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| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 23 May 2018 |
| **Officer of Strategic Commissioning Board** | Jessica Williams, Interim Director of Commissioning<br>Debbie Watson, Interim Assistant Director of Population Health |
| **Subject:** | **TAMESIDE POPULATION HEALTH INVESTMENT FUND AND BUSINESS CASE (2 OF 3) - PREVENTING AND MANAGING LONG TERM CONDITIONS** |
| **Report Summary:** | On 20 March 2018 the Strategic Commissioning Board agreed three priority areas for Population Health Investment –<br>• Delivering our new approach to Early Help for Children and Families;<br>• Improving Mental Health and Wellbeing in our neighbourhoods; and<br>• Preventing and Managing Long Term Conditions.<br>The paper outlines the three business cases within the **Preventing and Managing Long Term Conditions** workstream focusing on.<br>• Tobacco – Making Smoking History in Tameside;<br>• MacMillan GP in cancer prevention and care;<br>• Campaign and Social Marketing Programme – Find, Diagnose and Treat. |
| **Recommendations:** | The Strategic Commissioning Board is asked:<br>• To agree the proposals set out in the business cases.<br>• To agree investment outlined in section four of the report:<br>2017/18 - £313,401<br>2018/19 - £329,751<br>2019/20 - £190,000 |

**Financial Implications:**

**(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**

| **ICF Budget** | **£'000** |
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| **Tameside Council – Population Health Section 75 Strategic Commissioning Board** | 3,004 |
| **Additional Comments**<br>The proposed priority areas for investment as outlined in the report will be resourced via the non-recurrent Population Health reserve of £ 3.004 million.<br>It is essential that robust performance monitoring arrangements are implemented to ensure the aims of the investment are realised and the proposed impact is incorporated within the Medium Term Financial Plan of the Strategic Commission | |

**Legal Implications:**

**(Authorised by the Borough Solicitor)**

The Board should be satisfied that the proposals for investment represent value for money and on balance demonstrate that they will successfully prevent and manage longterm conditions.

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| **How do proposals align with Health & Wellbeing Strategy?** | The proposals and strategic direction are consistent and aligned. |
| **How do proposals align with Locality Plan?** | The proposals are aligned to the locality plan.<br>The proposals are consistent with the following priority transformation programmes:<br>• Healthy Lives (early intervention and prevention);<br>• Locality-based services. |
| **How do proposals align with the Commissioning Strategy?** | The proposals are aligned to the Commissioning strategy.<br>The service contributes to the Commissioning Strategy by:<br>• Empowering citizens and communities;<br>• Commission for the 'whole person;'<br>• Target commissioning resources effectively. |
| **Recommendations / views of the Health and Care Advisory Group:** | The Health and Care Advisory Group was supportive of the proposals. |
| **Public and Patient Implications:** | Public and patient implications have been considered for each of the proposals included in the document. |
| **Quality Implications:** | A quality impact assessment has been completed |
| **How do the proposals help to reduce health inequalities?** | The proposals will have a positive impact on health inequalities. The proposal seeks to reduce health inequalities, target the resources to where most needed and ensure services are accessible to all. |
| **What are the Equality and Diversity implications?** | An Equality Impact Assessment has been completed on this proposal. It is not anticipated that the proposal will have a negative effect on any of the protected characteristic group(s) within the Equality Act. |
| **What are the safeguarding implications?** | There are no anticipated safeguarding implications. Where safeguarding concerns arise as a result of the actions or inactions any providers and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. Any procured service will include minimum requirements for training and qualification of interpreters which includes standards and requirements for information governance, privacy and respect. |
| **Risk Management:** | A detailed risk log will be managed as part of the implementation following approval of the proposal. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Debbie Watson, Interim Assistant Director of Population Health |

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## 1.0 PURPOSE OF REPORT

1.1 On 20 March 2018 the Strategic Commissioning Board agreed three priority areas for Population Health Investment resourced via the non-recurrent Population Health 'ring fenced' reserve of £3.004 million. These were:

**Priority 1**: Delivering our new approach to Early Help for Children and Families;
**Priority 2**: Improving Mental Health and Wellbeing in our neighbourhoods; and
**Priority 3**: Preventing and Managing Long Term Conditions.

1.2 The proposals around Priority 1: the new approach to Early Help for Children and Families were agreed on 20 March allocating £1.2M aimed to ensure a move from reactive service provision, based around responding to accumulated acute needs, towards earlier intervention via targeted interventions, where problems can be addressed before they escalate taking a holistic whole family approach based on early intervention and prevention.

1.3 This paper outlines three business cases within the **Priority 3:** Preventing and Managing Long Term Conditions workstream focusing on.

- Tobacco – Making Smoking History in Tameside;
- MacMillan GP in cancer prevention and care;
- Campaign and Social Marketing Programme – Find, Diagnose and Treat.

1.4 The business case for the Lung Screening programme will be presented separately to a future Strategic Commissioning Board for decision.

## 2.0 BACKGROUND

2.1 Key messages to ensure maximum health impact include:

- Benefits can be derived from preventative approaches both in terms of improved outcomes for people and communities and reduced demands on public services;
- A high proportion of premature death, illness and health care demand is preventable;
- This burden falls more on the poorest, where prevention should be focussed and should start younger;
- The system together can make a significant contribution to prevention efforts.

2.3 The funding is ring fenced public health grant reserve. The public health grant is provided to enable local authorities to discharge their duty to improve the public's health. Statutory guidance states public health funding will be invested towards:

- Improving the health and wellbeing of local populations;
- Delivering and assuring health protection and health improvement responsibilities delegated from the Secretary of State;
- Reducing health inequalities across the life course, including within hard to reach groups;
- Improving healthy life expectancy; and,
- Ensuring the provision of population healthcare advice.

2.4 A recent review of premature mortality by the Health and Wellbeing Board aligned priorities outlined in the Joint Health and Wellbeing Strategy, agreed that the Board should consider an Action Plan for 2018/19 to strengthen the local drive towards a place-based approach to reducing early deaths, improving healthy life expectancy and delivering sustainable reductions in health inequalities, in order to realise our ambition to bring health experience in Tameside line with regional and national averages.

2.5 The focus is on the continuing importance of early identification of circulatory and respiratory disease and cancers, our 'big killer' to enable effective self-care and treatment to reduce further illness and mortality. The proposed approach endorses the current Locality Plan and RightCare priorities.

## 3.0 INVESTMENTS

**Investment 1: Making Smoking History in Tameside**

3.1 Reducing smoking prevalence is a key objective in the Greater Manchester Population Health Plan, the Greater Manchester Tobacco Strategy, the Greater Manchester Cancer Plan and Tameside's Health and Wellbeing Strategy. As smoking is the biggest cause of ill health and early death in the borough, it is central to the vision of the Strategic Commission to improve the population's health.

3.2 The ambition for a Smokefree Tameside is to make faster progress towards becoming a smokefree borough, to meet Greater Manchester ambitions to achieve a smoking prevalence of 13% for adults and 5% for 15 year olds by 2020/21. To achieve these ambitions we need to considerably scale up investment and commitment to tobacco control in Tameside across all partners.

3.3 Tameside has the highest smoking prevalence rate (22.1%) in Greater Manchester, and the second to highest in the North West region. Smoking is the biggest cause of ill health and premature death in the population, and a major contributor to health inequalities. There are about 24,952 households in Tameside with at least one smoker. When net income and smoking expenditure is taken into account, 7,941 or 32% of households with a smoker fall below the poverty line[1]. f these smokers were to quit, 3,088 households in Tameside would be elevated out of poverty.

3.4 In the North West, Tameside ranks 6th highest for smoking attributable mortality, including 5th highest for deaths from lung cancer and 4th highest for smoking attributable deaths from heart disease. Care Together will not realise its ambitions to improve the health of the population, reduce health inequalities and reduce health and social care costs unless tobacco control is invested in as a strategic top priority. It is estimated that smoking costs the Tameside economy £73.4 million, including £10.1 million to the NHS and £7.6 million in social care.

3.5 Smoking in pregnancy rates have been steadily declining over recent years to 15.4% in 2016/17. This decline has been contributed to by the work of a Midwife-led stop smoking service. However, in 2017-18 the rate has increased slightly to 15.9%, indicating that more work needs to be done to support pregnant smokers. The local rate is still significantly higher than the England average of 10.7%. The Greater Manchester tobacco strategy target is to reduce smoking in pregnancy rates to 6% across Greater Manchester by 2021 (now 12.8%). This is therefore a key priority in Tameside's tobacco control plans. Reducing smoking in pregnant women not only contributes to reducing smoking prevalence in the adult population, but also reduces risk for the unborn child and protects the subsequent infant and developing child from second hand smoke and from being at higher risk of becoming a smoker itself.

3.6 The current public health budget funds one part time midwife. Whilst that worker has achieved some important outcomes, further resource is needed to increase engagement with the pregnant women who smoke.

3.7 Whilst it is impossible to assess the current volume of illicit and illegal tobacco sales in Tameside due to its very nature, the Trading Standards team regularly find evidence of illicit

[1] The Poverty measure used is the 'before housing costs' relative measure

and illegal material which is then confiscated. Tackling the supply of such tobacco is a key strand in Tameside's tobacco control plan and is essential in reducing the supply of cheap tobacco to children, young people and adults.

3.8 This proposal has three strands:

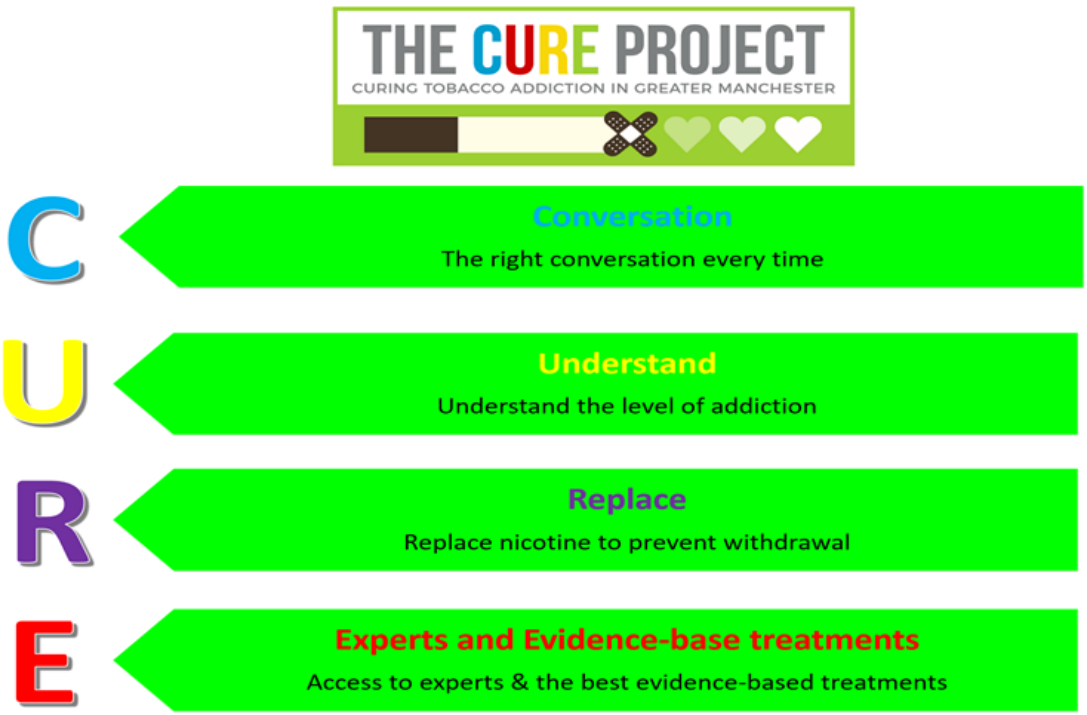
1. Piloting a nurse-led stop smoking/tobacco addiction service in Tameside & Glossop Integrated Care Foundation Trust (CURE pilot);
2. Increasing the capacity in the midwife-led stop smoking service;
3. Providing additional resource to tackling illicit and illegal tobacco.

**(1) Developing a nurse-led stop smoking/tobacco addiction service (CURE pilot) in Tameside & Glossop Integrated Care Foundation Trust (ICFT)**

3.9 In 2016-17 there were 2,885 incidents of smoking attributable hospital admissions in Tameside, which represents the sixth highest rate in the North West.

3.10 Helping someone to become smoke free is the single most cost effective intervention provided by the NHS and is 1/25th the cost of statins. This proposal outlines additional investment needed to pilot a new tobacco control scheme within Tameside & Glossop Integrated Care Trust which will learn from the CURE programme being developed in Wythenshawe Hospital (University Hospital South Manchester) by Dr Matthew Evison, Director of the Lung Pathway Board for Greater Manchester and a Cancer Consultant in Respiratory Medicine.

**FIG 1: The CURE Programme: curing tobacco dependency in the hospitals of Greater Manchester.**




3.11 The CURE project is a comprehensive secondary care treatment programme for tobacco addiction. Its aim is to systematically identify all active smokers admitted to secondary care and immediately provide nicotine replacement therapy for the duration of the admission. This is supplemented by a consultation with an expert tobacco addiction team to construct a long term treatment plan after discharge.

3.12 The term 'CURE' has been specifically chosen to 'medicalise' tobacco addiction and move away from the stigma of a lifestyle choice to disease treatment. There is strong evidence that secondary care represents a unique teachable moment when a smoker is admitted to hospital to seed the concept of a quit attempt and achieve successful long term abstinence. Data from Canada has demonstrated that comprehensive secondary care treatment programmes for tobacco addiction deliver immediate and highly significant reductions in admission rates and mortality.

3.13 Objectives of the Tameside project would include:

- Every health care professional is aware of the smoking status of every patient they care for;
- Every health care professional has the competence and confidence to offer help to stop smoking through direct action and referral;
- Every patient has access to the best available treatments and expert support to treat this disease;

3.14 Whilst Tameside figures need to be estimated, the CURE programme is based on the Ottawa model of smoking cessation which saw:

- Increase quit rates by 11%;
- At 30 days post discharge: 50% of patients are less likely to be re-admitted & 30% less likely to attend A&E;
- At 2 years post-discharge: 21% of patients are less likely to be re-admitted and 9% less likely to attend A&E;
- 40% reduction in the risk of death over 2 years.

3.15 A new nurse specialist-led tobacco addiction team would contribute to the local ambition to reducing smoking prevalence by supporting smokers who are accessing hospital services to quit. The team will establish referral systems from each department of the hospital and provide 1-2-1 quit support for all patients except pregnant women. The team would learn from the model of the alcohol addiction nurse practitioners in the Hospital Alcohol Liaison Service (HALS) team and from the Stop Smoking Midwife to establish strong and effective links with all hospital departments, resulting in a full case load of patients receiving stop smoking support whilst they are in and after they have been discharged from hospital. Patients would be referred on to 'Be Well Tameside' for continued support where appropriate.

**(2) Increasing the capacity in the midwife-led stop smoking service**

3.16 This project aims to expand the successful midwife-led service to further reduce smoking in pregnancy rates by supporting more pregnant women to quit smoking. The project will also prepare for and support the additional workload that will be required from the local delivery of the Greater Manchester tobacco strategy's Baby Clear and incentive scheme.

3.17 An additional full-time stop smoking midwife will provide additional capacity to the existing part-time stop smoking midwife (already funded by public health) to engage more pregnant women who smoke. It would also provide additional capacity to implement the GM tobacco strategy initiatives of Baby Clear and the incentive scheme, and managing the full-time Midwifery Support Worker which will be commissioned by the GM tobacco strategy team.

**(3) Scaling up activity to tackle illicit and illegal tobacco**

3.18 Sustained action is needed to reduce the supply of and demand for illegal tobacco, which is cheap and unregulated. Its low price undermines high taxation which is key to encouraging cut-downs and quits (the World Bank estimates a 10% price rise leads to c4% less consumption).

3.19 The illegal tobacco trade also makes it easier for children to start and keep on smoking, and is linked to low level and organised crime. As Tameside has high youth smoking rates, it is highly important that illicit and illegal tobacco continues to be tackled and the supply

reduced wherever possible. Smoking prevalence amongst 15 year olds in Tameside is 11.8% which is the second highest rate in the North West, the highest in Greater Manchester[2] and is significantly higher than the national and regional average. Smoking prevalence amongst 15 year old girls is 16.1% and is the fifth highest rate in England.

3.20 Detection dogs are a highly effective method of identifying illicit and illegal tobacco during retail inspections carried out by Trading Standard officers. Due to the speed at which detection dogs can identify tobacco in premises, the rate of inspection that a Trading Standards officer can carry out in one day is at least trebled.

**Return on Investment**

3.21 Every £1 spent on smoking cessation, saves £10 in future health care costs and health gains according to the NICE tobacco return on investment tool.

3.22 Smoking cessation interventions are considered among the most cost-effective available in the health care sector[3] and are a key component of tobacco control strategies because they offer smokers their best chance of quitting[4]. However, numbers of people contacting the core stop smoking services in Tameside and across the country have steadily declined over recent years. Therefore a more proactive approach to engaging and referring smokers needs to be put in place.

3.23 Nationally it is estimated that 25% of patients in acute hospitals are smokers – a far higher rate than national average. For people accessing secondary care services there are additional advantages of quitting, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, decreased infections and fewer readmissions after surgery.

3.24 Whilst Tameside figures need to be estimated, the CURE programme is based on the Ottawa model of smoking cessation which saw:

- Increase quit rates by 11%
- At 30 days post discharge: 50% of patients are less likely to be re-admitted & 30% less likely to attend A&E
- At 2 years post-discharge: 21% of patients are less likely to be re-admitted and 9% less likely to attend A&E
- 40% reduction in the risk of death over 2 years

3.25 Both the nurse specialist and midwife teams will use a standard 4-week quit measure plus other metrics (such as signing up to smokefree homes) as evidence of success. This will be backed up by the annual publication of smoking prevalence and smoking at time of delivery (SATOD) data by Public Health England in which a declining trend would be expected.

3.26 Public spending on tackling illicit tobacco shows a return on investment of about 10 to one[5] which suggests a sound economic rationale for further investment into this part of the local tobacco control plan. Success will be measured by the increase in weight and sticks of illegal tobacco that is confiscated as a result of inspections made accompanied by a detector dog compared to previous years. A visible increase in detector dog visits is also likely to have the benefit of providing a disincentive to traders to deal in illegal tobacco.

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[2] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132900/pat/6/par/E12000002/ati/102/are/E08000008/iid/91552/age/44/sex/4

[3] http://www.ncsct.co.uk/usr/pub/B7_Cost-effectiveness_pharmacotherapy.pdf

[4] http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf

[5] http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf

**Investment 2: Macmillan Gp In Cancer Prevention And Care**

3.27 Cancer is the leading cause of premature death in Tameside and Glossop. We have a relatively high number of cancers detected late, and consequently reduced survival rates, compared to the England average and other areas across Greater Manchester. One of the challenges we face in Tameside and Glossop relates to early diagnosis of cancer.

3.28 A key role to supporting delivery of the Cancer Agenda is the Macmillan GP as they can help to influence commissioning decisions and improve engagement around cancer. Macmillan provide grants to enable Clinical Commissioning Groups to employ Macmillan GPs, this role is seen as pivotal to the commissioning of Greater Manchester and local cancer services, pathways and new models of care as they are able to provide primary care clinical leadership to:

- influence the development of cancer services establishing relationships with a wide range of stakeholders including local GP commissioning leads, secondary care colleagues, specialist services for cancer and end of life care;
- improve patient experience, patient satisfaction and quality of care for people living with and beyond cancer and people affected by cancer;
- inform and influence the delivery of care for cancer patients, and to influence local GP peers as widely as possible in driving up standards of cancer care in primary care;
- work in partnership with key stakeholders to influence and facilitate change and improve delivery of care (across Health and Social Care, voluntary organisations at all points of care along the pathway) and local cancer services;
- enable a culture of change through communication, motivation, support and education of GP peers and other local stakeholders;
- raise the profile of cancer in primary care and encourage / facilitate uptake of models of good practice;
- ensure national and Greater Manchester strategies delivered within the locality.

3.29 The Macmillan GP has proven to be a vital link:

- facilitating training, education and development within primary care and ensure knowledge exchange sessions between wider stakeholders;
- enhancing the knowledge and skills of primary health care teams in providing care to cancer patients with regard to early diagnosis, pathways of care, symptom control and supportive and end-of-life care to ensure the delivery of optimal care as well as early recognition of needs at all stages of the cancer pathway;
- enhancing knowledge and provision of information on the availability of services to cancer and palliative care patients and routes of access to services within the locality;
- enabling cancer patients to have a greater understanding of their condition, treatment and navigation of the services and support available to them (including self-management);
- supporting the use of and roll-out of National, Greater Manchester and Macmillan programmes;
- representing patient views and opinions and ensure equity of service.

3.30 The CCG was awarded a grant from Macmillan to fund a Macmillan GP for two years with an understanding that, pending evaluation, the CCG had intentions to fund this post beyond this period (this is the usual Practice for grants given by Macmillan). Details of the amount contributed by Macmillan are included in Table 1 below.

3.31 To ensure equity of pay to other clinical posts within the CCG it was agreed in 2014-15 (via the Planning Implementation & Quality Committee, and Governing Body) that the CCG would invest Palliative Care Multi-Professional Education & Training funds (allocated to the locality by the Strategic Clinical Network) to supplement Macmillan funding for two sessions per week (for 49 weeks per year) at £350 per session plus 26% on costs for pension

contributions etc. In additional Macmillan agreed to additional resources to cover training and educational events and travel expenses. This total contribution is shown in table 1 below:

| Table 1 | Cost per annum |
|---|---|
| Grant received per annum from Macmillan (2 sessions per week at £202.55 per session plus travel expenses) | £19,850 |
| Contribution from the CCG (from Multi-Professional Education and Training funding) | £23,401 |
| The annual cost of the Macmillan post including pay award to be received in January 2018 (£353.50 per session) | **£43,251** |

3.32 A GP (Dr Mary Ann O'Mara) was appointed to this post and commenced on 01 June 2016 following a period of maternity leave. Dr O'Mara is paid by on a fixed 'Contract of Service' with the CCG, part funded by the CCG and part Funded by Macmillan. Macmillan funding is for 24 months on a sessional basis as per the other clinical leads within the CCG. The Macmillan GP reports into Dr A Lea, clinical Lead for the CCG. The CCG will carry out an annual appraisal, ensuring they meet their terms and conditions of employment.

3.33 The key objectives of the role are to:

- support primary care staff to optimise early identification of cancer and patients who may be approaching the last year of their lives;
- collaborate with providers in primary care, secondary care, CCG, public health, the voluntary sector and wider health and care community teams, supporting them to develop quality services;
- provide education to enhance skills in cancer and palliative care across NHS Tameside and Glossop CCG;
- work with the CCG to influence local commissioning decisions around cancer, palliative and end of life care pathways, aligned to national priorities;
- identify and promote good clinical practice and systems.

3.34 **Achievements:** The Macmillan GP is a member of the Tameside & Glossop Cancer Board, and a number of locality groups supporting delivery of the GM Cancer Plan in the locality. Achievements to date include:

- Extensive working with Tameside & Glossop Integrated Care Foundation Trust (ICFT) and other partners around development of referral pathways to improve early diagnosis of cancer.
- Good working relationships established between Primary, Secondary Care and other stakeholders which will enable better communication going forward and enable key work in Significant Event Analysis (SEA) to support delivery of improvements.
- Providing support of the implementation of the Recovery Package to ensure high quality care for patients living with and beyond cancer.
- Providing advice to practices on improving their cancer diagnosis and care, including via the Primary Care Quality Scheme.
- Working with other sectors in the locality around cancer prevention.
- Represent the CCG, ICFT and Primary Care, working with ICFT and other partners on Living With and Beyond Cancer agenda (referral and stratified follow up pathways) and key to developing a locality response and action plan to the Greater Manchester Cancer Plan.
- Exceeded the target of 60% with 75% of GP Practices signed up to Gateway C (the Greater Manchester / Christie School of Oncology online GP education portal) by the end of October 2017 (the next phase will include completion of the online Primary Care education learning tool).

- To identify solutions that reduce local inequalities, ensuring services are appropriate and considerate to the needs of the individual (to ensure none of the protected characteristic groups are disproportionately affected); for example tackling poor uptake of cancer screening for people with Learning Disabilities and ensuring this is addressed in the strategy plus working with Be Well Tameside and Hyde Community Action to increase screening uptake among Black and Minority Ethnic groups.
- Represent the CCG and Primary Care on the Greater Manchester Pathway boards for Acute Oncology and Living With and Beyond Cancer (LW&BC).
- Address specific queries from GPs to improve patient experience and support.
- Helping to establish a voice locally and in the wider Greater Manchester cancer community via the Macmillan GP network but also within Greater Manchester Cancer itself. Particularly around Acute Oncology and LW&B.
- Building up relationships with GPs and becoming established as a contact point for queries around cancer, described by one GP as 'very supportive and proactive' in their cancer audit report which they shared with the GP and therefore moved to a good position to influence.
- Undertaking GP education Target sessions
- Developing and circulating the neighbourhood cancer data packs, which identified areas for improvement within each practice; in August 2017 this data was also used to highlight possible improvement areas (which also supports Right Care data). Information, advice and support provided from the Macmillan GP aimed to reduce practice and neighbourhood variation.
- Successful application for a £1000 grant from Macmillan to deliver an event for GPs on improving cancer diagnosis through Significant Event Analysis – which will follow on from the Knowledge Exchange event (24 January 2018).
- Delivering the three day Macmillan Practice Nurse Cancer course (supported by Macmillan) – which enables PNs to broaden their chronic disease management skills to care for patients living with and beyond cancer. Also to equip PNs to carry out Cancer Care Reviews as part of the roll out of the Recovery Package.
- Key to developing a local Lung cancer screening pilot.
- Key to developing a pilot for Direct Access breast lump referrals within the Stalybridge Neighbourhood.
- Key to reviewing, developing, implementing and embedding an agreed suspected cancer colorectal pathway (including straight-to-test) and also routine STT lower and upper GI pathways.
- Established as a clinical lead in this area and helped to bring together key stakeholders across boundaries to move forwards in developing the locality Palliative care service.
- A series of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) events were held for GPs to coincide with the launch of the 'lilac form' at Tameside ICFT at the end of May. The aim of the sessions was to refresh knowledge of the guidance around DNACPR decision making, and to discuss difficult cases. Over 46 people attended the training which were held at a variety of venues (details available if requested).

3.35 The proposal is to continue to fund the post. Macmillan have stipulated that this role is essential if they approve funding (up to £635,000) for a 2 year pilot (outline pilot, provisionally approved at stage 3) aimed at influencing and improving care and support in primary and community care for People Living With Cancer and People Affected By Cancer (PLWC/PABC). The role is seen as key to clinically leading the development and implementation of this pilot.

3.36 In addition to ongoing membership of the locality's Cancer Board and Cancer Strategy group(s) commissioners have worked alongside the Macmillan GP to develop a work plan for 2017/18 (to June 2018), to include:

- Improving Early Diagnosis of Cancer in Tameside & Glossop (e.g. GP endorsed letters for all Bowel screening invites from the central hub, teaching around NICE guidelines).

- Review cancer risk prediction tools and implement e.g. Q Cancer Prediction tool.
- Be aware of recurrent themes in delayed diagnosis and consequently emergency presentations; barriers to diagnosis and early diagnosis.
- Targeted communications to practices around awareness campaigns to include promotional material and link in with Be Well campaigns.
- Set up a cancer champion in each surgery (clinical and clinical administrative role) to link with Macmillan information points and Greater Manchester cancer champions.
- Support development of practices level data packs with up to date Public Health England data to show variation in screening, 2 week wait (2ww) referral data, emergency presentations (Correlate any additional themes, recommend solutions) and use this to support practices to identify areas for improvement and to reduce local variation.
- Share information as it becomes available to keep practices informed and encourage feedback (e.g. Share Cancer Research UK (CRUK) patient survey results with GPs to get their thoughts on issues around early diagnosis; National Cancer Diagnosis Audit (NCDA) to look at practice level, regional and national learning and Primary Care Cancer (RCGP QI) Toolkit provides a collection of key evidence-based resources about cancer prevention, diagnosis and care relevant for the primary care setting).
- Support Practices to ensure they complete the modules on Gateway C and other e learning events (Cancer Research UK to support).
- Explore the role and implications of the Genetics service provision (breast/bowel initially).
- Provide two way feedback between Primary and Secondary Care (for example on Cancer Care Reviews) to share good practice and improvements made so far (this includes individual cases) and keep them informed of any developments. Develop dedicated section of the website.
- Prospectively review all patients who are diagnosed with cancer via an emergency admission at ICFT and collate themes for learning.
- Encourage GPs to complete SEAs on patients who have had delayed diagnosis and emergency presentation, analyse SEAs and share learning at a Macmillan funded event.
- Support Implementation of the Recovery Package as recommended both nationally and as part of the GM cancer plan.

3.37 It is proposed that the post is managed by the Governing Body GP member responsible for 'Ageing Well' and that a formal process of objectives and appraisals is in place, supported by the appropriate officer(s) in the commissioning directorate and with input from Macmillan.

**Investment 3: Campaigns And Social Marketing Programme – Find, Diagnose And Treat**

3.38 Social Marketing utilises traditional advertising media to 'sell' a concept or idea to drive social change. Social marketing is the use of commercial marketing techniques to,
"*Increase the acceptability of a social idea, cause or practice amongst a target audience"*
(Kotler, 2005)

3.39 Evidence shows it offers an impactful and cost-effective evidence-based methodology for driving behaviour change around public health issues. Public Health England in partnership with local authorities has led the field across government in taking tools and techniques from independent sector marketing and repurposing them for the public good, designing marketing programmes that have already changed the behaviour of millions of people, to drive health improvement as a means of prevention of illness, and to promote knowledge of symptoms with a view to early detection of disease.

3.40 It is proposed that sustain and develop the current social marketing programmes which allow identification of the 'missing thousands' from current disease registers in primary care, using risk stratification and insight. All programmes will seek to ensure residents:

- are engaged with their own health and wellbeing;
- understand how their lifestyle choices impact on their current and future health outcomes (and, in the case of parents, their children's health outcomes);
- can obtain sound advice about what constitutes a healthy lifestyle, and
- have access to appropriate services, products and tools to support and help them change their behaviour.

3.41 The campaigns will involve the identification of risk factors related to the development of Cardiovascular Disease, COPD and Cancer, including smoking, high blood pressure and physical inactivity. Proposed campaigns are:

**1) #Check It! Hypertension campaign**

The #Checkit campaign has ran in Tameside for 3 years and the proposed funding would scale up the existing investment. The rationale for the campaign is as follows;

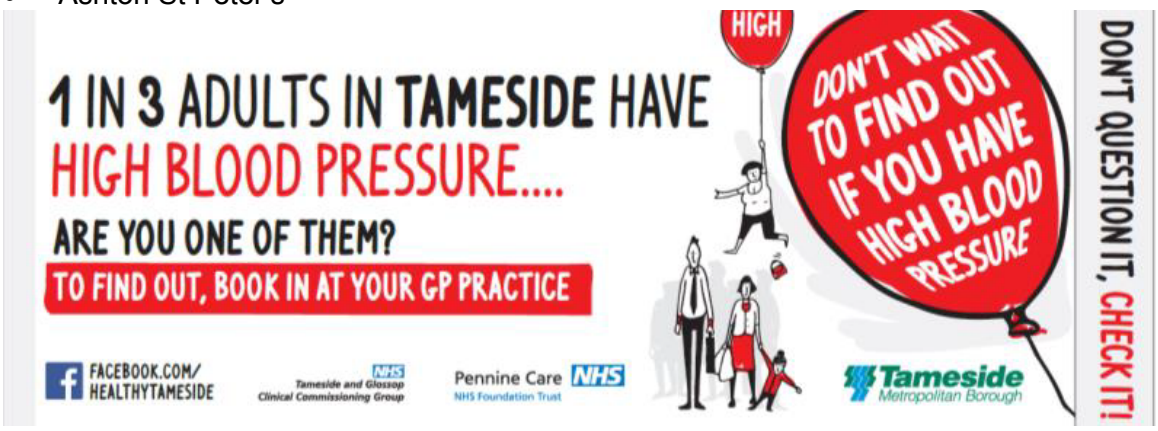
- 29.9% of people are estimated to have high blood pressure in Tameside &Glossop.
- 38,788 were known to their GP (via registers) in March 2017
- We are hoping to find some of the other 22,714 people currently undiagnosed
- We had identified 2887 more people with hypertension in the three years up to March 2017.

The campaign is intended to identify the missing 14% of Tameside residents who have hypertension. This is with the intention of ensuring those at risk receive a diagnosis, are treated and monitored, and their conditions managed. It is also to raise awareness of the steps residents can take to self-monitor and maintain their own blood pressure as a preventative measure.

The campaign is aimed at Tameside residents aged between 40 and 74. In particular those at increased risk of developing hypertension, which includes those who are overweight and/or smoke

The campaign will focus in the areas that are known to have higher prevalence of hypertension. This includes the following wards;

- Denton West
- Hyde Godley
- Longdendale
- Ashton Waterloo
- Ashton St Peter's



**2) Love your Lungs Campaign**

The aim of this campaign is to raise awareness of the signs and symptoms of Respiratory Disease (COPD) through community awareness events, encouraging early diagnosis and treatment.

The objectives of the campaign are:

- To increase awareness of the signs and symptoms of respiratory disease particularly COPD among the local population.
- To identify people who may have undetected COPD by providing lung function testing in the community.
- To refer people onto their GP for further testing if the test shows a low predicted FEV1% value (<80% for their age, height, ethnicity and gender).
- To uncover undiagnosed COPD patients and increase early diagnosis of COPD.
- To signpost to British Lung Foundation support services including our BLF helpline and local Breathe Easy groups.
- Provide access to local smoking cessation services to help residents access support to change their smoking behaviour.

The *Love Your Lungs* campaign was piloted during the month of November 2017. It included stakeholder engagement, media and digital work and 5 community screening events.

A minimum of 10,000 flyers, 10,000 COPD publications, and 1000 event posters were distributed to stakeholders across Tameside.

**Community screening events**

- 5 community events were delivered in supermarkets and markets in areas of Tameside with high prevalence on COPD.
- 620 people were screened for COPD by a health care professional using handheld spirometry.
- 125 people were referred onto their GP for further testing due to a low predicted FEV1% value (<80% for their age, height, ethnicity and gender).
- Information packs were given to everyone screened at an event. Information packs included information on COPD, lung health and disease.
- 79% of people found this information useful.

**Impact**

Awareness of COPD

20% (n=125) of screened participants took part in the campaign evaluation:

- 75% were more aware of COPD as a result of attending an event.
- 79% of people stated they now knew the signs and symptoms of COPD.
- 93% of people said they would now visit their GP if they developed any of the signs and symptoms of COPD.

**Diagnosis**

- 63% of people referred had visited their GP for further investigation.
- 25% intended to visit their GP.
- 61% of people who visited their GP had been offered further tests.
- 9% of those that visited their GP reported receiving a respiratory condition diagnosis.

**Smoking status**

- Current smokers made up 18% of the screened population.
- Be Well Tameside smoking advisors were present at all events.
- 16 of current smokers who attended an event were referred to Be Well Tameside at the events

The proposal is to upscale this campaign and to embed FEV1% testing (in particular for smokers) into Be Well, Active Tameside and NHS Health Check programmes.

**3) Don't Be the One – Greater Manchester stop smoking campaign**
http://www.dontbethe1.tv/
'Don't Be The 1' is a large-scale tobacco behaviour change campaign that launched across Greater Manchester in February and March 2018 by the GM Health and Social Care Partnership (GM H & SCP). It seeks to deliver a hard-hitting message that at least one in two long term smokers will die from their habit, balanced with a positive, empowering call to action that if you quit you can beat those odds.

The campaign focuses on a TV advert, complemented by paid-for digital advertising, social media activity and a website offering information and support. The GM H & SCP is also asking localities to amplify the 'Don't Be The 1' message by promoting the campaign via networks, finding case studies/stories to support content and PR effort and order print and digital materials for distribution through your channels. The proposal is to amplify the campaign.

**4) Physical Activity Social Marketing Programme**
The evidence base for the preventative effects of physical activity on ill health, disease and premature mortality is exceptionally strong. The biggest gains and the best value for public investment are found in addressing the people who are least active, and mobilising them for 30 minutes per week.

A local social marketing campaign is required to address the challenge of physical inactivity in Tameside. It is pertinent here to outline that physical activity for the purpose of this campaign is not solely sport in leisure centre settings, but covers sport in any setting, as well as active travel (walking, cycling), and physical activity for leisure and social purposes. It is also pertinent to outline that the benefits of physical activity are not solely physical, but are also mental and emotional.

The Physical Activity Campaign will have two aspects of delivery. Phase one will be the creation of a bespoke campaign targeted at specific audiences. It is proposed these are:

- Women and girls under 44 years of age;
- People with a long term condition.

The Population Health Investment will fund:

- The development of a creative brief to develop a bespoke campaign for physical activity in Tameside.
- Determination of a detailed audience profile to feed into the creative process.
- The creation of an appropriate local look and feel through a suite of branded/recognisable audiovisual resources (photography, video on demand etc). This may involve local case studies in Tameside settings/locations.
- Fully integrated strategic comms campaign plan driven by Tameside Active Alliance.

**5) Be Clear on Cancer**
Be Clear on Cancer campaigns aim to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay. The programme is led by Public Health England, working in partnership with the Department of Health, NHS England and Cancer Research UK. Be Clear on Cancer has been developed for bowel, lung, breast, blood in urine (as a symptom of bladder and kidney cancer), oesophago-gastric and ovarian cancers. An additional breast cancer campaign specifically for women over 70 years and a cancer symptoms campaign called 'Know 4 sure' have also been developed. The proposal is to upscale and locally target these campaigns.

3.42 These social marketing campaigns do have the potential to increase demand in primary care, in particular the targeted hypertension campaign and the Love Your Lungs which have a clear 'call to action' to see a GP. It is appropriate that people with diagnosed

conditions are supported and have access to the annual review processes and wide range of self-care and social prescribing support where appropriate. In acknowledgement of this, it is proposed that some of the social marketing budget is allocated to support each neighbourhood to build capacity in the appropriate areas. This could be by also funding spirometer training for example, or equipment or increasing neighbourhood capacity to carry out any tests needed for diagnosis. Certain results will then lead to use of existing protocols and pathways, e.g. hypertension guidelines. Clear administrative and clinical pathways will need to be developed. The Strategic Commission's Commissioning Directorate (including Primary Care Commissioners) will work with the Public Health team to develop the detail of the 'diagnose and treat' pathways to ensure the effects of the social marketing programmes are optimised and are translated into demonstrable improvements in terms of recorded prevalence and effective management. This will therefore ensure delivery of improved support and care for the population described in this report, investing as required to deliver effective diagnostic and treatment pathways, to include support from the locality's self-care and social prescribing opportunities.

3.43 **Impact:** Demonstrating evidence of effectiveness is integral to the social marketing programme to assure quality and effectiveness. Each programme has KPIs and will develop a full evaluation within six months, with individual business cases, including SMART communication objectives, aligned to policy, our strategic approach, evidence of effectiveness and a comprehensive evaluation plan with key performance indicator targets. All programmes will follow PHE Marketing evaluation framework to ensure to maximise return on investment for all campaigns.

## 4.0 VALUE OF THE PROPOSAL

4.1 The Population Health Investment funding is non-recurrent, and a key consideration is the sustainability of the interventions recommended for approval.

4.2 Rigorous evaluation of the outputs and outcomes from the prevention interventions will enable an assessment of the value to the health and social care community of different approaches. The proposals will be evaluated and monitored and reported back to the Strategic Commissioning Board.

4.3 The total value of the proposal to prevent and manage long term conditions is £313,401 in 2018/19, £329,751 in 2019/20 and £190,000 in 20-21. Total non-recurrent investment over three years is £833,152. Details for the three investment programmes are as follows:

| **Priority 3:**<br><br>**Preventing and managing long term conditions – find, diagnose and treat** | | | |
|---|---|---|---|
| | **Yr 1** | **Yr2** | **Yr3** |
| Tobacco - Making Smoking History | £190,000 | £190,000 | £190,000 |
| MacMillan GP in cancer prevention and care | £23,401 | £43,251 | |
| Social Marketing/ Comms programme – Find, diagnose and treat | £100,000 | £96,500 | |
| **Total** | **£313,401** | **£329,751** | **£190,000** |

## 5.0 DELIVERY / PROCUREMENT APPROACH

5.1 Investments two and three are both within in-house teams and as such there are no procurement issues to address.

5.2 Investments one requires a three year contract variation to be implemented within the Standard NHS contract that the Strategic Commission has with the ICFT.

## 6.0 RECOMMENDATION

6.1 As set out on the front of the report.