The Tailored Remote Service can be delivered on a cross-contract basis and will only be offered alongside the Face to Face Service and the Digital Service to individuals whom the Provider has identified as requiring tailored or specific support. These groups include, but are not limited to, the following:

- Those with a hearing impairment requiring British Sign Language;
- Those with a visual impairment;
- Women with a previous diagnosis of Gestational Diabetes;
- Service Users from Bangladeshi or Pakistani backgrounds who require a specific cultural and language tailored Service.

The Provider can request from the Commissioner agreement to deliver the provision of a Tailored Remote Service to support additional cohorts alongside those listed above, in line with local needs as identified across particular contract areas.

The Provider will work with local health economies to manage the trajectory of referrals in line with the volume of contracted interventions and work together with the local health economy and with the Commissioner to match supply and demand across the duration of the Contract.

The invitation and all follow-up contact will contain basic, accessible information about Type 2 diabetes and information about how to reduce the risk of developing Type 2. All contact made with potential Service Users must be grounded in theory and evidence from behavioural insights and the Provider must make use of templates provided by the Commissioner.

Where there is no response from the initial invitation to the potential Service User, the Provider must make additional attempts to contact the potential Service User via at least two of the following methods: letter, phone call, text message or email; within a period of one calendar month from the date of referral into the Service.

Where contact has not been established after one month

If it has not been possible to make contact after a minimum of three attempts and through different channels after one calendar month, the individual must be discharged back to their GP. A discharge notice to the individual must also be communicated, signposting them to NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

Where contact has been established

Where contact has been established with referred individuals, the Provider must explain the differences between the Face to Face Service and the Digital Service and offer the individual a choice between the Face to Face Service and the Digital Service as part of the same conversation. The Provider must support individuals to make appropriate choices, but should not influence choice for commercial or operational reasons. Where an individual is identified as requiring tailored support as listed in paragraph 3.2.6, the Provider must offer the option to partake in the Tailored Remote Service intervention as an alternative to the Face to Face Service or Digital Service.

The Commissioner may require the Provider to use an approved script and set of criteria for this purpose in which case the Commissioner will notify the Provider of the script and criteria and the Provider shall use that script and criteria. This also applies to all further references in this Service Specification to the Provider offering individuals a choice between the Face to Face Service and the Digital Service (and where applicable the Tailored Remote Service).

Where contact has been established and an individual accepts an invitation to participate in the Service, the Provider must offer a choice of appropriate dates and times for the Service User's Individual Assessment (as set out in paragraph 3.2.7 below).

If the individual declines the invitation to participate in the Service on three separate occasions, they must be discharged back to their GP.

If the individual accepts the invitation to participate in the Service, the individual will become a Service User and the Provider must notify the Service User's GP that the Service User has agreed to participate in the Service once Milestone 1 has been Achieved (as those terms are defined in Schedule 3A (Local Prices) of the Contract) in relation to that Service User. The Provider must comply with any template letters or discharge communication content that the Commissioner notifies the Provider must be used.

The Provider must comply with relevant clinical codes associated with data items and include clinical codes in all notifications as specified by the Commissioner under the Contract.

The Provider will work closely with local health economies to identify and implement a feasible and locally appropriate mechanism for ensuring data is fed back to the GP in read coded format and can be integrated within GP clinical systems; ideally by electronic transfer. The Provider will also work with the local health economies to ensure that there is a monthly update on referral and uptake rates, waiting list size and outcomes at CCG level.

Additionally the Commissioner may require the Provider to notify GPs about progression of Service Users through the Service. The Commissioner will notify the Provider if this is required and the Provider shall comply with such notification.

Where contact has been established but an individual indicates that they do not accept the Service then the individual must be discharged back to their GP. A discharge notice to the individual must also be communicated, signposting them to NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

3.2.7 Individual assessments

Individual assessments of Service Users ("Individual Assessments") form the first stage of the Service. The Provider will conduct Individual Assessments with all Service Users who accept the invitation to participate in the Service. The Provider will use Individual Assessments to confirm whether Service Users are eligible for the Service and to gather baseline data as specified in Schedule 6A. Data must be gathered at all points of Service delivery in accordance with the requirements of this Service Specification and Schedule 6A.

The Provider will also use the Individual Assessment to deliver a brief intervention in line with NICE guidelines (see NICE PH38 and PH49).The Individual Assessment may also be used as an opportunity to assess an individual's motivation for behaviour change. Motivational interviewing must be used to support Service Users in setting appropriate goals and if a desire to set unhealthy goals is identified during this process, the Service User may require additional advice on the risks of some elements of the Service (see paragraph 3.2.9).

Elements of the Individual Assessment might be conducted through remote or digital channels. Weight measurements need to be taken through calibrated and objective mechanisms for the Face to Face Service. For the Digital Service, the Tailored Remote Service and any remote catch-up sessions delivered as part of the Face to Face Service, weight measurements may be self-reported by Service Users.

If an individual has previously accepted the Service but fails to attend a scheduled and agreed Individual Assessment, the Provider must make at least two further attempts to offer an Individual Assessment at times and, where delivered in-person, venues appropriate to the individual. If the individual does not attend any of the offered Individual Assessments, the Provider must discharge the individual back to their GP, sign posting the individual to the NHS

Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

Attendance at Face to Face Service or Tailored Remote Service

If, following the Individual Assessment as part of the Face to Face Service or Tailored Remote Service, a Service User:

- does not attend the first group session after the Provider has offered the first group session on 3 separate occasions at times and, for the Face to Face Service, venues appropriate to the Service User;
- defers attendance at the first group session after the Provider has offered the first group session on 3 separate occasions at times and, for the Face to Face Service, venues appropriate to the Service User; or
- declines the Face to Face Service or Tailored Remote Service,

the Provider must discharge the Service User back to their GP, signposting the Service User to the NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

Where a Service User misses an in-person group session as part of the Face to Face Service, the Provider must offer a choice of either a remote catch-up session or alternative Face to Face group session to support the Service User in catching up on missed course content.

Attendance at Digital Service

If, following the Individual Assessment as part of the Digital Service, the Service User:

- has not registered for the Digital Service within the first calendar month post Individual Assessment; or
- does not have any recorded activity for the first calendar month post Individual Assessment,

the Provider must make a minimum of three attempts to contact the Service User, using at least two of the following means of communication: letter, phone call, text message or email.

Where the Service User cannot be contacted or declines the Digital Service, the provider must discharge the Service User back to their GP, signposting the Service User to the NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

The Provider must record details about the number of contact attempts made to offer the Face to Face Service, including date and method of contact as set out in this section. The Provider is not required to record all of this information under Schedule 6A but must share this information with the Commissioner if requested.

The Commissioner may, from time to time, require the Provider to offer a person the Services under other circumstances alongside those listed in paragraph 3.2.6, for example tailored remote and digital Services for specific characteristics, demographics, languages or population needs. Where the Commissioner so requires, it shall notify the Provider in writing.

<u>Service Users who smoke</u>

The Provider must conduct a very brief intervention (offering very brief advice) with Service Users who are smokers, as detailed in training provided by the National Centre for Smoking Cessation and Training and recommended in NICE guidance NG92. This will involve the following steps: i) Ask – if the Service User smokes (yes/no); If yes, ii) Advice – the best way to quit is with a combination of medication and support. Would you be interested in this? If yes: Act – refer to stop smoking service. The Provider will establish an appropriate referral mechanism with local health economies and systems. The Provider must maintain a record about Service Users who were screened for smoking, offered advice and referred to stop smoking services.

3.2.8 Intensity and duration of the Face to Face Service and Tailored Remote Service

The Provider must deliver the Face to Face Service and Tailored Remote Service in accordance with the following requirements:

- The Service must consist of a series of 'sessions' as opposed to minimal ('one-off') contact;
- The Service must be spread across a 9 month duration;
- 13 sessions must be provided to each Service User; each session must last between 1 and 2 hours;
- The minimum total contact time must be 16 hours;
- Additional contact outside of the 13 sessions and minimum of 16 hours, to further engage and support Service Users, to encourage retention and, where a Service User has missed sessions, to re-engage them to attend face to face is encouraged, and for the Face to Face Service, remote catch-up sessions must be offered to support session catch-up where appropriate. The Provider must consider how it ensures that Service Users are given appropriate individual support, including dedicated 1:1 time as required;
- The Provider will ensure that sessions are delivered in a format and at times that are appropriate to a range of diverse groups in the community and must include evening and weekend sessions to facilitate access for working people. Sessions must be offered at a range of times, days and, for the Face to Face Service, venues and accessible locations in order to maximise access to (and therefore uptake of) the Service, particularly for those of working age, BAME groups and more socially deprived communities;
- The design of the Service must allow Service Users to make behavioural changes gradually and throughout the 9 month duration of the Service;
- The Individual Assessment does not count towards intervention hours but the final session does. The Individual Assessment is counted outside of the minimum 13 sessions. Weigh-ins do not count towards session time in isolation although they could be part of a session.

3.2.9 Underpinning theory and approach for the Service

- The Provider must ensure that the Service is grounded in and delivered in accordance with behavioural theory. The Provider must be explicit regarding the behavioural change theory and techniques that are being used, and the expected mechanism of action of their intervention. The Provider must use a systematic method to identify links between the components of the intervention, the mechanism of action and the intended behavioural outcomes, to ensure that interventions are adapted for the target behaviours, population and context. This must be reflected in a logic model or theory of change, to clearly specify which techniques they are using and how they expect their interventions to produce the desired behavioural changes.
- Interventions must be developed in consultation with behaviour change specialists and Service Users, to increase engagement. Methods for developing and implementing behaviour change interventions are set out in Public Health England guidance "Achieving behaviour change: a guide for local government and partners".
- The Provider must utilise a behavior change framework which is evidence based, such as the COM-B model - see Michie et al (2011a)[5].

[5] Michie, S., et al. (2011a). "The behaviour change wheel: A new method for characterising and designing behaviour change interventions." Implementation Science : IS 6: 42-42.

- The Provider must demonstrate which behavior change techniques from the Behaviour Change Technique Taxonomy Michie et al (2011b)[6] are met by their intervention. As a minimum the intervention must include all the behaviour change techniques set out in NICE PH38 recommendations 1.9.2, 1.9.3 and 1.9.4[7].

- The Provider must ensure that all sessions and communications incorporate clear, targeted, and high quality communication of risk, which optimise understanding of the risk of developing Type 2 diabetes and how this can be prevented. Application of behavioural science approaches to behaviour change must be demonstrated; particularly in relation to promoting recruitment and retention/reengagement of Service Users, and session attendance. The Provider must comply with any materials and templates provided by the Commissioner.

- The Service must not be designed in a way which increases health anxiety, discourages face to face consulting, encourages inappropriate self-management and/or encourages the adoption of unhealthy behaviours, such as excessive exercise or disordered eating.

- The Provider must be explicit about the intended action expected of Service Users in response to non-face to face contact (marketing, invitation letters, leaflets, referral forms, text messages etc.) and the mechanism of action by which that is expected to occur (with reference to behavioural change frameworks as described above). Evidence and best practice must be considered and described by the Provider when producing these materials and communication channels.

- The Provider must ensure that family or peer support is accommodated where this would be helpful to a Service User.

3.2.10 Content of the Service

- The Provider must develop detailed content for the Service.

- The content must cover information about Type 2 diabetes, including long-term effects, risk factors and benefits of behaviour change. The intervention must provide information and practical tools on nutrition, physical activity and weight management based on national guidance set out below and detailed more fully in Annex 1 of this Service Specification.

- Providers must ensure that interventions do not rely solely on information-giving and encourage interactive engagement with Service Users.

- The Provider must consider the extent to which the intervention is delivered in a logical progression in line with behavioural change techniques as described in paragraph 3.2.9 above. The intervention must aim for steady progress on Service Users' goals.

- The distribution of content across the intervention must seek to maximise continued engagement by the Service User across the duration of the Service.

- The content of interventions must be tailored to individual Service Users where possible and must consider the social and psychological support needed to implement behaviour changes in environments which promote unhealthy behaviours.

- The Provider must advise Service Users that some individuals may be at risk of setting unhealthy goals and must avoid aspects of an intervention that could encourage this. For example, Service Users with a history of disordered eating may decide to avoid aspects of an intervention that they feel might worsen this tendency.

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[6] Michie S, Ashford S, Sniehotta FS, et al. (2011b). A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALORE taxonomy. Psychology and Health, 26 (11), 1479 – 1498.

[7] NICE Guidelines. 2017. Public Health Guideline [PH38]. Information provision; exploration of reasons and confidence for change; motivational interviewing; goal-setting; action planning; coping plans and relapse prevention; social support; self-monitoring; reviewing progress; problem-solving.

- The risks and benefits of remote or digital interventions that involve the use of adverts and social media must be considered by the Provider when designing the Service. The Provider must ensure that no unregulated content or adverts via social media or other platforms encourages the use of goals, methods or content which fall outside of the evidence and this Service Specification.

- The Provider must be aware of the risks of digital exclusion in the use of the Digital Service or digital components of a Face to Face Service or Tailored Remote Service and take steps to mitigate it.

- Across all Services, use of the Provider's own platform or a moderated platform is preferred for online interactions such as chat rooms, and in instances where third party forums are being used, Service Users must be made aware of risks and the need to only rely on recommendations from the Provider.

3.2.11 Delivery of sessions for the Face to Face Service (including remote catch-up sessions)

The Provider must deliver the Face to Face Service (including remote catch-up sessions) in accordance with the following minimum requirements:

- The Provider must ensure that the Face to Face Service is delivered using predominantly group sessions designed to be delivered to up to 20 Service Users in each group. Individual contact, in addition to the 13 sessions (either in person or remotely) may also be included to enhance delivery and retention. Larger group sizes may be used by exception (for example, a group exceeds 20 people where a Service User is bringing a family member or carer or where a Service User from another group has missed a session and attends to catch up either in-person or remotely). Sessions must be held within a reasonable timeframe and the Provider must ensure that these are not unduly delayed due to lower than anticipated group sizes. A record of group numbers must be kept and made available on request by the Commissioner.

- Group sessions, within the required 13 sessions, will be delivered face to face (in person) unless the Service User does not attend their planned in-person session and accepts a remote catch-up session.

- Service Users must be offered a choice of dates and times for each and any session to encourage attendance and also to offer the opportunity to catch up (either face to face or via remote means) where they have missed a session. This choice must be available throughout the duration of the intervention. The Provider must consider the extent to which the intervention is delivered in a logical progression.

- Service Users will not be able to formally transition from the Face to Face Service to the Tailored Remote Service once they have commenced on the Face to Face Service (but for the avoidance of doubt this will not prevent the Provider from offering remote catch-up sessions to Service Users on the Face to Face Service but only in instances where a session is missed and a remote session to catch-up on content is required and the Provider must ensure these Service Users are booked on to the next appropriate face to face session).

- The Provider must consider how it ensures that Service Users are given appropriate individual support, in particular with self-regulatory and cognitively demanding behaviour change techniques. This must include dedicated 1:1 time as required.

- If a group size diminishes as the Service progresses due to non-attendance, there is no minimum group size; a Service User who wishes to continue on the Service (if they haven't already attended the final session) must be allowed to do so regardless of group size. However, the Provider may introduce mechanisms for joining together groups if numbers of attendees in a group are small.

3.2.12 Delivery of Sessions for the Digital Service

The Provider must deliver the Digital Service in accordance with the following minimum requirements:

- Engagement with the Digital Service by the Service User shall be monitored and reported to the Commissioner. Effective engagement should be defined by the Provider "in relation to the purpose of a particular intervention" (Yardley et al 2016)[8] and engagement data collected accordingly.

- Engagement shall be characterised by the interest and subjective experience of using the intervention, combined with objective measures of the amount, frequency, duration and depth of usage. Examples of engagement might include: viewing materials, completing any active elements, engaging directly with human coaches, inputting self-monitoring data, or participating in moderated group sessions. Engagement would not include passive receipt of emails and other communications unless it could be demonstrated that these have been actively read through Service User feedback mechanisms embedded into the communication. Schedule 3A sets out the specific types of engagement methods that the Provider must ensure are used for payments to be claimed and this may include engagement methods proposed by the Provider where this is agreed with the Commissioner.

- The Provider must be able to demonstrate that their curricula/modules are designed to deliver engagement of Service Users for a minimum of nine months and must aim to deliver the same objectives and the same course content as the Face to Face Service and the Tailored Remote Service.

- To ensure engagement is spread over nine months, the Provider must promote and ensure that there is active engagement activity each month. Payment for the Digital Service is dependent on monthly engagement. Schedule 3A (Local Prices) sets out the specific requirements that need to be met for payment.

- The programme material for the Digital Service must be designed to allow Service Users with different levels of knowledge and different approaches to learning to progress at different paces. This must include promoting self-directed learning.

- The Service must comply with NHS guidance on push notifications to Service Users (if used) (see "Notifications and messaging guidance and restrictions", NHS Digital 2021).

- Access to the Digital Service must be flexible to accommodate Service User preferences about accessing the Digital Service at a time of their choosing and to work through content flexibly at their own pace.

- The Provider must consider how it ensures that Service Users are given appropriate individual support, in particular with self-regulatory and cognitively demanding behaviour change techniques. This must include dedicated 1:1 time as required.

- The Provider must ensure that Service Users are able to adjust their level of interaction with digital systems, for example adjust the frequency of prompts, to their preferred settings.

- The Provider will inform Service Users how to check and set preferences for how their personal information and Personal Data may be used. The Provider will inform Service Users about when digital interventions are likely to use mobile data, and provide an indication of how much data may be used (for example an average, or information on the size of an app). The Provider will inform Service Users that they may therefore incur costs related to data usage depending on how they access the internet and their internet service provider's charges.

3.2.13 Delivery of Sessions for the Tailored Remote Service

The Provider must deliver the Tailored Remote Service in accordance with the following minimum requirements:

[8] Yardley L, Spring BJ, Riper H, Morrison LG, Crane DH, Curtis K, Merchant GC, Naughton F, Blandford A. Understanding and Promoting Effective Engagement With Digital Behavior Change Interventions. Am J Prev Med;51(5):833-842. 2016

- The Provider must ensure that the Tailored Remote Service is offered as an intervention option to specific identified cohorts as set out in paragraph 3.2.6 alongside the Face to Face Service and the Digital Service.

- The Provider must offer a platform for the Tailored Remote Service which can support both videoconferencing and/or teleconferencing which is free at the point of access for Service Users.

- Service Users must be offered a choice of dates and times for each and any session to encourage attendance. This choice must be available throughout the duration of the intervention. The Provider must consider the extent to which the intervention is delivered in a logical progression.

- Where a Service User misses a session, the Provider must ensure that they are given the opportunity to catch-up before booking the Service User onto the next appropriate Tailored Remote Service session.

- Where the Tailored Remote Service is being delivered to a cohort of Service Users which requires specific tailoring, the Provider must ensure that the necessary requirements are fulfilled to ensure that Service User needs are met e.g. BSL interpreters, visually aided workbooks.

- The Provider must deliver the Tailored Remote Service using predominantly group sessions designed to be delivered to up to 20 Service Users in each group; these Service Users may span across multiple areas in which the Provider provides the Service under Contracts pursuant to the NDPP Framework Agreement.

- Individual contact, in addition to the 13 remote group sessions may also be included to enhance delivery and retention.

- Group sessions, within the required 13 sessions, should not exceed the recommended time limit for each session in order to maintain the effectiveness of the intervention.

- As per paragraph 3.2.7 and paragraph 3.2.9, Providers must ensure that sessions delivered as part of the Tailored Remote Service appropriately mirror the intensity, theory and content as delivered across the Face to Face Service.

3.2.14 Delivery of Services in extraordinary circumstances

The Provider must ensure that they have comprehensive business continuity plans in place in order to support continued access to and delivery of the Service during periods of disruption.

It is recognised that, due to unforeseen circumstances, there may be situations in which the delivery of the Face to Face Service cannot be facilitated in-person and the Commissioner requires the Provider to suspend the provision of the Face to Face Service. At any time during the Contract Term, on one or more occasions the Commissioner may at its absolute discretion require the Provider to suspend the provision of the Face to Face Service. If the Commissioner requires the Provider to suspend the provision of the Face to Face Service, the Commissioner will notify the Provider in writing. Upon receipt of such notification, the Provider will suspend the provision of the Face to Face Service and the Commissioner will work with the Provider to support with Service User management and continued the delivery of the Service in line with the principles set out in this paragraph 3.2.14 below.

Transition between in-person and remotely delivered Face to Face Service

- In circumstances where the Commissioner notifies the Provider that the in-person Face to Face Service is to be suspended in accordance with this paragraph 3.2.14, the Provider must offer affected Service Users the choice to transition to a remote mode of delivery. For the avoidance of doubt, this is not the Tailored Remote Service.

- Where Service Users accept this offer, the Provider must ensure that the Service User is given the appropriate information and guidance to support a smooth transition to remote delivery of the Face to Face Service.

- The Service must be delivered at all times in line with paragraph 3.2.10 and the Provider is responsible for ensuring the appropriate and successful integration of the Service User into the alternative provision.

- The Provider is responsible for ensuring that affected Service Users are appropriately recorded as having transitioned to a remote alternative of the Face to Face Service, and must ensure that affected Service Users are given the option to transfer back to in-person delivery once the Commissioner notifies the Provider that it may resume the Face to Face Service.

Pausing existing Service Users on the Service

- Only in instances where the Commissioner notifies the Provider that the delivery of the Face to Face Service is to be suspended in accordance with this paragraph 3.2.14 should existing Service Users be given the option to pause their participation in the Service until the Commissioner notifies the Provider that in-person delivery of the Service is to resume.

- The Provider must ensure that they have contacted all affected Service Users to discuss the alternative delivery of the Service and transition to the remote delivery of the Services in accordance with this paragraph 3.2.14 prior to Service Users confirming they wish to pause their participation in the Service and that Service Users are offered appropriate support in the interim prior to the resumption of the Face to Face Service.

- The Provider must ensure that Service Users who have chosen to pause their participation in the Service continue to receive reminders regarding the importance of annual glycaemic reviews.

- The Provider must ensure that Service Users who have chosen to pause their participation in the Service are accurately reflected in reporting requirements as outlined in Schedule 6A.

- Where a Service User chooses to pause their participation in the Face to Face Service, the timescales used for the purposes of calculating the relevant Milestone periods (as defined in Schedule 3A) will also temporarily pause until the Service User resumes their participation in the Face to Face Service. Once a Service User formally resumes their participation in the Face to Face Service, the relevant Milestone period will recommence.

Deferring new Service Users on the Service

- Where the Commissioner notifies the Provider that the delivery of the Face to Face Service is to be suspended in accordance with this paragraph 3.2.14 and new potential Service Users are being referred into the Service during suspension of the in-person Face to Face Service, the Provider must ensure that the individuals are offered the remote alternative of the Face to Face Service, the Digital Service and, for applicable cohorts as outlined in paragraph 3.2.6, the Tailored Remote Service before giving them the option to defer their place on the Service. The Provider must consider how it ensures that Service Users are given appropriate support during their period of deferral from the Service.

- The Provider must ensure that Service Users who have deferred their place on the Service continue to receive reminders regarding the importance of annual glycaemic reviews.

- Where Service Users are deferred on the Service, the Provider must notify their GP via a format as agreed with the Commissioner.

- The Provider must ensure that Service Users who have deferred their place on the Service are accurately reflected in reporting requirements as outlined in Schedule 6A.

Resuming the Face to Face Service following suspension

The Commissioner will notify the Provider in writing when the Face to Face Service is to resume. Following such notification, the Commissioner will work in collaboration with ICS's and the Provider to provide appropriate guidance and support in relation to the resumption of the Face to Face Service following the period of suspension.

3.2.15 Training and Competencies for the design and delivery of the Services

- The Provider acknowledges and agrees that the Services involve training, teaching, instruction, assistance, advice and guidance provided wholly or mainly for adults receiving healthcare. The Commissioner therefore considers the Services to be regulated activity for the purposes of regulations governing the use of Enhanced DBS & Barred List Checks and the Provider must carry out Enhanced DBS & Barred List Checks in respect of all members of Staff engaged in the Services who are eligible for such checks and must not engage any such person in the Services who is barred from working with vulnerable adults or is otherwise unsuitable for working with vulnerable adults. The Provider must ensure that any Sub-contractor is subject to similar obligations.

- The Provider will ensure that the Services are delivered or, where there is no human coaching element, developed, by suitably trained and competent individuals who are trained in delivery of behaviour change. The Provider will specify the type and level of qualification, training and / or competence to be required aligning with, for example, the Association for Nutrition 'wider workforce' training, Chartered Institute for the Management of Sport and Physical Activity accreditation, City & Guilds qualifications, and the Royal Society of Public Health qualifications. The Provider needs to demonstrate that these qualifications will ensure that front-line staff are appropriately selected and trained to deliver interventions in line with NICE PH49 for both overall behaviour change and for group based delivery. Providers may use the Health Education England Behaviour Change Development Framework (https://behaviourchange.hee.nhs.uk) to guide workforce development.

- The Provider must ensure that training focuses on behaviour change technique delivery, group management, communication and rapport. Training must demonstrate delivery of behaviour change techniques and allow front-line staff the opportunity to practice using them. Processes must be in place for assessing Staff competence and for ongoing monitoring of behaviour change technique delivery by a behaviour change specialist, including giving feedback to Staff.

- The Provider must ensure that all individuals involved in the delivery of the Services have sufficient and appropriate training and competencies required to deliver the actions and content of the Services and to manage confidential and sensitive personal identifiable data. This must include training in delivery of the Services. The Provider must also consider the creation of apprenticeships as a means of developing and maintaining skills. Training must be routinely monitored and updated as necessary, and suitable continued professional development strategies must be in place.

- The Provider will ensure that all Staff adopt a person-centred, empathy-building approach in delivering the Services. This includes finding ways to help Service Users make gradual changes by understanding their beliefs, needs and preferences and building their confidence over time. The health coaching approach may be suitable, as detailed in NHS guidance: https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/.

- The Provider must ensure that a multi-disciplinary team of health professionals or specialists relevant to the core components of the Services (i.e. diabetes, behaviour change, weight loss, diet, physical activity and mental wellbeing) is involved in development of the Services and the training of Staff. These must include, for example, a registered dietitian or a registered nutritionist (registered with the Association for Nutrition), a registered health psychologist trained in the application of the COM-B model or other suitable tools and a qualified physical activity instructor.

- There is not a requirement for health professionals to deliver content of group sessions, nor be involved in every session. In discussions about physical activity it would be beneficial to involve a qualified physical activity instructor who has been

trained in understanding and communicating the considerations involved with being more active.

- Access to the Service will accommodate the diverse needs of the target population in terms of availability, accessibility and customs as far as possible. The Service must be flexible and tailored to individual Service Users' needs, ability and cultural requirements. The Service must also provide culturally sensitive services and ensure access for people who have a physical or mental impairment. The Service must have access to appropriate interpreter services. The Provider must ensure that the Service complies with the Equality Act 2010 and would be accessible to wheelchair users and others with a physical disability. It must be available for people with low literacy levels, sensory impairment and learning disability and must welcome carers where needed.

- Staff delivering the Services will reflect the diversity of the population accessing the Services.

- In addition to in-depth behaviour change training, Providers where relevant, can draw on resources provided or recommended by Public Health England, for example:

    - Physical activity: applying All Our Health. PHE 2015.

    - Changing Behaviour: Techniques for Tier 2 Adult Weight Management Services. PHE 2017.

    - Health matters: physical activity - prevention and management of long term conditions. PHE 2020.

    - Helping older people stay active at home, Chartered Society of Physiotherapists (https://www.csp.org.uk/public-patient/keeping-active-and-healthy/staying-healthy-you-age/staying-strong-you-age/strength).

3.2.16 Weight Loss and Measurement

In relation to weight loss:

- The Service must involve collecting weight data for all Service Users. For the Face to Face Service and Tailored Remote Service, this must include a weigh-in or recording of a self-reported weight at every session. Where a Service User attends a remote catch-up session as part of the Face to Face Service in place of a missed in-person session, they will be required to self-report their weight as part of the session.

- Data collection of weight measurements for the Face to Face Service must be objective and must not be self-reported (except where it is being taken at a remote catch-up session) and taken using appropriately calibrated scales. Scales must meet Class III criteria for levels of accuracy as per UK Weighing Federation guidance (http://www.ukwf.org.uk/res/medicalguidancenotes.pdf) and "Weight Management Interventions: Standard Evaluation Framework" (PHE 2018).

- For the Digital Service: the Provider must request that Service Users undertake baseline, 3 month, 6 month and 9 month weigh-ins to monitor progress.

- Where weight is self-reported by Service Users as part of the Digital Service and the Tailored Remote Service, steps to ensure consistency of measurement must be encouraged, for example, using the same scales for each measurement taken. The Provider must also encourage Service Users to use regular weigh-ins as part of self-monitoring.

- The Commissioner will work with the Provider to ensure that people are given advice on options for weighing themselves where they do not have access to scales. There are likely to be a number of options for how people can access scales, including through their GP practice, pharmacy, or through other local services and retail outlets. The Provider must ensure that any Service User that this may affect is made aware of any options that the Commissioner deems appropriate.

- Body mass index (BMI) and waist circumference thresholds must be used as specified in NICE guideline PH46 (see Annex 2). See "Weight Management Interventions:

Standard Evaluation Framework" (PHE 2018) for details of measurement of height and weight.

- Motivational interviewing must be used to support Service Users in setting appropriate goals. The Provider must ensure that achievable goals for weight loss (for people who are overweight or obese) are agreed for different stages of the Service for example, within the first few weeks, at three months and at completion of the Service. Service Users must be encouraged to work towards their behaviour change goals as well as weight loss goals, for example, increased physical activity or eating more fruit and vegetables.

- The Provider must ensure that Service Users who are not overweight or obese are not encouraged to lose weight but are supported to maintain a healthy weight, and that weight loss advice for older participants manages any risk of Sarcopenia.

- The Provider must, wherever possible, work with Service Users to assess their dietary intake and support Service Users to plan sustainable dietary changes, aligned with the balance of food groups in the Eatwell Guide (refer to paragraph 3.2.14 below for further information), to achieve weight loss and help with weight maintenance.

- The Provider must design approaches to support individuals who are overweight or obese at baseline (as defined in Annex 2) to reduce their calorie intake. A calorie limit of no more than 1,900kcal for men and 1,400kcal for women should support weight loss at a rate of 0.5kg-1kg each week but calorie limits must take into account individual Service Users' circumstances, such as physical activity level. Weight loss of 5-10% of baseline weight should be used to support individuals who are overweight or obese to understand how much weight loss is required to achieve health benefits and to set achievable targets. Approaches need to support longer term sustainable behaviour change in order to maintain target weight.

- The Provider must design approaches to support individuals who are a healthy weight at baseline to maintain a healthy weight in line with NICE Guideline NG7.

- The Provider must consider making reasonable adjustments for Service Users with a learning disability. Public Health England guidance (Obesity and weight management for people with learning disabilities. PHE, 2020) states that people with learning disabilities may require alternative methods of weight measurement due to chronic constipation and/or atypical body shape. The Provider must work with the local health system to determine the best process for measuring weight where the mainstream method is not appropriate.

3.2.17 Dietary content

The design and delivery of the syllabus must be underpinned by the UK Government dietary recommendations as detailed in the Eatwell Guide[9] and support weight loss for Service Users who are overweight or obese, or the maintenance of a healthy weight in Service Users of healthy weight. The Eatwell Guide shows the proportions on the main food groups that form a healthy balanced diet. This involves increased intake of fibre, fruit and vegetables and oily fish, and decreased intake of saturated fat, sugar, salt and energy:

- Eat at least 5 portions of a variety of fruit and vegetables every day;

- Base meals on potatoes, bread, rice, pasta or other starchy carbohydrates; choosing wholegrain versions where possible;

- Have some dairy or dairy alternatives (such as soya drinks); choosing lower fat and lower sugar options;

- Eat some beans, pulses, fish, eggs, meat and other proteins (including 2 portions of fish every week, one of which should be oily);

- Choose unsaturated oils and spreads and eat in small amounts;

[9] Information about the Eatwell Plate can be accessed at www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx.

- Drink 6-8 cups/glasses of fluid a day;
- If consuming foods and drinks high in fat, salt or sugar have these less often and in small amounts.

The Provider must support Service Users towards achieving the Government's dietary recommendations:

- Use dietary approaches that are evidence based and sustainable in the longer term;
- Use motivational interviewing to support Service Users in setting appropriate goals.
- Service Users must be encouraged to set tailored and achievable short, medium and long term goals which help them to achieve their aims.
- The Service must encourage self-monitoring to help Service Users review their progress.
- The Service must inform Service Users about how to effectively utilise self-monitoring to ensure healthy goals are set. This is applicable for the Face to Face Service and the Tailored Remote Service, but particularly for the Digital Service.
- Service Users must be supported to consume wholegrain and higher fibre starchy carbohydrates in line with the Eatwell Guide (about a third of food eaten).
- For Service Users who are overweight or obese and therefore need to lose weight through calorie reduction, the Provider must ensure that this is achieved through the promotion of the balance of food groups as set out in the Eatwell Guide.
- Dietary advice must reflect the culinary traditions of the communities in which the Service is being provided, without making assumptions about what Service Users eat.

3.2.18 Physical activity content

- The Provider will support those Service Users who are not physically active, to aim to become active daily and minimise time spent being sedentary, with an aim of meeting or exceeding the England CMO recommendations for adults, older adults, disabled adults and pregnant and postpartum women (see Annex 1).[10] The Provider will tailor the support provided as part of the Service to meet the needs, goals and capabilities of individual Service Users. Care must be taken to set achievable goals bearing in mind the principle set out by the CMO recommendations that any physical activity is better than none: even light activity and activity in short bursts is better than being sedentary.
- The Provider will promote strength, balance and flexibility activities as set out in the CMO recommendations, particularly for older adults.
- The Provider will take a graded and structured approach to setting, monitoring and reviewing goals to ensure that those who have a very low baseline level of physical activity are supported to aim for the CMO recommendations within a personalised timeframe. Motivational interviewing must be used to support Service Users in setting appropriate goals.
- The Provider will support Service Users to reduce the amount of sedentary activity in their leisure and working time, by promoting and demonstrating the use of breaks after a prolonged period of sitting or other sedentary activity.
- The Provider will support Service Users to incorporate active travel into their daily routine either through walking or cycling skills and group activities; the Provider can use tools which encourage the incorporation of walking into daily routines such as those applied through the Public Health England Active 10 app. Active 10 promotes graded increases and encourages brisk walking. Providers may also use the NHS

[10] UK Chief Medical Officers' physical activity guidelines. Department of Health and Social Care. September 2019.

Better Health and NHS Live Well websites, which include interventions such as Couch to 5k.

- The Provider is required to measure physical activity for the Face to Face, Tailored Remote and the Digital Service using a standard self-reporting tool as determined by the Commissioner and when required by the Commissioner. Self-monitoring and reliable data capture to understand individual-level change in weight, diet, and physical activity are key behavior change techniques. Services must include methods to allow Service Users to accurately and regularly self-monitor their diet and physical activity behaviours.

- The Provider must encourage self-monitoring of physical activity by regularly liaising with Service Users about the number of steps undertaken in the previous week using objective measurement such as use of pedometers, activity trackers, or smart phone step counters. The Provider must promote self-monitoring in a way which ensures that healthy goals and patterns of exercise are embedded. Data on absolute step counts will be required over a measurement period of the previous seven days.

- The Provider must also encourage self-monitoring of activities that do not provide 'steps' (for example, cycling), strength, balance and flexibility activities and activities to reduce sedentary time. The Provider will be required to provide data on physical activity including calculation and reporting of step counts, e.g. by calculating percentage change, to allow comparison of Service User and Provider physical activity changes relating to the Service as determined by the Commissioner and as notified by the Commissioner to the Provider. The Recent Physical Activity Questionnaire (RPAQ) is the tool currently in use for this purpose.

- The Service may include supervised exercise and when used must build gradually to increase exercise capacity of the Service User. It is the Provider's responsibility to ensure that Staff providing supervised exercise are suitably qualified.

- The Provider must provide a choice of physical activities to accommodate as wide a range of Service Users as possible and must measure health inequalities in access and outcomes.

The Provider must ensure that content of the Service is regularly reviewed and adjusted to stay up to date with government standards, recommendations, guidance and new evidence.

3.2.19 Final Session

The "Final Session" is defined as the last session delivered by the Provider as part of the planned Service (for those Service Users still attending).

As part of the Final Session, the Provider must conduct a post intervention assessment of weight, wellbeing and achievement of individual goals for all Service Users who attend. For the Face to Face Service, the weight must be taken via objective means. BMI must also be calculated and arrangements for collection of Service User feedback / customer satisfaction survey must be agreed. Details of the data to be reported are provided in Schedule 6A.

The Provider must again ensure that links are made with local or national activities and services, in order to provide support for Service Users to continue with improvements made to dietary and physical activity behaviours and weight loss.

The Provider must ensure that Service Users are reminded about key sources of information and advice, such as NHS Choices.

The Provider must make available support and advice post intervention to Service Users to encourage the maintenance of improved lifestyles.

3.2.20 Discharge from the Service

The Service User is "Discharged" from the Service in the following circumstances:

- If after the Provider contacts an individual following referral, the individual does not respond to the Provider after one calendar month from referral provided that the

Provider has made a minimum of three attempts to contact the individual, and used various different communications channels as set out in paragraph 3.2.5 above;

- If, after the Provider contacts an individual following referral, the individual indicates that they do not accept the Face to Face Service;

- If, after the Provider contacts an individual following referral, the individual indicates that they accept the Face to Face Service, and have either declined, deferred or did not attend an Individual Assessment and/or a first intervention session for the Face to Face Service or the Tailored Remote Service where the Provider has offered the session on 3 separate occasions (including a remote catch-up option for participants on Face to Face Service) at times and, for the Face to Face Service, venues suitable to the individual;

- When a Service User misses three consecutive Face to Face Service or Tailored Remote Service sessions for no known reason, and for the Face to Face Service the Provider has offered appropriate remote catch-up sessions, and the Provider has made a minimum of three attempts to contact the Service User since the last attended session, using at least two of the following means of communication: letter, phone call, text message or email;

- For the Digital Service, where there is no recorded activity for three consecutive calendar months;

- When a Service User informs the Provider that they no longer wish to participate in the Service; and/or

- On completion of the Final Session (or once the Final Session has been delivered) . Once the Final Session is completed then the Service User is discharged automatically regardless of the number (or percentage) of sessions attended.

Discharge Requirements

The Provider must provide each Service User's GP and the Service User themselves, with notification of Discharge via template letters or discharge communication content as notified by the Commissioner and as included within Schedule 6A.

The letter of discharge must encourage the Service User to contact their GP to confirm a date for their annual review, including a blood test to confirm whether HbA1c or FPG levels have reduced.

The letter of discharge to the GP must advise that clinical guidelines recommend follow up of people with non-diabetic hyper-glycaemia and/or women with a previous history of gestational diabetes every 12 months, where follow up includes measurement of weight and HbA1c, as well as assessing and addressing cardiovascular risk consistent with standard clinical practice.

The Provider must comply with relevant clinical codes associated with data items and include clinical codes in all notifications as specified by the Commissioner under the Contract.

The Provider will work closely with local health economies to identify and implement a feasible and locally appropriate mechanism for ensuring data is fed back to the GP in read coded format and can be integrated within GP clinical systems; ideally by electronic transfer. The Provider will also work with the local health economies to ensure that there is a monthly update on referral and uptake rates, waiting list size and outcomes at ICS level.

3.2.21 Links to Tier 2 Weight Management and other services

The Provider must ensure that links are made with existing local networks and partnerships (for example, physical activity providers) throughout the development and delivery of the Service. This could include, for example, leisure and public health services, departments within Local Authorities, NHS Choices, and local physical activity schemes.

Alongside this, the Provider must ensure that they are aware of Tier 2 weight management services operating across the relevant geographical area applicable to the Service. These Tier 2 weight management services form part of the obesity pathway and they are commissioned

either locally, mainly by local authorities, or on a national basis for the NHS 12-week Digital Weight Management Programme ("NHS DWMP").

Typically, Tier 2 weight management services are multi-component lifestyle interventions that include diet, physical activity and behaviour change components. These services are typically delivered in group settings over 12 weeks and target overweight individuals, defined as having a BMI >25, although variation does exist across local authority delivered services.

The NHS DWMP is limited to individuals who have a BMI of ≥ 30kg/m² (adjusted to ≥27.5 for people from Black, Asian and ethnic minority backgrounds) and a current diagnosis of either diabetes and/or hypertension.

The NDPP is more intensive than most existing weight management services. Where an individual has been identified as having non-diabetic hyperglycaemia but is also eligible for a Tier 2 weight management service, they will be referred into the Service if they meet all other eligibility criteria as set out within this Service Specification.

3.3 Marketing of the Service

The Provider must undertake marketing and promotional activity in conjunction with the local health economy to advertise the existence of the Service, with a view to raising awareness about the availability and benefits of the Service amongst local primary care and to people in the geographical area covered by the Contract who may benefit from participating in a diabetes prevention programme. Any marketing or promotional activity must be designed to target groups in the community which are currently less likely to access services, or which are at a disproportionately higher risk of developing diabetes encouraging them to find out more about the Service.

In marketing the Service, the Provider must conform to any guidelines on social marketing of the Service under the Contract, for example to ensure alignment of messaging with any wider social marketing campaigns being undertaken in relation to diabetes, or health promotion more generally. This includes using any branding guidelines developed by the Commissioner specifically for the NDPP.

Where it is required that the self-referral pathway is stood up in accordance with paragraph 3.2.5, the Provider must ensure any marketing requirements that are required by the Commissioner are complied with. Additional support for marketing activity related to the self-referral pathway will be discussed with the Provider should it be required that this pathway be made available across the Service.

3.4 Intellectual Property

For the avoidance of doubt, notwithstanding General Condition 1.2, the Parties expressly agree that this paragraph 3.4 shall take precedence over General Condition 22 in respect of Intellectual Property.

Except as set out expressly in this Contract, no Party will acquire the IPR of the other Party.

The Provider grants the Commissioner a fully paid-up non-exclusive licence to use Provider IPR for the purposes of the exercise of its functions and obtaining the full benefit of the Services under this Contract, which will include the dissemination of best practice to commissioners and providers of health and social care services.

The Commissioner grants the Provider a fully paid-up non-exclusive licence to use Commissioner IPR under this Contract for the sole purpose of providing the Services.

In the event that the Provider or the Commissioner at any time devise, discover or acquire rights in any Improvement it or they must promptly notify the owner of the IPR to which that Improvement relates giving full details of the Improvement and whatever information and explanations as that Party may reasonably require to be able to use the Improvement effectively and must assign to that Party all rights and title in any such Improvement without charge.

Any IPR created by the Commissioner in the exercise of its licence rights under this Contract will be owned by the Commissioner.

The Provider must disclose all documents and information concerning the development of Best Practice IPR to the Commissioner at Review Meetings and must grant the Commissioner a fully paid-up, non-exclusive perpetual licence to use Best Practice IPR for the purpose of the exercise of its functions together with the right to grant sub-licences to Public Health England and any Participating Commissioner for the purpose of the exercise of their respective functions.

“Best Practice IPR” in this paragraph 3.4 means any IPR developed by the Provider including Improvements to such IPR in connection with or as a result of the Services.

“Improvement” in this paragraph 3.4 means any improvement, enhancement or modification to Commissioner IPR, Provider IPR or Best Practice IPR (as the case may be) which cannot be used independently of such IPR.

"IPR" in this paragraph 3.4 means inventions, copyright, patents, database right, domain names, trade marks, module names, rights in computer software, database rights, rights in get-up, goodwill and the right to sue for passing off, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights.

“Participating Commissioner” in this paragraph 3.4 means a clinical commissioning group (including any successor or replacement body), an Integrated Care Board or local authority in relation to whose geographical area the Services are delivered.

“Provider IPR” in this paragraph 3.4 means any IPR owned by or licensed to the Provider (other than by the Commissioner) that will be used by the Provider in the delivery of the Services (as set out in Appendix 3 of this Schedule 2A), including Improvements to such IPR.

The Provider shall ensure and procure that the availability, provision and use of the Service and the performance of the Provider's responsibilities and obligations hereunder shall not infringe any Intellectual Property Rights of any third party.

The Provider shall during and after the Contract Term indemnify the Commissioner against all Losses incurred by, awarded against or agreed to be paid by the Commissioner (whether before or after the making of the demand pursuant to the indemnity hereunder) arising from an IPR Claim. An IPR Claim is defined as any claim of infringement or alleged or threatened infringement by a third party (including the defence of such infringement or alleged or threatened infringement) of any IPR, used to provide the Services or as otherwise provided and/or licensed by the Provider (or to which the Provider has provided access) to the Commissioner in the fulfilment of its obligations under this Contract.

If an IPR Claim is made, or the Provider anticipates that an IPR Claim might be made, the Provider may, at its own expense and sole option, either:

- procure for the Commissioner the right to continue using the relevant IPR which is subject to the IPR Claim; or
- replace or modify the relevant deliverable with non-infringing substitutes provided that:
    - the performance and functionality of the replaced or modified deliverable is at least equivalent to the performance and functionality of the original deliverable; and
    - there is no additional cost to the Commissioner.

If the Provider elects to procure a licence or to modify or replace a deliverable pursuant to the provision above but this has not avoided or resolved the IPR Claim, then:

- the Commissioner may terminate this Contract by written notice with immediate effect; and
- without prejudice to the indemnity set out above, the Provider shall be liable for all reasonable and unavoidable costs of the substitute deliverables and/or services including the additional costs of procuring, implementing and maintaining the substitute deliverables.

3.5 Cyber Essentials

The Provider has and will maintain certification under the HM Government Cyber Essentials Scheme (basic level) until such time as the Provider obtains Cyber Essentials Plus certification in accordance with the provision below.

The Provider shall, as soon as is reasonably practicable after the Services Commencement Date, obtain certification under the HM Government Cyber Essentials Scheme to the level of Cyber Essentials Plus and maintain such certification for the Contract Term.

3.6 Digital Technology Assessment Criteria

The Provider must ensure that the Digital Service is compliant with the requirements of the Digital Technology Assessment Criteria ("**DTAC**") and ensure that the Digital Service is updated if requirements of the DTAC are updated.

Where a Provider is intending to use an existing product as part of the Digital Service and has completed a Digital Assessment Questionnaire ("DAQ") previously in relation to that product, they must still undertake and complete a DTAC review in relation to that product.

The DTAC should be used alongside the latest version of the NICE Evidence standards framework (ESF) for digital health technologies, to assess clinical safety, data protection, technical assurance, interoperability, usability and accessibility. The Service fits within Tier C of the ESF and evidence must be provided that the intended technology for the Digital Service:

- Has involved user groups within the design, development and/or testing phases;
- Demonstrates effectiveness for preventative behaviour change or self-manage functions;
- Uses appropriate behaviour change techniques (as outlined within this Service Specification);
- Can support and monitor reliable information content;
- Supports ongoing data collection to validate usage and value;
- Has appropriate quality and safeguarding measures in place; and
- Promotes equality and can be utilised to support hard-to-reach populations.

Please refer to the ESF for further information on the required evidence and how to apply the framework, which is currently available at:

https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies

3.7 Government Digital Service Technology Code of Practice

The Provider must ensure that the Service adheres to the requirements of the Government Digital Service Technology Code of Practice, which is currently available at:

https://www.gov.uk/government/publications/technology-code-of-practice/technology-code-of-practice

3.8 Identity Verification and Authentication Standard for Digital Health and Care Services

If the Provider's Digital Service is by its nature a service to which NHS Digital's "Identity Verification and Authentication Standard for Digital Health and Care Services" applies, then the Provider is required to ensure it adheres to this standard. Please refer to the Standard for applicability:

https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb3051-identity-verification-and-authentication-standard-for-digital-health-and-care-services.

The Provider agrees to provide evidence of adherence to the standard to the Commissioner on request.

3.9 Cyber Requirements for Remote Service Delivery

The Provider must ensure that any videoconferencing and/or teleconferencing platform that it intends to use to deliver the Tailored Remote Service or remote catch-up sessions for the Face to Face Service has undergone the appropriate risk assessment and adheres to all other security and information governance requirements as set out in this Service Specification.

A Data Protection Impact Assessment must be completed and be in place before any videoconferencing and/or teleconferencing platform is used to deliver any sessions remotely to comply with the Data Protection Legislation.

Further information on the use of video conferencing tools in relation to Service User engagement can be found here: https://www.nhsx.nhs.uk/information-governance/guidance/using-video-conferencing-and-consultation-tools/

3.10 Information Governance

The Provider will submit the "Data Output Specification" document in Schedule 6A to the commissioning support service specified by the Commissioner and in the manner specified by the Commissioner.

The Provider will invite all individuals they have contacted following referral and all Service Users to agree be contacted for the purpose of service evaluation and record their consent where given. The Commissioner will specify this proportion of Service Users and also the timing and manner of the invitation.

The Provider will respect any request by a Service User not to disclose information that identifies them in the documents indicated above.

For the avoidance of doubt, the requirements above are in addition to the information governance requirements set out elsewhere in this Contract.

3.11 Additional Service Delivery Requirements

The Provider must:

- provide the Service in the following geographical area **–** [to be defined at call-off]
- ensure that the number of Service Users who achieve Milestone 1 (as defined in Schedule 3A) for the Service does not exceed [number to be defined at call-off] during the Contract Term. This number is the "Intervention Cap" for the purposes of Schedule 3A;
- work with the Local Health Economy to agree and implement a strategy for managing demand within the Intervention Cap;
- ensure that no Service User is invited to participate in the Service after a period of [to be defined at call-off] years has elapsed since the Service Commencement Date. This period is the "Intervention Period" for the purposes of Schedule 3A;
- actively monitor and report to the Commissioner and Local Health Economies, the number of Service Users who achieve Milestone 1 across the Service throughout the Contract Term; and
- notify the Commissioner as soon as reasonably practicable where the number of Service Users achieving Milestone 1 (as defined in Schedule 3A) is predicted to exceed the Intervention Cap.

The Commissioner may at its discretion either:

- vary the Intervention Cap and/or the Intervention Period; and/or
- introduce a specific “Digital Service Cap” and/or “Tailored Remote Service Cap” (which it may subsequently vary), to require the Provider to ensure that the number of Service Users who have achieved Milestone 1 (as defined in Schedule 3A) and are participating in the Digital Service and/or the Tailored Remote Service does not exceed a figure that is equal or more than the specified cap; and/or

- notify the Provider that it will not vary the Intervention Cap and/or the Intervention Period.

Where the Commissioner varies the Intervention Cap, introduces (or subsequently varies) a specific Digital Service Cap and/or Tailored Remote Service Cap, and/or varies Intervention Period it will notify the Provider and the Provider shall comply with the variation.

For the avoidance of doubt:

- the Provider's consent is not required for any variations referred to in this paragraph 3.11 and General Condition 13 does not apply to such variations; and

- varying the figures for the purpose of this paragraph 3.10 includes increasing or decreasing the relevant figure.

The Provider will not be paid for the Service provided to any additional Service Users:

- invited to participate in the Service once the Intervention Cap has been reached in accordance with paragraph 2 of Part 1 of Schedule 3A;

- invited to participate in the Service once the Intervention Period has expired in accordance with paragraph 2 of Part 1 of Schedule 3A; and/or

- invited to participate in the Tailored Remote Service or the Digital Service once any specific Digital Service Cap and/or Tailored Remote Service Cap introduced by the Commissioner has been reached in accordance with paragraph 2 of Part 1 of Schedule 3A.

The Contract Term will be the period from the Effective Date to the day after which the Provider submits the data submission for the last Service User on the NDPP who completed the Final Session or other such day as agreed in writing between the Parties.

3.12 Transition

This Contract may require the Provider to provide the Service in an area where, at commencement of this Contract, there is an existing provider providing services under a contract that the Commissioner has previously called off. In such a situation, there will be a period during which the Provider is commencing delivery of the Service and the existing provider is winding down its delivery of services (i.e. it will not be accepting any new referrals to its service).

Prior to expiry or termination of this Contract, the Provider may be required to provide the Service in an area where there is a new provider preparing to deliver services under a contract that the Commissioner has newly called off. In such a situation, there will be a period during which the Provider is winding down its delivery of services (i.e. it will not be accepting any new referrals to its service) and a new provider is commencing delivery of their service.

These periods are referred to as "Transition Periods". This paragraph 3.12 sets out obligations on the existing provider and/or the incoming provider. During a Transition Period, the Provider may be the existing provider or the incoming provider depending on the nature of the Transition Period. Where the Provider is the existing provider or the incoming provider, the Provider will comply with the relevant obligations set out below.

The aim during the Transition Period is that:

- Primary care engagement is maintained and a steady flow of referrals into NDPP service continues;

- A high quality of service is provided to Service Users regardless of which provider's service they are referred to, or enrolled on; and

- There is an orderly wind down by the existing provider and mobilisation and commencement of delivery of the service by the incoming provider.

The existing provider is responsible for delivering the full intervention to all Service Users who have reached milestone one as defined in that contract, within the intervention cap and the

Intervention Period specified in that contract. The existing provider needs to maintain high levels of engagement of Service Users throughout the Transition Period, and ensure that there is a sustainable workforce and delivery model to manage the Transition Period.

During the Transition Period, there will likely be individuals who have been referred to the existing provider but who have not yet progressed to milestone one as defined in that contract prior to the Intervention Period expiring. Such individuals will be transferred, in compliance with the Data Protection Legislation, by the existing provider to the incoming provider.

The incoming provider must ensure that the approach adopted to enable such transfers between programmes is agreed with the local health economy and the existing provider. The incoming provider and the existing provider are responsible for complying with relevant data protection legislation and the duty of confidentiality throughout this process.

The existing provider shall provide to the incoming provider details on waiting lists of individuals and current session delivery locations to support sustainability of service delivery and the incoming provider is required to attend joint planning meetings through the Transition Period to support operational delivery. The existing provider will continue to provide data to the local health economy and will provide an operational point of contact until all Service Users being provided with the service by the existing provider have either completed the NDPP or have been discharged.

The incoming provider must support the local health economy and the existing provider in the delivery of a communications and engagement approach across local stakeholders to support a smooth transition of patient flow and service delivery.

The incoming provider must ensure it is able to provide the service to persons referred by the existing provider as if such persons were referred to the service by their GP and in accordance with all requirements in this Schedule 2A.

3.13 Review meetings

Review meetings between the Provider and the Commissioner in accordance with General Condition 8 of this Contract shall be conducted on behalf of the Commissioner by any person nominated by the Commissioner to act on its behalf. References to the "Commissioner" in the context of Review Meetings shall be construed accordingly.

The Provider shall attend monthly meetings (whether in person, by telephone or via videoconference) with the Commissioner Representative to discuss progress of the delivery of the Services and any key issues arising. Such meetings shall be held in addition to Quarterly Review Meetings. The Commissioner will provide a written record of the key outputs from such meetings to the Provider who will review and agree these within one month of the relevant meeting.

Unless agreed otherwise by the Parties, at least one week in advance of the monthly and quarterly Contract Review Meeting the Provider will deliver to the Commissioner the performance reports detailed in Schedule 6A in the format described as well as any additional reports notified to the provider in advance of the meeting.

The Provider shall attend meetings (whether in person, by telephone or via videoconference) as determined by local lead partner organisations, in whose areas the Service is being delivered, to review any specific local issues relating to the delivery of the Service including the level of referrals to the Services and any other matters as either the Provider or the relevant local partner organisations considers relevant to the Service. Local lead partner organisations may require a written record from such meetings with the Provider, and these should be agreed within one month of the relevant meeting. Such meeting records will be reviewed at Review Meetings between the Provider and the local lead partner organisations.

At least one week in advance of these meetings, the Provider will deliver to the local lead partner, the data and performance reports detailed in Schedule 6A, in the format described

3.14 Evaluation and Quality Assurance

The Provider will participate fully in any Quality Assurance processes as defined by the Commissioner and co-operate in undertaking ad-hoc audits and reviews as requested by commissioners in a timely manner. This will include the submission to commissioners of:

- Agreed data and reports from external quality assurance schemes
- Self-assessment questionnaires / tools and associated evidence.

The Provider will also participate in evaluations of the Service commissioned by or approved by the Commissioner.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The Provider will deliver the Service in accordance with all relevant clinical guidelines and other guidance and publications published nationally, in particular:

- NICE PH38 Preventing Type 2 Diabetes: risk identification and interventions for individuals at high risk (2012 and updated 2017)
- NICE PH 42 Obesity: working with local communities (2012)
- NICE PH 6 Behaviour change: the principles for effective interventions (2007)
- NICE PH 49 Behaviour change: individual approaches (2014 and updated 2019)
- NICE NG90 Physical activity and the environment NICE CG 43 Obesity: Guidance on the prevention of overweight and obesity in adults and children (2006 and updated 2015)
- NICE CG 189 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014)
- NICE PH 53 Managing overweight and obesity in adults – lifestyle weight management services (2014)
- NICE PH 46 BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013)
- NICE NG 92 Stop smoking interventions and services (2018)
- NICE NG183 Behaviour change: digital and mobile health interventions (2020)
- A guide to good practice for digital and data-driven health technologies. DHSC, 2021
- Changing Behaviour: Techniques for Tier 2 Adult Weight Management Services. PHE, 2017
- Evaluating digital health products. PHE, 2020
- Evidence standards framework for digital health technologies. NICE, 2018
- Health matters: physical activity - prevention and management of long term conditions. PHE, 2020
- Healthy Lives, Healthy People: A call to action on obesity in England. Department of Health, 2011
- Physical activity: applying All Our Health. PHE, 2015
- UK Chief Medical Officers' physical activity guidelines. Department of Health and Social Care, 2019

5. Applicable quality requirements

5.1 Applicable Quality Requirements

The Quality Requirements applicable to the Service are set out in Schedule 4 .

5.2 Equity and access

- In the delivery of the Service the Provider must comply with the obligations placed on the Commissioner by section 13G of the NHS Act 2006 (due regard to the need to reduce health inequalities) and section 149 of the Equality Act 2010 as if those obligations applied directly to the Provider;

- The Provider must promptly provide such co-operation to the Commissioner as the Commissioner reasonably requests regarding the Commissioner's discharge of its duties under section 13G of the NHS Act 2006 and section 149 of the Equality Act 2010; and

- The Provider will complete an annual Equality and Health Inequalities Impact Assessment (E&HIIA) and action plan to challenge discrimination, promote equality, respect Service Users' human rights and to reduce health inequalities in access to services and outcomes. The E&HIIA and action plan shall be provided to the Commissioner on the Effective Date and each anniversary of the Effective Date. Progress against the action plan will be reported by the Provider to the Commissioner on a Quarterly basis at the relevant Review Meeting.

The Provider must at all times adhere to all relevant health and safety and security Law in providing the Services.

Schedule 2A Service Specification

Annex 1

Government recommendations for diet and physical activity

Topic	Recommendation
Diet	
Carbohydrates[11,12]	Approximately 50% of total dietary energy[15] Carbohydrates are found in many different foods, but this recommendation means that starchy carbohydrates (for example, potatoes, bread, pasta and rice) should make up just over a third of the food we eat.
Free sugars[13]	No more than 5% of total dietary energy. This is equivalent to no more than 30g a day for adults.
Sugar-sweetened drinks[14]	Consumption should be minimised.
Fat[16]	No more than 35% of food energy[17] (33% total dietary energy).
Of which saturated fat	*No more than 11% of food energy (10% total dietary energy). This is approximately no more than 30g per day for men and no more than 20g per day for women.*
Salt[18]	No more than 6g for adults.
Fibre[19] (AOAC)	30g per day for adults.
Fruit & vegetables[20]	At least 5 portions of a variety per day. A portion is: 80g fresh, frozen or canned fruit and vegetables; 30g dried; or 150ml of juice or smoothie (maximum, which can only count as one of your 5 A Day).
Fish[21]	At least 2 portions (2 x 140g) a week, one of which should be oily.

[11] Carbohydrates, free sugars, sugars-sweetened drinks and fibre – SACN (2015) Carbohydrates and Health. www.gov.uk/government/uploads/system/uploads/attachment_data/file/445503/SACN_Carbohydrates_and_Health.pdf

[12] SACN's recommendations for carbohydrates were set as a percentage of 'total dietary energy' only

[13] As for footnote 10 above

[14] As for footnote 10 above

[15] Total dietary energy includes energy from food and alcohol

[16] Total fat, saturated fat – COMA (1991) Dietary Reference Values for Food Energy and Nutrients for the United Kingdom. London: HMSO.

[17] Food energy excludes energy from alcohol

[18] Salt – SACN (2003) Salt and Health www.gov.uk/government/uploads/system/uploads/attachment_data/file/338782/SACN_Salt_and_Health_report.pdf

[19] As for foot note 10 above

[20] World Health Organisation (1990) Diet, nutrition and the prevention of chronic diseases. http://www.who.int/nutrition/publications/obesity/WHO_TRS_797/en/index.html
World Health Organisation (2003) Diet, nutrition and the prevention of chronic diseases. http://www.who.int/dietphysicalactivity/publications/trs916/download/en/

[21] SACN (2004) Advice on Fish Consumption: benefits and risks. www.gov.uk/government/uploads/system/uploads/attachment_data/file/338801/SACN_Advice_on_Fish_Consumption.pdf

Red and processed meat[22]	For adults with relatively high intakes of red and processed meat (i.e. over 90g/day) to consider reducing their intake to the population average (about 70g/day).
Topic	**Recommendation**
Physical activity	**Adults (19 to 64 years)** • For good physical and mental health, adults should aim to be physically active every day. Any activity is better than none, and more is better still. • Adults should do activities to develop or maintain strength in the major muscle groups. These could include heavy gardening, carrying heavy shopping, or resistance exercise. Muscle strengthening activities should be done on at least two days a week, but any strengthening activity is better than none. • Each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous intensity activity (such as running); or even shorter durations of very vigorous intensity activity (such as sprinting or stair climbing); or a combination of moderate, vigorous and very vigorous intensity activity. • Adults should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of inactivity with at least light physical activity. **Older Adults (65 years and over)** • Older adults should participate in daily physical activity to gain health benefits, including maintenance of good physical and mental health, wellbeing, and social functioning. Some physical activity is better than none: even light activity brings some health benefits compared to being sedentary, while more daily physical activity provides greater health and social benefits. • Older adults should maintain or improve their physical function by undertaking activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week. These could be combined with sessions involving moderate aerobic activity or could be additional sessions aimed specifically at these components of fitness. • Each week older adults should aim to accumulate 150 minutes (two and a half hours) of moderate intensity aerobic activity, building up gradually from current levels. Those who are already regularly active can achieve these benefits through 75 minutes of vigorous intensity activity, or a combination of moderate and vigorous activity, to achieve greater benefits. Weight-bearing activities which create an impact through the body help to maintain bone health. • Older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at

[22] Red and processed meat – SACN (2011) Iron and Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339309/SACN_Iron_and_Health_Report.pdf

	least with standing, as this has distinct health benefits for older people.

Schedule 2A Service Specification

Annex 2

BMI classifications for overweight and obesity

Providers must refer to NICE Guidance PH46. The guidance provides detailed advice, including definitions and BMI and waist circumference thresholds. The key recommendations are listed here.

Recommendation 1 Preventing Type 2 Diabetes

Follow NICE recommendations 1–18 in Preventing type 2 diabetes: risk identification and interventions for individuals at high risk (public health guidance 38). This includes:

- using lower thresholds (23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among Asian (South Asian and Chinese) populations
- identifying people at risk of developing type 2 diabetes using a staged (or stepped) approach
- providing those at high risk with a quality-assured, evidence-based, intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes.

Box 1: International guidance on BMI/waist circumference thresholds

WHO advice on BMI public health action points for Asian populations (World Health Organization 2004)

Classification	**White European populations**	**Asian populations**
Underweight	<18.5 kg/m^2	<18.5 kg/m^2
Healthy weight	18.5–24.9 kg/m^2	18.5-23 kg/m^2
Overweight	25–29.9 kg/m^2	23.1-27.4 kg/m^2
Obese	30 or more kg/m^2	27.5 kg/m^2 or more

Schedule 2A Service Specification

Appendix 1

Tender Response Document

[Bidder tender response to be inserted prior to each call-off Contract award]

Schedule 2A Service Specification

Appendix 2

Local Service Requirements

[Note to Bidders: This draft prospectus setting out the Local Service Requirements is a template provided for information purposes only. NHS England reserves the right at any time prior to the Tender Submission Date at its absolute discretion to amend this template. A populated prospectus will be included in the procurement documentations for the Call-off Contract. It will be added here on contract award and will constitute the Local Service Requirements of that Contract.]

NDPP FW3
Prospectus [ICS NAMI

Schedule 2A

Appendix 3

Provider IPR

[To be inserted prior to each Call-off Contract award]