Executive Councillor

Open Report on behalf of Glen Garrod, Executive Director of Adult Care and Community Wellbeing	
Report to:	**Councillor Mrs P A Bradwell, Executive Councillor for Adult Care, Health and Children's Services**
Date:	**Between 12 January – 19 January 2018**
Subject:	**Local Stop Smoking Services (LSSS) Re-Procurement**
Decision Reference:	**I014239**
Key decision?	**Yes**

Summary:

The smoking of tobacco remains the single greatest cause of preventable illness and premature death in England. On average there are more than 1,300 smoking attributable deaths each year in Lincolnshire the majority of which come from our most deprived communities. The estimated smoking population of Lincolnshire is 103,214. This is estimated to cost society £191.2 million; £1,853 per smoker per year.

The Care Act 2014 places a duty on local authorities to enable access to services that contribute towards preventing or delaying the development of care needs. Since smoking doubles the risk of developing care needs, it is highly relevant when considering the provision of preventive services.

In health and care terms potential savings across the life of a five year programme could be £1.9m for local authorities and £8m to the NHS.

The current contracted Local Stop Smoking Service (LSSS) has been in place since January 2016 and involves the co-ordination, management and administration of specialist smoking cessation services through a network of sub-contracted providers (eg, pharmacists, GPs, military and voluntary sector) providing behavioural support with pharmacotherapy to achieve four and twelve week quits. It also incorporates the coordination of Tobacco Control initiatives, including education campaigns, media work, harm minimisation interventions and enforcement activity associated with distribution of illicit tobacco products and under-age sales.

A significant change in the scope of the current contract for LSSS was made in June 2017, with the inclusion of direct supply by the contract provider of Nicotine Replacement Therapy (NRT) and future pharmacotherapy changes into the contract. This was the result of a move away from NRT prescribing by GP practices.

This contract variation, coupled with the underperformance of the provider, has necessitated a review of the contract scope and a re-procurement of the service at the end of its initial term in 2018.

Recommendation(s):

That the Executive Councillor:

1. Approves that the Local Stop Smoking Services (LSSS) be re-commissioned and a procurement undertaken to deliver a contract, to be awarded to a single provider of a county-wide service for Stop Smoking Services effective from the 2 July 2018.

2. Approves that the scope of the commissioned service with effect from 1 April 2018 should exclude tobacco control initiatives, which it is proposed will be coordinated by the Council moving forward.

3. Delegates to the Director of Adult Care and Community Wellbeing, in consultation with the Executive Councillor for Adult Car, Health and Children's Services, the authority to determine the final form of the contract and to approve the award of the contract and the entering into the contract and other legal documentation necessary to give effect to the said contract.

Alternatives Considered:

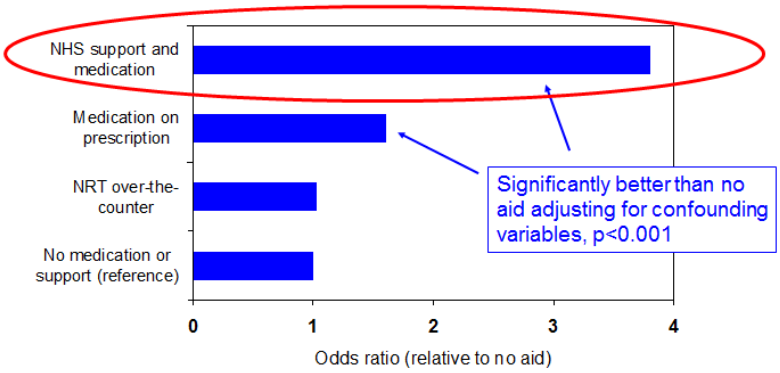
1. Negotiate a revised contract with the current provider

   The current contract contains the opportunity to extend through to 31st March 2019. However, the current commercial model and in particular the payment by results element poses a significant viability challenge to the existing provider. The re-commissioning of the service gives an opportunity to reconsider the commercial model and establish a more sustainable balance between value for money for the Council and the achievement of a reasonable return for the contractor. Submission of the new model to competition will enable the market to establish where that balance lies. Furthermore the scope of the contract requires review with the Tobacco Control element better fitting alongside the Council's other regulatory and enforcement functions.

2. Implement a different service model of behavioral support without pharmacotherapy

   A behavioural support only model has the similar value of effectiveness as an unsupported quit or buying products over the counter.

Fig: Specialist Stop Smoking Services are effective



Robert West. Smoking and Health, 2011

Data from www.smokinginengland.info; based on smokers who tried to stop in the past year who report still not smoking at the survey adjusting for other predictors of success (age, dependence, time since quit attempt, social grade, recent prior quit attempts, abrupt vs gradual cessation): N=7,939

Investment in this model would be as productive as the do nothing model

3. To do nothing

Without the Stop Smoking Services provided by Lincolnshire County Council, the support available for smokers to quit would be left to generic primary care support, retail and self-help. The evidence of success for these types of support is poor. There would be no measured outcomes for 4 week quits. We would cease to report smoking related statistics to Public Health England. This option is not in alignment with the Governments vision to create a 'Smoke-free Generation". Ceasing delivery of the service also brings a risk of reputational damage to the Council. It is estimated that the absence of a Local Stop Smoking Service would result in additional cost pressures close to £2m per annum across the Health and Care system.

Reasons for Recommendation:

1. Commercial model and scope

Recommissioning the service enables the commercial model to be reviewed to make it more viable for the market. This will lead to more market interest and a more sustainable service moving forward. It also allows the scope of the services to be reviewed and affords the opportunity for the Council to co-ordinate Tobacco Control activity alongside its other regulatory and enforcement functions.

2. Coordination of Tobacco Control Initiatives

The effectiveness of Tobacco Control initiatives, the coordination of which is within the scope of the current contracted service, has been restricted by the provider's more limited strategic reach, influence, and difficulties in recruiting.

As the Council has greater strategic influence and leadership ability, along with existing responsibilities for key stakeholders in tobacco control including LFR and Trading Standards, it is proposed that Tobacco Control initiatives should be removed from the scope of the commissioned service, and coordinated by the Council moving forward in order to deliver improved value from that aspect of the service.

3. The recommendation addresses and supports statutory requirements under the Care Act 2014 for Local Authorities to enable access to services that contribute towards preventing or delaying the development of health and care needs.

4. The alternatives considered have been deemed unsuitable in delivering the required outcomes of the service.

Background

1. Strategic Drivers

1.1. Smoking remains the biggest cause of premature mortality in England, accounting for around 80,000 deaths each year, approximately 1,200-1,300 deaths in Lincolnshire. The estimated smoking population of Lincolnshire is 103,214. This is estimated to cost £191.2 million p.a. or £1,853 per smoker p.a.

1.2. The Care Act 2014 places a duty on local authorities to enable access to services that reduce the need for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs. Since smoking doubles the risk of developing care needs, it is highly relevant when considering the provision of preventive services.

1.3. The Health and Social Care Act 2012 placed Public Health responsibilities, including the provision of stop smoking services within local authorities.

1.4. Smoking-related fires are especially important to consider in relation to fire-related fatalities. Whilst these fires only accounted for 6% of accidental dwelling fires in 2016/17, they accounted for 36% of fire-related fatalities. Key partnerships across Fire and Rescue, Trading Standards, Public Health and Environmental Health effectively manage the regulation, enforcement and legislation and smoking cessation to protect communities.

1.5. The cost burdens of smoking fall on the NHS and social care. Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society an additional £22.4m each year across Lincolnshire. This represents £12.2m in costs to local authorities, including care, housing

and other interventions; and £10.2m in costs to individuals who self-fund their care.

1.6. The evidence based model for smoking cessation of behavioural support with pharmacotherapy improves a smoker's chance of successfully quitting to four times greater than attempting to stop without additional support.

1.7. This service model of behavioural support and pharmacotherapy for Lincolnshire currently costs £1.249m per annum, with £649,000 budgeted for Behavioural Support and funded through a payment by results (PBR) methodology, and £600,000 budgeted for pharmacotherapy through a cost and volume methodology. Tobacco Control is funded via block payment at an annual cost of £145,000.

1.8. The service will provide support to approximately 5,500 adults annually. Approximately 3,000 of these will quit temporarily and 1,000 will quit for good. This contributes to a reduction in disease and disability and equates to more than 260 deaths avoided over the life of the programme.

1.9. On this scale of investment and activity the benefits of stopping smoking, notwithstanding the health and quality of life components benefits for individuals, can also be estimated to provide cash savings to the individual in the region of £3,600 per annum that can be fed back into the local economy, and in health and care terms potential savings across the life of the programme could be £1.9m for local authorities and £8m to the NHS.

1.10. In addition, there are wider benefits to stopping smoking which impact on reduced absenteeism, improved productivity and reduced sickness benefits, estimated to be in the region of £15m for Lincolnshire, incorporating £3m of savings to public sector employers across the lifetime of the programme and relevant to the scale of the planned interventions (DH/NSMC, Value for Money tool 2008).

1.11. Stop smoking services began to be formed in the early 2000's with Lincolnshire's service developing during that time. The table below shows the progress and changes that the service has experienced over the past decade of delivery. Originally the responsibility of public health within the NHS primary care trust (PCT), the service was based in Lincolnshire County Council, established within Health Communities at Beech House; it was one of the first in the country to be joint Local Authority/NHS teams. The later commissioner/provider split within the NHS moved the service provision out of public health and into Lincolnshire Community Health Services (LCHS), who expanded the service across the health network, and public health remained the commissioner of the service. Higher levels of investment and national campaigning saw a vast number of smokers supported to stop smoking during this period.

			4 Week Quit					National/£235*
Year	Set Quit	Quit Rate	Target	Actual		Investment	Reported Spend	VFM / Invst.
07/08	9,646	54.80%	5,229	5,283	PCT PH	917,000		173.57
08/09	9,772	53.20%	5,547	5,201	PCT PH	1,247,000		239.76
09/10	11,682	51.40%	5,826	6,010	LCHS	1,517,000	1,200,000	252.41
10/11	12,358	52%	6,382	6,426	LCHS	1,873,000	1,400,000	291.47
11/12	11,924	54.40%	6,473	6,485	LCHS	1,778,000	1,350,000	274.17
12/13	10,793	51.80%	6,560	5,591	LCHS Block	1,778,000	1,408,003	318.01
13/14	10,043	52.68%	6,561	5,291	LCHS Block	1,778,000	1,773,200	336.04
14/15			5,833	4,126	£1,233,474 Block/ £308,368 SC	1,560,000	1,224,991	378.09
15/16	4,000	65.55%	2,098	2,622	LCHS/N51 yr	1,541,842	1,541,842	588.04
16/17	4,788	48.04%	3,172	2,300	N51	649,647	509,078	282.46

1.12. In recent times there have been a number of changes that have impacted on user numbers accessing the service:

- re-commissioning the services away from long-established NHS provision to the private sector
- reductions in budget
- reduction in national campaigns
- the introduction of e.cigs
- smokers now being more entrenched i.e. the 'easy quits' have all gone.

1.13. Despite all this 70% of smokers when asked still want to quit smoking, they just need more support to do it. The service focus has been changed to now target the smokers who will benefit the most from quitting, e.g. pregnant women and partners, smokers with Serious Mental Health (SMI) issues and smokers with long term medical conditions (LTC) or those that have a planned surgical procedure. There is much evidence to support the benefits each of these groups experience by quitting smoking.

2. Current Service

2.1. The commissioning of a stop smoking service is a component of the draft Community Wellbeing Commissioning Strategy within Adult Care and Community Wellbeing.

2.2. In 2014/15 a re-procurement exercise took place for a Local Stop Smoking Service (LSSS) and Tobacco Control (TC) functions and the contract was awarded to Quit 51 with effect from 1 January 2016. The contract was for two and a quarter years with the initial term concluding on 31 March 2018, with a potential extension for one year, taking the contract through to 31 March 2019.

2.3. This contract is structured on a prime provider model, with the prime provider being responsible for all aspects of service delivery and performance. They sub-contracted out to other providers, most usually Primary Care or Pharmacies aspects of the behavioural support provided, as well as the prescription and supply of Pharmacotherapy. The prime provider is responsible for the day to day management of the work, training,

and ensuring the service meets all quality measures and indicators. They provide a 24/7 telephone service that is used to direct calls to the most appropriate provider and to offer stop smoking support to clients

2.4. The current service model consists of behavioural support to clients for four or twelve weeks (longer if a pregnant woman is quitting smoking) via a central core service or local sub-contractor. The provision of pharmacotherapy, either NRT or Champix / Zyban, has been prescribed traditionally through the client's local GP with the local authority reimbursing the clinical commissioning groups (CCGs) for the cost of prescribed products.

2.5. There is a block payment for the Tobacco Control function, covering the associated staffing and activity. This function brings together a countywide multi agency partnership to deliver the local tobacco control plan which includes elements such as: campaigns, education, tackling illicit and counterfeit tobacco, public protection and enforcement of regulation around proxy and under age sales of tobacco.

2.6. Electronic Cigarettes (E-cigs) emerged around 2007 and have grown in popularity with smokers who have become discouraged over existing less innovative forms of nicotine delivery systems, i.e. NRT patches, inhalators or gum and desire for a product that makes quitting smoking less clinical. An e-cigarette user may be a non-smoker or a smoker reducing their tobacco use by vaping.

2.7. Whilst there is recognition from PHE that E-cigs are 95% less harmful than cigarettes, there is limited, but growing information and evidence about a) the effectiveness of using an e-cig to help quit smoking and b) the long term health impact of e-cigs and their impacts on future health needs. The service supports people to stop using tobacco, i.e. quit with behavioural support and advice on managing their nicotine consumption.

2.8. Should evidence become available that concludes that long term impacts on future health needs and the effectiveness of using an e-cig to help quit smoking are such that it is considered medically acceptable to recommend use of e-cigs as a method of NRT, subject to NICE based guidance, MRHA regulations and updated policy from PHE, then the intention would be to incorporate their use within the contract.

3. Challenges for the Current Service

3.1. Contract Performance

3.1.1. The payment mechanism for the behavioural support element is a 100% payment by result (PBR) model, which means that the provider will only be paid on the number of quits achieved.

3.1.2. In 2016/17 4,794 people setting a quit date, resulting in 2,326 4 week quits; a quit rate of 48.6%. Performance is measured against the

council's 4 week quit maximum capacity of 3,172 quits, meaning the provider achieved just over 70% of the agreed outcomes (target quits) in their first full year.

3.1.3. 2017/18 year to date performance statistics indicate that there has been an improvement in performance levels, with 1,314 quits against a maximum capacity of 1,585 putting the provider at 82.9% of agreed outcomes. Despite the improvement, performance remains below the ceiling rate by a significant amount.

3.1.4. The provider has experienced a number of challenges including a lack of resources caused by recruitment and retention difficulties; a company buy-out has had management implications, and the deterioration of primary care performance amongst their sub-contractors with a reduction in the prescribing of pharmacotherapy linked with the service.

3.1.5. These challenges have been compounded by the 100% PBR payment mechanism, which has placed significant pressure on cash flow and consequent constraints on the provider's ability to invest in resources to improve performance. The provider is currently running at a loss to deliver this contract.

3.2. **Pharmacotherapy**

3.2.1. Primary care is challenging its role in providing prescription only medicines for local authority funded programmes. Such products are being withheld from clients across some practices, with a 'postcode lottery' beginning to develop with clients being signposted back to the service, which causes delays in treatment and the start to quit attempt.

3.2.2. In order to maintain an effective service with behavioural support and pharmacotherapy the contract was varied to move to the direct supply of Nicotine Replacement Therapy (NRT) countywide from 1st June 2017.

3.3. **Tobacco Control**

3.3.1. Helping people who have taken up smoking to stop represents only one of the six strands in tackling the cost and harm to local people from tobacco. For example, children and young people exposed to the smoke from older family members' tobacco use face a range of harms including an increase in sudden infant death syndrome, prolonged respiratory infections and household fires. The Tobacco Control element of this programme of work is required to address three other important issues:

- Ensuring young people and other non-smokers understand the harm they face if they choose to begin smoking;
- Helping non-smokers to avoid the negative health effects of breathing in the smoke from other people's use of tobacco and

- Preventing people from avoiding the safety controls put in place to safeguard them from counterfeit and non-duty paid tobacco products

3.3.2. The Tobacco Control function of the current contract is funded via a block payment of £145,000 for staffing and project activity as set out in paragraph 2.5 above.

3.3.3. The outsourcing of the Tobacco Control functions has led to mixed performance. Many of the responsibilities for Tobacco Control reside with statutory and local authorities (e.g. Lincolnshire Fire and Rescue, Trading Standards, and Environmental Health) where an external commercial agency has had little access with enforcement, regulation and excise intelligence and actions which has limited the partnership working that is so important with Tobacco Control.

3.3.4. Therefore an option to coordinate Tobacco Control activities outside the scope of the commissioned service is being proposed. This would instead be coordinated within LCC, strengthening existing local authority capacity and better supporting the work of Trading Standards, Fire & Rescue, the new 0-19 Service and driving partnership working with Environmental Health departments, Lincolnshire Police, Customs & Excise and the NHS on public protection issues around tobacco

3.3.5. This proposal will be cost neutral, with the existing £145,000 budget being utilised to fund posts and project costs within Lincolnshire County Council, covering targeted education for vulnerable young people, supporting national public health campaigns, coordinating the strategic partnership of tobacco control organisations locally and taking steps to protect the public from illicit and counterfeit tobacco

3.3.6. Subject to approval, it will need to be agreed where within the organisation this function of our overall approach to harm from smoking should be undertaken.

4. Market and Stakeholder Engagement

4.1. A Prior Information Notice was published on 27 October 2017. This initiated a process of pre-tender market engagement which incorporates a questionnaire and a Market Engagement Day held on 24 November 2017. This exercise will be used to establish the interest and current capacity of the market to deliver the proposed Service, and the responses and feedback received from potential providers will be used to test, validate and finalise the Local Stop Smoking Service Model described below. Prospective providers are aware of the estimated budget and broad service requirements and there is a good level of interest regarding delivery of this service.

5. Commercial Approach

5.1. Proposed Contract Scope

5.1.1. The core service will continue to provide co-ordination, management and administration of a specialist smoking cessation service, including a network of sub-contracted providers (including midwives, health visitors, pharmacists, GPs, military and voluntary sector) providing behavioural support to achieve four and twelve week quits.

5.1.2. The new contract will also include for the provision of pharmacotherapy as part of the service to all clients accessing behavioural support, i.e. the direct supply of Nicotine Replacement Therapy (NRT) and provision medications of Varenicline (Champix) and Zyban through a Patient Group Directive with Community Pharmacists.

5.1.3. Coordination of Tobacco Control initiatives will be excluded from the scope of the new service. Instead, it is proposed that these functions will be coordinated by the County Council and be shared across Community Safety, Fire & Rescue, and Public Health 0 – 19 from 1 April 2018.

5.2. Contract Structure

5.2.1. It is proposed that the Prime Provider model for a single countywide service with a single point of contact will continue. The requirement to work with a network of sub-contracted providers in the delivery of behavioural support enables the service to be flexible and responsive to the needs geographically.

5.2.2. The core service aim will be to deliver high quality, evidence based stop smoking interventions to the local population. The Service Provider will be required to work in collaboration with the Council and the NHS to tailor and deliver its services.

5.3. Payment and Performance Management

5.3.1. An affordable service that meets the Council's obligations in carrying its duties is essential. It is proposed that the same level of annual funding (£1.249m pa) is secured for the continuation of the services in scope, the final cost of the service to be determined via competition.

5.3.2. The current full Payment by Results (PbR) payment mechanism for behavioural support is intended to incentivise and reward positive performance, but has proved to be unsustainable for the reasons described at Paragraph 3.1.5.

5.3.3. It is therefore proposed that the payment mechanism for the new contract should be split between a core payment related to delivery of core contract activity and a performance related payment (or PbR) linked to the delivery of contract outcomes. This would allow the provider greater financial viability but retain an incentive to drive improvements in the delivery of the outcomes and the performance of

the contract. The pharmacotherapy costs component will remain an activity-based payment for the products supplied.

5.3.4. A clear governance, reporting and monitoring structure will be incorporated that will allow for efficient coordination of activities as well as gateways to enable any new initiatives to be introduced.

5.3.5. Contract performance will be driven through a performance framework linked to manageable, measurable and achievable targets aligned to the agreed key performance indicators. In this way the provider will be accountable against the required minimum activity expectations and the qualitative outcomes. The detail of the payment and performance mechanism will be finalised following analysis of feedback from the Market Engagement but it is anticipated that service credits will be levied where performance falls short.

5.4. Contract commencement and Duration

5.4.1. The optimum duration for the new contract will be tested as part of the market engagement exercise, but it is proposed that the contract term will be five years with an option to extend for a period or periods of up to a further two years, or a maximum of seven years. This longer term arrangement being intended to provide greater confidence and financial assurance for the provider, and to offer a greater incentive to potential providers who do not already have established infrastructure in the County. The contract will enable the Council to terminate early for poor performance.

5.4.2. The current contract ends on 31st March 2018, but it is planned for this to be extended by three months from the 1st April 2018 to the 30th June 2018 to allow for a reasonable implementation period to take place for a new Provider, including the production of a Patient Group Directive (PGD) for the prescribing of pharmacotherapy.

5.4.3. The current provider is looking for a change to the payment mechanism for the period of any extension as they cannot sustain the service based on PbR payments at the current level. They are therefore seeking an increased block payment for the extension period. This is being discussed so that it has the least impact on clients and stays within the financial envelope for the contract.

5.5. Tender process

5.5.1. The Procurement will be undertaken in accordance with regulations 74 to 76 of the Public Contract Regulations 2015 under "Light Touch Regime" utilising an Open Procedure method. The ultimate decision as to which provider is awarded the single provider status will be based on their evaluation performance.

5.5.2. Re-procuring the service will allow the Council to ensure the funding provided to the Provider is part of a legally compliant and effective commercial arrangement.

5.5.3. The Invitation to Tender (ITT) evaluation will focus on service quality and the capability of the provider and any organisations they may wish to form sub-contracting arrangements with to deliver the required work and quality outcomes across the county set against clearly defined financial budgetary controls.

5.5.4. The Invitation to Tender Document will include the following:

- A specification that is clear in scope, interpretation and expectations;
- Full terms and conditions;
- Appropriate award and evaluation criteria;
- A realistic, appropriate and robust performance management framework; and
- An emphasis on partnership working and effective referral/signposting mechanism.

5.5.5. Tender Timescales

Issue the ITT	30th January 2018
Evaluation period	6th March 2018 to 15th March 2018
Standstill period	27th March 2018 to 5th April 2018
Contact Award	6th April 2018
Mobilisation period	7th April 2018 to 1st July 2018
Go Live	2nd July 2018

6. Procurement implications

6.1. Under the Public Contracts Regulations (PCR) 2015 activities relating to social care are generally dealt with under a 'Light Touch Regime' (LTR) which conforms to the general principles of the EU Procurement Directive but does not impose any strict procedural requirements. Training services are also captured under this regime.

6.2. While this regime allows for a much greater degree of flexibility as well as unique exceptions it does not mean the Council is free to award contracts without any regard to competition

6.3. The threshold at which LTR contracts must be formally competed for is procurements is €750,000 or approximately £640,000.

6.4. At this point, the financial envelope for the Lincolnshire Stop Smoking Services is £1,249,647 annually. This is based upon combined service and pharmacotherapy budgets of £649,647 and £600,000 respectively. This would represent a total contract spend over the proposed maximum 7 year term of £8,750,000

6.5. It is the intention to issue an OJEU Notice for publication on 17 January 2018 and a Contract Award Notice will be issued on any award to a successful bidder.

6.6. To verify that there will be sufficient competition within the procurement, a Prior Information Notice was published on 27 October 2017. This initiated a process of pre-tender market engagement.

6.7. In carrying out this procurement the Council will ensure the process utilised complies fully with the EU Treaty Principles of Openness, Fairness, Transparency and Non-discrimination.

6.8. The procurement process shall conform to all information as published and set out in the OJEU Notice.

6.9. All time limits imposed on bidders in the process for responding to the OJEU Notice and Invitation to Tender will be reasonable and proportionate.

6.10. The Procurement will be carried out in line with the timetable in Appendix A.

7. Public Services Social Value Act

7.1. In January 2013 the Public Services (Social Value) Act came into force. Under the Act the Council must before starting the process of procuring a contract for services consider two things. Firstly, how what is proposed to be procured might improve the economic social and environmental wellbeing of its area. Secondly, how in conducting the process of procurement it might act with a view to securing that improvement. The Council must only consider matters that are relevant to the services being procured and must consider the extent to which it is proportionate in all the circumstances to take those matters into account. In considering this issue the Council must be aware that it remains bound by EU procurement legislation which itself through its requirement for transparency, fairness and non-discrimination places limits on what can be done to achieve these outcomes through a procurement.

7.2. It is clear that an effective Stop Smoking Service will have the potential to reduce the burden of disease e.g. respiratory, cardiovascular, cancer to help relieve the pressure on acute hospitals, care homes and the wider health system. The effects can be felt in the short term through reduced activity in primary care, fewer outpatients and emergency admissions to hospitals for people who have stopped smoking. Furthermore there is a

direct relationship with adult smoking and children smoking behaviour, a reduction in adult smoking contributes to a decline in children's smoking rates. Consideration will be given through the design of the procurement as to how wider social value can be obtained – e.g. through apprenticeships or the use of local service providers.

7.3. Under section 1(7) of the Public Services (Social Value) Act 2012 the Council must consider whether to undertake any consultation as to the matters referred to above. The service and the value it delivers are well understood. This is not a statutory service and it is unlikely that any wider consultation would be proportionate to the scope of the procurement.

Legal Issues:

8. Equality Act 2010

Under section 149 of the Equality Act 2010, the Council must, in the exercise of its functions, have due regard to the need to:

* Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act

* Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

* Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation

Having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

* Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic

* Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it

* Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding

Compliance with the duties in section 149 may involve treating some persons more favourably than others

The duty cannot be delegated and must be discharged by the decision-maker. To discharge the statutory duty the decision-maker must analyse all the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process

8.1. The key purpose of the service is to support people to stop smoking. Smoking is linked to health inequalities and people who smoke the most tend to come from groups with a protected characteristic e.g. LGBT, pregnant women and long term health and disabilities. The providers' ability to provide services which advance equality of opportunity will be considered in the procurement and providers will be obliged to comply with the Equality Act.

8.2. To discharge the statutory duty the Executive Councillor must consider the relevant material with the specific statutory obligations in mind. If a risk of adverse impact is identified consideration must be given to measures to avoid that impact as part of the decision making process.

8.3. An Impact Assessment has been completed and copy of is appended to this report at Appendix B. It is emphasised that as the core model has not changed the client journey will not be adversely affected and the service is and will remain open to all groups regardless of protected characteristic. In addition the improvements relating to the access for the dispensing of medications will benefit the client and have a positive impact on their ability to quit and thereby improving the provider's outcomes.

8.4. There is a risk that a change of provider will impact on persons with a protected characteristic arising out of the employment impact on staff. The staff employed by the current provider will be affected by the end of the current contract. Mitigating factors will relate to the legal protections that will be in place through TUPE and general employment laws. The contract that will be entered into will also contain clauses requiring the contractor to comply with the Equality Act.

8.5. In these circumstances it is open to the Executive Councillor to conclude that having considered the duty it considers that if appropriate steps are taken to keep matters under review and address issues as they arise through the procurement process that any potential there is for differential impact or adverse impact can be mitigated.

9. Joint Strategic Needs Analysis (JSNA and the Joint Health and Wellbeing Strategy (JHWS)

The Council must have regard to the Joint Strategic Needs Assessment (JSNA) and the Joint Health & Well Being Strategy (JHWS) in coming to a decision

9.1 The Council is under a duty in the exercise of its functions to have regard to its Joint Strategic Needs Assessment (JSNA) and its Joint Health and

Wellbeing Strategy (JHWS) in coming to a decision.

9.2 The JSNA for Lincolnshire is an overarching needs assessment. A wide range of data and information was reviewed to identify key issues for the population to be used in planning, commissioning and providing programmes and services to meet identified needs. This assessment underpins the JHWS 2013-18 which has the following themes:-

i. Promoting healthier lifestyles

ii. Improving the health and wellbeing of older people

iii. Delivering high quality systematic care for major causes of ill health and disability

iv. Improving health and social outcomes and reducing inequalities for children

v. Tackling the social determinants of health

9.3 Under the strategic theme promoting healthier lifestyles there are two priorities that are relevant;

- Reduce the number of people who smoke by supporting those who want to quit, discouraging people from taking up smoking and normalising smoke free environments
- Support people to be more active more often

9.4 Under the strategic theme of Delivering high quality systematic care for major causes of ill health and disability there are two priorities that are relevant;

- Reduce unplanned hospital admissions and mortality for people with Chronic Obstructive Pulmonary Disease.
- Reduce mortality rates from Coronary Heart Disease and improve treatment for patients following a heart attack

9.6 The Local Stop Smoking Service will contribute directly to these priorities.

10. Crime and Disorder

Under section 17 of the Crime and Disorder Act 1998, the Council must exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent crime and disorder in its area (including anti-social and other behaviour adversely affecting the local environment), the misuse of drugs, alcohol and other substances in its area and re-offending in its area

10.1 In commissioning a service that delivers positive outcomes for individuals by reducing the number of people who smoke, supporting those who want to quit, discouraging people from taking up smoking and normalising smoke free environments, the Stop Smoking Service may contribute indirectly to the achievement of obligations under section 17.

11. Conclusion

11.1. Local Stop Smoking Services are a fundamental part of the preventative care and support system in Lincolnshire and play a significant role in reducing the burden on the overall healthcare system. By providing appropriate interventions for smokers, helping to decrease the need for longer-term and higher cost social care and health services that smoking causes, and reducing pressure on an already overburdened system.

11.2. The challenges posed by the current contract scope, mechanism and performance means the procurement needs to go ahead in 2018. However by revising the scope, updating the payment mechanism, and implementing an effective performance management mechanism, the issues that are affecting the service will be more suitably addressed.

11.3. The focus of the procurement will be to establish a single provider for the county that will be able to fully meet the quality requirements set out by the Council, guarantee that they are able to properly meet demand, manage the wider subcontractor market effectively as appropriate, and ultimately to strengthen the market for delivery of Local Stop Smoking Services in Lincolnshire.

11.4. In addition by the embedding of Tobacco Control across directorates of the council, these elements will focus on prevention, enforcement, regulation and raising awareness across multi agency partnerships, and improve the Value for Money delivered by the tobacco control coordination budget.

Legal Comments:

The Council has the power to procure the contract proposed.

The decision is consistent with the Policy Framework and within the remit of the Executive Councillor if it is within the budget.

Resource Comments:

The current contracted Local Stop Smoking Service (LSSS) has been in place since January 2016, the current annual cost of the service is £1.249m. Proposed changes to current payment mechanism to one that is split between a core and performance related payments should allow a degree of flexibility and has the potential to drive greater efficiencies than those that are currently recognised is the existing contract. It is estimated that the absence of a Local Stop Smoking Service would result in additional cost pressures close to £2m per annum across the Health and Care system, therefore the continued maximum annual investment of £1.249m remains a prudent preventative investment.

Consultation

Has The Local Member Been Consulted?

N/A

Has The Executive Councillor Been Consulted?

Yes

Scrutiny Comments

This report will be considered by the Adult Care and Community wellbeing Scrutiny Committee on 10th January 2017. The comments of the Committee will be reported to the Executive Councillor prior to reaching her decision.

Has a Risks and Impact Analysis been carried out?

Yes

Risks and Impact Analysis

Attached at Appendix B.

Appendices

These are listed below and attached at the back of the report: Appendix A – Procurement Timeline LSSS Appendix B – Equality Impact Assessment LSSS

Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Phil Garner and Reena Fehnert who can be contacted on 01522 552292 or 01522 553658 philip.garner@lincolnshire.gov.uk / reena.fehnert@lincolnshire.gov.uk .

APPENDIX A

For the Review and Re-Procurement of the Smoking Cessation Service Contract: Philip Garner, Ros Watson, Bryony Morris, Reena Fehnert, Becky Walls, Paul Collins, Rachel Ogden.

Event Activity	Responsible	Date (w/c)
Paper to Procurement Board	RW	21 September 2017
Issue Contract extension or termination	MW/RW	30 September 2017
Recommendations to PH SMT	RW/PG	16 October 2017
Project Board Meeting – review financials and discuss evaluation criteria		24 October 2017
Sub group work on evaluation criteria	RW/RF/BW	24 October 2017
Draft Scrutiny Paper to Procurement Governance	AC/BM/RF	2 November 2017
Commissioning and Commercial Board (Councillor Hill)		**27 November 2017**
Project Board Meeting (approve final version of Tender docs)	All	12 December 2017
Adult Care & Public Health Scrutiny 10.00AM		10 January 2018
Procurement Board Approval of Tender docs (Mgt team meeting)	BM/RF	29 January 2018
Issue of Tender documents and Invitation	RF	30 January 2018
Tender out for submissions (30 full days)		31 January 2018 to 5 March 2018
Supplier Day		16 February 2018
Applications evaluated Evaluation Team: BM, PG, RW + RF (Moderating)	Evaluation Team & RF	6 March 2018 to 15 March 2018
Evaluation report and Delegated decision (PH SMT)	PG	16 March 2018 to 23 March 2018
Inform Bidders and initiate standstill	RF	26 March 2018
Standstill period	RF	27 March 2018 to 5 April 2018
Contract Award	RF	6 April 2018
Project Board Meeting (planning implementation, communications etc)	All	10 April 2018
Implementation/ mobilisation period	RW/BW	12 weeks

Project Board Meeting (planning implementation, communications etc)	All	10 April 2018