Agenda Item No: 5

Commissioning Prevention in Primary Care

To:	Adults and Health
Meeting Date:	14 December 2023
From:	Executive Director of Public Health
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2023/058
Outcome:	The Committee is asked to consider Primary Care prevention interventions and the proposal to commission them through a Section 76 with the Cambridgeshire and Peterborough Integrated Care Board (ICB)
Recommendation:	The Adults and Health Committee is asked to agree: a) The Primary Care prevention interventions. b) The establishment of a Section 76 with the ICB for Cambridgeshire County Council (CCC) and on behalf of Peterborough City Council (PCC) through a Delegation and Partnering Agreement. c) A Section 76 with a value of £1,000,000, £800,000 from CCC and £200,000 from PCC for it to commission the proposed prevention interventions. d) Delegate responsibility to the Executive Director of Public Health for awarding and executing a Section 76 with the ICB for it to commission primary care prevention services starting January 1 2024 and ending December 31, 2025.

Officer contact:
Name: Val Thomas
Post: Deputy Director of Public Health
Email: val.thomas@cambridgeshire.gov.uk
Tel: 07884 183374

1. Background

1.1 In July 2022 the Adults and Health Committee approved the allocation of £800,000 of Public Health Reserves to Prevention in Primary Care. The Strategy and Resources Committee had delegated responsibility to Adults and Health Committee for allocating the Public Health reserve funding.

1.2 Addressing obesity and its associated clinical risks are priority areas for the Local Authority and wider system. In particular, it supports the Local Authority's strategic ambitions to reduce health inequalities and people to have healthy, safe, and independent lives. It also supports the ambition to help people out of poverty and income inequality. Obesity leads to long term conditions that often mean people are unable to work and have high levels of sickness.

Obesity is also one of the four Joint Health and Well Being/Integrated Care Partnership Strategy priorities, which includes primary prevention but also the clinical risk factor associated with obesity.

1.3 The funding is for GP practices to contribute to the prevention of obesity and its associated clinical risks such as high blood pressure along with contributing to meeting the recommended targets for NHS Health Checks. It is proposed to establish a Section 76 with the ICB as this work, aligns with ongoing work that the ICB is undertaking with primary care and will support the engagement of GP practices. GP practices provide unique access to high-risk individuals and there is evidence that GP advice has an impact on patients' behaviours.

2. Main Issues

Rationale for commissioning prevention in primary care – GP practices

2.1 The increase in the rates of both childhood and adult obesity are well documented. Increases in recent years are associated with the COVID-19 pandemic. Childhood obesity amongst 11-year-olds is around 32% an increase from 28% in 2017/18. Since 2015/16 adult obesity has been around or above 60% of the population.
Childhood and adult obesity are inextricably linked as often they are part of families where adults are obese, and it is recognised that targeting adult obesity has an impact on childhood obesity.
Obesity in adulthood is associated with reduced life expectancy and high risk of, cardiovascular disease, stroke, cancer, liver disease, type 2 diabetes, respiratory and mental health conditions. For example, in Cambridgeshire as in England, around 25% of preventable deaths are associated with cardiovascular disease. Many of these health outcomes are preventable by reducing the rates of obesity and identifying early the risks associated with obesity such as high blood pressure and high cholesterol.

2.2 The causes of obesity are complex and social, economic, cultural, and environmental factors are linked and shape behaviours that contribute to obesity. It is a priority for the Joint Health and Well Being/Integrated Care Partnership Strategy because it demands a system wide approach. The work that is being taking forward as part of its delivery involves all parts of the system from planning to schools.

2.3 Primary Care is traditionally seen as providing treatment, but it is very well placed to support prevention and early intervention to prevent poor health outcomes. In 2018, it was reported that over 80% of people see their GP between once of three times per year, over 20% of these see them three times per year. There are also reports due to the increase in virtual consultations that this rate has increased. The funding will be for GPs to weigh all their patients who are seen in a practice at least once a year and to identify those with obesity related clinical risks.

2.4 The frequency of GP visits means that GPs have unique access to a large proportion of the 60% of the population in Cambridgeshire who are obese and are at risk of developing poor health. A visit to the GP practice provides the opportunity for patients to be weighed, to be provided with health behaviour advice, clinical treatment, and a referral if necessary to weight management support services. The weight measurements are incorporated into patient records and provide a benchmark for monitoring any improvements or worsening. Currently information about rates of adult obesity is from the national Active Lives Survey but this has limitations. These measurements will improve our understanding of the rates as it will provide a much more robust measure of adult obesity rates over time and in local areas.

2.5 GP patient records are unique and allows practices to identify those most at risk of poor health outcomes. The data is owned by the practices which again puts them in a unique position for accessing and identifying patients at high risk of poor health outcomes.

2.6 Public Health commissions NHS Health Checks which are a cardiovascular risk assessment for an eligible population. This proposal will enable identification of the eligible population and we will align it closely with NHS Health Checks, where activity has been slowly recovering since the COVID-19 pandemic.

2.7 Recent analysis of the identification and treatment of obesity related clinical risk factors in primary care clearly indicates that the outcomes from obesity could be improved. Table 1 shows the gap between the estimated prevalence of risk factors and identification, then secondly the gap between those diagnosed and treated. Practice data systems enables the identification of these cohorts and follow up by practices for addressing any health-related behaviours, diagnosis, and treatment when necessary.

Table 1: Obesity associated clinical risk factors (Cambridgeshire and Peterborough

Clinical risk factor	Estimated prevalence	Undiagnosed	Remaining patients to diagnose/assess to reach target	Diagnosed and untreated	Diagnosed and treated
Hypertension	167,364	33,473 (20%)	35,147 (21%)	19,749 (12%)	81,205 (49%)
Diabetes	61,567	13,112 (21%)		4,230 (7%)	BP managed: 16,330 (27%) BP managed to target: 27,895 (45%)

CVD risk assessment (QRISK >20%) and cholesterol reading	411,099	192,775 (25%)	167,619 (41%)	Assessed and untreated: 117,540 (28%) QRISK >20% and untreated: 8,675 (2%)	14,490 (4%)

2.8 In addition to having access to patients it is also well evidenced and researched that GP or nurse advice is well received by patients and is likely to be strong motivator for behaviour change.

What the funding will deliver

2.9 The Public Health funding is non-recurring, and the objective is to embed the routine weighing of adult patients when they visit their practice. There is stigma associated with obesity and if it is to be addressed it needs to be normalised into being an important part of care for everyone including self-care. Similarly, it is important to improve and embed into practice routine care, the identification and management of risk factors will contribute to the management of obesity.

2.10 The £800,000 from CCC and £200k from PCC is Public Health reserve funding. Activity across the two local authorities will be on a pro-rata basis that reflects the different funding allocations. In Cambridgeshire, the expected phasing of the funding is £400,000 each year for two years. Similarly in Peterborough the funding phasing will be £100,000 each year for two years.

The funding will enable the following activity in GP practices over two years.

- All practices will be offered funding to weigh and measure their adult patients (aged 18 - 85 years) on an annual basis.
- Practices that have high rates of the clinical risk factors, high blood pressure and cholesterol, which are associated with obesity, will be offered funding to identify these patients and text them advising them to contact their GP practice. The funding will enable 12 to 20 practices across Cambridgeshire and Peterborough practices to pilot this approach. These practices have already been identified by the ICB as having a high level of need and are termed the “deep end practices.”
- Alongside the identification of patients with high risks practices will also be asked to increase their identification of those patients eligible for an NHS Health Check, but this does not include any payment but is part of the drive to focus upon cardiovascular disease.

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2.11 The Programme has been developed over the past year through collaborative working between Public Health, the ICB and lead clinicians. It is a pilot, and the objective is to embed the interventions into primary care practice and ICB funding streams. Cardiovascular Disease is now a priority area for the Integrated Care System and the work over the past

year has helped to engage considerable support for the priority.

The ICB's Commissioning and Investment Committee has approved £219,000 over the next two years to commission the Eclipse Data Management platform to support practice engagement in this Programme. This will involve data being identified centrally and patients with a high risk being sent a text message advising them to contact their GP. The use of text messaging patients by GP practices is now common and there is evidence that it improves outcomes. Practices constrained by capacity will have the option using the Eclipse system.

2.12 The ICB has a system of governance and oversight of the Programme. The ICB Commissioning and Investment Committee will have a high-level overview of its investment. The ICB Cardiovascular Disease Prevention Oversight Group is co-chaired by the Cambridgeshire County Council Deputy Director of Public Health and will be responsible for ensuring that the Programme is progressing and delivering its outputs and outcomes alongside an overall evaluation. This Group reports into ICB Population Health Improvement Board which is co-chaired by the Director of Public Health.

In addition, the practices will be supported, and performance managed on an operational level by an ICB Manager who will report to the governance structure.

There is now a Cardiovascular Prevention Plan which includes population level early prevention as well as secondary prevention along with additional workforce capacity. These will help the Programme gain traction. For example, there is a system wide workshop planned for clinicians and other stakeholders in December to increase their engagement in the Programme and more widely.

Also, an additional contextual factor is the new NHS Major Condition Strategy, which although not published in full, clearly includes the major conditions associated with obesity and wider expectations around the role of the NHS in prevention and management.

Commissioning the Programme

2.13 There are number of commissioning options.

Option 1: Not Recommended
Competitive procurement: The rationale for commissioning GPs reflects their unique access to patients and their data for identification along with the influence that they have upon patient health related behaviours. It is likely that a competitive procurement would not result in any compliant bids that would deliver an effective solution.

Option 2: Not Recommended
Direct commissioning of GP practices: Currently we commission a number of Public Health services from GP practices. Under this option, the Public Contracts Regulations, and therefore a waiver would be required to directly award contracts. This would be based on the unique access, identification, and ability to influence the target population. (Pease note From January 1 2024 this will be the Provider Selection Regime will apply to any health related commission)

Option 3: Recommended option
Section 76 with the ICB: A Section 76 agreement will mean that the funding will be

transferred to the ICB for the commissioning of these services in primary care. This is the recommended commissioning approach due to the existing volume of commissioning responsibilities that the ICB has with primary care that engenders greater traction and influence. A clear governance system that includes a dedicated Manager to support and monitor the Programme will further enhance the traction and support for GP practices to deliver. The current capacity issues in practices have led to a decrease in GP commissioned activity and this help with the support that practices require.

The following legal advice was provided by Pathfinder Ltd.

Pathfinder Ltd advised that Section 76 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service (Conditions relating to Payments by Local Authorities to NHS Bodies) Directions 2013 permit payments to be made by a local authority to a clinical commissioning group. This is for expenditure incurred or to be incurred in connection with the performance of prescribed functions which includes the services set out in this report. N.B. Clinical commissioning groups have been replaced by integrated care boards.

2.10 System wide collaborative integration is an ambition for the organisations working across the system to maximise impact and use of resources. The ICB already through public sector agreements provides funding to help meet the additional demand for the weight management services that we commission. Along with other services, for example mental health. Addressing obesity is the current most challenging Public Health priority and as all the evidence indicates, it is the one where collaborative integrated working is most necessary.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

- There are no significant implications for this ambition.

3.2 Travel across the county is safer and more environmentally sustainable.

- There are no significant implications for this ambition.

3.3 Health inequalities are reduced.

The following bullet points set out details of implications identified by officers:

- Addressing obesity and reducing the associated clinical risk factors in the whole population and targeting areas with high rates with more specific interventions will address health inequalities.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

The following bullet points set out details of implications identified by officers:

- Addressing obesity and reducing the associated clinical risk factors will enable people to have improved health outcomes that will support them to have healthy, safe, and independent lives.

3.5 Helping people out of poverty and income inequality.
The following bullet points set out details of implications identified by officers:

- Obesity has a high risk of developing long term conditions that can lead to high levels of sickness absenteeism and unemployment.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

The following bullet points set out details of implications identified by officers:

- Reducing obesity and the risk clinical risks will enable more people to secure and retain employment and they are able to access a wider range of health improving services.

3.7 Children and young people have opportunities to thrive.

The following bullet points set out details of implications identified by officers:

- Addressing adult obesity will reduce the risk of obesity amongst children living with adults with an unhealthy weight.

4. Significant Implications

4.1 Resource Implications
The report above sets out details of significant implications in 2.8.

4.2 Procurement/Contractual/Council Contract Procedure Rules

The following bullet points set out details of significant implications identified by officers.

- The Public Contracts Regulations are not applicable to Section 76 arrangements, and therefore a competitive procurement is not required.
- The option of a competitive procurement has been considered and is not likely to achieve an effective or value for money solution.

4.3 Statutory, Legal and Risk Implications

The following bullet points set out details of significant implications identified by officers.

- Legal implications relate solely to ensuring that the funding from CCC and PCC is conducted in full compliance with the relevant legislation and guidance as set out in Section 76 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service (Conditions relating to Payments by Local Authorities to NHS Bodies) Directions 2013.
- Legal will prepare the Section 76 Agreement.
- Legal will prepare the Delegation and Partnering Agreement between CCC and PCC to delegate the functions from PCC to CCC and PCC's financial contribution.
- The statutory process that will be followed by CCC in relation to this proposal complies with all relevant guidance on the subject and legislation that prescribes how the funding must be utilised.
- The risks for this proposal have been explored in full in section 2 of the report.

4.4 Equality and Diversity Implications

The following bullet points set out details of significant implications identified by officers.

- Any equality and diversity implications arising from these service developments will be identified and addressed before any additional service expansion.

4.5 Engagement and Communications Implications

The report above sets out details of significant implications in 2.5.

4.6 Localism and Local Member Involvement

The following bullet points set out details of significant implications identified by officers:

- We will work with local members to ensure they are fully aware of service developments to inform their work with individuals and communities.

4.7 Public Health Implications

The following bullet points set out details of significant implications identified by officers:

- Obesity is the current biggest Public Health challenge. Identification and management of obesity and associated clinical risk factors will contribute to prevention and reduce the risk of poor health outcomes.

4.8 Climate Change and Environment Implications on Priority Areas

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Status: Neutral
Explanation: This service will not impact on buildings

4.8.2 Implication 2: Low carbon transport.
Status: Neutral
Explanation: This service will not impact transport

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
Status: Neutral
Explanation: This service will not impact on any of these factors.

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Status: Neutral
Explanation:

4.8.5 Implication 5: Water use, availability, and management:
Status: Neutral
Explanation:

4.8.6 Implication 6: Air Pollution.
Status: Positive
Explanation: Weight management services include supporting people to become physically active including using active travel alternatives.

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Status: Positive
Explanation: People using weight management services will be encouraged to be active and less dependent on motor vehicles. In addition, high temperatures pose a greater risk for obese people, and they are provided with information about these risks.

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Rebecca Bartram 07/09/23

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement and Commercial? Yes
Name of Officer: Claire Ellis 14/11/2023

Has the impact on statutory, legal and risk implications been cleared by Pathfinder Legal? Yes
Name of Legal Officer: Zoheb Fazil 07/09/23 and Emma Duncan 5/12/23

Have the equality and diversity implications been cleared by your EqIA Super User? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any engagement and communication implications been cleared by Communications? Yes
Name of Officer: Simon Coby 4/9/23

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Jyoti Atri 28/11/23

Have any Public Health implications been cleared by Public Health? Yes

Name of Officer: Jyoti Atri 28/11/23

If a Key decision, have any Climate Change and Environment implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton 5/9/23

5. Source documents guidance

5.1 Source documents

Public Health Outcomes Framework (PHOF) Public Health Outcomes Framework - OHID (phe.org.uk)

NHS Digital Data (digital.nhs.uk) & Appointments in General Practice - NHS Digital

Using text message reminders in health care services: A narrative literature review
Frank J. Schwebel, Mary E. Larimer
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6112101/

Perceptions of receiving behaviour change interventions from GPs during routine consultations: A qualitative study Epton T. et al 2020
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0233399