Agenda Item No: 6

Public Health Primary Care Commissioning and Procurement Governance.

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:	2023/020
Outcome:	The Committee is asked to consider the proposals for the commissioning of public health services from primary care and approve the proposed contractual arrangements.
Recommendation:	The Adults and Health Committee is asked to agree: a) The use of a waiver process to directly award contracts to individual primary care providers for delivery of Public Health services for 2023/24 and for future years in line with the Procurement Regulations current in the contractual period. b) To directly award contracts to primary care if in line with the regulations of the new Provider Selection Regime from 2024/25 onwards. c) The adoption of a Section 75 for the recharging of medicines and devices that are prescribed as part of the public health services provided by primary care.

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1. Background

1.1 The Health and Social Care 2013 saw a range of Public Health functions transferred from the NHS to local authorities. This included responsibility for commissioning a wide range of services from different providers including primary care. The contracts held by the NHS essentially novated to local authorities, as these contracts ended, competitive procurements were undertaken, and new local authority contracts were established.

1.2 The exception were contracts with primary care where Public Health was advised to undertake annual waivers, meaning that GP practices and community pharmacies would be awarded the contracts directly and did not have to take part in a competitive procurement. This reflects the unique position of primary care in relation to delivery and the value of contracts with, at that time nearly 90 practices, averaging up to around £23,000 to £25,000 per annum for all the services they provide.

1.3 Each practice and community pharmacy have an individual contract that is for the various public health services that they provide. The individual service specifications are included as part of these contracts. However, each year a waiver has been sought for the aggregated value of all the practice contracts for each of the services.

1.4 Practices are paid for each unit of activity that they complete. The average practice income from delivering primary care services fell during the COVID-19 pandemic due to decreased activity. Activity recovered in 2022/23 and is continuing in 2023/24. This is increasing the value of individual contracts towards the pre-pandemic value of circa £23,000 to £25,000 and the aggregated value of contracts, especially for NHS Health Checks and to a lesser degree, stop smoking services.

Table 1: Total costs and average practice income (actual) from delivering Public Health Services.

Public Health Services	22/23 total	22/23 average per GP (70 sites)
Long-Acting Reversible Contraception (LARCs)	622,170.85	8,888.16
NHS Health Checks	341,389.00	4,876.99
Stop Smoking Services	16,060.00	229.43
Chlamydia Screening	660.00	9.43
Total	**980,279.85**	**14,004.01**

1.5 The public health services commissioned from primary care includes GPs prescribing medications and devices as part of the service they provide. GP practices obtain these via the NHS Supply Chain and the former Clinical Commissioning Group (CCG) now the Integrated Care Board (ICB) recharge these costs to the Local Authority. GP practices are not involved in these transactions other than supplying the validating data.

1.6 The re-charge system was advised when Public Health transferred and has remained in place since then. However, the Local Authority now requires that any payment for goods/services needs to be linked to an entry on the Contract Register. This along with the

value of the re-charges means that we now need to formalise this arrangement through a Section 75 agreement.

1.7 This paper covers a number of procurement and contractual issues and requirements. The use of the flexibilities in the 2013 Health and Social Care Act have been reviewed and we need to ensure that we meet the current Procurement Regulations. Also required is consideration of the new Provider Selection Regime that will come into force in January 2024 as it is anticipated that this will have an impact on any contractual arrangements with primary care.

2. Main Issues

Commissioning Primary Care

2.1 Currently the services commissioned from primary care are:

- NHS Health Checks (mandatory service)
- Long-Acting Reversible Contraception (LARCs) (includes prescribing intra-uterine devices and sub-dermal implants)
- Stop Smoking Services (includes prescribing Nicotine Replacement therapy (NRT) and oral medication: zyban and champix)
- Chlamydia Screening and treatment
- Emergency Hormonal Contraception (EHC) (community pharmacies)

All these services are preventative, NHS Health Checks is a cardiovascular risk assessment and intervention service. LARCs and EHC are highly cost-effective means of preventing unwanted pregnancies. Stop Smoking Services help prevent smokers developing the poor health outcomes associated with smoking and chlamydia screening not only reduces the risk of infection spread but also poor reproductive health outcomes.

2.2 There are a number of reasons why direct contract awards to primary care were the procurement and contractual routes adopted for use with these providers. Overall, primary care providers are in a unique position to support prevention and early intervention to prevent poor health outcomes through providing these services.

- 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 frequency of GP visits means that GPs have unique access to a large proportion of the population.

- Along with the frequency of access GP practices through their patient records have access to patient clinical notes. Identification of people at risk or for example, need to be called for an NHS Health Check is dependent upon access to these notes. There are no other competitors who have the same access to patients and their clinical notes, and GP practices own this data.

- 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.

- With regard to community pharmacies the EHC service is aimed at the more vulnerable high-risk groups who would be unlikely to seek emergency contraception from a GP for a number of reasons, including not being registered or fears about confidentiality. Community pharmacies are very accessible in terms of locations and opening hours, relatively anonymous, all vitally important if it is to be obtained, within the very short timeframe to avoid an unwanted pregnancy.

2.3 The current Contract Procedure Rules (CPRs) allows us to make a direct award where Regulation 32 of the Public Contract Regulations is applicable. The Regulation allows for the use of a negotiated procedure without prior publication where competition is absent for technical reasons. However, the CPRs state that legal advice must be sought to confirm the regulation's applicability and identify any risks. Legal advice was sought externally and is found in Appendix 1. (This appendix is confidential and exempt from publication)

In summary it concluded that as the average spend per **individual practice is circa £23,000 a competitive tender was not required**. This advice was based on the general position under the Public Contracts Regulations 2015 ("the Regulations") that, all Contracts for Services with a value below £213,477 are exempt from the full requirement to go through a Competitive Process complying with the Regulations.

Moreover, the "threshold value" limit for Social and other Specific Services under 74-77 of the Regulations is £663,540 and above that sum are subject to the "light touch regime". These excluded categories do include training services related to administrative, social, educational, health care and cultural services and, accordingly, would appear to include certain categories of the services provided. Under this regime, the requirements for a full Tender Process when awarding a contract is dispensed with, but the Award of Contract requires a notice.

The advice also referenced the argument that as a principle a competitive process is not required under regulation 32 of the Regulations where "Competition is absent for technical reasons", which is relevant for GP practices.

2.4 The external legal advice also articulated the caveat that value for money should always be secured irrespective of the contractual arrangement. We have developed several processes over the years to ensure that our contracts with primary care are robust and that the services provide quality and value for money.

- Primary Contracts are based on a unit price for each intervention, we benchmarked our unit costs against other local authorities in the East of England. Across all the services our unit costs are below or average when compared with other local authorities.

- The Integrated Care Board (ICB) Primary Care Information Team extracts activity data from practice systems and sends to Public Health which is then cross referenced to payment claims.

- Due to the volume of practices and relatively low value it is not practical to have regular monthly contract monitoring. However, during the financial year practices are contacted virtually to discuss activity and data returns. Practices are visited if there are any concerns around activity and the data.

- Prior to the COVID-19 pandemic primary care audit tools were developed and there was an annual cycle of audits undertaken in practices. Post the pandemic we have reviewed and updated these tools but delayed the audit cycle due to practice capacity and Public Health team capacity. But these will be re-commenced shortly.

- Data from community pharmacies is captured through a data platform that (Pharmaoutcomes) enables data to be extracted from their systems which is used for validation.

2.5 Due to capacity in primary care, activity fell dramatically during the COVID-19 pandemic and was slow to recover but has improved in recent months. The relationship with GPs and pharmacies has been established over many years and they work collaboratively with our other commissioned services to boost capacity. They have shared data with our commissioned Behaviour Change Services to enable them to provide additional capacity and we have a commissioned the local GP Federations to provide additional NHS Health Checks. GP Federations are groups of general practices that form an organisational entity and share responsibility for delivering primary care services for their combined patient communities.

We want to maintain these commissioning and collaborative arrangements with GP practices due to the advantages that this brings to service delivery, but we acknowledge the workforce capacity issues and look to potential providers to support delivery.

Provider Selection Regime

2.6 Moving forward new legislation, the Provider Selection Regime (PSR), will, subject to parliamentary scrutiny and agreement, come into force in January 2024. These new regulations will require local authorities to follow the same procurement regulations as the NHS when commissioning health services. It will mean a more flexible approach to procurement and is in response to the creation of Integrated Care Systems. However, the Local Authority must have a clearly defined process for the decision.

2.7 The PSR has implications for how we commission the majority of the Public Health contracts. The Local Authority requirement to establish a process for adopting the PSR for health service contracts is currently being developed the Authority's Procurement and Commercial Team.

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In terms of the primary care contracts new ones will need to be in place for April 2024. Initial Procurement advice is that the contracts with primary care for health services would be subject to PSR regulations.

NHS Recharges for Medications and Devices prescribed as part of the Public Health Services commissioned from Primary Care

2.8 GP practices that provide Long-Acting Reversible Contraception (LARCs) and Stop Smoking Services (SSS) which as described above involves prescribing devices and medications.

- Nicotine Replacement Therapy (NRT) and oral medication Zyban (bupropion) and Champix (varenicline)
- Intra-Uterine Devices and Subdermal Contraception

The Integrated Care Board (ICB) supplies these devices and medicines to GP practices. through a FP10 request (NHS coding system) to enable them to provide the service. The ICB then recharges the costs from the Public Health Grant. The alternative option is to commission a supplier which would bring additional costs and the local authority would not. have the cost advantages associated with the scale of purchasing that the NHS Supply Chain has, which provides substantial leverage with the drug companies.

N.B. Nalmafene is medication used as part of structured alcohol treatment programme. The medication is prescribed by GPs and through the Drug and Alcohol Treatment Service that the Local Authority commissions from Change Grow Live (CGL). Recharges for Nalmafene against the Public Health Grant should only be made if it was part of a treatment programme with CGL alongside psychosocial interventions. Currently there is very limited prescribing of Namafene, approximately £1,000 per annum. Consequently, the ICB has agreed not to recharge. However, it is possible that in the future this situation could change.

2.9 The value of the re-charged FP10s over the last five years is shown in Table 2 below. The value fell during the COVID-19 pandemic but overall, as activity has recovered the re-charges have increased.

Table 2: FP10 Prescribing Costs recharged to the Local Authority.

Financial Year	Smoking: NRT and medicines	LARC – Implants/Injections	LARC – IUD/Coils	Nalmafene
2018-19	£301,444	£147,918	£161,876	£1378
2019-20	£304,485	£186,928	£215,660	£1142
2020-21	£266,684	£120,080	£137,459	£1183
2021-22	£239,383	£171,919	£210,263	£1108
2022-23	£232,624	£161,591	£218,774	£952

2.10 The use of a recharge arrangement is no longer tenable due to the requirement in the Local Authority that any payment cannot be made to third party unless it is linked to contracts. As part of the external legal advice secured regarding the commissioning of primary care, we received advice about the best contractual route for these recharges to minimise any risk to the Local Authority.

The external legal advice deemed that although the Section 75 of the NHS Act 2006 does state that the Secretary of State may by regulation make provision for "… the making of payments by a Local Authority to an NHS Body [for or in connection with the exercise by a

Local Authority on behalf of an NHS Body on prescribed functions of the NHS Body" there is nothing specifically relating to this re-charge agreement.

Therefore, the advice was that we follow the normal process of having a documented agreement that is, a Short Form Agreement setting out the obligations between the parties including payment.

2.11 We asked specifically if the provision of these medications and devices were covered under the Procurement Regulations. The advice was that the items supplied are provided by the NHS to NHS Contractors on a "free issue" basis, and here the cost is being recouped.

It was observed that it is not a "Public Contract" as this term is defined in the Regulations, i.e., a contract for pecuniary interest having as its object the supply of products. It is more of a function of reallocating grant monies. The Council never receive the products themselves. Making payments from grant payments are not generally subject to the Procurement Regime.

In relation to any similar governance issues the response was that generally, arrangements between NHS Bodies and Local Authorities under the NHS Act 2006 are part of the "joint arrangement" for the provision of health services associated with the reallocation of public health responsibilities from NHS Bodies into the hands of Local Authorities some years ago, which are frequently covered by "umbrella" agreements. As such, the legal opinion was that the intent of the Government is that these relationships are not "contractual," except where they need to be.

2.12 The legal conclusion was that it is more a case of documenting joint arrangements and allocating public monies. In some cases that this Agreement could be part of a general Joint Agreement related to spending on Section 75 activities, which is what other Local Authorities do, but it was acknowledged that that this is unrealistic in this context.

This was followed up with the Local Authority's legal team who supported the drawing up of a Section 75 to ensure that there is a documented agreement between the Local Authority and the ICB.

2.13 In 2.4 the processes for monitoring GP practice activity and spend were described to demonstrate that we meet the requirement to ensure that delivery is robust, and contracts provide value for money. Prescribing activity is an intrinsic part of this monitoring and again we receive the raw data from the ICB which enables us to identify claims that cannot be set against the Public Health Grant. For example, we can extract data relating to prescribing of LARCs for gynaecological purposes as opposed to contraception. At the end of 2022/23 we did a review of the F10 devices ordered and the LARC activity. We identified a number of practices where there was an apparent discrepancy. This resulted in six practice visits and conformation that the data was accurate.

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.

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

All commissioned services include a requirement of providers to demonstrate how they are meeting the net zero ambitions.

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

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

- Commissioned services include a requirement of providers where possible to offer virtual services to minimise travel across the Cambridgeshire.

3.3 Health inequalities are reduced.

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

- The majority of Public Health services are commissioned for the whole population, but providers are required to ensure that population groups who experience health inequalities are able to easily access services.

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:

- Public Health commissions primary care to provide timely and accessible services for the residents of Cambridgeshire. These proposals ensure that the commissioning and contracting processes support effective and accessible services.

3.5 Helping people out of poverty and income inequality.

- There are no significant implications for this ambition.

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:

- Public Health commissions primary care to provide services for the residents of Cambridgeshire. These proposals ensure that the services are of good quality and accessible.

3.7 Children and young people have opportunities to thrive.

- There are no significant implications for this ambition.

4. Significant Implications

4.1 Resource Implications

The report above sets out details of significant implications in 1.2, 2.4, 2.3, 2.9.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above sets out details of significant implications in 1.1, 1.4, 2.3, 2.5, 2.6, 2.7, 2.8, 2.11, 2.12, 2.13.

4.3 Statutory, Legal and Risk Implications

The following bullet points set out details of significant implications identified by officers: The paper lays out the existing and new statutory, legal and risk implications which will inform any ongoing and new commissioning of primary care to provide services and other health services that will under the new Provider Selection Regime.

4.4 Equality and Diversity Implications

The report above sets out details of significant implications in 2.2.

In addition, 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 following bullet point sets out details of significant implications identified by officers:

- Any equality and diversity implications affecting engagement and communications will be identified before any service developments are implemented and promoted.

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.

- The report above sets out details of significant implications in 2.1, 2.2. The services that are commissioned from primary care contribute greatly to preventing poor health outcomes and primary care clinicians have a key role in influencing health behaviours.

4.8 Environment and Climate Change Implications on Priority Areas

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Status: Neutral
Explanation: This is not covered in the paper

4.8.2 Implication 2: Low carbon transport.
Status: Positive
Explanation: Primary care services enable residents to access services closer to their homes with less need to travel.

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats, and land management.
Status: Neutral
Explanation: This is not covered in the paper

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Status: Neutral
Explanation: This is not covered in the paper

4.8.5 Implication 5: Water use, availability, and management:
Status: Neutral
Explanation: This is not covered in the paper

4.8.6 Implication 6: Air Pollution.
Status: Positive
Explanation: Primary care services enable residents to access services closer to their homes with less need to travel.

4.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Status: Positive
Explanation: Residents seen in primary care may have health conditions susceptible to climate changes. Primary care clinicians are able to advise how they can mitigate the impact of climate change on their health.

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley 30/11/23

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement? Yes
Name of Officer: Claire Ellis 14/11/23

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law? Yes
Name of Legal Officer: Emma Ducan 5/12/13

Have the equality and diversity implications been cleared by your Service Contact? 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 16/11/23

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 Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Emily Bolton 30/11/23

5. Source documents guidance

5.1 Source documents

Laws et al; National Library of Medicine 2009: An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary healthcare: a grounded theory study.

NHS Digital Data (digital.nhs.uk) & Appointments in General Practice - NHS Digital
An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary healthcare: a grounded theory study - PMC (nih.gov)

Swann et al Health, NICE/WHO/NHS systems, and health-related behaviour change: a review of primary and secondary evidence

Health systems and health-related behaviour change: (nice.org.uk)