SERVICE SPECIFICATION

The provision of Community Smoking Cessation Service for the treatment of Tobacco Dependency

1. Overview

1.1 Local Authority procuring the Service

West Sussex County Council

1.2 Why the Services are being procured

1.2.1 There are an estimated 87,000 current smokers aged 18+ in West Sussex that is 13% of the adult population. On average 1,300 deaths each year in West Sussex are attributable to smoking. The annual number of hospital admissions has increased by 13% since 2011/12. In 2016/17 there were 7,241 smoking attributable hospital admissions in West Sussex.

https://sfws-action-plan.netlify.com/

1.2.2 Tobacco use is one of the biggest causes of inequality in mortality and ill health between the richest and poorest in society. There are variations across the county, and within different population groups based on their sex and sexuality, their age and even their ethnicity and country of birth.

1.2.3 In West Sussex the picture is the same as that seen nationally. Low income and deprivation are associated with smoking. Therefore, those living in deprived areas, routine and manual workers, people with mental health conditions, groups that identify as LGBT and those aged under 25 are key groups requiring the support of stop smoking services.

1.2.4 Two in every five routine and manual workers are current smokers. Routine and manual workers in West Sussex are more than twice as likely to be current smokers compared to those in other occupations.

1.2.5 Those who report their country of birth as Poland had a prevalence of smoking that was almost double that of those born in England. There are an estimated 8,000 residents of West Sussex whose country of birth is Poland.

1.2.6 Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proven difficult to change, and tobacco use is the leading risk factor in terms of the causes of health inequalities.

1.2.7 The NHS Long Term Plan released in January 2019 takes a strong stance on public health as a matter of urgency. Demand for NHS services continues to grow for a number of reasons some of which are potentially modifiable; this includes improving upstream prevention of avoidable illness and its exacerbations. Smoking is the number one contributing factor that causes premature deaths in England.

https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/smoking/

1.2.8 In 2017/18 in West Sussex the rate of smoking at time of delivery was 9% or 747 women. Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy.

1.2.9 West Sussex modelled youth smoking prevalence in regular smokers aged 15 years (7.1%) is worse than the national average (5.5%) and South East region average (5.8%). However, there is a declining trend in the uptake of smoking in youths.

In the 2018/19 financial year we saw greatest engagement from those in the 45-59 age group (35%), with those aged 60+ (26%) second. The service saw 54% of total service users identify as female. Routine and Manual workers were the largest occupational group at 33%. Quit rates across all providers remained very good, with 49.8% of all service users registering a quit.

2. Scope of Services

2.1 Aims and objectives of Service

2.1.1 The aim of the Service is to address inequalities and reduce premature deaths and ill-health from smoking related disease as recognised in the Long-Term Plan, through the provision of stop smoking interventions that will treat tobacco dependency.

2.1.2 The national ambition of engaging 5% of smokers annually far exceeds recent local activity levels. Additional stop smoking services are starting to be delivered through the West Sussex Wellbeing Programme. These are complementary to this service. This activity also counts towards the 5% engagement.

2.1.3 Providers being paid via more than one arrangement or route of activity for delivery of smoking cessation, will not be considered for delivery of this community smoking cessation service
This approach reduces the risk of paying twice, this ensures best use of public funds and supports highest possible impact with the resources available.

2.1.4 The objectives of this community service are to:

- Proactively identify smokers from groups with highest smoking prevalence, using a Make Every Contact Count (MECC) approach, in line with the West Sussex (MECC) programme. https://www.westsussexwellbeing.org.uk/topics/information-for-professionals/making-every-contact-count
- Provide support and follow up in agreement with smokers who have set a quit date in accordance to service guidelines *National Local Stop Smoking Services and Delivery Guidance 2014. https://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf*
- Communicate risk and offer smoking cessation advice to smokers from target groups.
- Record four week smoking status within the Russell Standard

https://www.ncsct.co.uk/publication_The-Russell-Standard.php *West, R (2005) Accessing smoking cessation performance in NHS Stop Smoking services: The Russell Standard. NCSCT*

- Record validated quit status i.e. via a carbon monoxide (CO) reading.
- Arrange appropriate pharmacotherapy to support the quit attempt, this should be available for the duration recommended by the product specification e.g. up to 12 weeks for nicotine replacement therapy (NRT) and Varenicline and up to nine weeks for bupropion.
- Inform Service Users of all evidence-based licensed smoking cessation pharmacotherapy, including combination NRT as well as non-licenced products such as electronic cigarettes. Consideration must be given to clinical appropriateness of pharmacotherapy treatment where necessary e.g. in pregnancy.

2.2 Service description/care pathway

The smoking cessation service is designed to offer intensive one to one support and follow up, including advising on use of licenced products (eg nicotine replacement therapy) and non-licenced products (eg electronic cigarettes (e- cigs) for Service Users wishing to access Stop Smoking services. The Service Provider will:

- Use a MECC approach to identify and engage smokers into the service.
- Provide smoking cessation interventions that have a clear structure and content, which is communicated to Service Users at first contact, and to which they should commit.
- Provide smoking cessation services to smokers of tobacco products such as cigarettes (hand rolled or tailor made), cigars, pipes (including water pipes) and smokeless tobacco. Support is only offered to those using tobacco and therefore this service does not offer support to those vaping without also using tobacco**.** Those smoking other substances should be referred to DAWN the West Sussex Drug and Alcohol Wellbeing Network (led by CGL) who provides support to people of any age, who are looking to reduce or stop their drinking or use of drugs, (including New Psychoactive Substances (formerly known as "Legal Highs"), prescription or over-the-counter medication, performance and image enhancing drugs (including steroids).
- Provide smoking cessation services to smokers from target groups who are resident or working in West Sussex and aged over 12 years, as per Gillick competence. Gillick Competence is the term used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need to parental permission or knowledge. (https://www.nhs.uk/conditions/consent-to-treatment/children/)
- Provide one to one intensive support on a weekly basis for a minimum of 5-6 weeks, until a date within the Russell Standard is reached when 4-week status is monitored through recording of carbon monoxide (CO). Quit dates falling outside this period will not be counted or paid for.
- Arrange appropriate pharmacotherapy to support the quit attempt, this should be available for the duration recommended by the product specification e.g. up to 12 weeks for nicotine

replacement therapy (NRT) and Varenicline and up to nine weeks for bupropion.

- West Sussex Smoking Cessation Service is "e-cigarette friendly" therefore these can also be offered as a first line alternative to licenced medications, these should be discussed with Service users who show an interest. These items are currently not available on prescription and will have to be purchased by the service user. Behavioural support should be provided to Service Users who want to use unlicensed, self-purchased products as their aid to quitting.
- Record the data for each smoking cessation episode as it is carried out onto the West Sussex Smoking Cessation Template as specified by West Sussex Public Health. The source of the template may vary depending on the Service Provider. General practice-based providers will use a specified data collection template. Non-General Practice providers will be provided access to the PharmOutcomes system by public health and will generate and submit automated reports and claims each month as per Schedule B Part 1 of Public Health based Services Contract.
- Send the agreed letter of recommendation for Service Users where Varenicline (Champix) is appropriate, to their GP as this is only available on Prescription [Appendix A].
- Refer Service Users to another West Sussex Stop Smoking provider if an appointment cannot be made within 2 weeks.

2.3 Who is to be in receipt of the service.

All tobacco smokers aged 12 years and over who are resident or working in West Sussex are eligible for the service.

2.4 Exclusion criteria

Service Users who have not smoked in the 48 hours prior to attending their first appointment **with the exception of** pregnant women, hospital inpatients and/or prisoners as outlined in table 1 below:

https://www.ncsct.co.uk/usr/pub/Spontaneous%20quitters%20guidance.pdf

Type of client	Can be treated as part of a community-based multi-session behavioural support programme	Data can be submitted as part of national NHS Digital returns	Additional comments
Spontaneous quitter: smokers in the community who have **stopped smoking for more than 48 hours** before attending service.	Yes	No	Can be treated as part of a multi-session behavioural support programme and recorded for local accounting purposes (e.g. to justify resources or analyse performance).
Patient/prisoner in a structured behavioural support programme, but not completed during their stay and who has been continuously abstinent from smoking for **less than 14 days** prior to discharge/release.	Yes	Yes	Referral to a community stop smoking service upon discharge/release constitutes a **transfer** of their treatment, and the 48 hours rule regarding spontaneous quitting **does not** apply.
Patient/prisoner not in a structured behavioural support programme, but who requests a referral for support and has been continuously abstinent from smoking for **less than 14 days** prior to discharge/release.	Yes	Yes	Referral to a community stop smoking service upon discharge/release constitutes a transfer of their treatment, and the 48 hours rule regarding spontaneous quitting **does not** apply. For the purposes of data recording, client's quit date should be recorded as the last date on which they smoked.
Patient/prisoner not in a structured behavioural support programme, but who requests a referral for support and has been continuously abstinent from smoking for **14 days or longer** prior to discharge/release.	No	No	The patient or prisoner is deemed to be a non-smoker, and therefore the 48 hours rule regarding spontaneous quitting **does** apply. Local policies regarding the provision of stop smoking aids and relapse prevention to spontaneous quitters should be applied. If there are specific concerns regarding the interaction of prescribed medications and smoking status (e.g. for mental health patients), then the patient/prisoner should be referred to their GP on discharge/release for ongoing assessment.

2.5 Interdependencies with other services

2.5.1. Smoking cessation providers should be aware of the other service providers within their locality, including the West Sussex Wellbeing programme and work with them to ensure timely initial engagement.

2.5.2 Providers should work with community groups that are accessed by those with a higher prevalence of smoking (such as mental health service users, substance misuse service users, LGBT or routine and manual) and provide a smoking cessation service for them which may involve the use of outreach.

2.6 Information Provision

The Service Provider shall:

- Provide appropriate verbal and written information to the Service User, at the first appointment, which explains about the effectiveness, duration of use and side effects of all licensed and unlicensed products available to support a quit attempt. This shall be reinforced on follow up contacts.

- Ensure information, support and guidance is available to all wishing to access the Service. This may include interpreting services and or documents produced in different languages or formats.
- Have an understanding of and take account of the needs and requirements of different cultures, religions, race and gender.
- Ensure that no Service User is discriminated against. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

2.7 Any activity planning assumptions and caseloads

2.7.1The Service Provider should:

- Consider seasonal fluctuation, workload, staff capacity and any awareness campaigns they may wish to run in their assumptions.
- Submit an activity schedule to the commissioners before the start of each financial year, no later than 1st February (or next working day) and using the template provided at appendix B. Activity schedule should meet the Key Performance Indicators set out in Section 6, including the required minimum of 12 service users to set a quit date each year (minimum of 3 per quarter) at the start of each financial year.
- Inform the Council of any significant disruption to the Smoking Cessation Service which is likely to impact on delivery of the Contract such as staff vacancies.
- Target mental health secondary care service users, substance misuse service users, pregnant women, people with long term conditions and carers. With 30% or more setting a quit date from those classed as routine or manual workers.

2.7.2 The Service Provider and the Council will monitor delivery against this schedule alongside the Service Specification. The Council, at its discretion, may supply the Service Provider with a quarterly or annual performance statement to assist with monitoring.

2.7.3 The Council and partners across the health and care system in West Sussex maintain an overall oversight and overview of smoking cessation services. The activity schedule submitted by the Service Provider is subject to agreement with the Council and where necessary the Service Provider will be contacted by the Commissioner/ Council’s representative in order to agree any adjustments required to the activity schedule in advance.

In the event of significantly higher levels of activity being delivered, or forecast for delivery than those set out in the agreed activity schedule, The Service Provider is required to notify tca@westsussex.gov.uk immediately so a solution can be established.

Significantly higher levels of activity are defined as being 50% greater than the levels agreed in the activity schedule. The Council may apply upper limits on the number of Service Users accessing the service based on the annual activity schedule submitted by the provider and detailed in Appendix B. On this basis, The Service Provider may be directed to limit numbers of Service Users accessing the service for a defined period.

Payment will be made within agreed levels of activity and the Council reserves the right not to pay The Service Provider for levels of activity that are greater than 50% of those agreed in the activity schedule without written advance agreement.

3. Applicable Service Standards

3.1 Applicable national standards and guidance

Service standards and best practice guidance are located on the National Centre for Smoking Cessation and Training website at http://www.ncsct.co.uk/index.php

The Council will notify the Service Provider of new and revised applicable national standards and guidance as they are published on the website. The Council will advise of any changes to be made and the Service Provider will respond to these changes and incorporate them into the delivery of the Programme.

3.2 Applicable local standards

3.2.1 Service Providers under this contract should facilitate access to provide a full range of licensed products based on the Service Users need which is established through initial consultation.

3.2.2 Unlicensed products (e-cigarettes) can be discussed as an option to aid smoking cessation with those Service Users who wish to use them. These products need to be purchased by the Service User. It is recommended that they are purchased from a reputable independent vape shop which is free from involvement with the tobacco industry as per the WHO Framework Convention on Tobacco Control. https://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf;jsessionid=851D588B37E84112ED461B19888D902A?sequence=1

3.2.3 Service Providers under this contract must ensure all staff delivering this service have completed the West Sussex approved training programme prior to any delivery of the service takes place. This training will be provided free of charge through the Council.

The training consists of the following components, all of which need to be completed in this order:

- The e- learning National Centre Smoking Cessation Training (NCSCT) Stop smoking Practitioner training and certification https://elearning.ncsct.co.uk/england

  The additional specialty eLearning courses available on the NCSCT website, for mental health and pregnancy should also be completed.

- Successful completion of the NCSCT online course will be confirmed by provision of the certificate to the Council.

- One day face to face training. Details of this training can be found on the West Sussex learning and development gateway https://www.westsussexcpd.co.uk/cpd/default.asp Providers will also be informed directly as new training opportunities are made available.

3.2.4 On completion of the West Sussex approved training programme, verified through submission of the NCSCT certificate to the Council, a visit to new provider sites will be made by the primary care services coordinator from public health. This visit will provide service providers with:

- Access to the locally developed OnClick e-mentor tool for smoking cessation for ongoing training support. Access to the Onclick platform is restricted to up-to-date secure browsers such as Chrome, Firefox, Safari, IE11 and Microsoft Edge.
- Details of data collection and invoicing.
- A PICO Carbon Monoxide (CO) monitor, with a starter pack of consumables.
- Establish the Service Provider with all the necessary resources to commence delivery of the service.

3.2.5 The Service Provider must ensure that trained staff update their knowledge and skills through attendance of at least one of the West Sussex Provider Forum events annually as well as every two years using the OnClick e-mentor tool and with face to face training if available. This also is applicable to staff who have had a break in service of longer than 6 months. In order to maintain skills each smoking cessation advisor will be required to deliver a service intervention to a minimum of 1 Service User per month.

3.2.6 The Service Provider is responsible for provision of consumables and the calibration of CO monitors/replacement once it's beyond its five-year manufacturer's warranty.

3.2.7 The Council reserves the right to request an audit of anonymised smoking cessation interventions and quality assurance based on the seven dimensions of quality set out by West Sussex Public Health in Schedule F of the Public Health based Services Contract.

3.2.8 The Service Provider shall have systems and procedures in place, including training, to safeguard adults, children and young people to recognise and respond to abuse, exploitation and neglect (including, but not limited to, child sexual and criminal exploitation, trafficking and modern slavery and female genital mutilation) and shall adopt safeguarding policies and procedures which comply with the Pan Sussex Multi Agency Policies and Procedures.

The Service Provider will ensure that all staff who have contact with children, young people and families are properly selected and have appropriate checks in line with current legislation and guidance. https://sussexchildprotection.procedures.org.uk/

This includes that:

- References are always taken up
- Identity and qualifications are verified
- Face-to-face interviews are carried out
- Previous employment history is checked
- The appropriate type of criminal record check from the Disclosure and Barring Service (DBS) is carried out for all eligible staff, e.g. enhanced with barred list checks for regulated activities

involving children and/or adults
- Any abnormalities or discrepancies are taken up
- Repeat DBS checks are carries out according to organisational policy

The Service Provider will ensure staff working with children and families are trained, confident and knowledgeable in supporting parents and carers to keep their children safe when using social media and the internet.

3.3 Infection Control

3.3.1 Service Providers will have Systems to manage and monitor the prevention and control of infection.

- Someone with the appropriate knowledge and skills will be the named lead in infection prevention control (and cleanliness) for each provider.
- Policies, procedures, and guidance are required and should be in place including-Standard infection prevention and control precautions; Safe handling and disposal of sharps; Decontamination of reusable medical devices; Single-use medical devices; Safe handling and disposal of healthcare waste; Purchasing, cleaning, decontamination, maintenance and disposal of equipment; Environmental cleaning guidelines.
- Staff should be trained on infection prevention and control.
- Governance arrangements are in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately.

3.3.2 Service Providers will provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.

- Cleaning responsibilities and routines should be clearly outlined.
- Staff should carry out ongoing assessment of the standards of cleanliness.
- Adequate hand hygiene facilities should be available at the point of care.

3.3.3 Service Providers should have a system in place to manage the occupational health needs and obligations of staff in relation to infection, this includes:

- How exposure to infections will be managed.
- Prevention of occupational exposures to BBV- including risk assessments of the need for immunisations such as influenza vaccination and Hep B
- The responsibility of staff to report episodes of illness.
- The circumstances under which staff may need to be excluded from work.

3.3.4 Further information and guidance can be found in the NICE Healthcare-associated infections: prevention and control in primary and community care (updated 2017) here:

https://www.nice.org.uk/guidance/cg139

4. Statutory Requirements

4.1 Applicable Legislation

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 S.I. 2013/351 set out a number of mandatory public health functions for local authorities from 1 April 2013. These Regulations have been made by the Secretary of State for Health under powers conferred by the National Health Service Act 2006 and the Local Government and Public Involvement in Health Act 2007

5. Service Requirements

5.1. Description of the Service

The service provider shall deliver The Smoking Cessation service as specified in the NCSCT Standard Treatment Programme http://www.ncsct.co.uk/usr/pub/standard_treatment_programme.pdf

The NCSCT Standard Treatment Programme should be followed for sessions 1-6 as follows:

5.1.1 First Appointment **Face to face**

a. At the first appointment the advisor will:

- Determine eligibility for service.
- Discuss history of tobacco use and previous attempts to quit.
- Discuss the Service Users readiness to quit.
- Discuss the treatment programme.
- Explain the benefits of quitting.
- Discuss tobacco withdrawal syndrome and barriers to quitting.
- Use the Fagerstrom score to assess dependency.
- Explain the stop smoking medication options and e- cigarettes.
- Set a quit date.
- Explain and conduct a CO test.

- Deliver behavioural support for the Service User.
- Provide/arrange enough stop smoking medication for two weeks or where an e-cigarette is to be used suggest contacting an e-cigarette shop registered with the IBVTA for advice.
- Signpost to additional supporting information such as West Sussex Wellbeing Website, One You Website.
- Record the intervention on the appropriate template
- Arrange a follow up appointment on or around quit date.

5.1.2 Second Appointment (On or around the Quit Date) **Face to face**

b. At the second appointment the advisor will:

- Determine date of last tobacco use
- Continue behavioural support
- Address any concerns with progressing the quit attempt
- Review medication being used
- Provide additional appropriate stop smoking medication
- Record the intervention on the appropriate template
- Make the next appointment (depending on your appointment system you may also wish to book a 4 week follow up appointment within the Russell Standard of 25 -42 days post quit).

5.1.3 Third, Fourth and Fifth appointment **Face to face, telephone, text or email**

c. At the third, fourth and fifth appointment the advisor will:

- Deliver face-to-face, telephone, text or email support for weeks one, two and three post quit and continue behavioural change support
- Address any concerns with progressing the quit attempt
- Review use of stop smoking medication and e-cigarettes products to support quit attempt.
- Provide/arrange enough stop smoking medication for two weeks or where an e-cigarette is to be used suggest contacting an e-cigarette shop registered with the IBVTA for advice.
- Record the intervention on the appropriate template.
- If not already booked, set a 4 week follow up appointment within the Russell Standard of 25 -42 days post quit.

5.1.4 Sixth appointment **Face to face**

d. At the sixth appointment the advisor will:

- Deliver a four week follow up appointment to record an outcome with the Service User, this must be within Russell Standard of 25-42 days post quit date.

- Repeat CO monitoring (The quit outcome needs to be CO validated for a minimum of 85% of registered quits)
- For those Service Users who have successfully quit, discuss approaches to remain smoke free, including continuing with stop smoking medication and behavioural support for up to 12 weeks
- For Service Users who have not successfully quit, discuss next steps, which could include re setting a quit date and starting the quit attempt again
- Record the intervention on the appropriate template

e. Allow the Service User to continue to engage with the Smoking Cessation service for up to the 12th week intervention. Provided they have registered a successful quit outcome at the four week evaluation.

5.1.5 Recording Outcomes

The Service Provider must record a four week Russell Standard outcome for each Service User who has set a quit date, within 25-42 days post quit date. There are four possible outcomes;

1. CO-Validated Quit – Service User with CO validation whose reading is on or below 10 parts per million (ppm). Should be determined at a face-to-face appointment with the valid reading recorded.

2. Self-Reported Quit – Service User declares they have not smoked a single puff on a cigarette in the past two weeks. Determined by face-to-face appointment, telephone, text or e-mail.

3. Not Quit - When a Service User has not managed to stop smoking.

4. Lost to follow up – When a Service User does not attend the four week follow up face-to-face appointment and attempts have been made by telephone, text or email (up to three times, at different times of the day) have been unsuccessful.

5.1.6 When a Service User has not managed to stop smoking, the Service Provider’s stop smoking adviser should use discretion and professional judgment when considering whether a Service User is ready to receive support to immediately attempt to stop again. If this is the case, the Service User must start a new treatment episode. There is no limit to the number of times a Service User can access this service.

5.1.7 The intervention must be recorded on the PharmOutcomes West Sussex Smoking Cessation template or for GP providers a West Sussex specified data collection template. This should then be submitted to West Sussex Public Health Department and/or the councils nominated I.T system.

5.1.8 The Service User should be provided with a satisfaction survey at the end of their treatment programme. These will be used to monitor Service User satisfaction and to inform improvements in service provision, quality and development. [Appendix D]

5.2 Quality Requirements

I. The Service Provider shall fully comply with the Pan Sussex Multi Agency Safeguarding Adults Policy. http://pansussexadultssafeguarding.proceduresonline.com/

and the Pan Sussex Local Safeguarding Children's Board Inter-Agency Procedures for Children and Young People. http://sussexchildprotection.procedures.org.uk

and meet the safeguarding standards within the West Sussex Section 11 Self-Evaluation Tool in which demonstrates compliance with Section 11 of the Children Act 2004. [Appendix C]

II. The Service Provider shall ensure that relevant safety alerts and Medical & Healthcare Products Regulatory Agency (MHRA) notices are circulated to staff and acted upon where necessary.https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency

III. The Service Provider shall address complaints from Service Users in relation to this Service through their own complaints' procedure in the first instance. If further help is required, contact the Council as detailed within the contract.

IV. The Service Provider shall ensure that a process is in place for any member of the professional team to raise concerns in a confidential and structured way.

V. The Service Provider shall participate in the Council's organised audit of service provision.

VI. The Service Provider shall fully co-operate with any national or West Sussex County Council led assessment of Service User experience.

VII. The Service Provider shall demonstrate that clear and accurate records are kept.

VIII. The Council shall undertake visits to the Service Provider's premises/location of delivery as appropriate as part of quality monitoring, verification of claims and payments and to ensure that the Service Provider is meeting the Service Specification.

5.3 Consent

The Service Provider will:

- Inform Service Users that anonymised data collected will be used for the purposes of local monitoring and evaluation. Summary data will be forwarded for regional and national evaluation.
- Obtain consent to contact the Service User for follow-up appointments. The 4-week follow-up will need to be face-to-face to include CO-validation. Consent must be freely given, specific, informed and unambiguous. In order to obtain freely given consent, it must be given on a voluntary basis.
- Consent to sharing anonymised/aggregated activity data per named Service Provider with relevant professional bodies, such as the Local Pharmaceutical Committee (LPC), who will offer support to those Service Providers struggling to deliver to contract.

5.4 Location of Services

The Service Provider will be responsible for providing the use of a suitable consultation room which allows for privacy and dignity, is fit for the purpose of delivering healthcare and has access to broadband and necessary I.T. If providing the smoking cessation service in an outreach setting the Service Provider is responsible for ensuring that facilities used are of the required standard.

The Service Provider will ensure there is a delivery contingency plan in place in case of staff sickness or unforeseen changes to premises.

5.5 Hours of Service delivery

The Service Provider will determine when the service will be offered in order to best to meet the requirements of its Service Users in terms of access and to ensure capacity meets demand.

5.6 Equipment

5.6.1 The Service Provider must have adequate mechanisms and facilities, including premises and equipment, as are necessary to enable the proper provision of this Service.

The Council will provide, free of charge to the Service Provider:

- One Carbon Monoxide monitor (CO-monitor) and starter kit of consumables for new providers.

The Service Provider will be responsible for:

- The provision, storage, maintenance, calibration and servicing of all equipment and all associated consumables, including disposable mouthpieces, batteries, non-alcoholic cleaning wipes or any consumables required for the equipment to work within the manufacturer's instructions.

5.6.2 In the event that the Service Provider ceases to deliver the Smoking Cessation Service, the Service Provider must notify the Council and return the CO monitor. Failure to do so within a month of The Council receiving notification will result in The Council invoicing the service provider for the full amount necessary to replace the CO monitor.

In addition to a carbon monoxide monitor and the necessary consumables as outlined above, the service user will also need to ensure appropriate provision of nicotine replacement therapy (NRT). If this is stored on site, it will need to be in a lockable facility.

5.6.3 The Service Provider will need suitable IT infrastructure to:

- Access the data recording templates as specified by West Sussex County Council Public health.
- Receive electronic referrals from NHS Trusts or the West Sussex Wellbeing Website via a secure email address. The email address being used needs to be provided to the Council and must be monitored every working day and responded to within three working days.
- Facilitate timely inputting of information.
- Access the West Sussex Wellbeing website, for information for professionals as well as service users.

- Access the Public Health England (PHE) Campaign Resource Centre.
- Access the NCSCT website
- Access the Onclick e-mentoring tool. Access to the Onclick platform is restricted to up-to-date secure browsers such as Chrome, Firefox, Safari, IE11 and Microsoft Edge.
- Access to suitable I.T system to manage appointments

5.7 Mobilisation

Prior to commencing delivery of the service, the Service Provider will confirm to the Council:

- Staff designated to deliver the service have received all relevant training as stated in 3.2.5 and 5.6 and are competent to deliver the service. Contact details of the clinical lead/responsible person.
- On-going supervision and oversight arrangements are in place.
- That all trained staff involved in service delivery are fully aware and understand the relevant requirements, guidance and policies within the Service Specification associated with their function.
- How the Service Provider will promote the service to Service Users.
- Support interdependent functions within the Service Provider's team e.g. Admin Staff are aware the Provider will be offering the Service.
- The service activity for this service for the financial year ahead.

5. 8 Reporting of Incidents and Risk Management:

- The Service Provider must report all Serious Untoward Incidents (SUIs) to the Council on the next working day of occurrence and provide details of root cause analysis (RCA), recommendations and actions taken as a result.

6. Key Performance Indicators (KPI's) / Service Levels

The following performance indicators need to be measured and reported against

Performance Indicator	Annual Target	Method of Measurement
Service Users setting a quit date	At least 12 Service Users setting a quit date each year. This equates to a minimum of 3 Service Users setting a quit date each quarter.	Quarterly data reports taken from data collection system.
% of Service Users quit at 4 weeks (Russell Standard 25-42 days)	At least 35% of Service Users setting a quit date are recorded as a quit at 4	Quarterly data reports taken from data collection system.

	weeks post quit date.	
% of Service Users setting a quit date from targeted groups such as mental health service users, substance misuse service users, pregnant women and partners or routine and manual workers	At least 30% of Service Users setting a quit date are from the routine and manual workers	Quarterly data reports taken from data collection system.
% of Service Users quit at 4 weeks with a recorded CO-Validation reading	At least 85% of the Service Users who have recorded a 4-week quit, have these quits validated by a CO reading.	Quarterly data reports taken from data collection system
% of Service users returning a satisfaction survey	At least 10% of service users return a completed satisfaction survey	Six monthly review of the satisfaction survey responses returned to the Council

7. Reporting Requirements and Service Specification Review

7.1 Data Collection and Written Reports

Service Providers should collect the Department of Health minimum dataset for every Service User setting a quit date.

- http://www.ncsct.co.uk/usr/pub/SSS%20GSMF%20form%20v3.pdf

The Service Provider will record the data for each smoking cessation episode as it is carried out onto the corresponding West Sussex Smoking Cessation Template within PharmOutcomes or for General Practice a specified data collection template.

The PharmOutcomes system will generate and submit automated reports and claims monthly as per Schedule B Part 1 of Public Health based Services Contract.

Invoices from general practice need to be submitted to ctg.invoicing@westsussex.gov.uk using the template provided, on a quarterly basis. The exact dates for these submissions will be advised annually, but will be in line with the national reporting requirements

- Q1- September
- Q2 December.

- Q3 March
- Q4 June

The Council reserves the right to request the Service Provider to provide an audit of anonymised Smoking Cessation Interventions delivered.

7.2 Service Specification Review

It is recognised within this Service Specification that the Service may be subject to change due to a range of national and local policy initiatives. For example, government guidance and legislation, industry professional standards, NICE Guidance, Public Health England or West Sussex County Council Policy.

It is the responsibility of the service provider to make the necessary amendments to the service to reflect these changes. The Council will advise the Service Provider of any changes to be made.

This review may also include a review of tariff.

List of Appendices:

APPENDIX A – Champix Recommendation Letter

Champix (Varenicline) GP Information Letter

09 Oct 2019

Violet Patch Pharmacy
678 A Street in a Town
Narrow
EF45 6GH
0789 123456

Patient Details	
Name	Mickey Mouse [*From 1. Stop Smoking - Registration and First Appointment*]
Date Of Birth	01-Feb-2003 [*From 1. Stop Smoking - Registration and First Appointment*]
Postcode	AB12 3CD [*From 1. Stop Smoking - Registration and First Appointment*]
Address	123 Alphabet Road, Broad way [*From 1. Stop Smoking - Registration and First Appointment*]

Dear Selection of *GP Practice*

The above named patient has attended their appointment with your local Stop Smoking Service.

In conjunction with Patient Group Direction for the supply of varenicline by registered community pharmacists for Stopping Smoking, this patient has been assessed as meeting the criteria for the supply of varenicline by

the accredited pharmacist named below.

All the treatment options have been discussed with this client and they have been assessed as suitable for varenicline.

The patient has completed a varenicline assessment form and from the information provided, they do not meet any of the exclusion criteria listed in Patient Group Direction

Consultation Details	
Exclusions	*Confirm no exclusions apply*: One or more of: Tobacco users not sufficiently motivated to quit smoking; Client has had an unsuccessful attempt to quit; Hypersensitivity to varenicline or any of its excipients; Clients using other nicotine containing products; Clients with current (or a history of) serious psychiatric illness; Client under 18 years of age; Clients over 65 years of age; ...
Drug Interactions	Answer to *Relevant action taken* text box
Supply required	*Varenicline supply required?*: One of: Yes; No
Medication Supplied	
Medication	Selection of *Medication Supplied*
Quantity	Selection of *Medication Supplied*

This patient will be supported by the pharmacy stop smoking service throughout the 12 week course of varenicline which will be supplied under this PGD. If you have any concerns about this patient receiving varenicline, please inform the pharmacy as soon as possible.

Yours faithfully, The Practitioner

APPENDIX B- Activity Schedule

Name of Service Provider:

Date Commencing Delivery:

Month	**April**	**May**	**June**	**July**	**Aug**	**Sept**
No of 1st Appointments						
No of 4 week quits						
Month	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
No of 1st Appointments						
No of additional appointments Service Provider will have capacity to deliver						

APPENDIX C West Sussex Section 11 Self-Evaluation Tool in which demonstrates compliance with Section 11 of the Children Act 2004

SECTION 11 Self-Evaluation Toolkit 2018:

Guidance

1. What is section 11?

Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children and young people. Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

The Local Safeguarding Children Boards Regulations 2006 requires LSCBs to monitor and evaluate the effectiveness of what is done to safeguard and promote the welfare of children and advising organisations on ways to improve. All organisations will therefore be asked to complete a self assessment and provide evidence of how they comply with s11 when carrying out their day-to-day business. This audit will give an indication of how well organisations are working to keep children safe. The audits will be repeated biennially, and agencies will be asked to develop action plans to address any weaknesses identified.

It is important to remember that s11 does not give agencies any new functions, nor does it override their existing functions. Instead, it requires organisations to carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children.

The guidance is intended to assist in completing the s11 audit. The audit is an opportunity for each agency to demonstrate compliance with statutory guidance. It provides examples of evidence that may be relevant when considering minimum safeguarding arrangements. This document is designed not only to assist in completing the audit toolkit, but also to provide a multi-agency benchmark through the use of a common language. It is hoped that this will create a more consistent approach to considering safeguarding arrangements, at a strategic level, when addressing expectations across Brighton & Hove, East and West Sussex.

2. Who does section 11 apply to?

In accordance with *Working Together to Safeguard Children 2015*, s11 compliance is a mandatory requirement for the following key organisations:

- Local authorities and district councils that provide children's and other types of services, including children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services
- NHS organisations including the NHS Commissioning Board, Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts
- The police, including police and crime commissioners and the chief officer of police for the police area
- British Transport Police
- The Probation Services
- Providers of probation services required under section 3(2) of the Offender Management Act 2007 to act as a relevant partner of a local authority
- The Secretary of State in relation to his functions under sections 2 and 3 of the Offender Management Act 2007
- Governor of a prison or secure training centre, or in the case of a contracted out prison or secure training centre, its director
- Youth Offending Team/services
- United Kingdom Border Agency (under section 55 of the Borders, Citizenship and Immigration Act 2009)
- Contracted services, including those provided by voluntary services

However, each of the Sussex Local Safeguarding Children Boards (LSCBs) may require all of their respective member organisations not listed above to also complete the s11 audit.

If your agency's core business is not explicitly and directly to work with children and young people, it will be necessary to consider how your agency does come into contact with them in order to make a judgement about your agency's systems, structures, ability and capacity to safeguard and promote their welfare. Examples may include how a worker employed by adult services responds to a distressed child when undertaking a home visit to the adult client, or what actions a probation worker might take when working with an offender if concerned about a child. These two examples may be useful to consider, not only about the action the worker might take, but also about whether the wider organisational structure and systems are in place to support any action, i.e. as reflected throughout the Standards.

These issues, while likely to be part of your statutory function under s11 of the Children Act 2004, will also apply to services your agency commissions. You will therefore need to

consider whether your commissioning arrangements are sufficiently robust and address the need to safeguard and promote the welfare of children based upon these standards.

3. How to complete the section 11 audit tool

The s11 self-evaluation exercise covers nine key areas. Within each of these areas there are a number of standards that the agency should meet.

- To complete the tool, **evidence** should be given that would demonstrate how your agency meets each of the standards. Below are some examples, which may help you when thinking about how to evidence the ways in which your organisation complies with s11. They are intended as a guide only and are not an exhaustive list.
- It is important that the evidence you provide is detailed enough to enable any follow-up work to identify quickly the protocols, guidance or systems that are referred to in the evidence. Any **documentary evidence**, eg job descriptions, policies, procedures, should be included in your return.
- Use the **self-assessment rating** given below to rate how well the organisation meets individual standards within each of the areas.
- The s11 self-evaluation is a supportive process allowing each agency to identify the standards that they meet and those where further actions are needed. If, when completing the tool, you identify areas where your organisation is not complying fully with a standard, please identify what **steps are needed to meet the standard and the timescales** this will be achieved within.

6

7 4. Self-assessment rating

The traffic light system relates to how an organisation assesses itself against achieving the minimum standard. If your organisation assesses itself as red or amber, areas for development need to be recorded along with a timescale for completion on the separate action plan. It is worth noting that the scope of this model does not allow the demonstration of exceeding the minimum requirements, however we welcome you highlighting any best practice which you think could be shared with other agencies. A score of 'green', therefore, is understood to mean that the organisation meets the required minimum standard.

RED	Indicates that processes are lacking and need to be developed as a matter of urgency in order to meet minimum requirements for a specific standard.
AMBER	Indicates that processes are in place but they need to be reviewed or further improved for a specific standard.
GREEN	Indicates that the agency meets the standard fully with all processes in place and up to date, at least to the required minimum.

Each Sussex LSCB will collate responses from organisations participating in the s11 self-evaluation for their area and prepare a report for submission to the Board. The report will look at how well the LSCB area as a whole demonstrates that it can meet each s11 standard.

In order to assess LSCB area-wide compliance with standards, the following convention will be used to give an overall RAG rating for each standard for the LSCB as a whole, based on the responses of the participating agencies.

RED	More than a third of the agencies (> 33%) taking part rated a specific standard AMBER or RED.
AMBER	Between 20 to 33% of agencies rated a specific standard AMBER or RED.
GREEN	All agencies rated a specific standard GREEN or only less than 20% of the agencies rated a specific standard AMBER or RED.

For example, if 12 agencies participated in the self-evaluation exercise for the LSCB, and three of the agencies rated themselves 'amber' and two rated themselves 'red' for standard 6.2 (five agencies in total - 42%), the overall rating for the LSCB as a whole for this standard would be 'red'. If three of the agencies (25%) rated themselves 'amber' or 'red' for standard 2.3, the overall rating for the LSCB for this standard would be 'amber'. If two agencies (17%) rated themselves 'amber' or 'red' for standard 1.5, the overall rating for the LSCB for this standard would be 'green'.

Individual agency action plans will be monitored periodically by the LSCB and progress reported to the Board until all standards are rated 'green' for the LSCB as a whole. In addition, individual agency responses may be audited by other LSCB members in order to provide greater scrutiny through peer review.

The s11 self-evaluation is repeated every two years. Therefore, agencies will be asked to show progress on any standards that had a final rating of 'amber' or 'red' at the previous self-evaluation.

5. Examples of evidence that can be used to demonstrate compliance with section 11 standards

1) Senior management commitment to the importance of safeguarding and promoting children's welfare

Evidence:

1.1 The name of the person; they are named within the organisation's child protection policy.

1.2 The role of the designated lead with safeguarding responsibility is promoted regularly, including their job role; regular promotion of role within and external to organisation; named in safeguarding policies.

1.3 An up-to-date job description of the designated lead contains roles and responsibilities in relation to safeguarding and promoting welfare of children and young people; details of the regular training and supervision that they receive.

1.4 Routine audit and evaluation of work undertaken within agency to safeguard and promote the welfare of children, action planning and implementation to improve standards.

1.5 Checks are made by the commissioning body; relevant information is included in contracts.

2) A clear statement of the agency's responsibilities towards children is available for all staff

Evidence:

2.1 Child protection policies and procedures are in place and the date of the last review.

2.2 How safeguarding policies/procedures are disseminated to staff (eg in newsletters, emails, inclusion in team meetings, staff training); the format of the policies/procedures in the workplace and staff's access to these; policies and procedures are made available to all staff, volunteers, students, trustees and senior managers.

2.3 Child protection policies, procedures and guidance include online safety for staff (acceptable use of IT) and for children (how to stay safe online); the date of the last review of policies, procedures and guidance.

2.4 The organisation has clear complaints procedures for service users and staff; these procedures are understandable and easy to follow; how these procedures have been distributed and disseminated; evaluations/audits of the use of the complaints system; information on the expected timescale for responses to complaints; examples/reviews to demonstrate that complaints procedures have been used by adult and child service users and staff; evidence of guidance on how to make a complaint written in child-friendly language and format, e.g. leaflets, web pages, DVDs, etc.

2.5 The organisation has clear whistleblowing procedures which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct. These procedures enable staff and service users (adult and child) to confidentially report any concerns they have about an individual's practice or behaviour, and/or organisations practice in relation to children at risk, which may place them at risk of harm.

3) A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children

Evidence:

3.1 Name of the framework and when this was last reviewed; details of what the framework includes; safeguarding structure document; evidence of how staff are made aware of this.

3.2 The name of the person to whom each staff member is accountable is documented in staff procedures/welcome pack; examples demonstrating that staff are aware of the level of accountability they have.

3.3 Job descriptions and person specifications in place that recognise responsibilities for safeguarding and child protection. Clear written accountability framework that covers individual, professional and organisational accountability and which is widely disseminated.

4) Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families

Evidence:

4.1 The wishes and feelings of children, including those who cannot represent their views themselves, are regularly sought and recorded. These can be evidenced in decisions that relate to **them**.

4.2 Where statutory guidance requires, monitoring and recording systems capture that children are regularly seen.

4.3 Equality of access to services is monitored, audits undertaken of awareness of thresholds for intervention; agency ensures participation and user engagement from children, young people and their families is strong, with the involvement being genuinely sought, achieved and valued e.g. consultation and stakeholder engagement events, development of participation and engagement strategies **& how this informs service decision making and service delivery**; details of any initiatives that demonstrate that the agency is committed to continuing/ strengthening participation and engagement with children and young people and their families.

4.4 Information provided is in a format and language that can be easily understood by all service users. Different methods of communication are available to all children, including those with additional needs, to express their views.

4.5 Interventions take place at an early point when difficulties and problems are identified.

4.6 Staff feedback is considered in relation to the quality of service provision, e.g. through supervision, training, online methods, questionnaires, forums, etc.

5) Staff training on safeguarding and promoting the welfare of children for all staff working with, or, depending on the agency's primary functions, in contact with children and families

Evidence:

5.1 Outline of the induction process and training for new starters; information that is included in an induction folder for new starters; information on the content of induction training and that it meets all the requirements.

5.2 A record is kept of numbers **and percentages** of staff who have undertaken training on child protection and who holds this record.

5.3 Details of training available for staff, including multi-agency training; details of training pathways.

5.4 Safeguarding training includes how racial heritage, language, religion, faith, LGBTQ and disability are taken into account when working with a child and their family; staff are 'culturally competent' and understand how diversity, beliefs and values of children and families may influence the identification, prevention and response to safeguarding concerns.

5.5 Safeguarding training includes how a child's disability may influence the identification, prevention and response to safeguarding concerns.

5.6 There is guidance regarding mechanisms for reflective practice / learning from critical incidents / monitoring / supervision; evidence that senior managers monitor these arrangements; the information that staff receive about any further support that is available.

5.7 How the recommendations from serious case, learning or partnership reviews are shared with staff, e.g. newsletters, staff email updates; evidence of updating staff about changes to statutory requirements and how this is achieved; examples of how the most recent recommendations/requirements have been shared.

6) Safer recruitment

Evidence:

6.1 A safer recruitment policy is in place. Safer recruitment training is provided; records of recruitment panels are maintained by the organisation, including which member on the panel had completed safer recruitment training; audits of recruitment panels to evaluate compliance.

6.2 (and 6.4) Policies and protocols in place which outline the checks to be made before a person is appointed; staff personnel files document all the listed checks that were undertaken and the outcomes of these; audits of personnel files to ensure checks are being carried out appropriately; guidance for commissioned service providers specifying their responsibilities.

7.5 Organisational guidance, policy; name of officer responsible for referral; examples of the work being undertaken.

7.6 Name of the senior officer.

7.7 Information on the procedures used by the organisation when dealing with allegations against staff and volunteers, e.g. those developed in- house or county-wide procedures.

7.8 Where incidents are recorded (it is expected that incidents are recorded and stay on individual personnel files for ten years or until retirement, whichever is longer); retention periods for personnel file (e.g. provide retention schedule for relevant records).

7) Effective inter-agency working to safeguard and promote the welfare of children

Evidence:

7.1 That a senior officer attends meetings, or sends a deputy. Officers attend operational executive and/or other LSCB sub-groups regularly.

7.2 Policies used to support inter-agency working; where these are located and steps taken to ensure staff are aware of and working to these policies, e.g. terms of reference.

7.3 Staff working with children and families attend meetings/panels in relation to individual children, for example, core groups, child protection conferences, child-in-need meetings, etc.

7.4-7.5 Training and guidance for staff (covers when to make referral and when to refer to children and family services).

7.6 Participation in serious case, multi-agency and partnership reviews; if not needed in previous reviews, then this should be documented with any evidence of involvement in internal reviews/procedural reviews.

7.6 – 7.7 Information on the procedures and systems in place within the organisation that cover the aspects listed.

8) Information Sharing & Data Management

Evidence:

8.1-8.2 Details of the guidance used and the arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the LSCB

8.3 – 8.4 How guidance and training on information sharing are made available to staff (both at induction and for existing staff). Evidence of key safeguarding messages being disseminated via training, such as no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. Training or guidance available for staff and managers; staff know where to go if they have a query or concern about information sharing.

8.5 Consent to share information and situations when consent is not needed are covered in the training and guidance issued; evidence of consent and information sharing covered in supervision / management processes or appraisals.

8.6 Details about how staff are empowered / have the skills to involve parents and carers in discussions about consent and how children are supported and encouraged to discuss concerns about information sharing with parents/carers.

8.7 Outline details of record keeping and information security policies and how they are disseminated to staff; outline details of how record keeping guidance includes messages about accurate record keeping being an integral and important part of safeguarding practice and any reinforcement that all conversations, including casual conversations, which impact on decision making, are recorded.

8.8 Details of the guidance for staff to retrieve historical information – either stored electronically or in paper file on and offsite.

8.9 Details of record retention policies [with appropriate retention periods for client and personnel files.]

8.10 Details of how case management systems work at an individual practitioner and manager level to support with the management and prioritisation of incoming work, current and overdue tasks. Details of how such systems provide managers

with oversight of the timeliness and appropriate prioritisation of tasks by their staff.

9) Recognition and response to risk

Evidence:
9.1 – 9.3 Private Fostering

- Information for professionals about responsibilities relating to Private Fostering is easily accessible via the Pan Sussex Child Protection Procedures or via LSCB or work based websites
- Key staff access online and/or attend local training session.
- Leaflets for advice and guidance relating to Private Fostering are available for professionals, as well as for Parents, Children, and Private Foster Parents.
- Agency safeguarding policies include Private Fostering as an area of potential vulnerability for children.
- Access to legal advice is available to professionals, should this be required, in order to support Private Fostered children.

9.4 Consideration of Fathers and Other Significant Adult Males

Details of the guidance used; how guidance and training are made available to staff; quality assurance activity to ensure compliance with guidance (attach relevant documents as evidence). This standard relates to the **gathering** of family information, as well as **assessments**.

9.5 – 9.10 Child Exploitation

9.5 Policies for safeguarding and promoting the welfare of children and young people are compatible with the LSCB's guidance relating to child exploitation (including child sexual exploitation (CSE); preventative work through awareness raising activities or therapeutic outreach, including appropriate literature to target vulnerable young people (e.g. missing young people) and people whose work places them in a position where they will notice and could report worrying behaviours; codes of practice for staff with direct contact with children/young people at risk of child exploitation; procedures for reporting safeguarding concerns specifically mention child exploitation.

9.6 Managers and frontline staff attend LSCB training, or the safeguarding training and refresher training provided by the organisation includes an awareness of child exploitation and CSE, recording and retention of information, gathering evidence and information sharing.

9.7 - 9.9 Guidance/polices; steps taken to ensure staff are aware of and working to policy/guidance on child exploitation e.g. via quality assurance (QA) activity or framework. For example, case file audits evaluate whether professionals know

when/how to seek help and advice on child exploitation; they are aware of local protocols; they know how to recognise when a child is at risk of exploitation or is being exploited and understand the thresholds and timing for referral; they understand the routes and organisational procedures for referral; they know how to identify concerns about adults who may be perpetrators of exploitation.

If relevant, audits also evaluate whether staff know how to monitor online spaces where they have suspicions that a child is being groomed online and whether staff are aware of local geographical areas or locations that perpetrators tend to use to target potential victims.

QA activities evaluate whether assessments that address needs and welfare issues relating to children and young people always consider whether the risk of exploitation could be a factor and put in place targeted support to minimise risks; work is linked to the response to vulnerable young people, e.g. missing young people, children regularly absent from education, looked after children, young people misusing substances, etc and to other public protection issues.

QA activities evaluate attendance and engagement at local multi-agency meetings and processes in relation to individual cases; intervention as part of an agreed package of support for someone who is at risk of or suffering sexual exploitation; complying with requests for assistance from the police and other agencies, for example in helping to disrupt activity; proactive information sharing in the best interests of the child.

9.10 Evidence of any training or staff awareness raising which includes child trafficking and modern slavery (indicators and signs) and how professionals should respond.

- Relevant agencies are aware of their 'duty to notify' the Home Office of incidences of modern slavery using the National Referral Form.
- Further information is available on the NSPCC's Child Trafficking Advice Centre: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-trafficking/helping-children/#leaflets

9.11 – 9.14 PREVENT / Risk Of Young People Being Drawn Into Terrorist Related Activities

9.11 Details on the Prevent duties for specified authorities and risk assessment, if risks have been identified, in order to mitigate threat, risk and harm are available here: (HM Government Prevent Duty Guidance). Guidance issued by the Home Office identifies best practice for each of the main sectors and describes ways in which they can comply with the duty.

9.12 The name of the person; they are named within the organisation's relevant policy; evidence that staff are aware of this person's role and responsibility within the organisation.

9.13 Evidence that any statutory and mandatory induction and updating programmes contain Prevent awareness training. Managers and frontline staff have access to training which includes support to recognise and respond to the threat of children and young people being drawn into terrorism; sets out the referral process for children and young people who are vulnerable to radicalisation and/or who may be at risk through living with or being in direct contact with known extremists. Any evidence of activity undertaken by the agency to evaluate whether professionals know when/how to seek help and advice, thresholds and timing for referrals, when they suspect children and young people are vulnerable to being drawn into terrorism. Evidence of any QA or similar activities that monitor and scrutinise attendance at multi-agency meetings in relation to individual cases

9.15 – 9.16 Harmful Traditional Practices, including Honour based Violence, Forced Marriages, Breast Ironing, Spirit Possession and Female Genital Mutilation

- Key staff, particularly frontline staff and their managers, access online and/or local training relating to Harmful Traditional Practices.
- Information, both written and electronic, about Harmful Traditional Practices are readily available to staff and service users, which may need to include capacity for this information to be in other languages.
- Harmful Traditional Practices are included in agency safeguarding policy and guidance.
- Statutory referral pathway, in particular for FGM, to Children's Services and the Police is clearly stated and understood.

9.17 – 9.19 Domestic Violence & Abuse

9.17 There is a designated lead for Domestic Violence and Abuse who is responsible for coordinating your agencies response to the early identification and intervention of DV&A. Policies for safeguarding and promoting the welfare of children and young people are compatible with the LSCB's guidance relating to Domestic Abuse, including recognition, response, assessment and intervention and the organisation promotes an environment encourages disclosure.

9.18 Managers and frontline staff have access to single and multi-agency Domestic Abuse training that covers the **impact** on children (including unborn children) who are exposed, the impact on non-abusive parents, the support available for children, the

support available for non-abusive parents to empower them to protect their children and promote their safety and recovery, as well as interventions with the abuser. Training addresses expectations around recording, retention of information, gathering evidence and information sharing. Depending on their role, Managers and frontline staff have access to levels of training as follows:

- Staff with day-to-day contact with service users: training to enable them to recognise indicators of Domestic Abuse and respond, by providing information on local and national services and make onward referral
- Staff working directly with service users: training to be able to routinely enquire and, where appropriate, assess what type of service someone needs, provide immediate safety advice and make onward referral
- Staff offering statutory/specialist integrated support: training to offer tailored interventions to meet a children or adults needs, working alongside specialist Domestic Abuse advocacy services.

9.19 Guidance/polices; steps taken to ensure staff are aware of and working to policy/guidance on Domestic Abuse, e.g. via quality assurance (QA) activity or framework. For example, case file audits evaluate whether professionals know when/how to seek help and advice on Domestic Abuse, including how to ask about Domestic Abuse, and how to act when there is a disclosure. This should include: protecting the children, including unborn children; empower the non-abusing parent to protect the children and promote their safety and recovery; taking steps / contributing to multi-agency responses to identify the abusing partner and hold him or her accountable for their abusive behaviour and provide opportunities to change this behaviour. Staff understand the thresholds and timing for referral; they understand the routes and organisational procedures for referral. **Attach relevant guidance and QA documents to the return.**

9.20 Safeguarding Children who do not attend school

- Key staff, particularly frontline staff and their managers, access online and/or local training relating to Hidden Children, including children missing education or those who are educated at home.
- Safeguarding training includes how a child not attending school may influence the identification, prevention and response to safeguarding concerns.
- Staff are aware of the importance of speaking to the child alone and/or visiting the child in their home.
- Staff are aware of the increased importance of speaking to other agencies who may be involved with the child and/or family to identify, prevent and respond to any safeguarding concerns.

9.21 – 9.22 Working with 'hard to engage' families

- There is a clear procedure for conducting a risk assessment and escalating to a senior manager when families refuse to engage, and there are concerns about the safety and protection of children. Quality assurance activity that demonstrates appropriate and timely escalation of concerns.
- Staff have access to training in 'disguised compliance' and/or counter-argument in safeguarding or this is included in safeguarding training.
- Relationship based practice is used to better engage at risk families and there is continuity of worker.
- Professionals are aware of how unresolved trauma may manifest in families being 'hard to engage'. They are able to identify this early and use trauma informed approaches.

9.23 – 9.26 Neglect

- Managers and frontline staff have access to single and multi-agency Neglect training that covers the **impact** on children, including the long-term cumulative effects.
- Staff are aware of and can confidently use local strategies and tools to identify and respond to neglect.
- Staff have a good understanding of local threshold documents, as evidenced by quality assurance activity, know when safeguarding intervention is required and how to make appropriate evidenced based referrals.
- Staff are provided with reflective supervision to give key focus and purpose to work.
- Staff have knowledge of where to access professional advice when dealing with neglect cases.
- Through quality assurance work there is evidence of improvement via the appropriate use of local assessment tools.

9.25 **Online Safety**

- Staff have access to multi-agency training on Online Safety that covers how the use of technology may be a significant component of a range of safeguarding issues, such as online grooming and radicalisation.

- Online safety is integrated within single agency safeguarding training. This includes how children may be exposed to illegal, inappropriate or harmful material online; how they can be subjected to harmful online interaction with other users; and how their personal online behaviour can place them at risk.
- There is an acceptable use of the internet/social media policy and staff are aware of how to protect their professional reputation online.

Appendix A: Providing Suitable Evidence – Sharing Examples of Good Practice

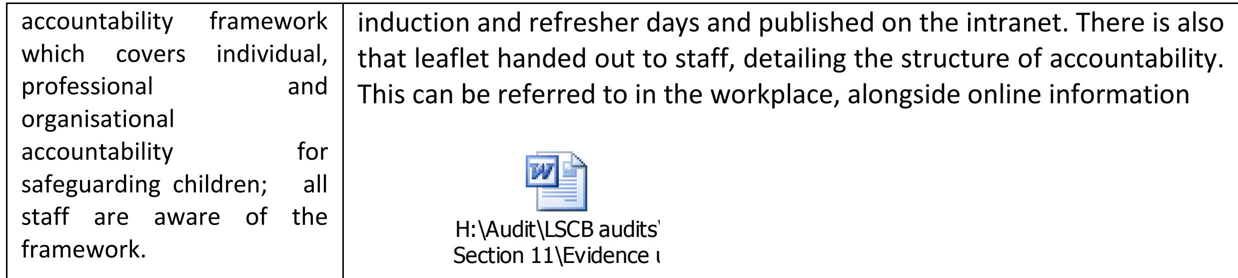
It is important to remember that the potential examples of evidence are not prescriptive and additional sources of evidence, activities and material may also provide valuable and credible sources of evidence in order to demonstrate compliance. Below are examples some good practice to bear in mind when completing your self-assessment.

Good Practice 1: Using narrative to explain what is in place within your agency/ what is being done to ensure that the standard is being met in a consistent way. This example tells a clear story about how the council is meeting this standard *(Mid Sussex District Council – 2014)*

Standard To Meet	Evidence to show that the standard has been met, maintained or improved
All staff and volunteers are made aware of the safeguarding policies and procedures and how they are applied in practice.	Keeping Children and Young People Safe is everyone's responsibility • All staff and volunteers are made aware of the safeguarding policy and procedures by: • Availability of policy and procedures on the intranet • Leaflets business cards and guidance notes upon induction • Training programme is in place including a new E Learning module for all staff to complete their basic level of knowledge • Posters are placed in council offices showing "what to do if" staff have a concern and it shows where staff can find the policy and procedures by having the website address on the posters • All contractors receive guidance on our safeguarding expectations. Regular attendance at team meetings as and when required to discuss procedures and concerns with staff teams as required • DO internal meetings held twice a year to disseminate changes and raise issues.

Practice 2: Embedding documents (or links to other websites) within your self-assessment toolkit works well to support evidence statements and provide evidence in their own right. *(Sussex Partnership NHS Foundation Trust)*

Standard To Meet	Evidence to show that the standard has been met, maintained or improved
The organisation has a clear	The Trust's safeguarding structure is clear, shared with all staff on

accountability framework which covers individual, professional and organisational accountability for safeguarding children; all staff are aware of the framework.	induction and refresher days and published on the intranet. There is also that leaflet handed out to staff, detailing the structure of accountability. This can be referred to in the workplace, alongside online information 

Good Practice 3: Describing how services work together in order to provide safeguarding support for children. ***(ESCC Transport and Operational Services – Transport Hub)***

Standard To Meet	Evidence to show that the standard has been met, maintained or improved
The work to address CSE is integrated into the wider work of your organisation, including addressing risks of CSE in all assessments.	The e-mailed safeguarding guidance was re-drafted 1 April 2014 to include reference to child sexual exploitation (CSE) and ensure that it includes the most up to date safeguarding information from the DFE. Although safeguarding is a regular subject of discussion in team communications the e-mail guidance will now be issued annually as a further reminder. The safeguarding officer is in regular contact with colleagues from the WiSE Team responsible for working with CSE. CSE information has been added to the regular training sessions provided to taxi crews who are being made aware of the valuable additional safeguards they can provided to vulnerable young people as 'eyes & ears;' in the community which links with the work that WiSE are engaged in with the taxi trade regarding the night time economy.

APPENDIX D– Service user satisfaction survey

<u>Stop Smoking Services Feedback Form</u>

It is important that Stop Smoking Services know if there is anything that they could do to improve or adapt the support that they provide to smokers during their quit attempt. Your views about this are very important to us and will be treated in the strictest confidence. The results of this survey will be used for research and service development purposes. **Please answer the following questions as honestly as you can, thank you!**

Please circle the appropriate number for each question:

Q1: Overall, how satisfied are you with the support you have received to stop smoking?

Very Unsatisfied	Unsatisfied	Satisfied	Extremely Satisfied
1	2	3	4

Q2: How likely are you to recommend the stop smoking service to others?

Very Unlikely	Unlikely	Likely	Extremely Likely
1	2	3	4

Q3: In the event you began to smoke again how likely would you be to return to the stop smoking service for further support?

Very Unlikely	Unlikely	Likely	Extremely Likely
1	2	3	4

Q4: Overall, how easy was it to contact your stop smoking service?

Very Challenging	Challenging	Easy	Extremely Easy
1	2	3	4

Q5: Overall, how satisfied were you with the process of arranging an appointment?

Very Unsatisfied	Unsatisfied	Satisfied	Extremely Satisfied
1	2	3	4

Q6: How satisfied were you with the appointment time of your stop smoking service provision?

Very Unsatisfied	Unsatisfied	Satisfied	Extremely Satisfied
1	2	3	4

Q7: How satisfied were you with the location of your stop smoking service provision?

Very Unsatisfied	Unsatisfied	Satisfied	Extremely Satisfied
1	2	3	4

Q8: How helpful did you find your stop smoking advisor?

Very Unhelpful	Unhelpful	Helpful	Extremely Helpful
1	2	3	4

Q9: How easy was it to get hold of your medicine once you had chosen which medication you were going to use for your stop smoking attempt?

Very Challenging	Challenging	Easy	Extremely Easy
1	2	3	4

If you scored **1** or **2** for any of the questions above, please explain why and make suggestions for improvement:

If you scored 3 or **4** for any of the questions above, please explain why: