SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	022
Service	Tier 3 Specialist Weight Management Service
Commissioner Lead	NHS Wirral CCG
Provider Lead	Wirral Community Health and Care NHS FoundationTrust
Period	01/04/2019 – 31/03/2020
Date of Review	01/12/2020

1. Population Needs

1.1 National/local context and evidence base

NHS England describes obesity and overweight as 'a global epidemic' with the World Health Organisation predicting that 2.3 billion adults will be overweight and more than 700 million obese in 2015. England has one of the highest prevalence's of obesity in the European Union. In 2010, a quarter of adults were classified as obese and this figure is increasing.

A recent report by the Local Democracy Think Tank (May 2015) states that the UK ranks 111th out of 133 countries in terms of obesity with nearly one in four people obese. The World Health Organisation projects that by 2030 nearly three-quarters of men and 64% of women in the UK will be overweight or obese. NHS England National Clinical Director of Obesity and Diabetes has recently reported that obesity is a crisis costing the NHS £10 bn a year. (Local Democracy Think Tank; Obesity-related health problems: the next great public health challenge, May 2015).

Obesity is directly associated with a number of medical conditions; these include but are not limited to: type 2 diabetes, metabolic syndrome, gallstones, cancer etc. It is estimated to lower life expectancy by 5-20 years.

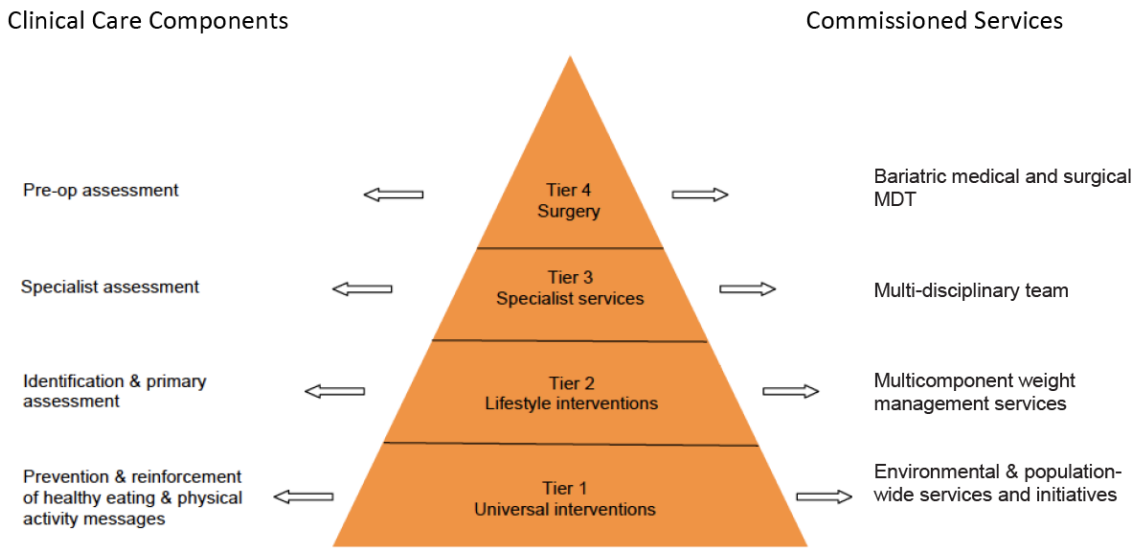
In Wirral, it is estimated that 65% of adults are of an unhealthy weight, with 26% being obese. The data also demonstrates that more deprived areas of Wirral are affected more strongly by obesity. This highlights the health inequalities present across the borough.

Wirral Council's Performance and Public Health Intelligence team have produced estimates of obesity and overweight prevalence in Wirral. This is against a total adult population (aged over 16) of 252,839. Please see below:

	Overweight	**Obese**	**Obese and overweight**
Men	53,396	31,342	84,738
Women	45,350	35,333	80,683
All	98,746	66,675	165,421

Source: Health Survey for England, 2012

The National model for managing obesity is outlined below:



Commissioning Guide: Weight assessment and management clinics (tier3), March 2014.

The commissioning responsibility for each tier is broken down below:

Tier 1 – Local Authority Public Health
Tier 2 – Local Authority Public Health
Tier 3 – Clinical Commissioning Group
Tier 4 – NHS England

This service specification relates to the Tier 3 service for adult obesity; providing specialist services in line with NHS England Policy and NICE Guidance.

This will be an integrated service with a number of providers contributing to delivery of this specification. NICE published guidance (PH11) in July 2010 for weight management before, during and after pregnancy. While women that are pregnant are not recommended to lose weight, it is still advised that they have access to appropriately qualified professionals to advise them throughout their pregnancy and ensure weight maintenance as the clinical goal. It is essential that all providers of tier 3 services work together and work closely with tier 1, 2 and 4 providers.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

The outcomes below are expected for this Service:

- high quality weight management programme for overweight and obese adults
- significant weight loss achieved by clients attending programme (reduced 'Body Mass Index' - BMI)

- reduction in sedentary behaviour
- reduction in burden of obesity related co-morbidities
- improved quality of life and self-esteem for clients
- long term behaviour change of clients who have undertaken full programme
- reduction in prescriptions for anti-obesity drugs
- equitable access and outcomes across target population
- compliance with CCG responsibilities for commissioning a tier 3 service.

3. Scope

3.1 Aims and objectives of service

The overarching aim of the Service is to provide a high quality programme to support adults who: are overweight/obese with complex co-morbidities through the provision of evidence based quality weight management interventions to adults (18 and over) who have a BMI of >39.9 with co-morbidities that require complex management.

The Service will encourage life-long behavior changes for clients in relation to eating and physical exercise. The broad objectives of the Service are:

- to promote long term behaviour change in clients
- to provide psychological support to enable people to understand and change behaviour
- to provide intervention options which include the offer of a range of delivery methods and education styles including opportunities for clients to learn apply learning, share and reflect their experiences.

The following interventions will be expected to be available as options within the tier 3 service:

- ***Multi Component Lifestyle Weight Management Intensive phase*** for clients, to be delivered over a maximum of 12 to 18 months, predominantly in a group setting although individual sessions should be accommodated where appropriate and at the discretion of the Service. This phase will cover a range of evidenced education and interventions that aim to assist clients to achieve weight management goals and outcomes. It is expected these interventions will support achievement of motivational, self-help skills and mental wellbeing goals.

- ***Nutrition Programme*** where the client is supported to make changes to their individual dietary requirements; inclusive of food preferences and flexible approaches to reducing calorie intake. Prescribed diets should not use unduly restrictive and nutritionally unbalanced diets due to long term ineffectiveness and potential harm. Clients should move towards eating a balanced diet, consistent with evidenced healthy eating advice; NICE PH53 and be reflective of cultural, religious and health needs.

- ***Maternity programme*** to provide information and advice to pregnant women around healthy eating and physical activity. The objective is not to lose weight but support women to improve their diet, continue or start to be physically active throughout their pregnancy and to monitor a woman's weight over the pregnancy to prevent excessive weight gain. The provider should keep in contact with the client and refer or signpost into local a weight management programme post birth (6 weeks).

- ***Programme of psychological support*** to be provided for clients who, following a *Multi-Disciplinary Assessment*, including a psychological assessment, are identified as requiring psychological intervention prior to the commencement of other tier 3 interventions. The psychologist will, where necessary recommend referrals to primary or secondary care mental health teams for additional support. NB: a small proportion (1%) of assessed participants may have personality disorders or extreme social anxiety.

- ***Pharmacotherapy provision,*** the tier 3 service will make recommendation for orlistat or other appropriate anti-obesity drug where appropriate following assessment. The monitoring and management of clients prescribed with orlistat or other appropriate anti-obesity drug via the clients GP should be undertaken by the tier 3 service.

  As part of the communication process/ tier 3 information referral pack, GP's are strongly recommended to prescribe orlistat to clients only as part of the tier 3 service. Appropriate monitoring and on-going assessment should occur as clinically necessary throughout the programme (pre intervention, post

intensive phase and on completion of the follow on phase).
The provider will liaise with clients' GPs to notify and request the appropriate pathology investigations including random glucose, fasting lipids, liver function tests, renal function tests and TSH testing as a minimum.

The service will also screen for the presence of obesogenic medication and its potential effects on weight management. This will be discussed with the client's GP to ensure an MDA approach to client care.

- ***Follow on intervention (from 12 on completion of the intensive phase)*** may take the form of a drop in session, for others it should be more involved and offer a structured programme of physical activity with support to maintain healthy eating and other behaviour changes and improvements. The service will provide a regular and frequent drop in session for clients to provide a weighing service and an opportunity to meet a dietician/nutritionist and/or a physical activity specialist, these sessions are also to be supported by workers with skills to help maintain client's motivation / adherence to the programme.

- Reduce number of people living with obesity, improving long term health outcomes
- Improve the health outcomes for individuals who are obese by supporting them to achieve a range of weight management, behaviour change and motivational outcomes over a 12-18 months
- Provide an integrated and holistic offer which motivates, empowers and facilitates individuals to achieve sustainable weight management outcomes, improvement in levels of physical activity and nutrition and increases in self-confidence and self-efficacy.
- Facilitate the achievement of weight management goals with clients.
- Ensure there is appropriate prescribing of anti-obesity drugs combined with lifestyle and behaviour change interventions within the programme.
- Actively manage clients in the weight management pathway in order to offer an option to bariatric surgery in line with NICE guidance and to act as a gatekeeper for access to bariatric surgery.
- Support clients into other weight management support programmes as an agreed part of the client's weight management pathway.
- Prepare clinically appropriate clients for bariatric surgery; supporting them to understand the risks of surgery, the need for behaviour change and support decision making process
- Ensure there is appropriate prescribing of anti-obesity drugs combined with lifestyle and behaviour change interventions within the programme.

Client Tracking
The individual action plan for each client and goals would be expected to be monitored throughout the tier 3 programme. Progress should be recorded against all aspects of the action plan with a view to capturing data to demonstrate the effectiveness of individual interventions and the overall service.

Assessment will cover:
- Reduction in weight and BMI or weight maintenance
- Reduction in body fatness e.g. waist circumference
- Improvements in blood pressure and other health assessments as appropriate
- Positive changes in dietary habits, physical activity and sedentary behaviour
- Improvement in self-esteem and mental wellbeing
- Prevention of excessive weight gain (pregnant women)

Appropriate validated tools or other robust tools should be used consistently to verify the outcomes achieved by clients. Feedback and communication to the Commissioner on a quarterly basis.

An assessment will be undertaken for each client, as a minimum at baseline, part way through the intensive phase, at the end of the intensive phase, regularly during the follow on intervention and at the end of the follow on intervention. The assessments of progress at completion of the intensive intervention and completion of the follow on intervention will be comprehensive. Assessments at 'part way' intervals can be shorter versions, but need to capture core measures (weight change, changes in associated behaviour, self-esteem).

The Providers of Tier 3 services will be part of a continuous pathway of care which will include the patient's GP, local weight management services commissioned by the Local Authority and specialist secondary care obesity services including bariatric surgery.

3.2 Service description/care pathway

NICE guidelines indicate that adults who are severely obese should have access to a range of services, which include tier 3 services. The service should have the capacity to support the individuals and their carers in addressing their weight and weight related needs.

The 'Provider' will:

- Provide referred clients with a multi-disciplinary assessment to set base line measures and to identify the client goals. This will inform the design and delivery of the client's programme in the service
- Engage the client in an 'intensive' multi component programme, to build motivation for change and to achieve weight management goals. It is anticipated this intensive intervention will be delivered over a period of 12 to 18 months
- Apply innovative and creative solutions to embed change, to set and achieve further weight management goals where appropriate and sustain behaviour changes
- Where appropriate, the provider will identify other step down pathways to support clients, which may involve collaborating with local providers of weight management programmes. These may be offered to clients within the follow on intervention.
- Recruit and provide ongoing staff continuous professional development and supervision to ensure a competent and skilled workforce.
- Ensure all staff are DBS checked and have the relevant qualifications commensurate with role and responsibility.
- Keep accurate participant data to measure programme aims on deliverability and acceptability.
- Put in place client confidentiality and data protection/ transfer protocols and systems.
- Ascertain participant's views and comments via surveys and focus groups to help inform further developments and promotion of the service.
- Coordinate and provide written quarterly progress reports against the key performance indicators and other aspects of service delivery as part of the performance management arrangements.
- Provide reporting data as accumulative as well as by the respective areas.
- Keep accurate up to date expenditure against the Service Specification Financial Plan.
- The Provider will make reference to the CCGs or Local Authorities as the commissioners of the service in all press releases, articles, presentations, web information and other publicity and communication where the service is cited.

The services provided will include the following in a community based setting:

- Initial appointment and assessment to look at changing behaviour, motivation and goal setting.
- Commencement of a 12-18 month weight loss course to include access to Gym facilities. This will build on weight loss management provided in tier 1 and 2 services.
- Where it is clear that the patient has unresolved psychological or mental health problems that are likely to prevent them fully engaging with the programme; clients should be referred to psychological services (e.g. CBT) for assessment and treatment prior to or in conjunction with the weight management programme, e.g. psychological assessment.
- If a decision is made for the patient not to continue with the weight management programme; the referrer must be informed within 5 working days.
- An individually tailored programme will be drawn up for each patient to best support their needs and goals. The Provider (Wirral Community Trust) will be responsible for providing co-ordinated access to:
    - Specialist Bariatric Physician (Assessment including sleep studies etc. if clinically appropriate)
    - Specialist Bariatric Nurse to support Specialist physician (including initial assessment of medication, height and weight, blood tests (biochemistry and haematology) and ECG test
    - Bariatric Dietician (Assessment and Follow Ups)
    - Physiologist (Assessment and Follow Ups)
    - Access to CWP Psychological (Assessment and Follow Ups) including pre-operative assessment
- Support groups should be established by the providers
- An MDT will consider a full evaluation of the patient both in terms of progress throughout the programme and next steps. This will include but is not limited to assessment of the following key elements:
    - Patient age and general level of health
    - Existing co-morbidities and their reversibility
    - Risk of future co-morbidities and their reversibility
    - Anticipated weight loss

- Compliance with tier 1-3 services and chance of long term behaviour change

Alternatives if bariatric surgery isn't undertaken

- Consideration of any contraindications for surgery e.g. uncontrolled disease, recent myocardial infarction/awaiting results, uncontrolled arrhythmia compromising cardiac function, BP at rest above 180mg systolic or 120mg diastolic, unstable psychiatric disorder, acute infection.
- Risk of peri-operative mortality
- Risk of post-operative complications of bariatric surgery
- Recommendation for discharge or referral to tier 4 services

- The MDT will include, as a minimum:
  - Bariatric Dietician
  - Bariatric Physician
  - Specialist bariatric nurse
  - Psychologist
  - Other relevant specialists specific to patient needs

The Provider must ensure each patient participating in the Tier 3 weight management programme has access to:

- A named therapist who will oversee their weight management programme
- A named contact (buddy) who will contact them via telephone, email, text or letter as often as required by patient
- Support and education to make healthy choices and ongoing encouragement to embed these changes within the patient's everyday life
- Advice on behaviour change techniques e.g. keeping a food/exercise journal
- Support to make realistic goals that can be achieved and maintained
- Support to regain independence and self-manage and monitor own weight
- Emotional and wellbeing support to boost self-esteem
- Information and signposting to other services that will complement the programme
- Support to develop coping skills and ability to overcome difficulties

Services are expected to establish programmes across Wirral to tackle the health inequalities noted earlier in the specification. The service should target the most deprived areas and must be located in a convenient, easily accessible location.

Where the patient has established complex co-morbidities; these should be managed by the patient's GP alongside this programme.

The service must ensure it has clearly established links and referral protocols with tiers 1, 2 and 4.

Follow up and discharge arrangements

It is not anticipated that clients will receive ongoing follow up after completion of their programme. However it may be appropriate for them to continue attending support groups. Clients should be signposted to other services that may support their ongoing healthy lifestyle.

Clients should be discharged back to their GP with a comprehensive discharge summary and treatment plan including any follow up requirements (as appropriate).

Clients deemed eligible for tier 4 services by the MDT should be referred to the tier 4 Provider with GP copied into referral.

Equity and Access

The provider must ensure:

- Services are delivered from convenient locations with easy access via public transport
- Flexible operating hours to accommodate working clients i.e. provision in evenings and weekends
- Services should be tailored to individual needs of different groups and communities
- Variety of options for clients to choose from; group sessions, 1:1s, support sessions etc.
- Respect and recognition of seen and unseen needs of target groups which include: gender, cultural, faith groups, disability, black and ethnic minority groups and sexuality
- Provider must complete an annual Equality Impact Assessment

Staff
The Provider must ensure that all staff are adequately trained and competence is maintained and developed; this includes registration with appropriate professional body(s). Supervision and Mentorship arrangements should be agreed and set in place. The Provider will ensure regular audit, patient satisfaction and personal appraisal are carried out. Appraisal should be carried out in accordance with National requirements for clinical staff. Staff are required to be DBS checked.

Clinical Governance
The Provider must have procedures in place to ensure Clinical Governance of the service. This includes but is not limited to ensuring clinical effectiveness, through evidence based best practice, staff competence, risk management and accurate/up to date record keeping. A clinical lead must be identified to take responsibility for the clinical governance of the service. The Provider should hold a Clinical Governance work plan that is monitored regularly.

Provider responsibilities
The Provider will be responsible for:
- Ensuring adequate and appropriately trained staff coverage at all times
- Purchase and maintenance of all equipment and consumables used by the service
- Protection of personal data in accordance with the Data Protection Act, 1998
- Ensuring premises are appropriate, accessible and CQC compliant
- Ensuring equal access to services, including provision for clients for whom English is not their first language, and those with a physical or learning disability
- Compliance with all local and national infection control standards. The Provider must have infection control policies that are compliant with national guidelines
- Ensuring appropriate indemnity cover from a medical defence organisation or the NHS Litigation Authority

The Provider must work with commissioners to ensure integrated weight management services are achieved.

3.3 Population covered
The service described above is for clients residing within Wirral and/or clients registered with a Wirral GP.

This service is for adults (aged 18 years and above) with a BMI ≥ 39.9 with co-morbidities that require complex management.

3.4 Any acceptance and exclusion criteria and thresholds
Inclusions
- Referrals will only be considered for adults (aged 18 years and above) as a treatment option of clients with obesity, BMI ≥39.9 with co-morbidities that require complex management, such as type 2 diabetes.

Referrals will only be accepted for clients who have complied with tier 1-2 weight management services and are motivated to change. This will include both clients who are seeking bariatric surgery and those who are not.

Referrals will be accepted from GPs and tier 2 Providers only.

Exclusions
The service will not accept referrals for clients with a BMI below 39.9.
The service will not accept referrals for clients who have failed to attend/comply with tier 1/tier 2 services.
Clients who are residing in Wirral/not registered with a Wirral GP
Clients who are not motivated to change and/or who are not able to comply with the programme.

3.5 Interdependence with other services/providers
The Provider should work with the following to support delivery of this service:
- Wirral CCG
- Wirral GP Practices
- CWP
- IAPT and other psychological services
- Wirral Patient forums

- Tier 1 and Tier 2 service providers
- Tier 4 service providers

This list is not exhaustive, Providers must work with any other organisations required to facilitate patient care.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- NICE at: www.nice.org.uk/Guidance/CG43. – Obesity prevention
- NICE at. www.nice.org.uk/Guidance/PH53 – Weight management: lifestyle services for overweight or obsess adults
- NICE Clinical Guidance 189: Obesity: identification, assessment and management of overweight and obesity in children, young people and adults. November 2014
- NICE at: www.nice.org.uk/Guidance/PH11 - Maternal and child nutrition

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Royal College of Surgeons & British Obesity & Metabolic Surgery Society, 2014, Commissioning Guide: Weight assessment and management clinics (tier 3)

4.3 Applicable local standards

- The operational systems will support the following principles
    - Clear lines of responsibility and accountability
    - A programme of quality improvement activities
    - Clear policies, procedures, clinical protocols, patient groups directions and algorithms aimed at managing risk and remedy poor professional performance
    - The provider will act on any recommendation in any Care Quality Commission report that the Independent Regulator requires to be implemented
    - Results and recommendations from annual Care Quality Commission and audits will be built into a programme of continual improvement and shared with the commissioner as part of the annual governance report.
    - The provider will ensure that a process is in place to carry out DBS checks on all staff legally required and annual professional registration checks are carried out for all clinical staff. All doctors will be registered licensed practitioners.

- Improve access to the tier 3 service, via increased learning disability awareness training
- Work with GP surgeries, hospitals and other health services to ensure that the particular needs of people with a Learning Disability are taken into account in their services, for example by providing longer appointment times and appropriate signage (reasonable adjustments).

4.4 Safeguarding

Applicable Local Standards

Safeguarding

- On occasions the team will assess and make an appropriate referral to social services if there are any concerns regarding safeguarding children, vulnerable adults, and other family members.
- Team members will contribute to the delivery of multi-agency safeguarding plans as appropriate
- Staffing structures must be in place to ensure induction of new staff and on-going case and clinical supervision of all staff. This must include safeguarding supervision from an appropriately qualified professional.

Safeguarding training

- The provider safeguarding team will ensure staff receive safeguarding training in accordance with statutory guidance “Safeguarding Children and Young People: roles and competences for healthcare staff (2010)” & “National Competence Framework for Safeguarding Adults endorsed by Learn to Care- Skills for care- Social Care Institute for Excellence (Galpin & Morrison: Bournemouth University (2010)”
- The provider must ensure the delivery of a comprehensive annual continuing professional development programme for all staff, ensuring within six months of joining:

- Staff attend multi-agency safeguarding training at the appropriate level, for children and adults.

Applicable Local Standards

- Wirral Safeguarding Adult Partnership Board Policies and Procedures
- Wirral MARAC policy and procedure
- Wirral CCG (2015) Commissioned Services Standards for Safeguarding Children and Adults at risk Policy.

Applicable National Standards

- Working Together to Safeguard Children (DE/DH 2010/2013)
- Children Act 1989 & 2004
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Care Act 2014
- Mental Capacity Act & Deprivation of Liberty Safeguards (2005)
- NICE CG89: When to suspect child maltreatment (2009/2013)

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

All providers will be required to comply with all sections in the NHS Standard contract.

NHS Providers have a duty to apply reasonable adjustments for all learning disabilities and impairments and across all functions (not just communications). Rusts are required to promote understanding of reasonable adjustments by utilising appropriate guidance and tools, such as those provided to:

- Improve understanding and awareness
- Identify steps and measures needed to develop and implement RA across a range of relevant Trust services
- Work progressively and positively in partnership with disability groups

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

Wirral Community NHS Trust
Wing 5
Ground Floor
St Catherine's Health Centre
Derby Road
Birkenhead
CH42 0LQ

7. Individual Service User Placement

Monitoring and Evaluations - Outcome Measures and Key Performance Indicators

Outcome	Evidence
Efficient and effective weight reduction • 60% clients demonstrate at least 5% weight loss at 6 months • 80% clients demonstrate weight loss throughout programme	Annual Audit reports to show percentage of clients achieving 5% weight loss at 6 months
Reduction in sedentary behaviour • Sustained increase in daily activity	IPAQ to be completed within initial assessment for benchmark data. This should be repeated at 3 and 6 months to demonstrate sustained

and sustained reduction in sedentary behaviour	increased activity. Benchmark IPAQ completion rates to be reported quarterly. Annual audit report to demonstrate outcome i.e. number of people moving to 150 minutes per week.
Improved dietary intake	Measured using a validated tool to be determined by provider and agreed by commissioner
Equitable access and outcomes within target population	Annual Equality Impact Assessment to be carried out and reported within annual audit report
Waiting times and access • 100% of clients to be contacted within 2 weeks of referral and offered an appointment to start the programme.	Monthly KPI data reports
Patient satisfaction and improved quality of life • 50% who complete 3 months to complete patient satisfaction survey • 85% of client's report positive satisfaction with the service • 30% of clients who fail to complete 3 months to complete questionnaire	To be reported monthly with annual audit demonstrating final achievement and summary of results and action taken. Complaints and compliments to be re Measure 'opt-in' rates; Did Not Attend (DNA) rates including DNA even once; stratified by gender and ethnic origin, to assess equality of access reported monthly

Service Indicators	**Target**		
100% clients to be contacted within 10 working days of referral and offered appointment	100%	99 – 95%	<95%
100% clients to receive appointment within 20 working days	98%	97 – 95%	<95%

Information requirements

Indicator	Frequency of reporting	Provided to	Consequence of breach
Total number of referrals received broken down by referrer i.e. tier 2 provider and GP	Monthly	CCG in information returns	In line with Clause 29 (Information Requirements)
Total number of referrals accepted	Monthly	CCG in information returns	In line with Clause 29 (Information Requirements)
Total number of clients receiving initial appointment	Monthly	CCG in information returns	In line with Clause 29 (Information Requirements)
Total number of clients receiving an appointment completing baseline IPAQ	Monthly	CCG in information returns	In line with Clause 29 (Information Requirements)
Total number of clients who complete baseline validated tool to assess dietary intake	Monthly	CCG in information returns	In line with Clause 29 (Information Requirements)
Total number of clients discharged	Monthly	CCG in information returns	In line with Clause 29 (Information Requirements)
Total number of clients referred to Tier 4 services	Monthly	CCG in information returns	In line with Clause 29 (Information

			Requirements)

Annual Audit

An annual audit will be completed to detail the following:

- Uptake and completion rates and 12-18 months
- Equality Impact Assessment – summary and actions taken
- Summary of achievement against key outcomes listed above;
    - 60% of clients achieving 5% weight loss goal by 6 months
    - 80% of clients achieving sustained weight loss throughout programme
    - Increase in activity and healthy eating – report demonstrating results of IPAQ and dietary intake tool at 12 and 18 months against benchmark
    - Summary of patient satisfaction including survey completion rates, responses, complaints and compliments
    - For clients who have completed programme; number discharged and number referred to Tier 4 services