Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	22 January 2020
Executive Member/	Councillor Eleanor Wills – Executive Member (Adult Social Care and Population Health)
Clinical Lead/	
Reporting Officer:	Dr Ashwin Ramachandra – Co-Chair Tameside & Glossop CCG, Clinical lead Long Term Conditions
	Dr Jeanelle de Gruchy, Director of Population Health
	Dr Sarah Exall , Consultant in Public Health
Subject:	**PERMISSION TO SPEND: APPROACH TO FUTURE COMMISSIONING – TENDER FOR THE PROVISION OF A HEALTH IMPROVEMENT SERVICE**
Report Summary:	This report outlines the proposed approach to the re-commissioning of Health Improvement Services with an annual budget of £1,092,000. The report seeks authorisation to tender the service for new contracts to start on 1 October 2020. The Council are working with STAR procurement to re-tender the service.
Recommendations:	That the SCB: (a) Approves a tender for the Health Improvement Service to commence 1 October 2020 for a five year period with a termination period of six months. (b) That approval is given for the Director of Public Health to approve the contract award following the tender, subject to compliance with the Council's Procurement Standing Orders
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	**Integrated Commissioning Fund Section** Section 75 **Decision Required By** Strategic Commissioning Board **Organisation and Directorate** Tameside MBC – Population Health **Budget Allocation 2019/20** £ 1,092,000 **Additional Comments** The report requests approval to re-tender the Health Improvement Service from 1 October 2020 with budget provision included within the Population Health directorate revenue budget, Table 1 within section 8 of the report provides indicative values for the component services that will be commissioned. It is essential that related procurement advice is sought from STAR and that the Director Of Public Health has robust assurance that the related contract award (when determined), provides value for money and will deliver expected outcomes.
Legal Implications: (Authorised by the Borough Solicitor)	Members need to be satisfied that the contract meets the priorities for improving population health and that if proceeded with is delivered efficiently and effectively (purpose of the tender) and that the necessary performance monitoring regime

	in place and held to account (contract). Section 135 of the Local Government Act 1972 requires all local authorities to have in place Procurement Standing Orders so as to ensure fair competition and good governance of their procurement process. It places an ongoing responsibility upon Executive Directors to ensure adherence with Procurement Rules in relation to contract tender, award, and management. The Council has a statutory duty to set a balanced budget, and to monitor budgets, so as to ensure statutory commitments are met whilst taking into account Best Value considerations. Integral to this process is the ongoing relationship between Legal Services and STAR in ensuring that obligations are met and statutory compliance achieved.
How do proposals align with Health & Wellbeing Strategy?	The proposals link with all priorities in the Health and Wellbeing Strategy in particular Starting Well, Living Well and Ageing Well programmes. The service links into the Council's priorities for People: • Decrease smoking prevalence • Promote whole system approach and improve wellbeing and resilience • Improve satisfaction with local community • Increase access, choice and control in emotional self-care and wellbeing • Increase physical and mental healthy life expectancy • Improve the wellbeing for our population • Increase levels of physical activity • Increase levels of self-care/social prescribing • Prevention support outside the care system. • Reduce rate of smoking at time of delivery
How do proposals align with Locality Plan?	The proposals will support the locality plan objectives to – • Improve health and wellbeing for all residents • Address health inequalities • Protect the most vulnerable • Promote community development • Provide locality based services
How do proposals align with the Commissioning Strategy?	This supports the 'Care Together Commissioning for Reform Strategy 2016-2020' commissioning priorities for improving population health particularly: • Early intervention and prevention • Encourage healthy lifestyles • Supporting positive mental health
Recommendations / views of the Health and Care Advisory Group:	The report was presented by Sarah Exall, Consultant in Population Health, to the Health and Care Advisory Group on the 11 December 2019. The clinical lead for this presentation was Dr Ashwin Ramachandra, Co-Chair Tameside & Glossop CCG, Clinical lead Long Term Conditions. The discussion in HCAG highlighted: • A diverse offer is needed to support patients who want to access service in different ways • It is essential to have innovative community offers, particularly for those people who do not attend their GP or other healthcare provider • It is important to maintain a strong primary care offer in addition to the community model

- It is important to have strong links between services and the Neighbourhoods offers
- Consider working with commercial providers of weight management
- IT infrastructure is very important in enabling information sharing between services
- Consider the use of apps and technology
- Consider working with schools to educate young people
- Think about how to use KPIs to manage the contracts.

Public and Patient Implications:

The recommendations will ensure continued access to services to improve health and prevent long term conditions.

Quality Implications:

The Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness. Any procurement exercise will be awarded on the basis of the most economically advantageous tender that balances the cost and quality advantages of tender submissions.

How do the proposals help to reduce health inequalities?

The provision of Health Improvement Services has a positive effect on health inequalities. The proposed stronger focus on reaching individuals and groups who are at greater risk of poor health will help to reduce health inequalities.

What are the Equality and Diversity implications?

An Equality Impact Assessment has been undertaken. The Health Improvement Services provided are available regardless of age, race, sex, disability, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity, and marriage and civil partnership. Some service provision is targeted to address health inequalities experienced by more marginalised groups.

What are the safeguarding implications?

There are no safeguarding implications associated with this report. Where safeguarding concerns arise 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 the provider. A Data Protection Impact Assessment (DPIA) will be carried out as part of the procurement process.

A privacy impact assessment has not been carried out.

Risk Management:

Risks will be identified and managed by the implementation team and through ongoing performance monitoring once the contracts have been awarded.

Background Information:

The background papers relating to this report can be inspected by contacting the report writer Sarah Exall, Consultant Public Health.

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1. INTRODUCTION

1.1 The current integrated wellbeing service, Be Well, is provided by Pennine Care. It offers smoking cessation, weight management, NHS Health Checks, community engagement, workforce development and training on brief advice and interventions, and population oral health. Since delivering the service, Be Well has performed well achieving good outcomes, having a flexible and open approach which is responsive to changes in local needs, and becoming a well-used and respected service in Tameside.

1.2 The service is due to be re-commissioned by 1 October 2020. This gives us an excellent opportunity to review the population health needs of Tameside's residents and any new evidence which has emerged since the current service was developed. This will enable us to improve the efficiency and reach of the service while building on the many positive aspects it has grown. We can also take stock of the current local health economy to ensure that the new health improvement service is able to make optimal use of the other assets in Tameside to maximise the efficiency, choice, clarity and range of services and facilities in the Borough.

1.3 This report summarises the current need and evidence base, and proposes the commissioning of a new service to address the needs of Tameside residents over the coming years.

2. THE CURRENT HEALTH IMPROVEMENT SERVICE

2.1 The current Health Improvement offer for Tameside residents is delivered through a holistic, integrated service. Following the 2015-16 redesign the contract remained with Pennine Care NHS Foundation Trust. The team was reconfigured so that all health and wellbeing advisors were trained up to provide holistic support in a range of lifestyle issues, and refer on to more specialist support where appropriate. The new integrated model has many positive aspects and has had a lot of good feedback.

2.2 The service in its current form began operating in March 2016 and forms part of the Pennine Care contract which came to an end in March 2019. The contract has been extended to the end of September 2020.

2.3 The current service has a number of aspects:

- Clients entering the Be Well integrated wellbeing service make a personal health plan supported by Health and Wellbeing advisors, identifying what behaviour change is most important to them to work on. Advisors see clients on a 1:1 basis over a number of weeks to offer support, including support with smoking cessation, diet, alcohol, stress and sleep. The Be Well service also produces and delivers a number of health workshops for clients.
- Oral Health has historically been an aspect of the Health Improvement Service and is focused on supporting the prevention of poor oral health among children and young people. The current Oral Health Offer is delivered by an Oral Health Co-ordinator with a small budget to purchase tooth brushes and paste. Training, information and advice on the care of oral health for the older age population is also included, with a particular focus on care homes and social care support.
- NHS Health Checks are a statutory function, and are offered every 5 years to everyone in England aged between 40 and 74 years who is not currently recorded as having a long-term health condition. The Health Check aims to identify those at high risk of, or with early signs of stroke, heart disease, kidney disease, dementia, or type 2 diabetes. The Health and Wellbeing Service currently offers health checks in the community for those meeting the eligibility criteria, and "mini health checks" for those who are outside the eligibility criteria. These checks are delivered in various community locations and at local events, particularly in communities where people

might not be as well served by healthcare interventions. Following the health checks, the team refer people into the Health Improvement service where necessary, or to their GP if problems needing treatment are found. Recently, additional diabetes and COPD checks have been introduced and included on top of the standard health check.

- In addition to the individual services, a community team attend events and locations to generate referrals to the Health Improvement advisors, to signpost and/ or refer to other services.
- The service delivers training courses to professionals, including some which are accredited by the Royal Society of Public Health. They are attended by a variety of people, including those from the NHS, Voluntary and Community Sector, and council. Courses include those on Stop Smoking, Physical Activity, Mental Wellbeing, Behaviour Change, and Healthy Eating.
- Finally, the Health Improvement service supports the delivery of a number of campaigns throughout the year.

3. CASE FOR CHANGE: OVERVIEW

3.1 Many aspects of the current offer are working well. Re-commissioning will, however give us the opportunity to make changes to optimise the efficiency and outcomes of the service, and to bring the offer in line with recent changes to local health needs and the evidence-base. It will also enable us to further develop an approach which is in keeping with the corporate plan and the principles of Public Service Reform:

- Shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services;
- An asset-based approach;
- Community independence and support for residents to be in control;
- A place-based approach;
- A stronger prioritisation of well-being, prevention and early intervention;
- An evidence-led approach;
- Collaboration with a wide range of organisations.

3.2 The main aspect of the offer which will see change is the **Be Well Integrated Wellbeing Service**, which supports smoking cessation and weight management, in addition to other aspects of wellbeing such as sleep and stress, “connecting with others”, “jobs/ training/ volunteering”, and “money”.

3.3 Since the service began, the wider wellbeing offer in Tameside has evolved, and there are now more options available to people wishing to improve their health. Some areas of 1:1 support therefore no longer need to be provided by Health Improvement services if stronger links to other services, such as Social Prescribing and the Health and Wellbeing College, are made. The new Health Improvement services should therefore focus on the two risks requiring specific evidence-based interventions: smoking and weight (see sections 4 and 5 for a detailed discussion of the health needs and evidence).

3.4 **Community development** is a vital part of services, and could be developed further to promote population level behaviour change and community readiness for change. This would both improve population awareness and understanding of health risks, and drive demand for Health Improvement support services. In particular, there is a need to build on and further increase the focus on communities at higher risk of premature ill-health to reduce inequalities.

3.5 The offers around **oral health, NHS health checks, training courses** and **campaigns** all work relatively well and could be maintained, with some minor changes to optimise efficiency and efficacy of the whole system.

3.6 Sections 4 and 5 will describe the health needs and evidence-base for the two main areas of service change: smoking and weight. Section 6 will describe the consultation which has informed these proposals, and section 7 will then describe the proposals for a new model.

4. CASE FOR CHANGE: SMOKING

4.1 Smoking is the biggest cause of ill health and early death in Tameside. There are approximately 29,781 smokers in Tameside, all of whom are at risk of developing a smoking related illness (such as COPD or cancer). About half of long term smokers (approximately 14,890) are at risk of dying from a smoking related disease. It is estimated that almost 6,700 potential years of life will be lost to people in Tameside aged 35-74 years due to smoking.

4.2 As well as the extremely high personal cost to those individuals and their families, there is a high financial cost to the Borough. It is estimated that smoking costs the Tameside economy £55.3 million including a cost to the local NHS of £11.8 million a year.

4.3 Smoking prevalence in Tameside has been declining over recent years. However, the rate of decline has slowed in the past 2 years, and Tameside still has the fourth highest proportion of people smoking in Greater Manchester, at 17% of all adults.

4.4 We are working to support the delivery of the Greater Manchester tobacco strategy which has ambitious goals to significantly reduce smoking prevalence across the city region. The ambition is to reduce smoking prevalence in the Greater Manchester population to 13% by the end of 2020, and to 5% by 2035.

4.5 Smoking is also the single biggest driver of health inequalities. Because smoking is so harmful, differences in smoking prevalence across the population translate into major differences in death rates and illness. Certain groups of people are known to be at higher risk of smoking, and consequently of developing smoking-related diseases and early death. Of people with serious mental illness (SMI), 43% of people in Tameside smoke: a figure which is 2.5 times greater than the general population. Almost 1 in 3 (28.9%) adults in Tameside working in routine and manual occupations are current smokers. This is the fifth highest in Greater Manchester and is higher than the England average of 25.4%.

4.6 Although data are not available at a local level, we do know that other communities at risk of social disadvantage and discrimination are more likely to smoke. For example, people who are lesbian, gay, bisexual or trans are more likely to smoke than the general population. Young lesbian, gay and bisexual people are also more likely to take up smoking earlier, and to smoke more heavily than heterosexual people.

4.7 According to the latest survey data (WAY survey, 2015) Tameside has the highest smoking prevalence in 15 year olds in Greater Manchester, and the second highest in the whole of the North West, at 11.8%. This compares with a national average of 8.2%. There is no expectation of changing the current arrangements that places no lower limit on age for smoking cessation (although quit aids are generally only available from 12 years due to licencing).

4.8 A successful stop-smoking service must be effective at generating and receiving referrals from other agencies, and at engaging and developing community readiness for smoking cessation. This is particularly important given that the numbers of people having a validated quit (where Carbon Monoxide (CO) is measured to confirm that they have not smoked) has almost halved over the past five years. This indicates that current smokers may be less likely to engage with smoking cessation than they have been in the past, as many of those still smoking today may have stronger addictions to tobacco than those who have already quit had.

4.9 Supporting Tameside's drive to increase the numbers of residents who successfully quit smoking, there are a number of projects underway or about to begin which will drive referrals into the system:

- A midwife-led tobacco addiction service identifies and supports pregnant smokers to quit during pregnancy through one to one specialist support. The team has adopted the Greater Manchester Babyclear approach, and is participating in a randomised controlled trial of a voucher incentive scheme.
- CURE is a new project in secondary care to identify and support smokers who are admitted to hospital, using a dedicated nurse-led stop smoking team. When patients are discharged from hospital they will be referred to the smoking cessation service.
- Targeted Lung Health Checks are in the process of being implemented in Tameside. All residents aged 55-74 who have ever smoked will be invited for an assessment of their lung health, with a CT scan recommended if they are at high risk of lung cancer. Current smokers will be identified, given immediate advice and support for their smoking, and referred to the smoking cessation service if they agree to this.

4.10 These initiatives make it vitally important that the new Health Improvement service can scale up its capacity to provide support for the new service users who will be entering smoking cessation. This will necessitate a greater focus on smoking cessation within the service and may include increased training and support for GPs and pharmacists to provide smoking cessation in order to build capacity across the system.

4.11 It is particularly important that the service can engage with and build readiness to stop smoking among groups at high risk of smoking and smoking related harm, as discussed above.

4.12 Working towards the GM targets in Tameside, and generating capacity within the system to manage referrals from the new local initiatives are enormous challenges which will require a significant increase in focus and investment.

4.13 In addition, a revision of the current model for smoking cessation will help to optimise the service, based on the latest evidence. Whilst there is some evidence for addressing certain risky behaviours at the same time as each other and this model is beneficial for some people, it is now known that smoking cessation is more effective when delivered as a specialist service. For this reason, the smoking cessation component of the Health Improvement offer should be adapted to focus on smoking alone, rather than remaining as part of a holistic, integrated approach to behaviour change.

5. CASE FOR CHANGE: HEALTHY WEIGHT

5.1 Maintaining a healthy weight is fundamental to good health and wellbeing. Being an unhealthy weight can lead to a range of poor health outcomes such as premature mortality, cardiovascular issues, reduced physical mobility, diabetes mellitus, and many more. The prevalence of obesity has increased dramatically in recent decades across the country. In Tameside, 65.5% of adults are now classed as overweight or obese, compared to 62% in England as a whole. This equates to an estimated 116,700 patients registered with GPs in Tameside who are overweight, of whom 18,700 are recorded as obese. In reception (age 4-5 years), 23.4% of children in Tameside are overweight or obese. By year 6 (10-11 years), this has increased to 37.0%; significantly higher than the England average of 34.3%.

5.2 Maternal obesity can increase health risks for both mother and baby both during pregnancy and after birth. For mothers, maternal obesity can increase risk of high blood pressure, gestational diabetes, and mental health conditions such as depression. Maternal obesity has also been related to low health outcomes for babies and children postpartum such as low breastfeeding rates and childhood obesity. Nationally, around half of women at

childbearing age are classed as overweight or obese. In Tameside, between 39% and 50% of births each month are to women who are of a healthy weight. A very small proportion (2-6%) is underweight, and the remaining births are to women who are considered to be overweight or obese.

5.3 There are great inequalities in the distribution of obesity and overweight in society. For example, children in the most deprived 10% of households are approximately twice as likely to be obese or overweight compared to children in the wealthiest 10% of households. It is also known that people from some LGBT groups, and from certain Black and Minority Ethnic Groups are at higher risk of developing overweight and obesity.

5.4 In Tameside, the prevalence of overweight and obesity in children differs across the Borough, with some communities affected more than others: for example, many of the wards in the West generally having higher levels of overweight and obesity than those in the East. It is also known that the family environment has a huge influence on diet, exercise, and on the weight of parents and children. This all points towards the importance of a strong focus on both families and communities for any population-level intervention for healthy weight.

5.5 Obesity costs the nation a substantial amount of money, both directly and indirectly. The cost to the NHS of ill-health related to overweight and obesity was estimated to be £6.1 billion in 2014/15. The costs to wider society were even greater, at £27 billion. By 2050, these costs are expected to be magnified, at £9.7 billion to the NHS and £49.9 billion to wider society.

5.6 The outgoing Chief Medical Officer's report on childhood obesity sets out the highly complex drivers of overweight and obesity, and the scale of the issue. The report recommends intervention at a number of levels, including: making the environment of children's institutions healthier; promoting opportunities for outdoor play; using intelligence and data to support action; advances in digital technology; ensuring that healthcare providers are skilled in discussing weight with parents and families; action by industry; and using national levers such as tax and legislation.

5.7 This multi-level approach reflects the complexity of the situation, and is based on the Social-Ecological model of behaviour change, which asserts that health is determined by influences at a number of levels (figure 1). This is the basis for the **"whole systems"** approach to achieving population-scale healthy weight recommended and tested by Public Health England.

Figure 1: Social-Ecological model of behaviour change: levels of influence

5.8 As part of the whole-systems approach, NICE Guidelines recommend the commissioning of weight management services. These services may be weight management programmes,

courses or clubs aimed at helping people lose weight through addressing diet and physical activity, which may be provided by the public, private or voluntary sector, and can be based in the community, workplaces, primary care or online. Evidence suggests that interventions consisting of a weight reducing diet plus/ minus exercise programmes/ advice may lead to a modest reduction in weight in the medium to long term, and may reduce mortality in those who are obese or overweight.

5.9 While modest benefits can be seen from individual behaviour change interventions, population level approaches which generate small benefits for a large number of people are likely to have a greater population impact compared to targeted 1:1 treatment. This is due to the larger numbers possible to reach through community and population-level interventions. This is the case for weight management. Despite any health gains for individuals using the service, having only a one-to-one behaviour change service will not be able to reach the majority of people who might benefit from losing weight. In support of this approach, evidence shows that success in weight loss and weight gain prevention is possible using low-intensity, community-level interventions.

5.10 Population-level approaches to weight management may also achieve success by targeting the other levels of influence described above. By working in groups and communities rather than at the individual level, the interpersonal, organisational, and community can be influenced, in addition to the individual.

5.11 On a population level, some geographical areas have been successful in reducing childhood obesity in particular. Several common characteristics have been identified from locations which had been able to do this:

- Included multi-level action across different sectors including community, schools and early year settings, industry and government city departments
- Involved strong leadership, often from a key figure such as a mayor, who shared a vision
- Involved ownership and community participation and mobilised existing structures within the communities
- Influenced individual and environmental factors
- Took a long-term approach with realistic targets and goals
- Were flexible enough to evolve as they were delivered and vary target groups or geographical areas
- Had strong communication/ marketing elements

5.12 Based on the evidence presented, a population- and asset-based approach to healthy weight is to be developed. This will be based in communities and will aim to change public knowledge, attitudes and behaviour towards food, physical activity and weight. The programme will focus on those communities in Tameside who we know have poorer health outcomes, and who are traditionally less well served by healthcare. It will aim to work at different levels within the system to facilitate behaviour change including at the individual, interpersonal, and community levels as detailed by the Social-Ecological model. Further details of the proposals are in section 7.

6. CONSULTATION AND ENGAGEMENT

6.1 Engagement with local GPs has been done through the GP neighbourhoods meetings, through the survey described below, and through a discussion of this paper at HCAG on 11 December 2019. Feedback from GP neighbourhoods meetings indicated variable use of the Health Improvement service by GPs, with some frequently referring and advising patients to use the service, and others preferring to use their own health Improvement and Health Checks services. Specific feedback identified that:

- The service is well regarded by those who use it, and most wanted to keep and enhance the smoking cessation and weight management offers;

- The Health Improvement service should be more closely integrated with other existing services, such as social prescribing and Live Active;
- There is some uncertainty among GPs about the different services available for similar things, and therefore organisations must work together to signpost people to the appropriate place;
- Increased promotion of the service to encourage self-referral could be done through leaflets in practices, and through PPGs and health champions;
- There were conflicting opinions about the value of community Health Checks: while some participants thought that Health Checks are better conducted by practices, others thought that Health Checks in the community should be expanded as they were valuable in targeting people who would not visit health professionals;
- Some GPs felt that cholesterol testing during Health Checks was of limited clinical value;
- Some suggested that AF screening kits may be of use, and others that the Rockwood frailty scale could be included in checks;
- Many GPs stated that they don't often see correspondence back from Be Well, and would value more information about the patient's outcomes and journey;
- Some GPs wanted Be Well practitioners sitting in practices;
- Some valued the 1:1 coaching aspect of the service, while others thought that the presence in the community and at events should be expanded;
- Some feedback indicated that their patients would feel more comfortable accessing a dedicated smoking cessation service, as opposed to an holistic wellbeing offer;
- While the ability for patients to self-refer to the service was valued by many, some also thought that an easier GP referral system would improve access for patients who may lack the confidence to self-refer;
- Use of the Elemental system was highlighted as a possible improvement;
- A suggestion was made for Be Well practitioners to promote and support screening and immunisations for eligible people.

6.2 A public engagement exercise closed on November 24 2019, which aimed to gather the thoughts, ideas and opinions of the general public, users of health improvement services/ facilities, and professionals who refer into these services. In total, 361 people responded to the survey. The results are currently being analysed and will be presented alongside the service specification to shape the development of the model. Prospective providers of the service will be expected to use the results of the survey to inform their bid, and to consider the assets and needs of the local population in their proposed service model.

6.3 Emerging themes so far suggest that respondents to the survey would like to improve their health in a variety of ways, most commonly reducing stress and anxiety, getting fitter and eating healthily. People typically visit their GP for such support, alongside family, friends and colleagues. A large proportion of respondents are unaware of local services or what they can offer. Many would prefer individual support, but there is also a sizeable proportion of responses so far who want other forms of service, including group based activity and online support. As may be expected, professionals seem to be more aware of available services than the public. As the survey is still being analysed, the themes and findings will be further explored and developed for use during the tender process, and therefore these themes are subject to change.

6.4 Specifically to smoking, History Makers, a consultation conducted across Greater Manchester in 2018, found that:

- 4 out of 5 respondents wanted to make smoking history, including over half of respondents who were smokers
- 79% wanted to protect children from smoking's harmful effects
- 78% were worried about the harm caused by second hand smoking
- 87% said they agree people should be given support to quit smoking

6.5 In 2018-19 the Tameside Food Partnership conducted a public consultation to investigate resident's perceptions and experiences of food. The consultation included discussion groups and an online survey which was completed by 975 Tameside residents. Some of the key findings of the food survey and focus groups included:

- 62% said they find it very easy or quite easy to eat healthily, and many respondents stated that they would like to improve their diet.
- The two biggest barriers to eating healthily at home were the cost of healthy food (35%) and lack of time (26%), with over one in five respondents saying that they are unable to afford balanced meals at least some of the time, and a similar number saying that they worry that food will run out before they can afford to buy more. The focus groups raised the need to improve personal knowledge through cooking classes; community innovations to improve the availability of fresh food (such as community food growing); advertising bans on unhealthy foods and drinks; and wider issues of access to healthy food including poverty and transport.
- The biggest barriers to eating healthily out of the home were the high number of places where unhealthy snacks are available (38%), healthier food being more expensive (37%), trouble finding healthy options in hot food takeaways (34%) and high number of hot food takeaways (32%). The focus groups also raised the importance of improving meals in hospitals and schools.

7. PROPOSED NEW MODEL

7.1 The evidence and local need described above all point towards a new model which closely follows public service reform principles (section 3.1).

7.2 Three separate contracts will be awarded within the financial envelope described:

- Oral Health Promotion;
- Smoking Cessation Service;
- Community Health Improvement service.

7.3 For **Oral Health Promotion**, we are currently investigating the possibility of providing the function from within other existing services to enable closer integration and alignment. The core oral health offer will remain unchanged.

7.4 For **Smoking Cessation**, it is proposed that the successful provider of the service will deliver a robust, expanded service which meets national standards and places strong emphasis on reducing inequalities.

7.5 The **Community Health Improvement** service will initially be expected to deliver services suitable for people transitioning from the existing service, possibly using more group-based or community resources in order to free up capacity for the development of a new, population-based approach.

7.6 Within the first six months of delivering the Community Health Improvement contract, the successful provider is expected to co-design and produce a model for health improvement which meets the needs of the local communities. The model will be based in neighbourhoods and take an asset-based approach. Collaborative bids will be encouraged, particularly involving partners from the voluntary and community sector who are already working in neighbourhoods, with strong ties to local communities. This will help to build strong services with close relationships to communities, and develop the service into a core component of the whole systems approach to obesity.

7.7 The provider of Community Health Improvement is expected to support and develop a range of projects across Tameside with a number of partner organisations in order to provide place-based offers which appeal to different individuals, groups and communities. Creativity and flexibility will be encouraged through the contract.

7.8 The providers of both the Smoking Cessation and Community Health Improvement services will be expected to develop strong links to wider strategies, programmes and organisations. Key links will be with neighbourhoods, social prescribing, workforce development, and physical activity.

7.9 It is expected that the successful providers will build in a robust evaluation methodology, and will work with partners (including TMBC) to adapt their work based on evaluation, emerging evidence, and feedback from service users throughout the lifetime of the contract.

Smoking/ Tobacco Control

7.10 At the heart of the proposed model is a stand-alone community stop smoking/ tobacco addiction service, with a greater specific investment compared to the current model.

7.11 The new service will need to demonstrate how it will increase engagement through local and Greater Manchester intelligence, and the effective engagement with high risk communities to develop a service that will be accessible and desirable to the people within them. The core treatment will follow the same guidelines and standards (NICE, NCSCT etc.) as currently employed.

7.12 The service will continue to provide training and support for stop smoking practitioners in other local stop smoking services such as GP practices, pharmacies and hospital.

7.13 The service will also need to take on a greater role in campaigns and initiatives such as smokefree homes, smokefree events and smokefree sports.

7.14 The service will need to have the capacity to respond to referrals from the forthcoming nurse-led tobacco addiction service at Tameside hospital (CURE project), and from the Lung Health Check programme.

Weight management, food and health

7.15 The new health improvement service will be a key part of a Whole Systems approach to healthy weight across Tameside.

7.16 This is the aspect of the Health Improvement offer which will see the most transformation. The provider is expected to draw on Public Service Reform principles to work with community organisations and the public across Tameside in order to co-design and produce a creative, broad-ranging, localised offer. The details of this will be designed by the successful provider of the service in collaboration with local communities and the council. However, the offer is expected to meet certain criteria:

- It will be place-based;
- The offer will follow a population-based approach: rather than individual 1:1 services, more emphasis will be placed on models which impact on whole communities to foster population-level behaviour change and action. This may include designs such as peer-to-peer, group sessions, and neighbourhood-wide movements;
- A range of options will be available to appeal to different groups of people with different needs (e.g. men/ women, socioeconomic diversity, etc.); while services should be accessible to all, they should particularly ensure they engage those in high-need groups;
- It will have strong links with existing services including general practice, social prescribing, statutory services, physical activity services, mental health services, and others;
- The offer will include the development of new services and the expansion of existing community offers for food, nutrition and weight, based on the findings of the food consultation;
- The offer will be informed by ongoing engagement with local people to ensure it meets the needs of communities. Potential providers will be expected to demonstrate

how their service responds to the findings of the food consultation and health improvement survey.

- The provider will continually evaluate and proactively gather feedback on the services. It must be flexible enough to respond to the results of evaluation and feedback, and to emerging evidence.

7.17 For people who need more intensive clinical treatment for their weight, there exists a "tier 3" service which sees people who have a very high BMI or who already have medical complications due to their weight. Before they can be accepted into tier 3 services, patients must have already worked with community services to try and manage their weight. It is proposed that as part of the service redesign, the current clinical treatment pathways are reviewed to make sure that the pathway is seamless and appropriate for the needs of patients requiring a more clinical 1:1 approach.

7.18 Weight management, nutritional education, and cooking skills could also be delivered through the rest of the service as part of community development, as brief advice and signposting during health checks, and through the workforce training and development offer to relevant organisations and staff. In this way, impact could be spread much wider than those in direct contact with the service.

7.19 Although there is a strong element of innovation to this approach, similar processes have been followed in other areas, with successful outcomes. The Social Prescribing Service in Tameside and Glossop underwent a similar developmental commissioning process with the provider which was awarded the contract, which now operates a successful, well-regarded service. For weight management, Wigan runs a community model using a partnership approach between commercial organisations, social enterprise, sports clubs and the Council. This offers a broad range of offers to different groups, and has exceeded participation targets in the initial set up phase.

Community development

7.20 Community engagement and development will be a much more important element of Smoking Cessation and Community Health Improvement services, and in particular the latter. This will increase community readiness to engage with health improvement messages, particularly within communities with the strongest health inequalities and the greatest barriers to improving their health. This will have the dual effect of generating demand for and activity in the service, and changing attitudes, knowledge and understanding at a population level.

7.21 Community engagement should be a thread throughout all of the aspects of the new service to maximise their reach.

Oral Health

7.22 The core oral health offer will continue unchanged. However, we are currently investigating the possibility of providing the oral health function from within other existing services to enable closer integration and alignment. This will support a sustainable population approach to oral health, as capacity to deliver can be incorporated and increased within these services. Oral health will continue to be funded from the budget identified within this report.

7.23 It is important that the full spectrum of the oral health offer to both children and older adults is not reduced. In Tameside, a five-year-old has an average of 1.17 decayed, missing or filled teeth, higher than the England average of 0.78 teeth per child. Moreover, poor dental health is a leading reason for planned admission to hospital in childhood across England. In addition, vulnerable older adults, such as those with dementia, those with loss of motor skills after a stroke, and those in residential and nursing care are also at risk of poor oral health. In turn, those with poor oral health and gum disease have a higher risk of wider health problems including diabetes, stroke and heart disease. Improved oral hygiene and

good tooth brushing can therefore reduce the risk of these, and other, health problems. Work across children's and older people's settings will continue wherever the oral public health function sits.

Community NHS Healthchecks

7.24 NHS Healthchecks are a statutory service, and are currently provided through a combination of GP and community offers in Tameside. A recent economic analysis suggests that better outcomes can be achieved if uptake of Healthchecks, treatment and behaviour change are all optimised, Healthchecks are targeted towards those who could benefit most, and if they are supported by population-wide interventions.

7.25 The current community Health Check model delivered through this contract already has a strong element of targeting those with the greatest need, and engaging those in need with services to support behaviour change. It is proposed that the new Community Health Improvement contract should include and build on this, commissioning an approach which encourages uptake in more deprived areas and among communities and groups with higher need of health advice and support. Brief interventions and advice should continue to be delivered at the time of the Healthcheck, where appropriate. Links to health improvement services, social prescribing and other services (including statutory services) should be optimised in order to maximise the benefits.

7.26 The current service also offers "mini Healthchecks" in community settings such as supermarkets and libraries. These are offered to people who don't fall within the age criteria for NHS Healthchecks, and cover most of the features of the full review, excepting blood tests. These have been instrumental in driving awareness and demand for Health Improvement services, and can support local strategies such as find and treat initiatives and wider programmes like hypertension or COPD awareness. As this works well and complements the community development and behaviour change components of the service, it is proposed that this is continued in the Community Health Improvement service.

Workforce training and development

7.27 The training courses delivered by the current service appear to be well attended and well received. Much of this training is accredited by professional bodies, and supports our local "Making Every Contact Count" (MECC) offer. MECC is an evidence-based method of enabling front-line professionals to have difficult conversations and to deliver brief and very brief interventions, opportunistically during routine appointments and contacts. It is important to maintain this good practice in any future services, with smoking cessation training delivered by the Smoking Cessation Service and training on behaviour change related to weight delivered by the Community Health Improvement service.

7.28 However, the training delivered needs to fit within the wider workforce strategy in order to reduce the risk of duplication, confusion, and gaps in the availability of training. The new providers would therefore be expected to work with providers of other training and workforce development across the council and NHS family in order to ensure consistency and coverage.

Campaign Support

7.29 Providers will be expected to continue to support events and social marketing campaigns through their community engagement and public marketing.

8. VALUE FOR MONEY

8.1 While some components of the service (e.g. smoking cessation) will be based on national quality standards, other aspects will be innovative and commissioned on an outcomes basis. The final model for Community Health Improvement will be developed during the initial phase of the contract in collaboration with the Council and successful partners. For

this reason it is difficult to directly compare the new service with existing models. However, potential providers will be expected to:

- Adopt an innovative approach, taking calculated risks to identify local solutions;
- Support Tameside's social value commitments to promote a vibrant local economy and strong local communities;
- Build on local assets to add value to the existing system;
- Have a plan to engage with and co-design the new approach with stakeholders, including the public;
- Follow a whole-systems approach, including action at the personal, interpersonal, organisational and community levels;
- Plan for continual evaluation and improvement throughout the life of the service.

8.2 The services will cost £1,092,000 per year in total. The largest value will be allocated to the Smoking Cessation service to ensure that activity is weighted towards this aspect of the offer. Smaller budgets will be allocated to the other services (Table 1). Calculations of costs for the smoking cessation service have been modelled using national modelling tools, which give an estimate of the cost for the capacity needed, including pharmacotherapy, within the smoking cessation service. The costs for the other components of the service will be based on current levels of activity and the outcomes we expect in the future. This breakdown is indicative only and subject to change.

Table 1: Indicative cost breakdown for Health Improvement services

Service	Indicative cost £'000
Smoking Cessation	575
Community Health Improvement	440
Oral Health	77
Total	**1,092**

8.3 There are approximately 29,781 smokers in Tameside. It is estimated that smoking costs the Tameside economy £55.3 million including a cost to the local NHS of £11.8 million a year. Smoking cessation is known to be one of the most cost-effective interventions available, with NICE estimates suggesting that **every £1 invested in smoking cessation saves £10 in future health care costs and health gains**. With use of the best available evidence and knowledge of current population health needs, the smoking cessation offer can be optimised, and therefore further improve the value for money of this intervention.

8.4 Weight loss interventions can be cost-effective by reducing the future risk of associated ill-health. A report for NICE estimates that for a weight loss intervention which achieves a 1kg weight loss, maintained for life (compared to the weight trajectory without the intervention), the programme would be cost-effective if costing less than £100 for 12 weeks. Further evidence[12] shows that this magnitude of weight loss is realistic for a behavioural weight management intervention over the medium- to long-term.

8.5 Poor oral health can place a significant burden on the NHS. In 2017/18, there were 282 extractions of children's teeth performed in hospital, of which over 100 were in children aged less than 5 years old – higher than the rate in the North West. Evidence suggests that oral health promotion schemes such as supervised tooth brushing in nurseries, and the provision of toothpaste and brushes are likely to be cost saving.

8.6 As the current contract is coming to an end and Tameside MBC is subject to a legal framework, which encourages free and open competition and a duty to establish Best Value we are obliged to conduct an open and transparent procurement process.

8.7 To ensure a competitive tender in terms of delivering best value, evaluation criteria against the most economically advantageous tender will be implemented as part of the procurement process.

9. CONTRACTING PROPOSAL

9.1 Consideration is given to re-tender Health Improvement services to ensure continued delivery of a Health Improvement Offer for a contract period of up to 5 years commencing 1 October 2020, with an annual budget of £1,092,000, with a termination clause of six months.

9.2 We are currently investigating the possibility of providing the oral health function from within other existing services to enable closer integration and alignment with these services. This will be funded from the budget identified within this report.

9.3 The remaining service will be split into two distinct contracts: smoking cessation and community health (including community Health Checks). This would allow a greater range of potential providers to bid for the contract than if a single provider were sought. Procurement of the Smoking Cessation service would be undertaken using a standard procedure with flexibility built into the contract to allow for changes in needs and evidence. We propose that the community healthy weight service would be commissioned using a developmental, outcomes-based specification. Bid will be sought detailing how potential providers will approach the development of the model, using principles of co-design and public service reform, as described above. The final model would then be developed during the initial phase of the contract, following the plans set out through the tender process. For both smoking cessation and community healthy weight, strong consideration will be given to maximising the social value of the contracts, following STAR procurement processes.

9.4 The Council are working jointly with STAR procurement to undertake the tender.

10. ALTERNATIVES CONSIDERED AND DISCOUNTED

10.1 In collaboration with STAR, various options for the procurement process have been considered and discussed. It is felt that the process described in section 9 will give the best combination of flexibility, innovation and delivery, and therefore this is the recommended approach.

11. EQUALITIES

11.1 It is not anticipated that there are any negative impacts on equality and diversity as a result of this proposal. An EIA is in progress. This is a live document which will be updated to reflect the results of the public engagement which is ongoing. See appendix 1.

12. RISK MANAGEMENT

12.1 The approach described in this report will lead to a transformation of the Health Improvement Service in the Borough. The approach is developmental and should lead to innovation and new, locally-developed programmes, particularly within the healthy weight aspect of the service.

12.2 As with any transformation, there are potential risks involved. We are engaging with local residents and stakeholders to identify and mitigate against any risks. These are being collated and managed in the risk register for the project. Broad areas to consider are:

- Ensuring that the positive work done by the service over recent years is learned from, built upon, and maintained;
- Maintaining the momentum and positive view of the service among stakeholders, using a strong initial marketing drive;
- Ensuring that there is capacity within the system to bid for and deliver this service. The collaborative, developmental approach to the tender aims to support potential providers to further develop their models following award of the contract, and so help to ensure this.

12.3 The principles of the model have been developed to diminish these risks, but they will need to be monitored as the new approach is developed. Monitoring and evaluation will also continue after the service is developed to identify any issues early and support the provider to address them.

13. CONCLUSION

13.1 The current health improvement contract comes to an end on 30 September 2020. The above report outlines the case for change and the proposed new model for the services.

14. RECOMMENDATIONS

14.1 As set out on the front sheet of the report.