Herefordshire Council

Decision maker:Decision maker:	Cabinet member for Health and Wellbeing
Meeting date:Meeting date:	9 February 2018
Title of report:	Commissioning of NHS Health Checks and targeted stop smoking services
Report by:	Integration and BCF Commissioning Manager

Classification

Open

Decision type

Key

This is a key decision because it is likely to result in the council incurring expenditure which is, or the making of savings which are, significant having regard to the council's budget for the service or function concerned. A threshold of £500,000 is regarded as significant.

This is a key decision because it is likely to be significant having regard to: the strategic nature of the decision; and / or whether the outcome will have an impact, for better or worse, on the amenity of the community or quality of service provided by the authority to a significant number of people living or working in the locality (two or more wards) affected.

Notice has been served in accordance with Part 3, Section 9 (Publicity in Connection with Key Decisions) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.Notice has been served in accordance with Part 3, Section 9 (Publicity in Connection with Key Decisions) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

Wards affected

(All Wards);

Purpose and summary

Further information on the subject of this report is available from
Amy Pitt Tel: 01432 383758, email: apitt@herefordshire.gov.uk

To approve procurement of NHS Health Checks and Stop Smoking services.

NHS Health Checks and stop smoking services are public health services for early identification, treatment and interventions to prevent the onset of avoidable disease and development of long term conditions, which would otherwise take up a high level of health and social care resources. These are services mandated by Public Health England, to be funded from the ring-fenced public health grant, for which responsibility transferred from the NHS to local authorities in 2013. The existing contracts are due to expire in March 2018. The recommendations being made take account of the evidence base, lessons learnt following review of current services and available resources to ensure cost effective delivery to achieve outcomes.

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Recommendation(s)

That:

(a) a direct award is made to Taurus Healthcare to deliver NHS Health Checks for a period of up to two years effective from 1 April 2018 with a maximum contract value of £461,700;

(b) a direct award is made to ToHealth for software to support this delivery for a period of up to five years effective from 1 April 2018 with a maximum contract value of £95,000;

(c) stop smoking behavioural support is delivered in-house by the council's Healthy Lifestyle Trainer Service effective from 1 April 2018 with an expected cost of £29,000 per year;

(d) stop smoking pharmacotherapy is re-procured under an any qualified provider contract effective from 1 April 2018 for a period of three years with a maximum contract value of £142,743;

(e) the Director for Adults and Wellbeing, following consultation with the Cabinet Member for health and wellbeing and the s151 officer, is authorised to take all necessary operational decisions to implement the above recommendations.

Alternative options

1. Allow the existing contracts for stop smoking and NHS Health Checks to expire on 31 March 2018 and these services to cease. This option is not recommended as both these services are key to improving the health of the local population and are mandated by Public Health England as a condition of the council receiving the ring-fenced public health grant. Smoking related illness costs the council £3.3m per year, according to the ASH economic assessment tool, due to social care costs required to meet smokers' needs.

2. All the services could continue to be provided using the current delivery model of any qualified provider (AQP). This option is not recommended, with the exception of pharmacotherapy provision that can only be provided by qualified pharmacists. The model has not met expected targets as most of the approved providers were unable to market and deliver services in the county. For NHS Health Checks, this is due mainly to GP practice lists being the only available source for inviting the eligible population to a check. Nationally, it has not been possible to secure a suitable process for third party providers to access this information within data protection regulations. As a consequence, GP organisations are the only practical option for delivery of the service. For stop smoking, the cost of identifying and recruiting smokers to stop is not cost effective due to the number of alternative services and products available, therefore a targeted service to support the most vulnerable is recommended.
3. To contract with a single external provider for stop smoking behaviour change. This option is not recommended because evidence from the AQP universal model has shown that external providers have not been able to establish effective accessible services locally. The recommendation to support a more targeted number of individuals reduces the cohort and becomes less attractive to external providers to deliver the service. The most effective

provider so far has been the council's in-house Healthy Lifestyle Trainer Service (HLTS) working in conjunction with a number of local small volume providers, mainly pharmacies.

Key considerations

4. Councils have, since 1 April 2013, been responsible for improving the health of their local population and for commissioning the range of public health services transferred to them from the NHS by the Health and Social Care Act 2012.

5. An increasing proportion of ill health, and consequently of expenditure on health and social care, derives from lifestyle factors rather than communicable diseases. Hypertension (high blood pressure), smoking, high cholesterol, and obesity are the four most important risk factors across England contributing to premature deaths. Smoking remains the leading risk factor for mortality with 18% of all deaths attributable to it, with a further 7% of deaths attributable to excess weight. The Joint Strategic Needs Assessment (JSNA) states that 41% of premature deaths in Herefordshire are from coronary heart disease where these are contributory factors. These diseases impact on quality of life as long term conditions, with resultant costs and increased demand for care services.

   Stop Smoking

6. Smoking rates in the county have fallen from 19% in 2012 to 14% in 2017, which is equivalent to about 22,000 individuals currently smoking, with the prevalence of 24.6% for routine and manual workers showing the need for a targeted approach to reduce health inequalities.

7. The tobacco control plan for England (July 2017) sets out the government's priorities for action to improve population health as: prevention first, supporting smokers to quit, eliminating variations in smoking rates and effective enforcement. Consideration has been given to delivering these services within the wider prevention strategy of nudging people to making healthier choices through informing, making every contact count, promotion of messages, with individual behaviour support being offered only to those who need it most. The Wellbeing Information and Signposting for Herefordshire (WISH) service and the forthcoming new Healthy Living Network will be utilised to do this. These initiatives are expected to have the effect of discouraging people from taking up smoking and encouraging them to seek to quit, drawing on resources that are open to anyone, such as through over-the-counter pharmacy products.

8. Taking a population based approach to making behaviour changes for healthier lifestyles is a long term plan that involves primary prevention, for people to avoid taking risks, and secondary prevention, for reducing those risks. Given the competing demands on finite council resources, it is recommended to target high risk population groups with more intensive stop smoking interventions. NICE guidance recommends recruiting 5% of a smoking population per year (equivalent to 1,100 people in Herefordshire) to access stop smoking services, this will be undertaken through making advice and support available to the wider population such as making every contact count. Even small numbers making sustainable changes is cost effective and will contribute to changing norms of behaviour as demonstrated by the reduction in smoking prevalence over the past ten years. Since there are insufficient resources to offer support as a universal offer, then an evidence based approach can prioritise target groups. The national diabetes prevention programme provides evidence that there is still a significant health impact in reaching a small

percentage of people at risk.

9. Findings from the service review of the stop smoking service (Appendix 1) are that:

- AQP model has not worked, as Taurus and Ice Creates withdrew provision, and two providers did not begin because the tariff and market were not sufficient for them to be viable, leaving only small scale provision by pharmacies.
- The Healthy Lifestyle Trainer Service (HLTS) was utilised to provide the service from July 2017 and has already demonstrated capacity to meet current demand and is continuing to grow capacity further as awareness of this single point of access grows. This is because historically HLTS has operated a targeted approach to lifestyle support, focusing on disadvantaged communities and people who are struggling to make positive lifestyle changes, therefore in the past we have not supported large numbers like pharmacies, but have reached our target population.

10. Arrangements for provision of pharmacotherapy (NRT and Varenicline) were considerably delayed, due to remaining public health transition issues concerning funding and other responsibilities for non-NHS prescribing, including pharmacy support for updating local NRT guidance, so the pharmacotherapy contract was not in place for the first year of service delivery.

11. The performance of the service has been poor and the number of 4 week quitters has been reducing. In 2016/17, only 126 individuals stopped smoking against a target of 555 and up until the end of Q2 2017/18, just 45 individuals had stopped against a target of 524.

12. The poor performance does not mean that the overall stop smoking service is not needed as this remains the most important preventative measure regarding illness and avoidable deaths (shown in Appendix 1). A recent evidence review discusses new models for this provision. It sets out models that are more cost effective, such as offering more provision of group support plus pharmacotherapy, introducing text messaging and telephone support, and allowing for the use of E-cigarettes in quit attempts. The proposal will encourage introduction of these new methods of provision.

13. It is proposed that a targeted support service, rather than a universal service, be adopted as it offers the most cost effective solution within available resources and more control for recruitment levels. The activity level proposed is making contact with 1.8% of the smoking population, instead of the 5% suggested by NICE as a national norm. This amounts to targeting 400 people using current prevalence estimates. Using the evidence base, including that within the tobacco control plan for England, the target groups and referral routes identified for this service are:

    - pregnant smokers (Herefordshire prevalence of 14.3% smoking at delivery against the national level of 11%), as even a short period of reduced smoking during pregnancy significantly reduces the long-term impact on the foetus

    - people referred under the pre-operative health optimisation pathway, as stopping smoking even a short time before a major operation reduces the likelihood of adverse complications during surgery and improves the rate of recovery

    - people at high risk identified via an NHS Health Check and through relevant indicators on the GP quality and outcomes framework (QoF) such as hypertension, as these individuals are more likely to suffer significant ill health in the near future if they continue to smoke

14. The details of referral and recruitment eligibility will be further developed between the HLTS and referrers but initial discussions have been held with the Clinical Commissioning Group (CCG) on these priorities. The HLTS will train and support referrers (mainly NHS staff) to refer those who have high motivation to quit. The referral pathways will provide a more successful recruitment, as the evidence shows that smokers respond to clinician advice to quit, particularly when the risk of disease is high. Quit rates could be higher than estimated due to this. The HLTS would also offer less intensive support, such as peer group support and telephone support, as a choice. The HLTS has developed competencies in group work through coaching delivery of the diabetes prevention programme.

15. The service will be inclusive of provision of pharmacotherapy in line with the evidence for success using a voucher system providing nicotine replacement therapy, or a prescribed drug under a Patient Group Directive. It is recommended that this be procured through open tender for Herefordshire pharmacies under an AQP contract.

16. A procurement plan for the AQP provision of pharmacotherapy to support stop smoking involves launching the tender in Mid-February 2018 and evaluating the first tranche of applicants in the middle of March. Contracts would be awarded to the first tranche of applicants in order to allow the list to commence in April 2018.

17. A memorandum of understanding (MOU) to November 2018 is in place to share the CCG's licence for pharmoutcomes which provides monitoring and reporting information on stop smoking services.

NHS Healthchecks

18. NHS Health Checks are a mandated service. Councils are required to ensure that all residents between the ages of 40 and 74, other than those already on certain disease registers, are invited to attend a health check every five years, with 20% of the eligible cohort invited each year. The actual health check is delivered by a nurse and comprises a lifestyle questionnaire, complemented by measurement of height, weight and blood sugar. Advice is given, based on the health risks identified through this process.

19. Findings from the service review of NHS Health Checks (Appendix 2) are that the AQP model has not worked. Data protection regulations prevented other providers from accessing necessary data held by GP practices, a situation reflected nationally. Nonetheless, GP-only provision has been successful with Herefordshire ranking 27th best out of 152 councils in England and 2nd out of 15 comparator councils for take-up of NHS Health Checks. This amounts to 22,861 health checks completed at the end of the four years to [March 2016]. As such, it is clear that the GP federation, Taurus Healthcare, has been providing a good service.

20. It is recommended that the council directly award a contract to Taurus Healthcare to provide NHS Health Checks, including identification and invitations to the eligible population. This is based on Taurus Healthcare, as the GP Federation, being the only body capable of providing NHS Health Checks in Herefordshire, as it has exclusive access to patient data and is able to utilise the day-to-day contact and interaction GPs already have with the patient base.

21. The direct award is also recommended as the market is not yet mature enough to deliver this service which was demonstrated through the lack of providers delivering the service on the AQP. The intention will be to work with Taurus to ensure they link in and develop

relationships with other local providers to support in delivering the health checks. In addition, health and social care organisations are working together to develop the 'primary care at home model' which is supporting people closer to home and within GP clusters, therefore this allows time for the transition of the model.

22. HealthSmart software, provided under a contract with ToHealth, is used to deliver NHS Health Checks. It is both a delivery and management system, providing digital displays to enable the person receiving and delivering the health check to undertake the lifestyle choice discussion, standardising the quality and content. It collects all monitoring data and can download results directly into patient records, meeting the data protection requirements of the GP practices. It also provides the payment information, thereby reducing administration and contract monitoring work, as well as the information needed for national reporting. The current software contract with HealthSmart for NHS Health Checks ends on 31 March 2018. The total cost of this provision during the current contract period is £70,500 and the maximum estimate for the next three years is £60,000. A direct award is recommended for this system for five years with break clauses within the contract, from April 2018, for the following reasons:

- The current contract meets expectations for functionality and performance.
- It has been resource intensive to embed this within GP systems, involving training and support and it is now operating smoothly and effectively. Any change would involvesimilar levels of resource to set up and embed and this is not only costly but would seriously affect performance for this still relatively new service. Continuity is important for provider engagement and continuous improvement.
- There are no equivalent alternative systems available in the market.

Community impact

23. These services utilise the JSNA, best evidence and latest guidance to achieve desired outcomes for healthier communities. The services will be equitable and accessible across the county for those who are eligible. They have the potential to reduce demand on acute and intensive services within the health and social care system. The services will help meet the corporate objectives of enabling residents to live safe, healthy, independent lives and securing better services, quality of life and value for money.

24. The services fall within the implementation of the council's adults and wellbeing blueprint for developing self-care and building community resilience within healthier communities under a strategic preventative approach. The report approving the JSNA at the Health and Wellbeing Board meeting of 17 July 2017 provided the case for continuing to invest in healthy lifestyle programmes and NHS Health Checks and stop smoking service. The proposal has no negative impact on looked after children or the council's parenting role and indeed will have a positive impact in developing norms of behaviour in adults that act as good role models. If these services are not provided, there would be a considerable impact on the health and wellbeing of the community and higher system costs, with loss of quality of life due to the development of long term conditions.

25. These services form only one part of the council's strategic preventative approach directed at creating a shift towards people being more aware and taking action to make healthier choices. All of this work is underpinned by comprehensive and evidence based information on the WISH website and elsewhere and is being built into the work of the forthcoming Healthy Living Network, community connectors, community brokers and care navigators to have healthy conversations and promote healthier lifestyles. The community impact of this

strategic preventative approach, joining up these initiatives and targeting provision, will help to create healthier communities.

Equality duty

26. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

27. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

28. These will be demonstrated in the development of the contract specifications and other appropriate stages within the procurement process and the management of the in-house service operating under the council's policies and procedures. The programmes are designed to address inequalities in health through targeted approaches as the most deprived in the population are disproportionately affected by avoidable disease.

Resource implications

29. The funding envelope for 2018/19 is a reduction in both service budgets against 2017/18 but for both stop smoking and health checks it does allow for some flexibility in the event of an increase in provision. The proposal has set realistic expectations of performance, which if met, could influence future commissioning intentions due to their importance at preventing ill health. The breakdown for each service is set down below for the proposed contract period of 2 years, it is assumed that the service will still be required in subsequent years however the model for this is to be scoped:

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
	£	£	£	£	£	£
NHS Health Check	230,850	230,850	0	0	0	461,700

NHS Health Check software	19,000	19,000	19,000	19,000	19,000	95,000
Stop smoking pharmacotherapy	47,580	47,580	47,580	0	0	142,743
Stop Smoking Behavioural Support	29,000	29,000	29,000	0	0	87,000

Legal implications

30. The council has a statutory responsibility for the commissioning of public health services pursuant to the Health and Social Care Act 2012. Furthermore the council must have regard to the salient aspects of the NHS Constitution when undertaking commissioning of public health services. Only certain public health services are “mandated” (ie required by Regulations) to be commissioned. The only mandated service referred to in this Report is NHS Healthchecks: accordingly it must be re-commissioned. The council has a discretion as to whether to re-commission or decommission the other services referred to in this Report and Public Health commissioners have undertaken a review of evidence and performance of the service before making a recommendation that all services outlined in this Report should be re-commissioned.

31. In respect of the procurement implications, it should be noted that each proposed direct award of contract falls below the relevant financial threshold set out in the Public Contracts Regulations 2015, above which a competitive tendering process is required. Therefore the proposal to make direct awards without a tendering process is compatible with the council’s obligations under procurement law and there should be no grounds for legal challenge in this respect.

32. The council has a wider duty to obtain best value in the provision of its services; best value concerns consideration of quality as well as cost and in respect of externally commissioned services, it is often benchmarked through tendering processes and regular contract management. In respect of the services for which a direct award is now proposed, the arguments in support of best value are set out in the Report. It is apparent that the council’s Public Health commissioners do consider that, in respect of both the NHS Healthchecks service and the HealthSmart software, the incumbent providers have been delivering a service which meets commissioning needs within available budgets. The Report proposes that the recommissioned NHS Healthchecks service with have a focus on working with smaller providers and supporting the development of the council’s model of primary care at home.

Risk management

33. If the recommendations are agreed, identified performance risks are slow implementation and not recruiting additional capacity for the HLTS to act as the only provider. Hoople Ltd has been successful in recruiting sessional staff to ensure flexible provision, including delivery of diabetes prevention, so there is track record to mitigate this risk. Taurus Healthcare has a good track record for this delivery and will be contracted to meet minimum numbers with penalties for not meeting them.

34. The reduced timescales on implementing this service change is tight, however the procurement exercise will be light touch for the pharmacotherapy and we are working with providers currently to ensure services will be available.

35. There are financial risks of take up being higher than planned that can be mitigated by close monitoring of activity, reducing activity levels in line with budget.

36. There is reputational risk if the council fails to discharge its public health responsibilities, if the recommendations are not agreed, creating risks for service users and public health leaving the council open to legal challenge.

37. Relevant risks will be managed within the adults and wellbeing directorate through the directorate leadership team's risk register. Risks will be identified by the public health commissioning lead for these services and through identification of risks at the public health contracts monitoring board.

Consultees

38. Political groups have been consulted.

Appendices

39. Appendix 1: Stop smoking service review
40. Appendix 2: NHS Health Check service review
41. Appendix 3: Economic impact assessment of services

Background papers

42. None

Further information on the subject of this report is available from
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