UNISON Eastern Region

FATAL FLAWS

UNISON's response to Cambridgeshire & Peterborough Clinical Commissioning Group's Consultation on Older People's Services

June 2014

The Consultation on the sweeping plans to reorganise Older People's Services in Cambridgeshire & Peterborough is controversial for many reasons.

However UNISON has no opposition in principle to the CCG's professed aims of achieving the integration of services that are currently delivered by different organisations, and breaking down barriers between providers to ensure improved, seamless care for patients. Indeed for the past 25 years we have consistently argued for this approach, and against various market reforms to the NHS and steps to fragment services.

UNISON's criticism, and our opposition to the way the whole process has been handled, centres on the question of whether the huge, complex, costly and confusing exercise of putting these services, worth £147m a year from 2015, out to competitive tender is best way to achieve any greater integration of services. We are convinced it is not.

Even more bizarre was the CCG's announcement that the "integrated" contract could be divided up into four separate lots, covering the various localities in Cambridgeshire and Peterborough, or as a whole.

The logic of this – with the theoretical possibility of each contract going to a separate, rival consortium, each seeking to "integrate services" while compounding a new and crazy local postcode lottery – was hard to fathom, since if the objective had been to simplify the

contracts it would have been much easier to separate out specific services, each to be provided on a CCG wide basis.

But this was no passing phase of silliness: one privately-led bid that is focused on only one of the four localities, Peterborough and Borders, has strangely made it onto the final shortlist of four, leaving huge doubts on what system and type of services CPCCG's leaders actually want to establish.

Tendering: the wrong way to go

CPCCG's method of approach reflects the prevailing logic and focus of the 2012 Health & Social Care Act, in which Section 75 and many other clauses seek to impel CCGs to put an ever-longer list of services out to tender to "Any Qualified Provider".

But there is nothing in the Act – or the subsequent guidance and regulations which further strengthen this pressure on CCGs – to show how competitive tendering and the involvement of profit-seeking private sector companies does anything to secure the integration of services.

Far from creating a framework in which local providers of different services can work "seamlessly" together for the benefit of patients, the possible inclusion of private companies in NHS contracts creates very visible commercial conflicts of interest: a company's predominant duty is not to patients but to deliver profits to its shareholders.

Private companies do not and cannot collaborate on shared values with NHS providers: nor do they have the same relationship with their staff, as the recent meeting between private bidders and the trade unions revealed very clearly.

Given this obvious contradiction, we have seen no clear explanation of why the CCG could not more simply, quickly and effectively have reshaped the high class services delivered by Cambridgeshire Community Services NHS Trust (CCS) and other local NHS Trusts through a process of negotiation, to develop services closer to the requirements of the CCG.

Indeed CCS has led the way in establishing a 24/7 district nursing service working with the East of England Ambulance Trust to keep patients out of hospital when they can be cared for at home – one of the objectives the CCG claims they want to achieve through contracting.

Working with CCS and other Trusts would have ensured continuity in services, in place of the disruptive, protracted and wasteful process, in which a massive and complex document was drawn up: this gave the impression that an NHS provider without a private sector partner would stand no chance of success – and effectively pressured CCS into ill-conceived and unsuccessful partnerships with private companies Circle and Capita that have resulted in it now being excluded from any of the bids under consideration.

The process has also wasted management time and effort among NHS providers and CCG commissioners: it resulted in a large number of initial expressions of interest, including many of the big private sector players, all of which had to be examined by the CCG, even though many of them were clearly inappropriate, and were eventually withdrawn or discarded.

In the end the long list has come down to the current shortlist of four, in which three bids are led by private, profit-seeking companies (Care UK, Interserve, and Virgin Health) all of which – for some reason unclear to the unions – have managed to survive this long into the process, while only one NHS-led bid has survived.

Flawed legal advice

The CCG has argued (in its response to 'Frequently Asked Questions') that "legal advice" was the key factor in persuading them to use "an open procurement process":

> "The new NHS Regulations 2013 apply directly to CCGs from 1 April 2013. These regulations require the CCG to advertise opportunities for providers to provide healthcare services …"

The CCG is not alone in this view. An April 2014 survey by the *Health Service Journal* shows that this fear of infringing the legislation is said to be the main factor behind many (29%) of CCGs opening up tenders[1].

However this is not the only legal advice available.

We note and welcome the recent positive decision of the country's largest CCG, Northern, Eastern and Western Devon CCG, to reshape its community health services WITHOUT opening up to competition. This decision was also taken on legal advice[2].

The Devon CCG decided that to ensure "a more seamless service" two of the three contracts are to go to existing NHS community health service trusts, while the third is to go to the Royal Devon & Exeter Foundation Trust. The decision has been taken on the basis of Monitor's guidance on Section 75 of the Act, in which Monitor argues that CCGs can avoid tendering services when they can show this would not be in the best interests of patients.

Precisely this argument could and should also have been made in the case of Cambridgeshire & Peterborough. Instead, with the CCG already millions in the red when it embarked on the procurement, the tendering process has achieved little other than wasting large sums of money and management time, weakening the existing provider, and creating a prolonged period of uncertainty and plunging morale among NHS staff. For all this cost, it has yet to show it can deliver any improvement in terms of service integration and improved patient care.

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[1] 'CCGs open services to competition out of fear of rules', HSJ April 4

[2] 'Devon CCG proposes awarding contracts without competition', HSJ June 6

Indeed, while there has so far been no benefit to patients from the tendering exercise, there is the danger, as pointed out in the CCS response to the consultation, that some vulnerable groups of patients (including children) are dependent on services that could easily be destabilised by the knock-on effects and upheavals of implementing the Older People's Services plan, and lose out:

> "Staff within the Trust have expressed strong concerns about the potential fragmentation of services and the de-stabilisation of working arrangements across those services that will remain with CCS and those that will transfer to a new provider. This potential fragmentation has the potential to impact negatively on the CCG's ambition to develop more joined up integrated services."[3]

Given the ambitious aims of integration, and the character of the services which CPCCG apparently wants to improve, it could also be argued that local NHS providers are the only ones with the expertise and experience to deliver what is required: this is another avenue that could open up an exemption from the tendering process even under the Section 75 Regulations.

From January 2012 onwards to the implementation of the Act in April 2013, ministers repeatedly and heatedly denied that CCGs would be compelled to put services out to tender. But while Devon's major CCG is putting this to the test, UNISON regrets that CPCCG, sadly hiding behind partial legal advice, has simply caved in to what may well prove to be an empty threat, making a nonsense of their professed ambitions for integration of services and disregarding the interests and needs of patients.

A flawed process

The early documents from the tendering process make it quite obvious that CPCCG initially intended to push through this far-reaching reorganisation of services ***without any public consultation at all***, with the documents withheld from the press and public, and a decision made behind closed doors.

The original ISOS (Invitation to Submit Outline Solutions) document, seen by UNISON, which was published (only to potential bidders) in October 2013, included (page 79) a timetable for the Procurement process which allowed no time at all for consultation.

It would have had the preferred bidder selected, approved and appointed by June 13, with "mobilisation" immediately afterwards – completing the whole complex process in just eight months from start to finish.

[3] CCS Letter to CPCCG June 10 2014 in response to consultation: 'Proposals to improve older people's healthcare and adult community services'.

Fears were raised even more among staff and local people when it emerged that a majority of the initial shortlist of ten bidders drawn up by CPCCG were either led by private companies or private companies with no NHS partner.

A combination of a stacked shortlist and a hugely secretive, opaque selection process was the worst possible way to proceed.

Not only did this approach leave out any public consultation – or proper consultation with trade unions on the implications for any staff facing a transfer to a new employer – it also left no room for any consultation with the GPs working in the 108 practices covered by the CCG on how they viewed the proposals.

Cutting GPs out of the loop

It was clear that if the initial approach had not been challenged the small minority of GPs who are actively involved in the "clinically-led" CCG Board would have pressed ahead to implement their own plan, with little if any regard for the views and concerns of their colleagues, let alone the local public or the health workers who are responsible for delivering the services to patients.

This type of disconnect between the Boards of CCGs and the GPs who are in theory part of the decision-making process has been underlined by a recent BMA General Practice Committee poll in *Pulse* magazine[4]. This showed that just 20% of the grassroots GPs who responded felt that their CCG was improving patient care, compared with 68% of CCG board members – indicating a 'mismatch' between GP and commissioners' experiences. It would be interesting to see what the equivalent figures would be among GPs in in Cambridgeshire and Peterborough.

Perhaps the desire to keep most GPs out of the process, and count their passivity as endorsement, helps to explain the CCG's striking lack of any serious proposals in either the Consultation document or the ISOS document to improve Primary Care, and tackle the uneven quality of GP services for Older People, which would seem to be an essential component of any serious plan to reshape care.

Instead any GP who managed to plough their way through the thickets of obscure and largely unreadable documentation would have found in the FAQs (page 23) the bland (and possibly over-optimistic) assurance that "We don't anticipate that GPs' workloads will increase".

[4] 'Two-thirds of GPs cut out of consultations over £5 per head vulnerable patient funding' , *Pulse* June 13 2014, available http://www.pulsetoday.co.uk/commissioning/commissioning-topics/ccgs/two-thirds-of-gps-cut-out-of-consultations-over-5-per-head-vulnerable-patient-funding/20006992.article#.U5xs8I1OXxk

The reason is clear: the plan is to dump much of the extra work onto other providers, whether the GPs like it or not.

Legal challenge

So determined was the CCG to force through the plan in secret, with no public or professional debate, that it took the threat of a legal challenge, and repeated public exposure by the Stop the Sell Off campaign to force any transparency into the process.

Eventually a (heavily redacted) version of the main (and largely by then out of date) ISOS document was grudgingly published, along with a vast and repetitive array of other documents.

The approach remains furtive, secretive and constructive towards providing any hard information to the local public. Even now **ALL** of the financial detail of the (ominously entitled) Invitation to Submit Final Solutions is redacted – even basic information on the expected budget of the CCG for Older People's services, which clearly should be in the public domain.

Against the CCG's wishes, two other results of the pressure on the CCG were the current public consultation, which ends June 16, and an extended procurement timetable – (aiming to complete the process by January 2015, which even now is argued by CCS to be too hasty).

A vast amount of information which would be useful for local communities and campaigners is sequestered away from any public scrutiny in a 'Data Room' for bidders only: so private companies seeking to make profits from the NHS have been able to access the information, but not campaigners trying to protect the NHS against profiteers.

This is not public engagement, so much as engagement with the private sector, and the teams of lawyers, management consultants, marketing companies and accountants – many of which are operating at taxpayer's expense, diverting vital funds from patient care.

Failure to engage

The Consultation which arose in this way is of course not really a consultation on whether and how to proceed, but a very limited exercise in which the CCG laboriously "explains" its plans, asks skewed and limited questions which allow only the most limited critique or opposition, and then promises only to "consider" the feedback they have had "when evaluating each bid against our criteria".

In other words it is a consultation beginning only **AFTER** all the big de facto decisions have been taken, **AFTER** the tendering process has been almost completed, and **AFTER** the CCG has already decided how the final stage of tendering will be handled.

There is no chance for those responding to the Consultation document as it is written to oppose or to stop the CCG taking the community services contracts for Older People and Adults away from the existing high quality NHS provider.

Unusually for a consultation document, no actual choices are offered, and those who participate are not asked which option they may prefer: all the decisions have already been taken.

Moreover while the public view has been sidelined and ignored, there has been if anything even less willingness to engage seriously with **staff** working in the affected services, or the trade unions representing them**:** here the CCG has not even been willing to go through the motions of asking staff views on how best they can work with colleagues in other provider organisations. The divide between purchaser and NHS provider has never been greater.

Flawed questionnaire

The Consultation document concludes with a Questionnaire posing questions for individuals seeking to respond to the proposals. This was drawn up by a firm of marketing analysts for an undisclosed – but almost certainly exorbitant – fee, and is a perfect example of bias and restricted options. It reveals the cynical purpose of the "consultation", to go through the motions without really taking any account of local views.

Question 1 asks people whether or not they endorse the publicly argued reasons for the changes to Older People's Health services, without offering them the option to say whether or not they agree with the actual changes.

Question 2 asks whether the CCG's "vision will be successful in achieving the following", but then confusingly offers boxes to tick which relate only to levels of agreement with the objectives themselves (which are couched in such a way that almost nobody is likely to oppose them). There is nowhere to answer the question itself.

Question 3 is an open-ended question asking for comments on existing services for older people.

Questions 4-8 each offer a series of generally positive (if slightly fanciful and idealised) objectives, but for some reason require the participant to choose only one to be "important", and one "least important". It is not clear why any of these objectives are incompatible with the others, or what the CCG might be able to conclude from the various confused answers.

Question 9 is another open-ended invitation to submit "final thoughts or comments", again giving no idea what might be the value of the information it gathers.

Two of the questions invite participants to support increased use of voluntary sector providers, but nowhere is there an option to argue for greater reliance on proven local NHS providers.

Question 6 invites people to support the use of "technology such as Skype/Telehealth" to provide support for people with long-term conditions, without any reference to its appropriateness given the capability of the older patient, or explanation on who should provide suitable equipment and software.

Question 7 reinforces the suggestion in the Consultation document that there might be an offer of a 24/7 "urgent care system that can send a team to the patient, both to assess and treat at home" – despite offering no discussion at all of the cost, financial affordability or organisational/managerial issues to be addressed in delivering such a service across the CCG population.

Nor is there any question inviting participants to identify their preferred bidder, even from vague and anonymised summaries of their proposals. Whatever the results of the Questionnaire, and whatever the wider public views may be, all of the decisions remain firmly in the grip of the minority of clinicians leading the CCG.

In other words the Questionnaire is effectively useless either for conveying information or gleaning the actual views of the local community on the actual proposals drawn up by the CCG. It's not fit for purpose. The CCG should demand a refund: if they don't, maybe this shows they just didn't want to know what people really think, and wanted simply to go through the motions of a consultation before pressing ahead regardless?

Flawed consultation document

The Consultation document begins with an obvious problem: the sheer number of different providers delivering unconnected services to the 140,000 older people living in Cambridgeshire and Peterborough – although it proceeds to focus almost exclusively on community health services, which as CCS points out in its response, represents just 30% of the total value of the services out to tender.

The pie chart on page 10 of the Consultation document shows that half of the current spend on Older People is on acute hospital care (which is almost ignored in the Consultation): a smaller share is allocated to mental health (which is barely discussed at all) and even less to End of Life Care.

The big question is what the total value of the Pie actually adds up to. Nowhere in the Consultation does it refer to the financial issues: it does not even reveal the total spend on the services involved – £107m this year: this is now apparently regarded as secret, since it is one of the redacted figures from the ISOS and ISFS documents.

There is good reason for the CCG to want to keep quiet about this: it is just one EIGHTH (12.5%) of the CCG's commissioning budget, despite the fact that the older population constitute one SIXTH (16.2%) of the population, and older people are on average more costly to care for than those of working age. So there is an immediate concern that the

pressures on services are compounded by inadequate and ill-adjusted spending by the CCG itself. This of course is not discussed.

Spending on older people is due to rise to £142m from next year (an increase of 33%) with the addition of £47m from the "Better Care Fund" that has been top-sliced from the NHS budget – although this change and its implications are not discussed in the Consultation. At least some of this money will almost certainly have to be spent on social care.

From 2015 onwards the budget for Older People's Services is expected to decline each year as the prolonged government NHS spending freeze (to 2021) forces a year by year reduction in the tariff paid for treatment, while the numbers of over 65s in the local population are set to rise over the next period by 33% in Cambridgeshire and 23% in Peterborough, with much bigger rises for the more vulnerable over 85s.

Rather than draw out the implications of this, the Consultation (page 11) admits that "funding is not increasing in line with growing demand".

Worse, it goes on to give the impression that better organised and joined-up care delivers not only better health outcomes (which UNISON has argued for many years) but also save money – for which there is little if any evidence.

The "CCG Vision" (page 12) appears to centre not only on "joined-up" care, but on MORE care being available – allowing older people "access to care in ways that allow them to maintain their independence", and ensuring that people with long term conditions can access "the right support either at home or in their local community" (whatever that means) and people feeling "confident about the care they receive at home".

All of this suggests a big investment in improved levels and quality of provision, with local councils ending their contracts with poor quality domiciliary care contractors delivering inadequate services with super-exploited staff on zero hours contracts or minimum wage, and the NHS investing in properly resourced community-based multi-disciplinary teams. Sadly the Consultation is outlining no such plan.

The scenarios on pages 14-16, and many of the "proposals" on pages 17-18 appear to be sheer fantasies unconnected with the cash-strapped, fragmented and under-resourced services that have been provided so far. Almost all of them involve substantially more care available, despite the earlier warnings of frozen and falling budgets.

Where are all the extra resources and staff with specialist expertise going to come from? What additional staffing and resources would be required to make this a reality? What management resources would be required to administer a far more complex integrated system? How long would the "full care package" at home, suggested on page 16 and elsewhere be provided for?

Are any of the suggested new and extra services – such as packages of home care, "hospital at home" and community teams available 24/7 to deliver "urgent" care –

financially viable or affordable on the planned budget? What scope would any NHS or private provider have to address "housing problems" as mentioned on page 18? Are there any examples anywhere in this country or elsewhere of services working in this way?

Nothing would please UNISON and its members more than being able to deliver services along these lines: but nothing in the document shows how this is likely to come out of the procurement process, especially if any of the services are handed over to private providers which lack skills, staff and expertise in delivering this kind of service.

Sadly, similar fantasies are given full rein in the four anonymised "Outline Solutions" in which each of the bidders sets out their stall in trying to impress. None of them refers to finances or affordability, or mentions the constraints we know they will face if they win the contract. The futility of these statements is underlined by the fact that they are anonymised to prevent the public knowing which bidder said what, while in fact the public is not invited to express any preference between one bidder and another anyway.

Flawed assumptions

The Consultation document confirms that after making some correct initial points on the growing older population, and rising level of need for services, the CPCCG plan is based on evasions and wishful thinking, and in particular on a number of deeply flawed assumptions which lead to misleading conclusions.

- The huge underlying assumption behind the entire procurement exercise is that a new contractual arrangement for Older Peoples Services can achieve the impossible: an expanded service, improved quality of care, new services (none of them costed) and seamless 24/7 health & social care – all for not only no extra costs, but while delivering year-by-year savings despite rising demand and caseload.

- Another underlying unspoken assumption is that a wholesale change in the delivery of services to older people can be achieved with no extra burden on GPs, and no real change on the ways in which GPs are currently working.

- A third very large assumption is that the private sector offers appropriate expertise that is not available from existing NHS providers.

- And this links to the related assumptions that the private sector may be more efficient in delivering these services or has track record of success in the community contracts it has won already, and can be relied upon to deliver on promises: none of these is in fact supported by the evidence. We only need to look at the fiasco of the Serco contract in Suffolk, and their recently-abandoned management contract at Braintree Hospital to see that this assumption is false.

- Finally, and equally implausibly, the CCG tacitly assumes Older Peoples services can be separated from CCS/CPFT/CUH & not leave gaps and problems sustaining other

services: this view is strongly challenged not only by UNISON but also by the CCS response to the Consultation.

Mission impracticable

It's clear that the high hopes and pipedreams of the initial CCG proposal are unlikely to materialise. Neither the organisational structures nor the financial resources that are required to develop a completely seamless service are likely to be available in the current context of frozen budgets, the continuing cuts in public service spending and share of GDP spent on health which are currently endorsed by all three major parties, and the damaging and divisive Health & Social Care Act, which Labour has now committed to repeal if elected in 2015.

Equally worrying is the absence in any of the CCG documents of any convincing discussion of possible fall-back options in case of private failure – bearing in mind that existing NHS teams are likely to be dispersed if any privately-led bid is successful.

There is also a deafening silence on the certain problems that will be faced in the recruitment and retention of appropriately-qualified staff if NHS terms and conditions and pension rights are scrapped by a private consortium, or if a 2-tier workforce is introduced, which will create new divisions rather than move towards integration and seamless services.

The private employers are only grudgingly willing to accept the basic TUPE regulations, which as UNISON has seen elsewhere offer limited and temporary protection: it can subsequently be discarded by private bidders once the contract has commenced.

Worryingly it appears that all of the private sector bidders have a history of containing and reducing their staffing costs by diluting the skill mix of the staff they employ, despite the recent warnings from the Francis Report that the right mix of more highly qualified staff is the key to quality care.

It's also worth noting that there are no details at all, even in sketchy and idealistic fashion, on how the 70% of services which are not community services might be delivered under the contract, and what changes and disruptions might be imposed on hospital care and mental health services.

Without even a vision of what the CCG hopes to see in these services, it's hard to see this exercise ending well.

Flawed bidders

Accord Health is a link-up of giant private multinational contractors Interserve with Provide (a social enterprise aka Central Essex Community Services) and North Essex Partnership Foundation Trust.
The original Accord bid has been scaled back to focus only on Peterborough/Borderline, although they had originally bid for the contract to cover all four areas.

Accord would be the employer, and would be constituted as a "social enterprise" involving Interserve, Provide and NEPFT: but it would divide up any profits ("surpluses") from the contract to give 50% for Interserve and its shareholders, with the other 50% retained within the not for profit arm of the organisation.

Interserve are far from benevolent employers. Since they took over a facilities management contract at University Hospitals Leicester last year they have faced repeated allegations in the local *Leicester Mercury* newspaper that they were undermining staff working conditions, pushing up catering prices, and failing to meet cleaning standards as they have tried to squeeze more effort out of staff to maximise their profit.

In a meeting with the trade unions, Accord claimed that they would recognise unions but did not appear to know what this meant. They would not commit to honour future pay rises under Agenda for Change for the NHS staff who would transfer under TUPE, nor to guarantee any new staff recruited would be employed on the same terms as those transferred.

This does not give any grounds for confidence that the organisation could engage with staff to maximise effective working, or recruit or retain the necessary skill mix of staff to deliver consistent and acceptable quality services.

Care For Life is led by Care UK, linked with Lincolnshire Community Health Services Trust and Norfolk Community Health & Care NHS Trust).

However when they met with trade unions, Care for Life made the surprising revelation that staff working for the consortium would be employed by three separate employers, depending on where they work. When asked by unions about the complexity this would create for trade union and staff negotiations, and have implications for equal pay it was clear that the consortium has no comprehension of the issue, and had not heard of Equal Pay Audits.

Worse, it is clear that while the two NHS employers in the consortium would recognise unions, and have no problem with Agenda for Change or staff staying on the NHS Pension Scheme, Care UK – the main player in the bid – do not recognise unions and claim to have legal advice that they would not be obliged to recognise unions for staff transferred under TUPE. They also intend to employ any new staff on Care UK contracts, and to insist that any promoted staff also accept Care UK contracts, creating their own 2-tier workforce, with Care UK staff outside the NHS Pension Scheme.

Perhaps it's no surprise Care UK is so anti-union: it was co-founded by Tory Party donor (and benefactor of former Health Secretary Andrew Lansley) John Nash, and is now largely owned by the giant private equity corporation Bridgepoint, and has been accused of tax avoidance by the *Guardian* and *Independent*.
Its NHS contracts include some highly notable failures. In 2012 the company was found to have failed to process 6,000 X-rays at an urgent care centre it was running in NW London.

The same year Care UK's contract to provide musculoskeletal triage services in Buckinghamshire was criticised as a costly failure as waiting times increased. Through its primary care subsidiary Harmoni, Care UK was also involved in the failure of the NHS 111 helpline service.

Care UK is currently embroiled in an ugly dispute in Doncaster with former NHS staff who provide care for adults with learning disabilities.

The company took the service over last September , with a bid that undercut the NHS. It is now trying to slash staff pay through cuts in weekend pay, unsocial hours payments, overtime, and reduced holidays and sick pay. UNISON has responded with two week-long stoppages – and warnings that the same could happen where Care UK take on other former NHS contracts.

And as this response is completed news has emerged of problems with Care UK's contract to run the 111 non-emergency phone line in Suffolk, with calls from Ipswich Borough council's leader and Suffolk County Council's shadow health spokesperson for the company to be barred from re-bidding for the contract.

Virgin Care Ltd – the company owned by the Virgin Group, named after its base in the tax haven of the Virgin Islands, emerged from the takeover of loss-making primary care provider Assura.

The enlarged company, with big Virgin backing, broadened its scope, and went on to develop bids to run community health services. Virgin has since won major community health contracts in Surrey and Devon, but like all of the leading companies involved in community health services has yet to show much in the way of profits from any of them.

The company is reportedly hoping simply to grab enough contracts to create conditions to create some economies of scale – and the clout to force up contract prices.
If they won the Cambridgeshire & Peterborough contract they would be working with IBM Technology and mental health service provider Beacon Healthcare.

The company has told unions it would transfer NHS staff on the basic TUPE regulations, leaving the prospect of a 2-tier workforce for new recruits, although Virgin claimed that their Virgin Care terms & conditions would be of equal value to Agenda for Change, and that staff could choose – although staff on AfC would face larger deductions to cover their NHS Pension.

Virgin Care's existing services reflect the penny-pinching approach: Virgin was castigated in February by the Care Quality Commission, which found after two inspections of the Urgent Care Centre they were running in Croydon's University Hospital that reception staff with minimal training or experience were taking decisions on whether patients should wait for the UCC, or go straight next door to the A&E department for more complex treatment. This said the CQC put patients at risk.

Virgin has also been consistently failing to meet its target of assessing 95% UCC patients within 20 minutes, reaching only 70%.

There have also been criticisms of Virgin's services in Surrey, with the director of nursing warning of risks to patients. The Chief Executive Officer became prickly and defensive when questioned on these issues by trade unions, and made it clear he did not want to be there and found dealing with unions to be beneath him.

Uniting Care Partnership – Cambridge University Hospitals Foundation Trust has linked up with Cambridgeshire and Peterborough Foundation Trust in the only bid NOT led by a private company. But it turns out that with minimal publicity they have linked up with the all-purpose contractors Mitie which would be involved in a subsidiary capacity in a new Home Care service, and advising on drawing up the bid.

The consortium would also be working with East of England Ambulance NHS Trust to provide a 24/7 clinician-staffed contact centre and emergency teams, and a third sector provider to provide a wellbeing service.

Mitie will employ no staff for their role in the contract: staff would remain in the NHS. This is just as well, since the company is developing a poor industrial relations record: staff in its rail services arm have been on strike over what the RMT union calls a "derisory pay offer from a company that can afford to pay its workers properly."

The plus side of the bid is that it is grounded in local experience, CPFT would be the employer, and all NHS terms and conditions would remain, alongside collective bargaining and trade union recognition. The proposal for integrated care based on 18 neighbourhood and community teams has support from clinicians, from Trusts in Hinchingbrooke and Peterborough, from GPs and many more as well as the trade unions as the most NHS friendly bid. IT systems are already in place.

The negative side is that there appear to be no explicit plans to link up with CCS and build on that Trust's expertise. UNISON would urge this as a logical development for Uniting Care if they succeed in winning the contract.

Other responses

C.A.T.C.H (Cambridge Association To Commission Health) Patients Representative Group

This group's interesting response to a presentation from the CCG's Clinical Lead Dr Arnold Fertig confirms that UNISON is by no means alone in raising concerns over the achievability and viability of the CPCCG grand vision.
It highlights the lack of any financial analysis, and brings in experience of the actual process of cuts in mental health services that have shown "care in the community" plans to be unaffordable.

C.A.T.C.H also points at the lack of any discussion of the role to be played by GPs, and the lack of any evidence of greater joint working between the NHS and local authorities, despite the need for home help and housing services to make seamless care work.

C.A.T.C.H is also critical of the consultation taking place so late in the process and offering only one option, raising the broader question of what the CCG really wants to achieve.

The Questionnaire is seen as being far from neutral, and especial criticism centres on questions 4-8. C.A.T.C.H asks how much the market research company was paid for its efforts in producing it.

“The fear is that this is a PR exercise and not a meaningful consultation.”

And after asking what safeguards would be put in place to stop a successful bidder walking out before the end of the contract if it proved unprofitable, C.A.T.C.H concludes by asking whether the eventual contract will be so complicated it will be almost impossible for the CCG to manage and monitor it effectively.

Cambridgeshire County Council Adults Wellbeing and Health Overview and Scrutiny Committee

In a much softer response, which sets out to identify bases of agreement with the CCG approach, the Committee is nevertheless concerned to ward against acceptance of any unrealistically low priced bid, and in particular a “loss leader”, either of which would be a prelude to later upheavals and pressure for increased spending.

The committee also calls for more information sharing by the successful lead provider, while making no mention of the obsessive secrecy with which the procurement process has been shrouded throughout by the CCG.

In UNISON’s view the omens are not good for any such transparency unless the NHS bid is adopted.

The committee echoes the concerns of the CATCH group on the complexity of the information to be handled in the monitoring and management of the contract, and also queries whether suitable expertise exists in the CCG.

In an interesting new angle, the committee goes on to emphasis concerns over equity of service especially in the Fenland and other more rural parts of the CCG population.

And in another issue relating to equity, it argues strongly for the need for safeguards to ensure that new services based on the “self management” of care are used only where it is appropriate to the patient, especially given the growing numbers of older people with dementia.

Cambridgeshire Community Services NHS Trust

In a June 10 letter to the CCG's Chief Operating Officer, the CCS Chair and Chief Executive raise a number of concerns.

It notes that the decisions on the Older Peoples Services come while work funded by Monitor is ongoing in Cambridgeshire and Peterborough with Price Waterhouse Cooper to address the issues of a "Challenged Health Economy". It warns that the up to 7-year contract that the CCG is about to award might cut across other recommendations on securing local services.

CCS is also "disappointed" at the lack of any detail from the CCG on the necessary "levers, incentives and penalties that will be used to hold the lead provider to account" or how the lead provider arrangement will work with all providers to improve outcomes for local people.

The Trust points out its experience of "significant increases in activity across a range of community services in recent years without a parallel investment in the majority of cases", and the need to address this imbalance. If not, "there is little to be gained from a lead provider arrangement that the CCG cannot achieve within the existing commissioning powers".

UNISON shares the CCS concern that because of the almost exclusive focus on community services, "the fundamental and significant changes that are anticipated to health services locally across hospital, community and mental health services" are completely lost sight of.

CCS raises detailed concerns that the precise list of services covered by the procurement must be finalised to allow no room for confusion or misinterpretation.

The Trust makes clear that some of the adult community services covered also deliver care to children:

> "Examples of such services are minor injury units, radiography, podiatry, and nutrition and dietetic services to name but a few. To avoid any fragmentation, duplication or a gap in service provision, agreement will need to be reached with the Trust on how children continue to receive these services."

CCS argues that staff within the Trust have

> "expressed strong concerns about the potential for fragmentation of services and the de-stabilisation of working arrangements across those services that will remain with CCS and those that will transfer to a new provider".

This potential fragmentation, argues CCS could impact negatively on the CCG's ambition to develop more joined up integrated services.

Arguing that the planned starting date for the new contract of January 5 2015 is simply impossible if the process is done properly, CCS strongly urges the CCG to agree to a 'go live' date of 1 April 2015

"to avoid de-stabilising services, particularly during a time when services across the system will already be under the known pressures of the winter period."

And finally while stressing that the Trust will remain in business even after the services are hived off in the new contract, CCS raises concerns on behalf of staff that have been conspicuously lacking from the CCG:

> "The successful bidder will inherit a first class workforce committed to providing the highest quality of care for adults and older people. We seek your reassurance that the CCG's contract with the Lead Provider is explicit in terms of adhering to the legal requirements of TUPE."

Only one viable option: the Uniting Care Partnership

UNISON's preferred option would have been a negotiated process between the CCG, CCS, CPFT and CUHFT to improve services and establish joint working in the key areas relating to older people. Instead the CCG has gone for the complex, costly and long drawn-out alternative of competitive tendering and procurement.

This process, which has been conducted with minimal if any constructive engagement with staff, unions, local providers or the local community, has now reached its final stages with the key financial details shrouded in secrecy, reams of complex and probably unenforceable target outcomes, vague and uncosted plans and total silence on the plans for hospital care and mental health services for older people.

This process has now resulted in a fait accompli, in which four bidders remain, three of which are led by private companies with a string of failures and problems behind them, no clear track record of expertise in the complexity of these services, and little appetite for constructive dialogue and working relations with staff and trade unions.

It's clear from the limited options available, therefore that the only serious bid left on the table is the NHS bid from Uniting Care Partnership, with its long-established working relations with the unions and continued commitment to the NHS and its values.

In choosing this bid as the only viable option, UNISON still warns the CCG that without addressing the underlying issues of resources for this underfunded and neglected but increasingly important sector of the NHS the new contract will achieve none of the objectives proclaimed by the CCG and address none of the problems.

We will continue to represent our members in the Uniting Care Partnership but also those in CCS whose jobs and the services they deliver are put potentially at risk by this massive upheaval, and we will continue to urge the Uniting Care Partnership to work in an even wider and more constructive partnership with CCS to preserve and improve health care and liaise even better with social care in Cambridgeshire and Peterborough.

Researched for UNISON Eastern Region

by Dr John Lister
June 2014