Bournemouth, Poole and Dorset councils
working together to improve and protect health

Public Health Dorset

BUSINESS JUSTIFICATION

Community Health Improvement Services 2019:

Business Justification

Version no: 2
Issue date: 23/10/2018

Purpose of this document

This document provides a template for business cases in support of small and medium size investments – typically those below £2 million whole life costs that are **not** novel or contentious in nature.

Please note that this template is for guidance purposes only.

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Draft	19.10.18	Draft for Project Team	Will Haydock
Draft 2	23.10.18	Draft for SMT	Will Haydock

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TEMPLATE AND SUPPORTING GUIDANCE

Appendix

1. Purpose

This business case is to seek approval to procure providers of a range of Community Health Improvement Services, namely:

Lot 1: Health Checks

This is a check designed for local residents aged from 40 to 74 years old, with some exceptions. The process, as laid out in government legislation, assesses a range of health factors, including smoking status, family history of coronary heart disease, body mass index, cholesterol level, blood pressure, physical activity levels, cardiovascular risk score, and alcohol consumption.

In 2017-18, 6,241 health checks were completed by GPs with a further 1,492 conducted in pharmacies.

Lot 2: Emergency Hormonal Contraception (EHC)

Emergency contraception can prevent pregnancy after unprotected sex or if the contraception you have used has failed – for example, a condom has split or you have missed a pill. EHC uses chemicals that affect the release of an egg, and therefore can prevent pregnancy. There were 5,620 EHC interventions delivered in 2017-18.

Lot 3: Long-Acting Reversible Contraception (LARC)

LARC refers to contraceptive methods that require administration less than once per cycle or month, specifically: copper intrauterine devices; progestogen-only intrauterine systems; progestogen-only injectable contraceptives; progestogen-only subdermal implants. Under the current contract, there were 7,695 instances of LARC in 2017-18.

Lot 4: Needle exchange

Needle and syringe programmes (NSPs) supply needles and syringes for people who inject drugs. In addition, they often supply other equipment used to prepare and take drugs (for example, filters, mixing containers and sterile water). The majority of needle and syringe programmes are run by pharmacies and drug services. They may operate from fixed, mobile or outreach sites. The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment. They also reduce the risk to the public from discarded needles by providing the opportunity for disposal of used sharps.

In 2017-18, there were 17,497 visits to pharmacies for needle exchange.

Lot 5: Supervised consumption of methadone and buprenorphine

In some instances where an individual is prescribed medication to help treat a substance use disorder, clinical guidance recommends that the patient is observed while taking what is a potentially toxic medication, to reduce the risks to the individual concerned and the wider community. In 2017-18, 708 individuals were registered for supervised consumption.

Lot 6: Smoking Cessation

Several treatments are available to support people looking to stop smoking, including:

- Psychosocial behaviour change support, which offers people personalised support while they go through the process of quitting;
- Nicotine replacement therapy, which provides a low level of nicotine, without the tar, carbon monoxide and other poisonous chemicals present in tobacco smoke, reducing harm and reducing unpleasant withdrawal effects;
- Prescribed medication (i.e. Varenicline), which reduces cravings and blocks the rewarding and reinforcing effects of smoking.

In 2017-18, 841 people started a quit attempt with support from their GP, 359 people had quit at 4 weeks and 140 people had quit at 12 weeks. Through Pharmacies 2,286 people started the quit, 783 people had quit at 4 weeks and 489 people had quit at 12 weeks.

The overall cost of these services will be variable, dependent on activity. However, as an illustration, the total spend across these areas was approximately £1.1m in 2017-18.

	2017-18 Spend			2018-19 Budget
	GP Practices	**Pharmacies**	**TOTAL**	**TOTAL**
Health checks	£162,232.00	£41,711.40	**£210,707.40**	**£600,000**
EHC		£116,311.92	**£116,311.92**	**£784,000**
LARC	£602,618		**£602,618**	
Supervised Consumption/Needle Exchange		£295,265.53	**£295,265.53**	**£300,000**
Smoking Cessation	£33,730.00	£322,553.91	**£356,283.91**	**£520,000**
Total	£415,294.88	£775,842.76	**£1,197,901.64**	**£2,204,000**
Weight Management				*£175,000*

The current spend is considerably under budget, as current provision of particularly health checks is not meeting demand. It is anticipated that spend will increase in 2019-2020, as the payment schedules for some activities are updated to reflect current priorities and costs, and delivery of health checks should increase from what are currently low levels.

However, this should be manageable within current budgets. Within the current public health grant, £600,000 is allocated for health checks, with activity forecast to increase up to 15,000 checks annually – almost doubling activity compared to the 7,733 checks delivered through GPs and pharmacies in 2017-18. Therefore increased accessibility and activity should be delivered with no increase in budget.

2. Strategic Context

Health Checks

Under The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, it is stated that 'each local authority shall provide, or shall make arrangements to secure the provision of, health checks to be offered to eligible persons in its area.' Therefore some provision of health checks is required. This project seeks to fulfil this requirement.

EHC and LARC

The same regulations note the public health responsibility of local authorities to ensure there is 'advice on, and reasonable access to, a broad range of contraceptive substances and appliances'. Lots 5 and 6 under this proposed project would form part of the local offer, and are included in the format proposed because they are specifically cost-effective interventions (as discussed below).

In relation to LARC specifically, NICE guidance states: "Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods."[1] Therefore some provision of LARC is required. This project supplements the offer through specialist services, for the reasons described in section 3 below.

Needle exchange and Supervised consumption

Lots 4 and 5 represent part of the commitment of Public Health Dorset to the Bournemouth, Poole and Dorset 2016-2020 Alcohol and Drugs Strategy. Specifically, one of the objectives of this was: 'For those who do use alcohol and other drugs, they do so in a way that reduces risks of immediate or long term health damage, including death.' 'Reducing the harm caused by drugs and alcohol' was also one of the 'wider priorities' listed in the Bournemouth and Poole 2013-16 Health and Wellbeing Strategy.

Nationally, needle exchange is identified in the 2017 Drug Strategy as a key requirement for local commissioners: 'Key to supporting improved health is action to prevent blood borne infections by vaccination (where available) and by maintaining the availability of injecting equipment through needle and syringe programmes'.

Supervised consumption is an essential element of a drug treatment system that delivers opiate substitution therapy (OST), as defined in the 2017 guidance "Drug misuse and dependence: UK guidelines on clinical management".

Smoking cessation

'Reducing the harms caused by smoking' was an objective of the 2013-16 Dorset Health and Wellbeing Strategy. Smoking cessation aims to reduce the number of people smoking in the local area, and therefore the harms associated with this.

3. Case for Change

A. Business needs

Please provide the compelling reasons for investment in the required services or assets, with reference to:

- *The investment objectives for the procurement*
- *The problems with the status quo.*

All the services included in this project are currently offered in some format. However, the contracts for this provision, including available extensions, expire in March 2019. Therefore any

[1] See https://www.nice.org.uk/guidance/cg30/chapter/1-Recommendations

provision beyond this point will require new contracts to be put in place or alternative arrangements to be accepted.

Health Checks

As noted above, the offer of a health check to the eligible population is a mandatory part of local public health service delivery. Some form of offer is therefore required. Current provision is inequitable and unreliable, with some patients reporting waits of up to six months for an appointment. Uptake has been particularly low in some areas of the county, including priority areas for addressing health inequalities. Therefore it is proposed that changes are made in order to offer more accessible provision.

EHC and LARC

Local residents have access to a range of forms of contraception through primary care and specialist sexual health services such as GUM clinics. However, public health regulations state that as well as there being a choice in principle, there should be 'reasonable access to a broad range of contraceptive substances and appliances'. Primary care provision is offered through booked appointments, and specialist sites are more limited geographically and generally offer appointments with some drop-in sessions – but not in an open access format. Community-based provision, as currently delivered through pharmacies, is an open access ('drop in') service. The proposal will therefore mean that services are available in a wide range of locations at accessible times and places.

While LARC fittings would still be by fixed appointment, in the absence of this project LARC would only be available from the limited number of specialist sites. Therefore the project offers the opportunity to maintain genuinely accessible services for LARC.

Needle exchange

Under the core community treatment contracts for substance misuse, services already provide specialist needle exchange. However, NICE guidance for needle and syringe programmes recommends that there are both specialist programmes and 'community pharmacy-based needle and syringe programmes'.[2] This is recommended on the basis that specialist services will operate via a limited number of times and locations, and it is advised that 'services are offered at a range of times and in a number of different locations'. The proposal will ensure this recommendation is met.

The proposal will also incorporate disposal facilities for other client groups, such as diabetics who inject insulin, for whom the local authority holds responsibility in terms of waste disposal. This responsibility previously rested with PCTs and has not as yet been systematically absorbed by the local authorities.

Supervised consumption

For any system offering opioid substitution treatment, which the commissioned community substance misuse services do, supervised consumption of medication is required for a particular cohort of service users in order to ensure the safety of the individual and the wider community.[3]

[2] See https://www.nice.org.uk/guidance/ph52

[3] See https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

This should therefore be provided at accessible times and places to ensure continued compliance with treatment.

This project seeks to ensure there are providers able to offer this service across the local area. In addition, other models to deliver supervision will continue to be explored.

Smoking cessation

NICE and Public Health England have published guidelines for health practitioners and stop smoking services on the best ways to help people quit smoking.[4] The guideline includes evidence-based interventions that should be available to adults who smoke including: behavioural support; non-nicotine medications to help cravings and withdrawal symptoms; nicotine replacement therapy (NRT) and very brief advice. These are the elements of the service model that is being proposed as part of this project.

In addition, the guideline recommends prioritising specific groups who are at the highest risk of harm from smoking, such as women who are pregnant and people with mental health problems. This requirement is being taken forward through separate workstreams, where Public Health Dorset has worked with maternity and mental health services to develop pathways and protocols to ensure that those at the highest risk of smoking-related harm receive the support they need.

B. Benefits

*Please provide a summary of the **main** benefits associated with the investment, distinguishing between qualitative and quantitative; cash releasing and non-cash releasing; direct and indirect to the organisation, as appropriate.*

Health Checks

Key potential benefits of health checks include disease identification, changing health-related behaviour, increasing referrals to other health improvement services

Researchers at the University of Cambridge have conducted an evidence synthesis[5] on each of these points and found the following:

In terms of disease identification, one new case of raised blood pressure is found for approximately every three to four NHS Health Checks, with one new diagnosis of hypertension made for approximately every 30-40 NHS Health Checks. A new case of diabetes is made for every 80-200, chronic kidney disease between 60 to 600 and a person with a modelled cardiovascular disease risk ≥ 20% every six to ten. In the two studies that include only those with cardiovascular disease risk ≥ 20%, almost one in two NHS Health Checks resulted in a diagnosis of hypertension20,21. In all these studies though, is not possible to know how many of these are directly a consequence of the NHS Health Check or how many would have been identified within routine practice.

[4] See https://www.nice.org.uk/guidance/NG92

[5] The Primary Care Unit, University of Cambridge and RAND Europe (2017) NHS Health Check Programme rapid evidence synthesis, prepared for Public Health England.

In terms of changing health-related behaviours, the only factor consistently examined is smoking, and in this case there is a separate service to begin discussions with potential service users (LiveWell) and a separate lot proposed as part of this project to offer support to individuals who choose to take up this opportunity. Evidence suggests that prevalence of smoking reported in the medical records was not significantly different among attendees than non-attendees a median of two years after the NHS Health Check.

There is some evidence that reductions in risk factors for cardiovascular disease and other conditions are more substantial amongst patients who have attended a health check, along with prescribing of drugs such as statins to reduce risk and treat relevant conditions.

This suggests that health checks may have some effect on people's long-term health, and therefore costs across the health and social care system, though these are not likely to be cashable in terms of the public health budget.

EHC

Research suggests that EHC is cost effective. Based on analysis published in 2010 in the Journal of Family Planning and Reproductive Health, both ulipristal acetate (UPA) and levonorgestrel are cost effective based on avoiding the cost of an unintended pregnancy (£948).[6]

Therefore there are significant savings to the healthcare system, though these are generally not cashable by PHD or PHD-commissioned services.

LARC

In November 2016, increasing uptake of LARC one of just six areas where Public Health England identified preventative interventions estimated to improve health and wellbeing and save money to the health and/or care system within a five-year horizon.[7]

Current NICE guidance states that:

- all currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- intrauterine devices, the intrauterine system and implants are more cost effective than the injectable contraceptives
- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies.[8]

Therefore it is appropriate for LARC to be offered locally both on the basis of patient choice and cost effectiveness in comparison to other methods of contraception.

Needle exchange

NICE guidance states that delivering needle and syringe programmes (NSP) is cost effective in controlling HIV and reducing Hepatitis C prevalence, particularly when offered alongside

[6] See https://srh.bmj.com/content/familyplanning/36/4/197.full.pdf
[7] See https://www.gov.uk/government/publications/local-health-and-care-planning-menu-of-preventative-interventions (p.6)
[8] See https://www.nice.org.uk/guidance/cg30/chapter/Key-priorities-for-implementation

recruitment into OST. It is also recommended that NSP provision includes interventions to encourage clients to attend OST programmes.[9]

Therefore, given that Public Health Dorset does not commission HIV or HCV treatment or related services, these savings are not necessarily cashable. However, they reflect significant savings to the wider health and social care system, as well as society as a whole.

Supervised consumption

As noted above, supervised consumption increases the safety of service users on OST. Research suggests that in England and Scotland opioid-related deaths reduced fourfold after the introduction of supervised consumption.[10] This could deliver significant, if non-cashable, savings to society, and the offer of supervision is required if our commissioned services are to be able to deliver treatment in line with national guidance.

However, evidence for using supervised consumption by default is of relatively low quality, with researchers recommending that decisions as to whether OST should be delivered via supervised consumption or take-home doses should be made on a case-by-case basis.[11]

The project proposed would therefore offer the option for service users to access supervised consumption facilities as appropriate, with no requirement or guarantee of business for the providers concerned.

Smoking cessation

Current NICE guidance states that commissioners should ensure the following evidence-based interventions are available for adults who smoke:

- behavioural support (individual and group)
- bupropion
- nicotine replacement therapy (NRT) – short and long acting
- varenicline
- very brief advice.

NICE concluded:

> "Evidence showed that all the stop smoking interventions recommended for adults are effective. But to get the most benefit, staff delivering behavioural interventions must be trained to the NCSCT training standard. All the interventions are clinically effective, cost effective and cost saving to both the NHS and local authorities."[12]

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[9] See https://www.nice.org.uk/guidance/ph52 and https://www.nice.org.uk/guidance/ph18/documents/needle-and-syringe-programmes-economic-modelling-revised-full-report-september-082

[10] Strang J, Hall W, Hickman M, Bird SM (2010) Impact of supervision of methadone consumption on deaths related to methadone overdose (1993-2008): analyses using OD4 index in England and Scotland. *British Medical Journal*, 341: c4851

[11] Saulle R, Vecchi S, Gowing L. (2017) Supervised dosing with long-acting opioid medication in the management of opioid dependence. Cochrane Database of Systematic Reviews 2017, Issue 4. Art. No.: CD011983. DOI: 10.1002/14651858.CD011983.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011983.pub2/full

[12] See https://www.nice.org.uk/guidance/ng92/chapter/rationale-and-impact#evidence-based-stop-smoking-interventions-2

Although these savings would not be cashable in terms of the public health budget, this project therefore seeks to procure these services with the specific requirement that staff delivering interventions have received appropriate training.

C. Risks

*Please provide a summary of the **main** risks associated with the investment, distinguishing between business and service risks during the design, build and operational phases of the project, as appropriate.*

See risk register below.

No	Risk Description	Risk Status *Open or Closed*	Risk Lead	Date Identified	Current Controls *How do we currently manage this risk?*	Current Risk *High / Medium / Low*	Movement Since Last Review *Improving / Deteriorating / No Change*	Is the current level of risk acceptable? *i.e. Yes or No, based on the current controls*	Any Issues to Highlight Since Last Review?	Further actions identified to achieve an acceptable level of risk	Target Date for further actions
1	**Financial: spend is determined by service user demand, with particular risks around health checks and supervised consumption, where it is anticipated activity will increase considerably over the period of this contract.**	Open	S Callaghan	18/10/2018	(i) Modelling of likely activity has been undertaken to understand expected spend, and budgets have been allocated accordingly (£600,000 for health checks in 2019-2020 compared to a spend in 2017-18 of £210,707). (ii) There is the option to close a lot for a period if there is overspend.	Medium	No Change	Yes	None	Review activity at the end of Q1 2019-2020 to check how likely increased demand is.	01/07/2019

2	**Strategic: All lots have strategic importance to Public Health Dorset. In particular, smoking cessation is a key objective of the 2013-16 HWB plan and Health Checks are a mandatory requirement. If performance is poor, this puts at risk the delivery of PHD's strategic objectives**	Open	S Callaghan	18/10/2018	PHD monitor activity on a monthly basis and will dedicate staff resource, particularly in year 1 of contracts, to ensure coverage and mobilisation are sufficient to ensure adequate performance	Low	No Change	Yes	None	Review activity on an ongoing basis (monthly for PharmOutcomes users).	01/05/2019
3	**Reputational: Potential providers such as GPs are key partners for within the wider health and social care system. If PHD proposals for this project are not acceptable to this group, the reputation of PHD may be compromised, affecting joint working on other issues.**	Open	S Callaghan	18/10/2018	(i) Consultation with stakeholders prior to procurement going live to ensure potential concerns/issues are understood; (ii) Clear communication with potential providers about the process once finalised	Low	No Change	Yes	None	Review engagement of providers during procurement process	15/02/2019

4	**Reputational: These are all public-facing programmes and members of the public have expressed frustration where they have been unable to access a health check, for example. Failure to provide an accessible service may affect the wider reputation of PHD, which is important for its role as a trusted provider of healthcare information**	Open	S Callaghan	18/10/2018	(i) Consultation with stakeholders prior to procurement going live to ensure potential concerns/issues are understood; (ii) Clear communication with the public once services are live to ensure they understand what they can expect and why the provision is arranged as it is.	Low	No Change	Yes	None	Review engagement of providers during procurement process Review activity to anticipate any temporary pause in activity being introduced to allow communication with providers and the public.	15/02/2019

5	**Service delivery: All services would be at risk if there is inadequate coverage across the area.**	Open	W Haydock	18/10/2018	(i) Consultation with potential providers prior to launch of procurement to ensure proposals are likely to be acceptable; (ii) The proposed framework will be open for 4 years, allowing plenty of time for potential providers to sign up; (iii) Any single lot can be closed with alternative provision arranged if the market does not provide acceptable coverage.	Medium	No Change	Yes	None	Review engagement of providers during procurement process	15/02/2019

4. Available Options

Please provide a description of the main options (or choices) for investment, together with their relative advantages and disadvantages (a SWOT analysis).

Please bear in mind:

- *That a minimum of **four options** should be considered, including the 'do minimum' or 'do nothing' (unless there are compelling reasons to the contrary)*
- *That these options may differ in potential business scope, service solution, service delivery, implementation and funding, depending on the nature of the investment*
- *That the investment appraisal for each option should be contained as an appendix and prepared in accordance with the tools and techniques set out in the Capital Investment Manual and HM Treasury Green Book.*

Four possible procurement options are explained and assessed below. The options are rated according to how well the proposal meets each of the guiding principles of effectiveness, efficiency and equity, as follows:

- Red: Does not satisfy this principle
- Amber: Satisfies the principle to some extent
- Green: completely satisfies this principle

All options maintain the possibility of having different providers for each element, as the nature of the requirements are sufficiently different. Therefore, in choosing a preferred option decision-makers may feel that a single approach is not possible for all areas of activity. I.e. the option is available to choose a separate route for a particular 'lot' if required. Under the section below covering the preferred option, the specific lots where the preferred option is not clear-cut are discussed in detail.

The option of 'do nothing' in terms of providing no services is not presented here, as it would contravene the statutory requirements of the council, at least in terms of most services. The case for providing some element of service in all these activity streams has already been made in this document under sections 2 and 3. What is discussed, however, is the option of keeping the current arrangements in place – i.e. making no change.

Option 1: No change

Keep arrangements as they are currently without any procurement process

The proposals contained in the business case do not generally suggest radical change is required for most service areas under discussion. Therefore for supervised consumption, LARC, EHC and smoking cessation this could be an acceptable option. Coverage across the county for these areas is comprehensive, and performance is good.

In the case of supervised consumption and LARC, there may be opportunities to deliver services more efficiently in areas where there is more concentrated demand (i.e. urban centres), to avoid duplication where specialist services either already offer the service, or potentially could. Under the current arrangements there is not perfect equity of provision, but it is acceptable.

Two areas where this model is more challenging are health checks and needle exchange. Current delivery of health checks is well below Public Health Dorset's aspirations, and there is no indication that an improvement in performance would be possible while maintaining current arrangements. Pharmacies do not have access to the relevant data to target their offer, and initially uneven provision has combined with low activity rates as part of a vicious circle meaning that providers have not invested in making checks more accessible. The current provision of needle exchange is reliant on a payment system that is relatively complicated and not fully understood by providers, who have made it clear they would prefer a simpler payment structure.

Furthermore, there are legal issues with allowing the current arrangements to continue. The current contract will expire in March 2019 and there is no option to extend this further as all extension options have already been used. Any provision delivered beyond this point, without new contracts in place, would be on the provider's terms and conditions, with no ability to enforce training or quality, which have both been identified as potential areas for development by commissioners. Therefore, although the risks with this option are relatively low and provision is generally acceptable, this option is not recommended.

	Option 1: No change		
	Effectiveness	Efficiency	Equity
Health Checks	Current provision is poor in terms of both accessibility and reliability, with a small number of people accessing health checks, some individuals waiting up to 3 months for an appointment, and not all data being reliably collated and used within primary care.	The current provision does not require unreasonable input from commissioners to operate at this low level of performance, and the costs are relatively low (though only due to the low activity rates).	At present access to a health check is highly variable by locality.
Needle Exchange	Needle exchange is easily accessed from a wide range of sites. The quality of the intervention received, however, in terms of harm reduction advice and signposting to treatment, is relatively poor.	The pricing mechanism for needle exchange is complex and not fully understood by providers. The equipment distributed is not well tailored to all service users' needs, with the only units of supply available being packs of a week's equipment.	While provision is generally accessible across the area, and the same equipment is distributed to all, the needs of all service users are not identical, and therefore some may be better served by the system than others.
Supervised Consumption	There is good coverage and the interventions are generally delivered safely, though not with specialist drug worker input.	There is a considerable cost associated with this mode of provision, not only directly through this contract but also through dispensing costs that accrue to Public Health Dorset.	With good coverage across the county, and a comparable service, this is at present an equitable service.
Long-Acting Reversible Contraception	The current arrangements allow for access to LARC and provision is offered that is of high quality.	The delivery of LARC within primary care settings may not be as efficient as through specialist centres due to issues of scale.	Although coverage is not perfectly even, a comparable service is offered across most areas within the county.

Emergency Hormonal Contraception	The provision of this service through pharmacies is accessible and of good quality.	The use of a pharmacy setting, where the delivery of EHC fits with other comparable services, is highly efficient as it requires little additional resource outside of the delivery itself.	The quality of the provision (in terms of any associated counselling) will be partly dependent on the individual staff, and there is insufficient resource quality assure in great depth.
Smoking Cessation	The current provision is relatively effective, though it is not necessarily delivered by the most specialist, appropriate staff.	As with EHC, this mode of delivery is highly efficient as it is available alongside other services and does not require additional resource.	The quality of provision, given the potential importance of specialist talking therapies, may be variable, and not all pharmacies offer this service.

Option 2: Single provider

Conduct a procurement process seeking to award a contract to a single organisation, either for all lots or by activity area.

For most lots, this option has the potential to be highlight effective, as the scale of provision would allow for a certain level of specialism that these lots cannot provide when they are a small element of each local provider's work, as at present.

However, because levels and concentrations of need vary considerably across the county, a single approach or design may not be possible. If a blanket approach were used, while it might deliver efficiency, it would not, in fact, offer equity of provision, as it is likely that services would be more easily accessible and specialised in areas of concentrated need.

A more tailored approach, by contrast, would fail to deliver efficiency. However, the efficiency of the procurement process and ongoing contract management should also be noted: with only one provider this would be considerably more efficient for the Public Health Dorset in terms of internal team resources allocated to this process.

	Option 2: Single provider		
	Effectiveness	Efficiency	Equity
Health Checks	Experience with the current model of single providers for large areas, it would appear that this is unlikely to lead to accessible services being provided in the county.	A single provider model could be managed with a relatively low commitment of resource from PHD, and could deliver economies of scale.	It would be challenging for a single provider to genuinely offer an equitable service across the county as it would be difficult to provide venues and staff that were equally accessible in all areas for this one activity stream.
Needle Exchange	A single provider for needle exchange would be likely to have the technical expertise to improve the delivery of harm reduction interventions and signposting to treatment.	To deliver the maximum efficiencies, a single provider of needle exchange would be fully integrated with wider community drug treatment, which is not possible for 2019 given the timescales of other contracts.	

Supervised Consumption	There could be improvements in the quality and integration of the intervention if it were delivered by specialist drug workers, which would be more likely if this were a specialist provision.	In urban locations, a single provider could offer a highly efficient service, but this would not be possible outside of these areas, where it would be prohibitively expensive to administer on the very small scale required.	The difference between provision and accessibility in urban, as opposed to rural, locations would be pronounced.
Long-Acting Reversible Contraception	A specialist service could offer a highly tailored and effective service.	These interventions require considerable specialist expertise, and yet the scale of them is not such that they can be delivered by a single provider in isolation from other relevant services (e.g. dispensing of other drugs).	Without the use of existing services that operate in accessible locations, it would not be possible to provide a genuinely equitable service in all areas of the county.
Emergency Hormonal Contraception			
Smoking Cessation			

Option 3: locality based lots

Potentially a different provider for each area, possibly with a different tailored specification

This option could provide strong effectiveness, given the opportunity to tailor of the offer to each area. However, this may lead to some issues around equity, as each locality may be served differently, therefore scoring suggests this would generally be 'medium'.

The procurement option raises efficiency concerns, however, as it would be a considerably more intensive process, including in relation to contract management, with a significant number of locality lots required to ensure coverage across the whole area.

	Option 3: Locality lots		
	Effectiveness	Efficiency	Equity
Health Checks	Clarity about the location of provision in each area could improve take-up. A locality-based system could ensure the accessibility of services.	This model would require a relatively high level of commissioner input to manage the large number of lots, and no single provider would be guaranteed economies of scale.	If there were a sufficiently large number of lots, the accessibility of this service could be preserved for all areas. However, this would lead to challenges in ensuring the quality of provision across all areas
Needle Exchange	This option would allow for a more appropriate targeting of the offer to the specific needs in each locality.		While the targeting of the offer by locality could improve the effectiveness at the aggregate level, it would mean that the same options were not available to all service users.

Supervised Consumption	It is unlikely that this model would allow for provision by specialists, given the split into individual localities, and therefore the quality would not be improved from the current provision.		If there were a sufficiently large number of lots, the accessibility of this service could be preserved for all areas. However, this would lead to challenges in ensuring the quality of provision across all areas
Long-Acting Reversible Contraception	It is unclear whether the size of lots would lead to greater accessibility than specialist provision already in place.	Given the specialist nature of this provision, it is possible that having fewer providers could deliver some efficiencies.	
Emergency Hormonal Contraception	Lots would have to be prohibitively small to ensure the genuine accessibility of this service, given its emergency nature, as distinct from that provided through specialist services.	This model would require a relatively high level of commissioner input to manage the large number of lots, and no single provider would be guaranteed economies of scale.	
Smoking Cessation	This model might allow for more specialist provision, targeted to the specific needs of a local area.	Given the specialist nature of this provision, it is possible that having fewer providers could deliver some efficiencies. However, the additional contract management costs for PHD would be significant if the effectiveness improvements were to be delivered.	

Option 4: Any Qualified Provider (AQP)

Any provider that meets the criteria to deliver would be permitted to, and paid according to activity. The end user would determine where they wanted to access the service.

	Option 4: Any qualified provider		
	Effectiveness	Efficiency	Equity
Health Checks	Given the issues with single providers across large areas, it is possible this model might increase the accessibility of the intervention.	This model would be highly efficient for PHD in terms of procurement, and in terms of the providers, would lead to services being offered as part of wider work, rather than being set up as a dedicated project.	While this model would mean that in theory every customer would receive the same service, there is still likely to be variation in quality.
Needle Exchange	While this model would not lead to provision by specialists, it is likely that there would be an accessible service of good quality as at present.		While provision is generally accessible across the area, and the same equipment is distributed to all, the needs of all service users are not identical, and therefore some may be better served by the system than others.
Supervised Consumption			As at present, this is likely to be an accessible service that is comparable across all areas of the county.

Long-Acting Reversible Contraception	Given the expertise of the providers, this would offer a reliably effective service that is likely to be accessible.		While this model would mean that in theory every customer would receive the same service, there is still likely to be variation in quality.
Emergency Hormonal Contraception	The key to the effectiveness of this provision is that it is delivered in a timely fashion. This would be more likely with the coverage this model should afford.		
Smoking Cessation	While this model would not lead to provision by specialists, it is likely that there would be an accessible service of good quality as at present.		

This model would offer a high level of efficiency in terms of the procurement process, as it can be relatively simple and places the power in the hands of the end user. In offering the responsibility of choice to the service user, AQP is a good fit with the Alcohol and Drugs Strategy objective: 'Ensure people are able to access appropriate treatment and harm reduction interventions at times and places fitting their needs.' Given that all providers should offer the same service, and there would be numerous providers across the county, this should offer equitable provision.

The approach of allowing any qualified provider to offer the service should open up provision to the widest possible number of providers and locations, therefore leading to a highly accessible service. The risks with this model are therefore that the costs may increase, despite the efficiency gains (methods to mitigate this risk are covered under the relevant section of this business case), and that, given the sheer number of potential providers, quality assurance may prove to be a challenge. However, several of these activity streams are relatively straightforward provided that the staff have the appropriate knowledge, skills and training.

In summary, in terms of effectively meeting the need of patients across the Pan Dorset area, this model is based upon an idea that the customer ultimately oversees where the business is activated. However, this is dependent on the quality of provision in reality. Therefore, ensuring appropriate training of provider staff would essential in making this model work to its maximum.

5. Preferred Option

On the basis of the above, please:

- *State why the recommended option optimises value for money(VFM)*
- *Describe the services and/or assets required.*

Of the options under consideration, only Option 4 (Any Qualified Provider) increases the effectiveness, efficiency, and equity of the current provision. While options 2 and 3 both have a high potential for effectiveness, this is not matched by efficiency or equity, when option 4 is likely to be considerably more efficient. Option 4 includes no 'Low' scores for any of effectiveness, efficiency or equity.

Given the pressures on staff time and commissioning budgets being experienced at present, and anticipated to continue during the course of the proposed contracts (4 years), it would appear that

Option 4 simultaneously offers the potential for improvements in service and efficiency gains. For all service areas, it scores highest on efficiency.

Despite this potential for efficiency, however, Option 4 does entail some risks. Given that spend will be determined by activity, and the choice of provider and level of activity is in the hands of the service user, there would appear to be little potential control of the budget for commissioners. However, as outlined in the risk assessment, there are opportunities to mitigate this risk, and indeed halt any further payments and activity if required.

For only two proposed lots is Option 4 not the highest scoring. Needle exchange would be equally well served by Option 2 (One Provider), while smoking cessation would be well placed under Option 3 (Locality Lots). However, Option 3 for smoking cessation would sacrifice the likely efficiency of Option 4. Moreover, this would not be possible without other lots following suit, as smoking cessation would be isolated from the other lots being provided, would likely reduce take up by providers, as they would have to go through a separate process simply for smoking cessation, which advice suggests would not be viewed positively.

In terms of needle exchange, Option 4 on its own will not deliver the optimum level of efficiency, and Option 2 would deliver a higher level of effectiveness, due to the specialism that could be employed. This potential lack of effectiveness is a concern, given the importance elected members in Bournemouth and Weymouth have placed on the issue of drug-related litter. Therefore, it is suggested that in addition to the proposed any qualified provider, a review is conducted to consider the specific issues regarding public injecting and drug-related litter in urban centres such as Weymouth and Bournemouth.

	Option 1: No change			Option 2: One provider			Option 3: Locality lots			Option 4: Any qualified provider		
	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity	Effectiveness	Efficiency	Equity
Health Checks	Low	Medium	Low	Low	High	Medium	Medium	Low	Medium	Medium	High	Medium
Needle Exchange	Medium	Low	Medium	High	Medium	Medium	High	Low	Medium	Medium	High	Medium
Supervised Consumption	Medium	Medium	High	High	Low	Low	Medium	Low	Medium	Medium	High	High
Long-Acting Reversible Contraception	High	Medium	Medium	High	Low	Low	Medium	Medium	Medium	High	High	Medium

Emergency Hormonal Contraception	High	High	Medium		High	Low	Low		Low	Low	Medium		High	High	Medium
Smoking Cessation	Medium	High	Medium		High	Low	Low		High	Medium	Medium		Medium	High	Medium
	7	7	6		10	3	2		7	2	6		8	12	7
	20				15				15				27		

**Scoring Low as 0, Medium as 1, High as 2*

6. Procurement Route

Please state how the asset or service will be procured in accordance with the Government Procurement Agreement (WTO) and the EU Consolidated Public Sector Procurement Directive (2004).

This may involve the use of an existing contract; a call-off contract or framework agreement; or the requirement for a new procurement under the above.

It is proposed that a flexible framework agreement is used, with separate lots for each area of activity. This arrangement has strengths and weaknesses as outlined below:

Strengths	**Weaknesses**
Maximum potential coverage	No guaranteed quota/income for providers
Fair to whole market	Requires ongoing management/administration
Allows for new entrants	No price competition
Focus on End User choice	Fixed performance criteria
Simple for providers to complete applications	Delivers only basic service requirement

This proposal requires approval from the Joint Public Health Board.

There will be one set of Framework terms and conditions, and one procurement document (explaining the Framework model), but a specification for each lot.

There will be a fixed price for each unit of activity for each lot, and a pass/fail evaluation to identify the qualified providers based on a set of minimum criteria.

The light touch regime permitted by Contract Regulations for Health Services allows for Framework Agreements to be modified. In this case the modification will be that new applications to join the Framework will be permitted at any time. This will help mitigate the risk that there is inadequate or inequitable coverage of providers.

7. Funding and Affordability

Please indicate:

- *The capital and revenue costs of the proposed investment*

- *How the investment will be funded*
- *Any affordability gap (as appropriate).*

The proposed model of delivery is not expected to have a significant impact on budgets or costs. Current expenditure on these activity streams is under budget, because poor engagement and performance (particularly in relation to health checks) has meant that less activity has been billed for than was hoped. Therefore, there is capacity within the current budget for activity levels to increase considerably. For example, the 2017-18 budget for health checks was £600,000 compared to an actual expenditure of £210,707.40.

The investment in the new services will be funded, as at present, through the allocation of the Public Health grant made to Public Health Dorset. The aim is that overall this is relatively cost neutral. However, potential increases in spend in relation to health checks, supervised consumption and needle exchange have all been noted.

For health checks, the option remains to close down the lot for a period, if the limit on spending has been reached.

For supervised consumption, commissioners and providers are exploring alternative, more efficient solutions to dispensing drugs as part of a broader review of how treatment services can increase the number of people engaged in Bournemouth.

For needle exchange, it is the change in pricing structure that may increase costs. However, other changes to the equipment being distributed may deliver savings against which this can be offset. Nevertheless, there may be a risk of up to £10,000 as outlined elsewhere.

The public health grant is determined on a year-by-year basis, and therefore the allocated budget for this activity stream may change over the four year period of the contracts. In order to mitigate this risk, the same strategies can be applied as would be for activity-led cost pressures. That is, any lot can be terminated at any time and alternative pricing or provision can be explored and developed. For several of the services where a gap in availability would be challenging, there is already alternative provision available through primary care and specialist services (e.g. LARC, EHC). This has the potential to reduce the accessibility and equity of the service, as discussed above, but it would continue to provide some offer while alternative models of provision were put in place.

8. Management Arrangements

Please indicate how the investment will be delivered successfully with particular reference to:

- *Project management arrangements*
- *Business assurance arrangements (if applicable)*
- *Benefits realisation monitoring*
- *Risk management*
- *Post project evaluation (if applicable)*
- *Contingency plans (if applicable).*

Project management is being undertaken as follows:

Sophia Callaghan	Project sponsor
Will Haydock	Project manager

Darryl Houghton	Payment processes
Vicky Nichols	Financial information
Hayley Haynes	Data analysis
Gaby Lever	Project administrator

In addition to these staff, individual theme leads are involved in overseeing the work for their specific areas:

- Health checks: Susan McAdie
- Needle exchange: Will Haydock
- Supervised consumption: Will Haydock
- LARC: Jenni Lages
- EHC: Jenni Lages
- Smoking cessation: Stuart Burley

Ongoing management of the framework will require:

- Providers can send in a new application at any time
- This will use the message field in the e-procurement portal (Supplying the south west)
- Evaluation of qualified providers (pass/fail)
- Send notification of place on Framework (lots qualified, rates etc.)
- Assess invoice claims and check work delivered

Support for this function will be provided by business support and the procurement business partner. Ongoing analysis of activity and financial data will be conducted in-house using current staff as under the project management team. The project team will produce a post project report in summer 2019, reflecting on the service provision once the contracts are live. It is therefore essential that staff resource is allocated to the ongoing contract management and evaluation of these services.

Approvals This document requires the following approvals.

Name	Sign of Approval	Date of Issue	Version
Sam Crowe Acting Director of Public Health Dorset		29/10/2018	