Notes on Staffordshire Cancer and End of Life Memorandum of Information. John Lister Feb 27 2015.

1. The document contains 21 mentions of “integration” or “integrate” without once explaining how this integration is supposed to take place, unless the provision of services is taken from many existing providers and reallocated to just one.

2. In fact the document leaves open the question of why the four CCG commissioners do not find ways of **integrating their efforts to work through one committee on commissioning services** rather than introduce an new quite probably private sector – and untested commissioner, who having won the contract would after year 2 be guaranteed a prolonged period of unchallenged control over hundreds of millions of pounds of commissioning budget.

3. This gives no genuine accountability for this vital service, and could result in seriously destabilising the financial viability of the acute trusts and other providers, which are currently performing much better than the national average on almost every measure.

4. The four CCG Boards boast a grand total of just 18 GPs (3 of these non-executive members in North Staffordshire), but have engaged in this controversial project without any proper consultation with the remaining 453 GPs in 127 practices which they claim to represent, let alone the 771,500 people covered by the CCGs, which have yet to be offered any proper consultation.

5. Instead of consultation, we are told that various “engagement” activities have allegedly taken place with undisclosed numbers of people in various settings. However since this latest document remains profoundly vague on exactly what the “transformed” new services might look like, how they are supposed to work, or what services the freshly appointed “Prime provider” might choose to “disinvest” from (4.5), with no opportunity for local people to challenge, it’s not clear what the purpose or conclusion of this limited engagement might have been.

6. It is normal in contracts and “transformations” as large as this to go to proper public consultation, in which a policy is proposed, options offered, and public views invited. Cambridgeshire & Peterborough CCG, which had developed much more detailed proposals for the contracting of a “lead provider” for the entire range of Older People’s services, last year bowed to pressure to open up a consultation despite initially trying to press through the £800m contract without doing so. In the event the weight of public opinion no doubt had an impact in the decision to award the contract to the NHS-led bid.

7. Despite all the huffing and puffing – in which Macmillan seeks to justify its squandering of millions of pounds donated by supporters on promoting a project that seems to be headed

towards private sector control of cancer and end of life budgets – the Staffordshire proposals are not new at all, but follow the policies outlined back in 2012 by Professor Paul Corrigan and Dr Steven Laitner in the "Right Care Casebook" pamphlet "the Accountable Lead Provider".[1]

That pamphlet makes clear that the CCGs adopting this approach will in effect be handing over control to another commissioner:

> "We also want commissioners to make their life easier for themselves by *not* commissioning these Programmes of Care via the existing micro-commissioning and micro-contracting methodology. […]
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> "We want commissioners to commission these Programmes of Care via an Accountable Lead Provider. By doing so, they give the job of service transformation and programme integration to **a powerful health care provider** in the centre of the pathway (between primary care and hospital inpatient care). In order to be able to manage the programme **they will need to be able to both provide care and subcontract care** to other providers.
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> […]
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> As the name suggests **The Accountable Lead Provider is a provider of care**, **not just a "navigator" or "integrator".** This is because the power needed to provide accountable integrated care **can only be delivered from a provider within the pathway of care** and ideally in the centre of the pathway. **The Accountable Lead Provider is not a commissioner**, it is a provider, an integrator and programme manager, **a provider that both provides and subcontracts healthcare." (pp2-3)**

8. An almost identical – if much smaller-scale (£35m/year) – plan has also been drawn up by North Essex CCG to hive off "Care Closer to Home" to a 'Lead Provider', although in that case there is a period of consultation, albeit minimal and with no details.

Like Staffordshire, which offers an 8-year extension after a 2-year preparatory period, the North Essex plan aims to offer a long contract (7 years).

9. The Memorandum nowhere discusses the numbers of patients, or makes any assessment of the scale of services required. However NHS England, working with the Right Care initiative, has published **"comprehensive data packs"** to assist CCGs in "commissioning for

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1 http://www.rightcare.nhs.uk/downloads/Rightcare_Casebook_accountable_lead_provider_Aug2012.pdf

value".[2] They include data on the four CCGs involved in the Staffordshire plan. Interestingly they show differences between the four CCGs: the only CCG for which Cancer comes out top of a list of programme areas offering greatest opportunity for improved performance on both quality and spending is Cannock Chase.

In Stoke on Trent Cancer comes second on the list for quality related improvements, but is not among the top programme areas for potential cash savings.

In North Staffordshire, Cancer comes fourth on the list of potential cash savings, but is not among the biggest potential areas for quality improvement.

Stafford & Surrounds has lower mortality rates than the average of the top five CCGs in England on all of the main specialist services (Cancer, neurological, circulation, respiratory, gastro intestinal and trauma): it scrapes in at third on the list for potential cash savings.

10. The Memorandum as consistently and deliberately vague on almost every detail.

- Para 3.5 asserts the cost of cancer services is "incrementally rising" but quotes no local (or current) figures.
- Para 3.7 asserts that the highest spending of the 4 CCGs spends more than twice as much per person and the lowest spending: but this is used as an excuse to delegate the commissioning elsewhere rather than the trigger for a proper examination of why spending may vary.
- Para 3.9 asserts "patients ***very often*** report a negative experience", without giving any details of how many, how often, what proportion of the total is involved, where the patients access care, or how such reports are collected.
- Para 3.10 Declares that "It is intended through this Procurement to make the experience of care for cancer as seamless and joined up or "integrated" as possible." This objective is perfectly acceptable. But instead of explaining how this will be done, or offering any evidence from experience elsewhere, the rest of the paragraph asserts: "The approach of procuring a Prime Provider will enable this to happen as well as ensuring sustained patient choice."

11. Para 4.5 specifically opens the prospect of the "Prime Provider" deciding for themselves which services should continue and which should suffer "disinvestment". No clear rationale for such decisions (such as local demographics; inequalities and health needs; availability of efficient and affordable public transport links) and no opportunity for disempowered local communities, faced with the loss of local services, to be consulted prior to disinvestment.

[2] http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

This amounts to giving the "Prime Provider" carte blanche to close whatever services they choose with no possibility of further discussion.

12. Many of the "outcomes" set out in 4.7-4.14 cannot be guaranteed in advance ("top three in England" leaves out the possibility that other services also improve: "excellent and equitable" is a subjective judgment. The promise of "access to local services" (4.10) has to be hedged with "where appropriate" because of possible disinvestment). These "outcomes are deliberately imprecise, and offer no real basis to monitor the success or failure of the Prime Provider over the next ten years.

13. Awarding any contract which might be won by a private sector bid for 10 years is a major gamble, given the recent track record with private sector providers (UnitedHealth pulled out of primary care contracts, Serco pulled out of a variety of contracts, Circle pulling out of Hinchingbrooke Hospital contract 3 years into 10-year deal, etc). No sensible commissioner would leave so little scope to hold contractors to account.

14. The Commissioners argue (4.15) that success will depend on factors such as "a clear business case and strategy for change" – but no such business case would be drawn up until two years into the contract. All of the factors in 4.15 are just as elusive. There is no suggestion that failure by the Prime Provider to deliver as promised would result in penalty payments, withholding of finance, or any sanction at all – let alone the early termination of the contract. This leaves the Prime Provider free to do exactly as they wish for eight years.

Indeed 4.19 (and later 6.2.5) makes clear that the CCGs don't want to stipulate how they want the outcomes delivered – the whole bundle of services is to be handed over to unquestioned control by Macmillan and the Prime Provider.

15. As was done in Cambridgeshire, the CCGs plan (4.21) to conduct a dialogue behind closed doors with those bidding for the tender, around an Outcomes Framework to be part of an Invitation to Submit Outline Solutions (ISOS) document. In Cambridgeshire, the CCG for months resisted Freedom of Information Act requests for publication of the ISOS document, only eventually releasing a heavily redacted version with all the financial details removed. Staffordshire communities should expect similar secrecy to prevail.

16. In a pamphlet[3] on the proposed model of contracting Capsticks the lawyers warn (p4-5) that the problems posed for providers also need to be taken into account:

> ""If the commissioners see the prime approach as a way to simply shoehorn a wider package of services together for a reduced budget without provider-side buy in to

[3] Delivering the Prime Contractor approach to NHS services: "Command and control" or "accountable care provider"?, available http://www.lgcplus.com/Journals/2015/02/13/c/q/e/Capsticks-Prime-Contractor-Paper.pdf

> the process then the approach is essentially a kind of enforced provider roulette." […]
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> "The majority of the benefits of the prime contractor model tend to show up in the commissioners' side of the ledger in terms of reduced numbers of contractual arrangements to manage, reduced administration, greater integration of contractual arrangements and more manageable cost. **However, the commissioners should also consider the impact of their approach on the provider side** and how fair and equitable it is to expect the providers to introduce a new system and take on management of wider services from day one **at a significantly reduced margin and substantially increased risk profile."**

There is no indication that the Staffs CCGs have taken any heed of this advice or shown any concern for the future viability of providers.

17. In Para 6.1.12 there appears to be an attempt to minimise the requirement to pay VAT, suggesting again that the CCGs are looking to involve a private sector Prime Provider, since NHS organisations are not liable for VAT.

18. para 6.2 and the attached diagram wilfully distort the proposal, by lumping all of the various providers that would deliver the services into a single block of "third party providers". Unless the Prime Provider effectively moves in to take over provision of all the services, effectively commissioning itself, the need to contract with a range of providers (and therefore an element of complexity, made worse by the Health & Social Care Act) wil remain a problem.

19. Para 6.2.9 drops in the bombshell that the Prime Provider will need to show how the

> "fee for managing and providing Cancer Care Services can be 'self-funding' whilst ensuring that the services are value for money and affordable."

This means inevitably that less of the budget for cancer care will be spent on cancer care, in order to guarantee the "fee" (profit) of the Prime Provider.

One reason why several private bids were withdrawn for the Cambridgeshire Older People's services contract was because there was insufficient guarantee of a profit to be made. Para 7.2.1 shows that the Staffordshire Cancer and End of Life contracts seem to be heading in a similar direction:

> "Through service re-engineering the appointed prime provider will be expected to deliver the outcomes of this project within the identified cost envelope. **In addition** the prime provider **will be expected to release savings** to the Commissioners reflecting their respective financial positions which will vary between commissioners."

Since their profit also must come from the limited cash on the table, this means only the most desperate private sector bids, and the most ruthless private companies willing to slash services to preserve their profits will persist with their bids.

20. Para 6.2.2 falsely implies that the new Prime Provider would be able to establish a "seamless and integrated pathway across health [NHS] and social care [local government]. The question of "how" is prudently avoided by an empty abstract assertion. However Paras 6.4, 6.5.1, 6.5.2, 6.5.3 give a hint of the nightmarish nonsense of the competition laws that have now been brought into the NHS by Andrew Lansley's Health & Social Care Act, raising real questions over the extent to which any "Prime provider" will be able to integrate or establish "common control" over organisations which are now separate.