Executive Decision Report

Decision maker(s) at each authority and date of Cabinet meeting, Cabinet Member meeting or (in the case of individual Cabinet Member decisions) the earliest date the decision will be taken	For Decision by: Cabinet Date of decision: 6th July 2015	h&f hammersmith & fulham
	For Decision by: Councillor Weale, Cabinet Member for Adult Social Care and Public Health Date of decision: *TBC*	THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA
	For Decision by: Councillor Robathan Cabinet Member for Adult Social Care and Public Health Date of decision: TBC	City of Westminster
Report title (decision subject)	Cardiovascular Disease Prevention Service	
Executive Director	Liz Bruce, Executive Director of Adult Social Care and Health	
Reporting officers	Judith Ralphs – Senior Public Health Commissioner Linda Pinder- Category Procurement Manager	
Key decision	Yes	
Access to information classification	Public A separate report on the exempt Cabinet agenda provides exempt information in relation to the procurement process.	

1. EXECUTIVE SUMMARY

1.1. This report recommends that the City of Westminster on behalf of itself, The London Borough of Hammersmith and Fulham and the Royal Borough of Kensington and Chelsea award a single supplier Framework Agreement to Supplier 2 for the provision of Cardiovascular Disease Prevention services for a period of 3 years commencing 1st October 2015, with an option to extend for one year.

1.1.2. This report also recommends that the London Borough of Hammersmith Royal Borough of Kensington and Chelsea and Fulham, Westminster City Council, all enter into their own Call-Off contract with Supplier 2 for the provision of Cardiovascular Disease Prevention services for a period of 3 years commencing 1st October 2015, with an option to extend for one year.

1.1.3 In accordance with the procurement strategy (Gate 1 CAB) that was signed off on the 22nd January 2015 and approved by the Adult Social Care Commissioning and Contract Board on the 17th November 2014, an OJEU open procurement found Supplier 2's tender to be the most economically advantageous submission.

2. RECOMMENDATIONS

2.1 This report recommends:

2.2.1 **For the London Borough of Hammersmith and Fulham** to note the award of a framework agreement for three years, with the option to extend for one further year to Supplier 2

2.2.2. To call off of the framework agreement and enter into a contract for three years from 1st October 2015, with the option to extend for a further year (subject to performance) with the recommended provider. To delegate the decision to award a one year extension to the "call off" from the framework to the Cabinet Member for Adult Social Care and Public Health in conjunction with the Executive Director for Adult and Social Care and the Section 151Officer

2.3.1. **For the Royal Borough of Kensington and Chelsea**, to note the award of a framework agreement for three years, with the option to extend for one further year to Supplier 2.

2.3.2. To call off of the framework agreement and enter into a contract for three years from 1st October 2015, with the option to extend for a further year (subject to performance), with the recommended provider.

2.4.1. **For Westminster City Council** The Contract Approval Board recommend that the Cabinet Member for Adult Social Care and Public Health call off of the framework agreement and enter into a contract for three years from 1st October 2015, with the option to extend for a further year (subject to performance).

2. REASONS FOR DECISION

3.1.1 In accordance with the procurement strategy (Gate 1 CAB), the project team developed a specification and completed a compliant OJEU procurement to identify one provider to deliver the Cardiac Prevention Services to all three Boroughs. Out of the two providers who submitted a tender, the tender evaluation process found Supplier 2's tender to be the most economically advantageous submission. Details of the evaluation are provided in Part B.

3.1.2. Supplier 2's tender, which constitutes an unconditional and irrevocable offer, is financially affordable as it is within the Three Boroughs' total budgeted expenditure for this service.

3. BACKGROUND

3.1 Project Drivers

4.1.1 Cardiovascular Disease (CVD) which can cause heart conditions and stroke remains the second biggest cause of premature death in the area covered by the 3 boroughs and is the greatest disease-related cause of health inequalities. Most premature deaths from CVD are preventable. People with diabetes and chronic kidney disease are also at higher risk of CVD.

4.1.2. In LBHF 34% of all deaths were caused by CVD and H&F ranks in the worst national category for preventable CVD deaths with 268 per year.

4.1.3. In RBKC CVD accounts for 34% of all deaths and RBKC ranks better than the national average in preventable deaths with 185 per year.

4.1.4. In Westminster CVD accounted for 36% of all deaths and Westminster ranks worse than the national average with 329 preventable CVD deaths per year.

4.1.5. The populations of the three boroughs are different. There is higher prevalence of CVD amongst people who live in areas of deprivation, and amongst Black Minority Ethnic communities, and these populations are higher in both LBHF and WCC than in RBKC. Of the 308,963 residents who live in the top two quintiles of

deprivation in the three boroughs, 42% live in LBHF, 34% live in WCC, and 24% live in RBKC.

4.1.6. WCC currently commissions a cardiovascular disease prevention service from MyAction which is based at Imperial College Health Partners. This is an evidence-based community CVD prevention programme. This service is based on evidence from a multi-centred randomised controlled trial in eight European countries of a multidisciplinary, family-based cardiovascular disease prevention programme[1,i] Among other sources of research evidence, it is also based on European guidelines for the prevention of cardiovascular disease.[ii]

4.1.7. An evaluation of 166 participants in this service 2013/14 demonstrated that statistically significant improvements had been made in key risk factors which included:

- Reduced Waist circumference,
- Adoption of a Mediterranean diet,
- Increased physical activity
- Reductions in Blood Pressure and unhealthy lipids.

4.1.8. The programme has also successfully reached the most deprived parts of Westminster; 438 people from the most deprived quintile have completed the programme as compared to 157 from least deprived (from 2009-2014).[2]

4.1.9. There is no current cardiac prevention programme for LBHF and RBKC residents at high risk of CVD. There are a range of services for people with individual risk factors, to which people at high risk can be sent e.g. stop smoking services, weight watchers and dieticians, and treatments for high blood pressure, cholesterol and physical activity programmes. When patients are identified as at high risk through a health check, it is then up to the patient and to their GP if they are followed up to check whether they have taken up the referrals or treatment.

---

i This research found that nurse-coordinated multidisciplinary, family-based cardiovascular disease preventive programmes could statistically significantly reduce a variety of risks for CVD such as lifestyle change (including diet and physical activity); the management of raised blood pressure, lipids and blood glucose; and smoking. These factors account for most of the risk of heart attack worldwide at all ages in both men and women [see Yusef S, Hawken S, Ounpuu S, Dans T et al. Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. *Lancet* 2004; 364: 937-52]

ii Perk, J, De Backer G, Gohike H, Graham I et al. European guidelines on cardiovascular disease prevention in clinical practice. *European Heart J* 2012. DOI: http://dx.doi.org/10.1093/eurheartj/ehs092

4.1.10. Cardiovascular disease has significant costs to the Three Borough Area;

Three Borough Costs of CVD related diseases 2012-13 (Data source: Depart of Health programme budgeting data 2012/13)

	Social costs (non NHS costs including diabetes)	Total expenditure health Including diabetes	Total expenditure health and social costs including diabetes
H&F	**£1,196,000**	**£23,184,000**	**£24,380,000**
RBKC	£1,054,314	£21,811,000	£22,865,314
Westminster	£2,876,000	£27,232,000	£33,853,000

Thus for an investment of £1,023,991 over three years in LBHF (see exempt report) for a CVD prevention, programme these health and social costs for LBHF may be reduced. For example each stroke prevented saves £73,000. Diabetes UK reports that one in 20 people with diabetes incurs social services costs. More than three-quarters of these costs were associated with residential and nursing care, while home help services accounted for a further one-fifth. The presence of complications increases social services costs four-fold

Reductions will occur through a percentage of the 1,200 programme participants either avoiding or delaying the onset of diabetes, heart disease and strokes, resulting in lower adult social care support needs and reduced health needs, and increased disability free years. 80% of diabetes is preventable, and diabetes accounts for 50% of preventable sight loss.

4.1.11 The new Three Borough Cardiovascular Prevention service is not designed as a MyAction programme but as an evidence-based community CVD prevention programme with a greater community focus and with hard outcome targets. The new service specification has been developed with key performance indicators using guidance and evidence from:

- Cardiovascular prevention guidance from Nice 2010[3],
- European Guidelines on cardiovascular disease prevention in clinical practice 2012[4]
- Joint British Societies' guidelines on prevention of cardiovascular disease in clinical practice 2005[5].

This includes clinically meaningful targets for reductions in blood pressure, body mass index, adoption of a cardio-protective diet, physical activity, smoking

cessation, alcohol reduction, and improvements in anxiety and depression (see appendix A for KPIs).

Activity levels of 1,350 residents per year, 400 each for RBKC and LBHF and 550 per year for WCC are based on projected figures of eligible high risk residents from NHS Health Checks and a proportion of people with diabetes and other relevant medical conditions which put them at high risk of CVD and can be referred to this programme.

The new service is also targeted to those most at risk:

- 70% of Service Users to come from the two most deprived quintiles in each of, LBHF, RBKC and WCC.
- 50% of Service Users from black, minority and ethnic groups.

5. PROCUREMENT PROCESS AND PROPOSAL

5.1. Award proposal

5.1.2. The procurement process and tender evaluation, detailed below, found Supplier 2 tender to be the most economically advantageous submission, with an overall score of 88.80%. It is therefore proposed that Supplier 2 is awarded the contract to deliver Cardiac Prevention Services across the three Boroughs.

5.1.3. Should the proposal be approved, a voluntary Alcatel standstill notification will be dispatched to the unsuccessful tenderers via capitalEsourcing notifying them of the outcome of the exercise. A standstill period of 10 days will then be applied prior to formal award of the contract.

5.2. Gate 1 CAB - Procurement Strategy

5.2.1. In accordance with the procurement strategy (Gate 1 CAB) that was signed off in 22nd January 2014 and by the Adult Social Care Commissioning and Contract Board, the project team ran an OJEU open procurement.

5.2.2. Approval was agreed to let a single supplier Framework where each borough will call off their own 3 +1 year contract from the Framework.

This solution:

- Provides consistent service provision across all boroughs contracting on the same terms of contract and for the same length of time;
- Means there is one supplier to manage and develop relationships with;
- Contributes to the consolidation of the Cardiac prevention supply base;

- Delivers cost benefits to the three boroughs through supplier economies of scale and increased attractiveness of opportunity.

5.2.3. A Price: Quality ratio of 50:50 was used to evaluate Tenders; approval for the quality/price spilt was sought and approved by the Westminster Cabinet Member for Finance, Corporate and Customer Services and Contract Approval Board.

5.2.4. The procurement was run in full compliance with public procurement legislation. An OJEU notice was published and tenderers were invited to complete a three stage process (open procedure).

5.3. Gate 1 – Contract Model

5.3.1. The contract model that was agreed as part of the procurement strategy at Gate 1 CAB was: to run a single supplier frame work, with Westminster as the host Borough with each of the other Boroughs calling off against the framework

5.3.2. This strategy allows for each Borough to retain its sovereignty and provides the benefits that the economies of scale the Tender can achieve.

5.4. Gate 2 – Supplier Selection Overview

5.4.1. The Invitation to Tender (ITT) documents were released to all providers via capitalEsourcing on 16th February 2015. ITT documents included: a detailed Specification outlining the requirements of the service; Instructions to Tenders document which explain how Tenderers should complete the Tender and how the Tender will be evaluated; a Form of Tender; and a Commercial and Technical response document. Tenderers were given six weeks to submit their bid, with the closing date set at 30th March 2015.

5.4.2. Tenderers were required to complete a three stage evaluation process as set out below:

Qualification Envelope (pass / fail)	Insurance, history of providing the service and financial standing, this section covered: Form of Tender; Compliance Table;
Technical Envelope (50%)	Tenderers were assessed on the basis of their written responses to the published award criteria
Commercial Envelope (50%)	Tenderers were assessed on the total three year price.

5.4.3. Both tenderers were compliant.

5.4.4. Tenderers were able to ask clarification questions until 4th March 2015, during this time the project team received only three clarifications. All clarifications were responded to via the portal. All clarification questions came from one of the Tenderers.

5.4.5. Twelve providers did not partake in the process beyond opening the initial details on the capitalEsourcing portal. These providers were asked why they hadn't responded; only one provided a response saying that that they did not have the required time to be able to give a good account of their processes, and provide the attention to detail that a programme such as this would require.

5.4.6. On the 30th March 2015, the Tenders were opened on capitalEsourcing. Two Tenders were submitted from the following organisations:

- Supplier 1
- Supplier 2

5.4.7. The two Tenders that were submitted both passed the Qualification envelope. They were then evaluated against the Technical and Commercial award criteria detailed in Appendix A.

5.5. Gate 2 - Technical Evaluation

5.5.1 Tenderers could receive a maximum weighted score of 50% for the Technical Envelope (Quality). Tenderers were assessed on the basis of their submissions to the award criteria. The criteria reflect the Requirements outlined in the Specification. Each award criteria has a sub-weighting to ensure that its relative importance is reflected in the overall scores. The sub-weightings add up to 100%.

5.5.2 Each member of the evaluation panel marked each Tenderer's written submissions individually, scoring it against the relevant section of the Specification/ Requirement and the Marking Scheme.

5.5.3 Before this information was shared between members of the evaluation panel in order to reach a consensus score, Tenderers were required to undertake a clarification meeting, the meeting was not assessed but was used to clarify the evaluation panel's understanding of some of the technical responses. The clarification meetings took place on the Friday 24th April 2015.

5.5.4 The panel then met to reach a consensus score for each Tenderer's response to each award criteria on 24th April 2015. The final consensus scores were then multiplied by their relevant sub-weighting and applied to a formula to calculate their percentage score for Quality. Each Tenderer's scores are shown in detail in Exempt report Appendix B.

5.5.5 The outcome of the Technical Envelope Evaluation is shown below:

Technical Evaluation Panel J Ralphs, C Mead, M Henry, Dr T Willis & Dr Neha Shah	Final % Technical score Envelope – maximum 50% (details in Appendix A)
Supplier 2	38.80%
Supplier 1	34.80%

5.6 Gate 2 – Commercial Evaluation

5.6.1 Tenderers could receive a maximum weighted score of 50% for the Commercial Envelope. Tenderers were assessed on the Total 3 Year Cost. The scores for the Commercial Envelope are shown below:

	Commercial score Envelope maximum 50%
Supplier 2	50%
Supplier 1	37.92%

5.7 Gate 2 – Final Evaluation Scores

5.7.1 Each Tenderer's percentage score for the Technical Envelope and Commercial Envelope were then added together to determine the most economically advantageous submission, i.e. the one with the highest total percentage awarded. The outcome is shown below:

	Technical Score	Commercial Score	Final Overall Score
Supplier 2	38.80%	50.00%	88.80%
Supplier 1	34.80%	37.92	72.72%

5.7.2 Consequently it is proposed that Supplier 2 is awarded the Contract to supply Cardiac Prevention Services across the three Boroughs.

5.8 Non-Financial Benefits

5.8.1 As shown in paragraph 5.5.5, Supplier 2 scored highest on quality. The Tender Evaluation Panel are of the opinion that Supplier 2 will:

5.8.2 Deliver all of the Requirements in the Specification (see Part B) to a high standard

5.8.3 Provide a new service for residents in LBHF and RBKC and who currently do not have a contract.

5.8.4 The service will be for 400 LBKC residents per year

5.9 Contract Mobilisation

5.9.1 As part of their Tender, the recommended provider submitted a contract mobilisation plan and outlined a plan for implementation. In order to ensure a smooth contract mobilisation process, upon contract award this plan will be reviewed and updated to ensure key activities are logged and responsibilities assigned.

5.9.2 Mobilisation Meetings will be scheduled and begin immediately.

5.9.3 The Supply Contract contains a timeline of key activities that the project team agreed prior to going out to Tender. This will shape development through to the planned 'go live date' of 1st October 2015.

5.9.4 There is a scheme of incentivised payments to ensure targets are met. 20% of payment is held back, and paid incrementally once 90% and 100% of activity targets are met.

5.9.5 Supplier 2 will attend quarterly meeting, and produce reports which will include detailed information relating to activity targets, Progress on achieving the objectives and outcomes as provided in the Tender documentation.

6. CONSULTATION

6.1. The Adult Social Care Commissioning and Contract Board approved the recommendations set out in this report on 22nd January 2015.

Cabinet Members for Public Health and Adult Social Care were updated on the commissioning process on:

6.1. Consultation meeting with Cllr Lukey held on October 23rd 2014

6.2. Consultation meeting with Cllr Weale held on October 10th 2014

6.3. Consultation meeting with Cllr Robathan held on November 18th 2014

7. EQUALITY IMPLICATIONS

7.1. An equality impact analysis was undertaken prior to tender and the findings integrated into the specification. The service has been designed to ensure high take up in areas of deprivation and black and ethnic minority groups.

8. LEGAL IMPLICATIONS

8.1 This service has been commissioned by Westminster City Council on behalf of the Three Boroughs. The service has been commissioned in line with the Local Authorities' new duties under the Health and Social Care Act 2012. Westminster City Council will enter into a framework agreement with the successful provider. Westminster City Council and the other boroughs will then each enter into their own call-off contract with the successful provider under the framework agreement. Legal advice on the procurement process has been provided by Sharpe Pritchard.

8.1.2 The proposed contract award has been carried out in accordance to the Three Boroughs Contract Standing Orders and the relevant Public Contracts Regulations.

8.1.3 Bi-Borough Legal Services will be available to assist the client department with preparing and completing the necessary contract documentation. Implications for LBHF and RBKC completed by: Kar-Yee Chan, Solicitor (Contracts), 020 8753 2772 and by Rhian Davies, Corporate Solicitor, for WCC.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. The available budget across the three councils is £5.4m over 3 years (£7.2m over 4 years 3+1 year extension) as follows:

	2015/16 (6 months) (£)	2016/17 (£)	2017/18 (£)	2018/19 (6 months) (£)	Total 3 Yr budget (£)	(1 Yr extension) (£)	Total 4 Yr budget (£)
LBHF	**200,000**	**400,000**	**400,000**	**200,000**	**1,200,000**	**400,000**	**1,600,000**
RBKC	200,000	400,000	400,000	200,000	1,200,000	400,000	1,600,000
WCC	500,000	1,000,000	1,000,000	500,000	3,000,000	1,000,000	4,000,000

Total	900,000	1,800,000	1,800,000	900,000	5,400,000	1,800,000	7,200,000

9.1.2. The budgets for each borough will be held within the respective borough.

9.1.3. Implications for LBHF, RBKC and WCC have been verified by: Tim Carr Public Health Finance Business Partner.

10. RISK MANAGEMENT

10.1. Adult Social Care and Public Health operate within a risk management framework based on the Shared Services agreed policy. Risks are identified, assessed and reviewed with mitigations planned against perceived risk. Market testing and maintaining statutory duties are key risks on the Strategic Shared Services risk register, risks numbers 4 and 8 respectively. The report proposals positively contribute to the management of Public Health Service risks as also noted on the risk register as do the projected savings contribute to the management of budget risk, risk number 1.

10.2. Implications verified by Michael Sloniowski, Shared Services Risk Manager, telephone 020 8753 2587.

11. PROCUREMENT IMPLICATIONS

11.1. Procurement implications are contained throughout the body of the report and have been reviewed by Westminster Procurement Team.

11.2. The procurement set out in the body of the report has been carried out in accordance with each authority's contract standing orders and procurement legislation. This was a Part B service when the procurement commenced and has been carried out in accordance with all EU and UK procurement legislation. Nevertheless, the procurement process has also adhered to the principles of non-discrimination, equal treatment, transparency, mutual recognition and proportionality.

11.3. The award recommendation adheres to the three Boroughs' Contract Standing Orders.

11.4. The current contract with current supplier expires on 30th September 2015. The project team had planned to award in Mid July 2015 in order to allow 2 months for mobilisation.

Appendix A

KPIs for new CVD prevention service

Outcome	Key Performance indicator	Method of Measurement	Period of Activity Covered
Prioritisation of health inequality groups	70% of Service Users to come from the two most deprived quintiles in each of LBHF, RBKC and WCC. 50% of Service Users from black, minority and ethnic groups. .	i. Proportion of Service Users from each lower supra output areas post codes. ii Proportion of Service Users from minority ethnic groups starting and completing programmes. iii all protected characteristics.	Quarterly
Services are accessible to the groups at risk	At least 65% of appropriate referrals start a prevention programme. .	i. Sources of referrals ii.Numbers of referrals iiiTypes of referrals reason for delays or non-starters. iv..Diagnosis if CKD, diabetes, HIV or other condition associated with increased risk.	Quarterly
The Provider works with the whole family to increase likelihood of behaviour change	For Service Users with families: At least 50% have family members who attend initial appointments or part of the programme.	Assessment and programme records. Number who attended at least initial appointments or part of the programme Reasons why family members have not attended.	Quarterly
The Services successfully engage with Service Users so they are able to make changes	At least 65% of patients complete the course	Reasons for drop out, time of drop out and demographic characteristics of drop outs.	Quarterly
The Services reduce CVD risk in at risk group (≥15%CVD risk in 10 years)	75% of Service Users who complete the programme make reduction in at least one risk factor **These risk factors are:**	Clinical measurement	Quarterly
	Blood Pressure 70% of Service Users, who on initial assessment had blood pressure higher than recommended levels of:	Before and at the end of programme results.	Quarterly

	≤ 140/90 ≤ 130/80 for CKD and diabetes are within these limits at the end of programme.		
	Smoking Cessation 10% of those Service Users who smoke at programme start have achieved a four week quit rate. Another 10% have a harm-reduction plan.	Clinical data / questionnaires, before and at the end of programme and carbon monoxide testing.	Quarterly
	Body Mass Index For Service Users with a BMI of > 25: 40% of this cohort reduces BMI by 5% by end of programme. 55% of this cohort make a reduction in BMI score.	Standardised clinical measure.	Quarterly
	Waist circumference 45% Service Users with waist measurement >102 cm male >88cm female Reduce their waist measurement by 2%	Before and at the end of programme results.	Quarterly
	Lipids 85% being prescribed atorvastatin 20mg via a recommendation to GP unless the drug is contraindicated	Clinical data/questionnaires before and at the end of programme results. Levels of Total Cholesterol and LDL recorded	Quarterly
	Cardio protective diet 50% of Service Users achieving a 2 point increase in Mediterranean diet score or similar standardized measure	Mediterranean diet questionnaire or similar standardised validated questionnaire/s.	Quarterly
	Physical activity 70% of Service Users achieving personalised physical activity target. 45% of Service Users who were previously inactive are undertaking at least 150 minutes per week of moderate intensity physical activity by end of programme	Clinical data/questionnaires before and at the end of programme results.	Quarterly

	Anxiety and depression 100% of Service Users to be assessed for psychological comorbidity and 60% of those with clinically significant scores to achieve a reduction in score on an appropriate and approved mental health scoring tool e.g. HADS.	number of Service Users seeing clinical psychologist as 1:1 session and in groups following assessment. Validated questionnaires such as HADS.	Quarterly
	Alcohol 20% reduction in units drunk per week in 65% those who were above recommended daily levels. Number and percentage of: Men drinking > 21 -28 units a week; Women >14 units a week.	Clinical data/questionnaires to measure units of alcohol before and at the end of programme results	Quarterly
Service Users views and experiences contribute to Services improvement	80% of Service Users satisfied with the quality of Services and Staff.	"family and friends questionnaire " Feedback by age, gender and ethnicity. number and type of complaints.	Quarterly
Service User safety is upheld	Minimal number of Serious Incidents and adequate remedial action taken	Complaints and Serious Incidents	Quarterly

References;

1 Wood DA, Kotseva K, Connolly S, Jennings C, Mead A, Jones J, et al. Nurse-coordinated multidisciplinary, family-based cardiovascular disease prevention programme (EUROACTION) for patients with coronary heart disease and asymptomatic individuals at high risk of cardiovascular disease: a paired, cluster-randomised controlled trial. Lancet 2008 Jun 14;371(9629):1999-2012.

2 MyAction Annual report 2013-14

3 Prevention of cardiovascular disease NICE 2010

4 European Guidelines on cardiovascular disease Prevention in clinical practice (version 2012) European Heart Journal (2012) 33, 1635–1701

5 Prevention of cardiovascular disease in clinical practice
Heart 2005 91: v1-v52
Prepared by: British Cardiac Society, British Hypertension Society, Stroke Association Diabetes UK, HEART UK, Primary Care Cardiovascular Society,