Appendix 2 Organisational and MP Responses

Acorn Surgery Patient Participation Group

Cambridgeshire and Peterborough CCG llth June 2014

Acorn Surgery PPG
[redacted]

Proposal to Improve Older People's Healthcare and Adult Community Services - Consultation Response

Sir/Madam,

Please find enclosed the response from the Acorn Surgery Patient Participation Group (PPG)

This PPG's main concern is in relation to questions 4 to 8 of the consultation document. As stated in the document, these questions have been received from the organisations who have declared an interest in providing the services. We consider that with these questions the prospective organisations are in effect attempting to drive patients and the general public to accept a hierarchy of services which will in turn determine where the successful bidder will allocate their resources. It could be construed that the potential service providers are determining the service(s) they will provide and not the CCG. Is this permissible under the European Procurement Directive? We have therefore not answered questions 4 to 8 as the PPG consider that all statements are of equal value to patients.

The PPG is keen to learn if the collective answers to questions will be used by the CCG to determine the level of service(s) to be provided.

Yours faithfully
Steve Watson
on behalf of Acorn Surgery PPG

Cambridgeshire Community Services NHS
NHS Trust

10 June 2014

Andy Vowles
Chief Operating Officer
Cambridgeshire and Peterborough CCG

By Email

[redacted]

[redacted]

Tel: [redacted]
Fax: [redacted]

Direct Dial: [redacted]
Email: [redacted]

website:
www.cambscommunityservices.nhs.uk

Dear Andy

Proposals to improve older people's healthcare and adult community services

I am writing to set out Cambridgeshire Community Services NHS Trust's Board's formal response to the above consultation and welcome the opportunity to do so.

Firstly, we would like to fully endorse the Clinical Commissioning Group's vision for services across acute hospital, mental health and community services which are:

- more joined up
- better planned
- focus on supporting people to remain independent
- enable fewer patients to be admitted to hospital as an emergency where this can be safely avoided

As you will know, the Trust has introduced a range of innovative service models with commissioners that have successfully supported these aspirations. However, for the CCG's vision to be fully and successfully implemented, clarity on the lead provider role and system wide agreements will be critical. We therefore set out below our specific comments in relation to the CCG's proposals:

Contract term

In general, we support the longer term approach the CCG is taking in relation to the seven year contract term for this procurement which has the potential to promote stability within the system. However, the Trust is concerned about how this fits with the current work that is taking place, led by Price Waterhouse Coopers, in relation to the local system being a Challenged Health

Economy. We can see a risk that the CCG enters in to a longer term contract before being clear on the vision for the overall system to address the major financial challenges across all care group areas.

The Lead Provider role

The Trust Board was disappointed at the lack of detail and focus on the lead provider role and the purpose of the capitated budget in the consultation document, associated presentations and consultation sessions. The community health services element is only circa 30% of the overall value of the procurement and hence our surprise there has been little information explaining how a capitated budget will be used to improve the care for older people and how the CCG will contract manage the relationship with the Lead Provider. These elements are fundamental to the CCG's proposals. Clarity is needed on the necessary levers, incentives and penalties that will be used to hold the lead provider to account and how the lead provider arrangement will work with all providers and stakeholders to improve outcomes for local people.

Historically, community and mental health providers have been disadvantaged through the predominance of block contracting arrangements locally whilst acute hospitals have been funded through a payment by results commissioning arrangement. The impact of significant increases in activity across a range of community services in recent years, without a parallel investment in the majority of cases, is well known. Unless contractual arrangements with the Lead Provider and those they sub contract with address this inherent imbalance there is little to be gained from a lead provider arrangement that the CCG cannot achieve within the existing commissioning powers, responsibilities and arrangements.

It is recognised that resources need to transfer from acute hospital settings into community services if aspirations for maximising care in the home setting and avoiding hospital admissions are to be achieved. The CCG will need to ensure that the contractual arrangements are explicit in this respect, particularly where pump-priming or parallel running are required to achieve a change in how services operate. Similarly, the approach and specific requirements the CCG will incorporate in to contractual arrangements with the Lead Provider to enable a preventative approach to be taken to health and well-being and hospital admission avoidance needs further clarity and detail being available for public consumption/accountability.

Given the predominant focus on community services within the consultation and associated documentation, the fundamental and significant changes that are anticipated to health services locally across hospital, community and mental health services and the benefits the CCG is seeking to achieve through a lead provider and capitated budget is completely lost. As the community services block contract accounts for only 30% of the services (by value) within the procurement, this detracts from the value of the consultation and seems to be a lost opportunity for the CCG to explain this change to the general public.

Services within the consultation

The CCG has published a high level list of services affected by the consultation. It is imperative that the final list of services within the procurement is finalised as soon as possible after the dialogue process concludes to ensure clarity and to aid transition and mobilisation plans. The CCG must ensure there is no room for interpretation of which services are within this contractual arrangement. For example, if an older person has a planned operation, would the costs of this operation fall within the procurement capitated budget or would the hospital submit an additional invoice for surgical activity (noting that surgical activity falls outside the procurement contract). This is just one example of the potential confusion which must be avoided if public monies are to be utilised in the most effective way.

We have previously made the point and would like to reiterate that some of the adult services within the procurement also provide services to children, whether through specific staff who

focus purely on children or through integrated teams that provide care for all age groups. 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, whether through negotiation of revised contractual arrangements with the Trust or incorporation of these services into the scope of the procurement

We would urge the CCG to consider removing the Minor Injury Units and Radiography Services from the scope of the procurement. The CCG is about to embark on a redesign project (or potentially a separate procurement exercise) in relation to the urgent care pathway for 111 services and GP out of hour services. We therefore believe that it would be prudent to remove these services from the scope of this procurement and to link them with the CCG's strategy for urgent care as this will create greater flexibility and opportunity for the CCG to procure an integrated urgent care pathway for the system overall. In addition, as I am sure you will appreciate it would be very disruptive for patients and staff within these service areas to transfer to a new provider as part of the current procurement, and then to be subject to a further change so soon.

Fragmentation of services

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 has the potential to impact negatively on the CCG's ambition to develop more joined up integrated services. Care needs to be taken during the mobilisation phase to ensure the potential for fragmentation does not occur.

Mobilisation

The Trust has consistently raised its concerns about the CCG's timescales for mobilisation of the procurement outcome. To re-iterate, as we have shown in writing, it is simply not possible to achieve a 'go live' date for the new provider's contract to commence from 5 January 2015. The extensive work involved in relation to staff consultation, estates management, contractual and information management/technology is huge and the Trust cannot commence staff consultation until the preferred provider has been formally appointed and a contract signed. The Trust Board has written formally to the CCG and discussed extensively the risks and implications of this timescale You will know that based on our collective experience of procurement transfers locally we consider that the earliest 'go live' date would be 1 February 2015. However this is dependent on contracts being signed within an unusually short time period and does not allow any contingency in the timeline at all. We would strongly urge 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.

The Trust should give notice to its own suppliers and sub contractors to provide the necessary six month notice period. We have agreed not to do so until the CCG Governing Body decides on the 8th July the final timescales for the procurement after considering feedback from the consultation.

CCS NHS Trust's future viability

Given the predominant focus on the future of community services within consultation documentation, the message colleagues from acute and primary care settings, as well as patients and local people have gained and shared with our staff is that this procurement will

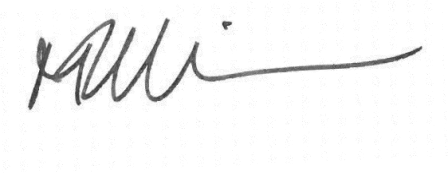
result in the demise of the Trust. We therefore take this opportunity to re-iterate that the services within the CCG's procurement account for circa 45% of the Trust's service portfolio across Cambridgeshire, Luton, Suffolk and Peterborough. As confirmed by the Trust Development Authority, the Trust therefore remains a viable 'going concern' and we will build on our recent successes in winning new contracts, continuing to expand our existing portfolio of services in line with our (and the local system's) five year strategic plan. We ask that the CCG's response to consultation is clear on this point to ensure further ambiguity across the system and negative impact on our staff is removed.

Staff well-being and adherence to TUPE

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.

We look forward to receiving your response in relation to the above issues and reiterate our commitment to ensuring a safe and effective transfer of services affected by the procurement.

Yours sincerely



Heather Peck
Chairman

Matthew Winn
Chief Executive

Cc: engagement@cambridgeshireandpeterboroughccg.nhs.uk

Freepost Plus RSCR-GSGK-XSHK

Cambridgeshire County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Proposals to improve older people's healthcare and adult community services

Consultation Response

1. Background and Introduction

This document sets out the response of the Cambridgeshire County Council Adults Wellbeing and Health Overview and Scrutiny Committee (OSC) to Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) proposals to improve older people's healthcare and adult community services. The OSC considered the proposals at its final meeting on 1st April 2014.

The nature and quality of healthcare provision for the growing number of older people and working-age adults with long-term conditions has a major impact on the lives of Cambridgeshire residents. The OSC has therefore given priority to considering how the procurement process for these services can be undertaken in a way which results in positive outcomes for service users and their carers.

The OSC set up a member working group to examine and comment on the CCG's arrangements for the future commissioning of older people's healthcare and adult community services at its meeting on 5th December 2013. During February 2014, the working group met with the CCG, and examined and commented the CCG draft public consultation plan, early drafts of the public consultation process and the draft consultation questions.

The Committee as a whole considered reports from the CCG on the procurement process and public engagement arrangements at its meetings in December 2013, and February, March and April 2014.

2. Consultation process

The Committee welcomes the decision by the CCG to undertake public consultation at this stage in the procurement process, before a decision has been made on which bidder will be awarded the contract for these services, and it supports the way in which the consultation in being conducted.

It welcomes the positive response by the CCG and the bidders to OSC requests that material summarising each of the bidders proposed outline solutions was published with the consultation documents.

3. Overarching comments

3.1 Programme Aims

The Committee supports the broad aims and objectives of the programme to provide more preventative care 'upstream' in the community, and to reduce demand for acute services, in the context of the financial and demographic pressures on the CCG and other parts of the health and care system.

In particular, we support the aims set out in the CCG vision of care being better organised around the needs of the patient through:

- More joined up and co-ordinated care
- Better planning and communication
- More patients supported to remain independent
- Improved community and out of hospital services and fewer patients admitted to hospital as an emergency where it can be safely avoided

These aims relate closely to the recommendations of the Committee's review of delayed discharge and discharge planning, which it conducted in 2012-13 in response to member concerns about the impact on patients of the large number of delays from hospitals serving Cambridgeshire residents, particularly Addenbrooke's.

Key recommendations from this review, which reported in May 2013, highlighted the need for:

- Greater collaborative working between health commissioners, providers and the County Council to resolving the issues underlying delayed discharge
- Redirection of resources towards community based services, including those services aimed at admissions avoidance.
- Improvements in discharge planning processes, including streamlining and improving the assessment and discharge planning pathway from the point of admission onwards, and strengthening communication and joint working between primary care, hospital and discharge planning staff
- Information systems which enable a single multi-agency assessment process, and effective communication and information sharing between all those involved in discharge planning
- Closer working between the NHS and County Council to identify and resolve gaps in capacity through investment in reablement, community rehabilitation and step-up beds, community based health and social care services that would enable safe weekend discharge, residential and nursing home care at benchmark prices, and home care.
- Gaps in support for people with mental health or related issues to be addressed, particularly in ensuring prompt identification, referral and access to secondary mental health services for people with more severe mental health problems; adequate provision of liaison psychiatry in hospitals for working age adults and older people; and provision for patients with alcohol problems, homelessness or other support needs.
- A multi-agency admissions avoidance strategy and provision, involving Local Commissioning Groups and GP practices, including integrated rapid response teams, a single point of referral for GPs to access, an effective and reliable 7-day admissions avoidance service, community and district nurse provision, multidisciplinary team working in all GP practices, and use of telecare, falls prevention and equipment.

The full review recommendations are attached as Appendix 1.

Recommendation: The CGG commission a service that can demonstrate that it will take forward the recommendations of the review, and build on the work that has already been undertaken by NHS organisations and the County Council to reduce delays and improve the discharge planning process.

3.2 Financial risk and deliverability

The OSC recognises that the cost of the programme has to be taken into account when the CCG selects its preferred bidder, and that if the competitive bidding process results in the CCG getting good value for money, it releases resources for other services.

However, the Committee is concerned that the CCG does not run the risk of accepting a bid that is undeliverable in practice, by giving too much weight to the pricing of the bid. In particular, we oppose acceptance of a 'predatory' bid i.e. one which is set at an unrealistically low price, as this could lead to the provider seeking to negotiate for more funding at a later date, or seeking to reduce services to the level that the funding covers. This would provide an unstable basis for service provision.

The OSC also considers that a 'loss-leader' bid should be avoided, as while it might save the CCG money for the duration of the contract, it would not be sustainable in the longer term.

Recommendation: The CCG is very rigorous in testing the financial realism and deliverability of the bids, and ensures that the above concerns are addressed when it decides which provider should be awarded the contract.

3.3 Information-sharing and informatics

Contractual

It is essential for the quality of delivery of the service that there is effective information sharing between the different organisations involved in the contract, including sub-contractors, and this should be specified in the contract. The successful provider should be able to demonstrate how this will be achieved. Members are concerned that the lead provider and its associated providers do not monopolise the knowledge resulting from the contract, which could potentially lead to a situation in which the incumbent provider would have a competitive advantage over other organisations in future.

Patient confidentiality and information sharing

Data gathered by the provider should be made accessible to the wider NHS and to public health services, in a form which enables the NHS as a whole to learn from this new contractual arrangement while protecting individual patient confidentiality. In particular, safeguarding arrangements should be in place to ensure that data is not shared indiscriminately or passed on to commercial organisations without the explicit consent of patients.

Information flows in a complex outcome-based contract

With an innovative outcome based contract on this scale, it is imperative that the CCG has a detailed comprehension of how the range of different interventions being provided contribute to the high-level outcomes that the CCG has defined, and which of these are most effective, if the desired service improvements are to be fully achieved. The CCG therefore needs to ensure that it has the specialist capacity to analyse and interpret complex clinical and patient flow data and understand their links to the high-level outcomes.

Recommendation: The CCG takes the above issues into account when awarding the contract

3.4 Equity of service delivery

There needs to be greater emphasis in the proposals on ensuring equity of service delivery across the County, particularly in Fenland, including clarification as to how the extra costs of providing an equitable service in rural areas will be met. It should be recognised that in order to provide an equitable service across the County, different approaches may be

needed in each geographical area, which take account of demographic factors, accessibility and transport issues, and any gaps in current provision. The CCGs Equalities Impact Assessment should take rurality into account.

3.5 Relationship with the local authority

There needs to be a clear explanation in the proposals as to how the provider will relate to the County Council in relation to social care, and the district councils in relation to housing, both at a strategic level and at the level of day to day practice, with clarity about who is responsible for what.

3.6 Patient Choice

The proposals need to be clearer about how patient choice will be achieved, and how this can be assured, in terms of where people are treated, and the nature of services that they receive.

3.7 Practice boundaries

The current procurement process does not cover Cambridgeshire residents whose GP practice is close to the County boundary and is not registered with the CCG; for example residents who use the Gamlingay practice receive health services from Central Bedfordshire and social care from Cambridgeshire. The CCG should take steps to ensure that arrangements are made for patients of these GP practices to benefit from more co-ordinated care, and be proactive in inviting the practices to consider joining the CCG.

3.8 Contract compliance

It is essential that there is a robust performance management system to ensure that any failures to provide the required levels of care are quickly identified and dealt with, with provision for termination of the contract if the provider fails to deliver.

4. COMMENTS ON SPECIFIC PROPOSALS

4.1 Organising care around the patient

- There is still more to be done to ensure that people are not discharged from hospital or inpatient rehabilitation without services being arranged or their carers being informed. Involvement of carers needs to include members of the extended family and others who provide support who may not be registered with the person's GP as the main carer or as the next of kin.
- Part of the role of specialised support should be to have an overview of the patient, and ensure that they are regularly reviewed, including ensuring that they have medication reviews.

4.2 Delivering seamless care

- The 24/7 single point of access is a very positive move, provided the following are addressed
    - Ensuring that callers get through to the telephone service quickly, and that they get a rapid and effective service in response. This is dependent upon there being sufficient staff, at the right skill levels, at all times to deal appropriately with callers and to handle the volume of demand
    - An effective system of performance monitoring, which looks at quantitative issues such as response times for calls, as well as the quality and appropriateness of the resulting service.

    - Clear and effective working relationships with the 111 service and other telephone access points
    - Extensive publicity about the service, including clear information about which telephone service people should call.
- There should be a very strong focus on ensuring that older people with mental health needs receive joined up care, given the large and growing number of older people with dementia or other mental health issues. Involvement of mental health professionals throughout the service, including within hospitals, is essential
- We strongly support the single electronic records system, while recognising that it will be challenging to implement in practice.
- Partnership working with voluntary organisations to provide support and direct patients to services needs to be properly resourced, with clear and agreed expectations as to what they will deliver, and to what standard, and how information sharing and patient confidentiality will be dealt with.

4.3 Supporting older people to stay independent

- Healthcare reviews also need to involve social care
- The value and cost effectiveness of community healthcare contact points should be kept under review, and the approach changed if necessary, to ensure that resources are used to best effect.
- The use of technology needs to be appropriate to the individual concerned – some older people in particular may not be comfortable with this approach.
- There need to be safeguards to ensure that self-management of care is only used where appropriate, particularly in view of the growing number of people with dementia, which may not necessarily have been diagnosed, who would not have the capacity to manage their care.

4.4 Reducing emergency hospital admissions, readmissions and long stays in hospital

- Involvement of mental health services, and ensuring there is sufficient community based mental health provision is an essential element of admissions avoidance
- Proposals relating to the 24/7 urgent care system, case management by multidisciplinary teams, community services, and hospital based community teams need to be clear about how they would work in practice. In particularly in relation to how they ensure that the right people see the patient at the right time, and that they work effectively both in relation to providing joined up care, and in making best use of staff time and resources.
- Partnership working with the ambulance service is key to admissions avoidance, and the proposals need to be clear about how this will be done. Conversely, all parts of the system need to work in a way that ensures that people are admitted to hospital when they should be.

4.5 End of life care

- We strongly support the focus on end of life care, and would not wish to choose between the different proposals, as all are important.
- There needs to be an agreed way of dealing with the situation where a carer or family member is not aware of or does not agree with the patient's wish or clinician's view that they should not be resuscitated.

Cllr Kilian Bourke
Chairman Adults Wellbeing and Health OSC (to May 2014)

C.A.T.C.H. Patients Group's feedback in reply to the consultations on the proposals to improve older people's healthcare and adult community services.

On 24th April Dr Arnold Fertig was kind enough to give our group a presentation as part of the public consultation on the proposals to improve older people's healthcare and adult community services.

There follow the group's observations and comments:

In general terms the proposals would appear to improve the care of older people. Plans to avoid hospital admissions whenever possible, and to treat people in the community, or at home are welcome. This will depend to a large extent on the evening and weekend care and support that will be made available. But there is no detail on any of these aspirations nor any financial analysis showing how they will be achieved and funded.

One of our members who has considerable experience in the area of mental health care points out that similar "care in the community" plans have proved unaffordable. Cuts are constantly being made, particularly in staffing; the vital provision of community psychiatric nurses and support workers is minimal except for seriously unwell patients. Named care co-ordinators keep changing. How will a similar outcome be avoided?

GPs will play an important role in these proposals yet there are no details about how this area will be developed. NHS England now commissions most primary care services. What is its involvement?

The consultation document mentions the CCG working closely with L.A.s to provide "joined up care" but there seems little evidence of this happening. Nowhere is there an authoritative statement from the L.A.s supporting this strategy and committing to co-operate with it. Home Help and Housing are vital to the success of this strategy.

The King's Fund Report states that the new Health and Well-being Boards will play a key role in co-ordinating the different groups of commissioners; but there seems to be no mention of this.

Concern was expressed about the timescale remaining for the awarding and implementation of the contract. Analysing the Consultation returns, building points raised into the negotiations with bidders, awarding the contract in September 2014, and the contract starting in January 2015 seems ambitious, if not foolhardy.

Elderly people need advocates. The important work of Community Matrons was raised in the context of co-ordinating and continuity of care and a provision for them should be written into the contract.

It was felt that this consultation was a little late in the process. We are being consulted on one option only and the view was expressed that a consultation on several different answers to the problems of older people's care would have been useful before necessarily settling on the present one.

It is not clear exactly what the CCG is looking for to solve the problems. They state they are looking "to find <u>one</u> organisation or <u>a group</u> of organisations to deliver these improved services". "We need new style contracts with <u>a number of service providers</u>". This does not seem to be a focussed way of commissioning anything.

CCS provide a good part of the present services yet they are no longer in contention to win the bid as their partners have dropped out of the process. Concern was expressed about continuity of staff as they provide district nurses, visiting physiotherapists, dietitians, and podiatrists . It was felt that T.U.P.E. costs involved in transferring staff could very expensive

and could affect margins of the successful bidder. Concern was also expressed about the possibility of CCS not allowing their premises to be made available to be used by the successful bidder.

The wider availability of sensitive personal information carries risks, especially in the hands of private organisations. There need to be absolute guarantees backed by heavy penalties that such information will be available only to those delivering services and used only for delivery of care to the individual to whom the information refers. The individual concerned must also have access to their personal information on request.

On the subject of the questionnaire it was felt that it was not neutral in the way some questions were asked and unsatisfactory in other ways. Questions 4to 8 were particularly criticised in that they appeared to be asking which areas were not important, with the implication that they could be cut from the specification. Given the format of the questions it was difficult to imagine what useful analysis could be made from the answers. Questions have been raised asking what instructions were given to the market research company about the purpose of the questionnaire and how much have they been paid?

The consultation process seems to be rather chaotic; questionnaires, public meetings. group meetings, groups being asked to submit responses some to the questionnaires, some not; consulting various other stake holders; adverts on some radio stations etc. It is difficult to see how all the different responses in all their different guises will be collated and analysed in any coherent form. The fear is that this is a PR exercise and not a meaningful consultation. It is not a request for approval or agreement.

What safeguards would be put in place to prevent the successful bidder from walking away from the contract if they found it unprofitable before the contract end date?

Finally, concern was expressed that the contract to be awarded will be so complicated that it will be impossible to manage effectively. It is not clear whether the “provider” will be one or more than one. Will the “provider(s) be subcontracting out some of the services which will create a chain of command difficult to manage effectively? Will they subcontract some services to present providers (e.g. CCS)? If so it rather makes a mockery of the exercise. It will take huge expertise and vast experience normally only found in the upper echelons of private and public organisations to manage such a contract. Does the CCG have that expertise?

Cambridgeshire Older People's Enterprise (COPE)

From: Robert Boorman [redacted]
Sent: 18 June 2014 13:19
To: C&P CCG Engagement
Subject: Dear Dr Fertig

Dear Dr Fertig

Further to your recent talk to a group of COPE members' about the Clinical Commissioning Groups' proposals, I have read the Outline solution summaries A, B, C & D and produced some comments as follows:

Outline solution summaries A, B, C & D are clearly responding to a list of specific questions using normal NHS jargon.

None of the submissions have indicated how many and what staff will be allocated to provide the necessary services which the organisations propose to provide.

1. Without the staffing ratios, together with the current provision by Cambridgeshire Community Services how can comparisons be made?

2. I assume that all are working to the current budget of £900 million, yet no figures are quoted to judge and compare.

3. What incentives will be provided to encourage reduction in Hospital admissions?

4. What penalties if the hoped for reductions does not materialise?

5. What action will be taken if dementia or other factors cause older patients refuse to accept medical or social care?

6. Will Charities or the voluntary sector have a budget to pay for their interventions?

7. How many respite beds are currently available in the system and will be provided in the new regime?

8. Will grant funds are available to support communicating with older people to reduce social isolation and loneliness and to encourage fitness, balance through exercise?

9. Cambridgeshire Older People's Enterprise (COPE) currently provides this to nearly 3,000 Cambridgeshire people partly funded by Local Authority Grants.

Robert Boorman
COPE Health Spokesman

Grantchester Parish Council

Grantchester Parish Council has read the consultation document and attended one of the public meetings in relation to these proposals. We have a significant number of elderly people living within our parish, including a sheltered housing complex. Local primary care providers and community groups come together to offer support to our older residents, but inevitably they will increasingly rely on secondary health services as their health care needs become more complex. It is important, therefore, that such services are local, relevant, accessible and responsive. There is a clear intention within the proposed new delivery model to bring this about.

We welcome the commitment to developing a joined-up healthcare service for older and vulnerable people with a single named coordinator as a first point of contact, and recognise the benefits this will bring. We also understand the requirement of the CCG to go out to tender in order to select a provider. We are, however, disappointed that there is a strong possibility that the tender will be awarded to an organisation based outside this region – three out of the four bidders being based outside Cambridgeshire and Peterborough. We would be disappointed were this to happen, given that the CCG has a clear local remit and we would hope would seek to work with local providers. We would welcome assurance that any model of care is based on a clear analysis of local need, and not on a more generic 'formula' that has been applied elsewhere.

We would also seek assurance that introducing another commissioning body will not take moneys away from front line care and into the profit-making concerns of the providing organisation. Commitment to the principle of health care being free at the point of contact must also be commensurate with a public benefit ethos by the providing organisation. It is not clear what the role of the CCG will be in ensuring that top-slicing for administrative purposes or to pay shareholders does not happen, and would welcome their a commitment to a public service commitment not drive for a profit making.

Finally, we would ask the CCG to ensure that the successful bidder recognises and builds on, but does not exploit the role of carers' organisations, the voluntary sector, private care providers and local authorities without which any health care provision would be greatly impoverished.

For all the reasons outlined here, and on the strength of the information set out in the bidders' proposals, Grantchester Parish Council would strongly recommend the allocation of the contract moneys to the UnitingCare Partnership.

Cambridgeshire and Peterborough CCG
Lockton House
Clarendon Road
CAMBRIDGE
CB2 8FH

11 June 2014

Dear Sirs,

Older People's Healthcare and Adult Community Services Consultation
Joint response

Healthwatch Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire have considered the information set out in the consultation document and gathered a range of supporting information, including the views of the public and partner organisations. This response is informed by those considerations.

We understand that the current position is unsustainable and that there is a compelling case for major change. Healthwatch are one of the very few organisations working across health and social care and we recognise the imperative for whole system transformation. The experiences we hear from the public presents a weight of evidence for integration and re-design. However, by not including social care, this procurement cannot address whole system change. This is a major shortcoming. Furthermore, we observe that system redesign of this scale has happened in other areas without any procurement.

We are concerned that there is not adequate awareness that this procurement is much bigger than community services. There has been a major focus on community services although the community services element of the budget represents less than one third of the total procurement amount, the remaining two thirds relates to the acute sector and mental health.

We would like to highlight that negotiations with the acute sector will be time consuming and complex and we are very concerned about how long these could take particularly given the historical nature of local funding flows from commissioners to acute trusts and the known financial pressures on our local acute hospitals.

We acknowledge the potential benefits of a new provider being able to present radical innovation in opportunities to engage the public in a radical new health culture which may have the opportunity to drive behaviour change.

We strongly recommend that patient experience needs to be mainstreamed throughout every aspect of the new service(s). The Preferred Provider needs to be required to embed patient experience and not solely commission out; as in Outcome Domain A.

We consider that the existing timescale, particularly the anticipated 'go live' date of early January 2015, is not realistic, primarily due to the acute contracts needing to be renegotiated and the time required for CCS staff to be TUPE'd. There needs to be minimal slippage and deadlines need to be realistic, in order to keep public and staff confidence.

We have concerns about the way in which this procurement and other related 'Integration' agendas, ie the Better Care Fund, are being separately progressed. We understand that the intention is that these will be joined up through the Joint 5 Year Strategy and that this

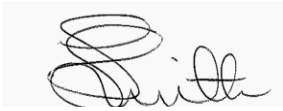
challenge is being addressed. It is possible that government will pause or cancel the Better Care Fund. If this were the case our concern would still remain for the whole local health economy. A sector based on competition does not easily lend itself to rapidly transforming into one build around collaboration. Futhermore, are acute providers designing alternative business models based on the outcome of this procurement?

We would highlight the very specific expertise that is required to manage outcome-based contracts is very different to traditional contracts. Managing outcome relies on gathering very different intelligence especially if the Preferred Provider is a private company.

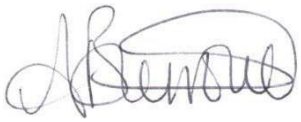
We note the desire of some bidders to create a common patient data system which will be available to field workers, and in some cases patients and carers. We wish to flag the risks that this extension of data access to people outside of the NHS and social care environment will raise and to be assured that new and robust systems to protect its security and integrity will be integral part of the contract.

In summary, we appreciate the greater potential benefits and that change is imperative but wish to raise awareness of the inherent risks. Our health and social care system has recently undergone radical change and is becoming increasingly fragmented with changes to providers, commissioners and regulators. This, combined with the demographic change and financial challenge faced by our CCG, compels us to highlight the significant risk of destabilising the system through unforeseen and unintended consequences.

Yours sincerely,

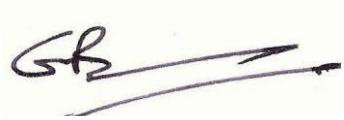


Sandie Smith Chief Executive
Healthwatch Cambridgeshire



Angela Burrows Chief Executive
Healthwatch Peterborough

Rosie Newbigging
Chief Executive Officer Healthwatch
Northamptonshire



Geoff Brown
Chief Executive Healthwatch Hertfordshire

Sender: Sandie Smith
Chief Executive Officer
Healthwatch Cambridgeshire
[redacted]

Healthwatch Northamptonshire

From: Rosie Newbigging [redacted]
Date: 16 June 2014 15:39:15 BST
To: Bawden Jessica [redacted]
Cc: "Sandie Smith [redacted]
[redacted]
[redacted]
Subject: RE: Older People's Healthcare and Adult Community Services Consultation

Hi Jessica

I recommend you publish the following statement:

“Healthwatch Northamptonshire is a signatory to the statement from the four Healthwatch organisations expressing strong reservations about the proposals as they current stand. The Healthwatch Northamptonshire Board additionally agreed to formally register opposition to the proposals. The Healthwatch Northamptonshire Board agreed this was a logical action to take in the light of the considerable concerns and reservations expressed in the joint response.”

Hope that is clear

Best wishes

Rosie

Rosie Newbigging

Chief Executive Officer

healthwatch Northamptonshire

Healthwatch Northamptonshire CIC
[redacted]
Mobile: [redacted]
Direct Dial: [redacted]
Main No. [redacted]
www.healthwatchnorthamptonshire.co.uk

Disclaimer:
‘This email (an any attachments) may contain privileged and/or confidential information. If you are not the intended recipient, please do not disclose, copy, distribute, disseminate or take any action in reliance on it. If you have received this message in error please reply and tell us and then delete all copies from your system. Any opinion or advice or information contained in this email is not necessarily that of the owners or officers of this company. Should you wish to communicate with us by email, we cannot guarantee the security of any data outside our own computer system.’

HUNTINGDONSHIRE PATIENTS CONGRESS

Report from a Special Meeting held at 6 pm on Monday, 24th March, 2014 to consider the Consultation Document issued by the Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) in respect of the tenders recently invited to help reconfigure services for Older People

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Present:

From the CCG: Dr. Neil Modha, Chief Clinical Officer
Jessica Bawden, Director of Communications and Human Resources
Susan Last , Patient Engagement Officer

From the Congress: Roy Stafford, Huntingdon Patient Congress Chairman
Sandy Ferrelly, Vice Chair and Lay Rep, Hunts Health
Patient representatives from:

- 4 Hunts Care Partners practices
- 8 Hunts Health practices
- The Bus Pass scheme
- Cambridge & Peterborough Mental Health Trust
- Diabetic Association
- Hunts Breathe for Life
- NICE

Aoologies: Lyndon Hutchison, Lay rep, Hunts Care Partners

Presentation:

1. Neil Modha made a detailed presentation of the rationale behind the CCG's decision to invite tenders for a "lead provider" to act as a central co-ordinating organisation for Older People's care. He explained that present services were divided between many separate arms of the NHS – the local general hospitals (Hinchingbrooke & Peterborough), tertiary hospital (Addenbrookes) and specialist hospital (Papworth), Mental Health services, the Community Services organisation including its many arms such as District Nursing, Physiotherapy, Chiropody, Specialist Nurses and the like plus the separate services provided by charities such as the Macmillan Trust and hospices and the support services, nursing and care homes provided by Cambridgeshire County Council or privately run. It had been realised that liaison between these different providers was leading on occasions to patients "falling between the cracks", having to re-provide the same information many times over to different people, not being clear about what was available and by whom and who they should ask, and a consequential unnecessary duplication of cost at a time when the NHS in general is under acute financial pressure. He said that relatives/carers often felt excluded at a time when they, too, needed additional help to prevent their health breaking down, and that this, and the general lack of joined-up care could result in too many elderly people being admitted to hospital unnecessarily, particularly at weekends, being kept in hospital for too long whilst care provision at home was being sorted and thus, in general, affecting their ability to live independent but supported lives. The proposal to tender services was in accordance with the requirement that the CCG, as a public body, has to demonstrate that they are achieving good value for money. This has not been achievable to date since there is no available or reliable national benchmarking in this particular area.

2. Neil emphasised the CCG belief that services for Older People would be considerably improved if there was a single point of contact which patients and their relatives/carers could contact for advice, support or action on any component of their care and on a 24/7 basis. A start had already been made on this with the establishment of Multi-Disciplinary

Team (MDT) working, bringing together all the component parts responsible for one person's care where appropriate, such as Mental Health staff for patients with dementia or social workers for people in care or nursing homes, but more needed to be done. He emphasised that all decisions, for example the sharing of care records across all services, would remain completely under the control of the patient him/herself. He said that, at present, there were many disparities between various parts of the CCG patch, which resulted in unevenness in patient provision. In answer to a question he also confirmed that the final solution agreed would not be a "one size fits all" solution but would recognise the characteristics of each of the 4 "patches" within the CCG, from the comparatively affluent Cambridge City, to the rural deprivation around Wisbech and parts of Huntingdonshire, and the range of ethnicity in Peterborough.

3. Further copies of Neil's slide presentation and of the consultation brochure can be obtained by telephoning 01223 725304 or by e-mail to www.engagement@cambridgeshire andpeterboroughccg.nhs.uk. All present agreed that they would take this information back to their respective patient groups and encourage as many people as possible for whom this proposal to complete and return the consultation questionnaire on Pages 37-42 of the brochure.

Questions:

4. In answer to questions from the floor:

4.1 Neil explained that current services for older people cost the CCG £900m. p.a., that it was proposed to apply this level of funding to the finally tendered solution and that it was anticipated that a more cohesive co-ordination could reduce waste and allow funding to be diverted to achieve real patient benefit.

4.2 Many bids had been received at the initial Expression of Interest stage but that this list had been reduced to 4 tenders by an initial analysis of all elements, such as financial viability, and including patient representation in the evaluation. The CCG had taken the decision to go out to consultation earlier than originally anticipated so that patient views could be analysed and presented to the tenderers for consideration and inclusion in their final proposals. He explained the anticipated timescale – that the CCG would provide a summary of patient views to all tenderers by early July with a view to the next stage – more detailed tenders - being returned at end July. To this end he asked that patient responses should reach the CCG by no later than 16th June to allow time to summarise and consider. Analysis of the responses would lead to elimination of 3 tenderers and final detailed discussions occurring with the Preferred Provider. Subject to satisfactory conclusion of these discussions a final contract would be signed with a 3-month mobilisation period before the service is finally handed over to the successful organisation early in 2015.

4.3 This tender was being viewed with interest by other parts of the country as the CCG is leading the country in tendering for a solution that will be "outcome" rather "task" driven. Previously services have been measured by, say, how *many* times a nurse visits a patient rather than whether a quick nurse visit really provides the *right kind* of help a patient needs or whether, for instance, linking with outside organisations such as charities could give greater benefit by a patient having more visits from people with the time to chat, limiting the effect on health of isolation and the like. The financial solution would be driven with bonuses for measurable improved outcomes, such as a reduction in unnecessary hospital admissions, rather than automatic lump sum payments for "tasks" completed.

4.4 All staff currently in post and affected by this proposal would be TUPEd over to the new lead provider. The 4 tenderers selected included all-NHS organisations (such as a partnership between Cambridge University Hospitals Trust and the Cambridge & Peterborough Foundation Trust (Mental Health)), through a mix of NHS and not-for-profit organisations (such as Care UK with Lincolnshire Community Health Services NHS Trust and Norfolk Community Health & Care Trust) to a wholly private organisation (Virgin Care Ltd). He stated that, during the first stage of the process, Virgin Care had said they did not regard this as a profit-making arm of the larger

Virgin family but that they wished to apply the benefit of commercial experience to improving patient care.

4.5 It was anticipated that the contract would be let for a minimum of 5 years in the first instance, to allow time for evaluation and for investment certainty.

4.6 The catchment area of the C&P CCG also covered some parts of Northamptonshire (around Oundle) and Hertfordshire, which looked towards Cambridgeshire and Peterborough for NHS services. The CCG was funded for this activity.

Questionnaire:

5. Congress members then split into groups to answer the patient questionnaire with a view to providing a summary of Congress opinion to the CCG:

Q.1:	19 x Strongly Agree.	6 x Agree
Q2a:	10 x Strongly Agree	15 x Agree
Q2b:	23 x Strongly Agree	2 x Agree
Q2c:	25 x Strongly Agree	
Q2d:	20 x Strongly Agree	5 x Agree

Q3: Not applicable for group completion

Q4: All groups were unwilling to comment and felt each item was equally important

Q5: Although some groups made an attempt to complete this the same opinion was expressed. There was total divergence in views and concern was strongly felt that a “least important” should not be cited on the grounds that this could be dropped for money saving

Q6: As above

Q7: As above

Q8: As above

Q9-14: Not applicable for group completion

6. Congress members challenged the CCG team on the appropriateness of the form of Q.4 to Q.8. The feelings strongly expressed were that all the statements made in each question were equally important and that to select any one as Most Important or one as Least Important would give the successful tender the licence to drop the Least Important aims if or when financial pressures required that savings be made and cite lack of enthusiasm from patients to explain this. Jessica Bawden said that the questionnaire had been devised by an independent market research company, who would be analysing the returns, and that this format had been their recommendation. In spite of this reassurance, however, Congress members remained unhappy.

7. On behalf of the Congress Roy Stafford expressed the thanks of all present to the CCG Team for spending the time to discuss the CCG proposal. He confirmed that all Congress members would promote completion of the questionnaire and/or attendance at the many open events (set out on P.24-28 of the brochure) within their local networks.

Julian Huppert MP

Cambridgeshire and Peterborough Clinical Commissioning Group Proposals to improve older people's healthcare and adult community services.

Comments from Julian Huppert MP

1. I welcome the decision of the C&P CCG to undertake the consultation and the publication of the proposals to improve older people's healthcare and adult community services. I am broadly supportive of the proposals contained within the paper and welcome the opportunity to make the following specific observations.

2. I welcome the opportunity that the changes in service provider bring to allow for greater integration of the services provided for older people and the inclusion of all the services listed on page 13 of the consultation. I am concerned that the current division of care depending on whether people are suffering from acute illness, non-acute physical illness and disabilities or mental health (including dementia services) is confusing for older people and can result in duplication of care and breakdown in communication.

3. I hope that the changes will enable the Cambridgeshire and Peterborough Clinical Commissioning Group to review the system that has been developed in South Devon and Torbay for the identification of people who are at risk of hospital admission across multi-disciplinary teams and to enable assessment of their needs to take place before admission is needed.

4. It is important to develop of training for paramedics and other staff to enable assessment and where appropriate treatment to be given to people in their homes, to avoid unnecessary admission to hospital.

5. Dementia awareness training should be provided for people across the organisation running the services as people with dementia who are admitted to acute wards often find that their needs, outside their acute illness, are not well catered for.

6. The inclusion of acute and community services within one organisation will hopefully result in better coordination and communication between services and the development of multi-disciplinary teams that fully meet a patient's needs without reference to an outside organisation.

7. I welcome the emphasis on prevention and the opportunity for older people to undergo regular health checks. The new provider should also develop working relationships with the local authority housing providers to ensure that older people are informed about the housing choices and options that may be open to them.

8. Development of a record system to that patients can access, to include pharmaceutical services so that older people can access their medication passport that details the medication that they are taking and the doctor who has responsibility for reviewing each medication. This would provide useful information for patients, carers and the health professionals involved.

Other points

1. The service should aim to enhance and provide dignity of care for older people.

2. Older people and their carers should be involved in discussion about the care received.

3. Prevention and the provision of measures that promote wellbeing and flourishing should also be a key priority for the organisation.

4. End of life care should enable people to die with dignity and free of pain wherever possible. The organisation should respect the wishes of patients where living wills and non-medical directives have been put in place by the patient.

Peterborough City Council

Telephone: [redacted]

Email: [redacted]

[redacted]

Cambridgeshire and Peterborough Clinical Commissioning Group
Zone B, City Care Centre, Thorpe Road,
Peterborough, PE3 6DB

16 June 2014

Cambridgeshire and Peterborough Clinical Commissioning Group Proposals to improve older people's health care and adult community services.

Consultation response from Peterborough City Council

Thank you for inviting us to comment on the CCG's procurement of community health services. I have discussed this matter at length with colleagues and senior officers. The Council is supportive of the CCGs vision for more joined up care, better planning and communication, more patients supported to remain independent, and improved community out of hospital services and fewer people admitted to hospital as an emergency, where it can be safely avoided. However we feel the points below are of vital importance if this model is to be successful in delivering outcomes for Peterborough residents:

1. The objectives and work streams developed jointly with the CCG and LCG within the Peterborough Better Care Fund submission must continue to be driven forward as a priority and the funding for these, £11.999 million (total BCF allocation for Peterborough) in 2015/16 from the CCG, must remain separate.

2. The model of delivery for Peterborough must be tailored to the Peterborough system and demographic. This will need to recognise the key agencies and providers in Peterborough, and also the attributes of the patient population. Peterborough has lower life expectancy and higher mortality than Cambridgeshire, which are linked to higher levels of deprivation. The Health and Wellbeing Board are leading on the priority of improving Cardio Vascular Disease prevention, treatment and interventions and would wish to see this focus factored into any model for delivery of community health services to the city.

3. Integration of health and care and support services is key to delivering better outcomes. Integrated services should be delivered by all agencies working together and it is vitally important that any new provider recognises Peterborough City Council as the key partner to support and aid in delivery of integration.

4. The local system will be impacted by the Care Act 2014 and any model of provision developed by successful bidders must be able to support the implementation of the legislation and its subsequent regulations and guidance in Peterborough.

Our Better Care Fund submission sets out the following vision which we would expect to see in the forefront of any future service transformation:

Our long-term shared vision is to bring together all of the public agencies that commission and provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting. To be successful, this transformation will require the contribution of a range of health, housing, and social care commissioners and providers, as well the greater involvement of the community and voluntary sectors.

In Peterborough we are developing a 'Model of Care' that has at its heart 'building resilience' in the Community, with families and individuals. This has emphasis on the individual, family and communities emotional health alongside the care, support and interventions required. We recognise that mental health, wellbeing, and physical health are intrinsically linked and there is a need to accommodate a duality of approach.

It is my belief that Peterborough City Council, Cambridgeshire County Council, and the Clinical Commissioning Group believe that the Better Care Fund offers an important opportunity to transform the health and social care system and delivery in Cambridgeshire and Peterborough to meet the needs of a rapidly ageing population better, and by doing so, ease the pressure on the system more generally, enabling it to provide better services to the whole population of the county / City. The Better Care Fund offers a unique opportunity to re-think how a significant amount of public money could be more efficiently and effectively spent.

Fundamentally, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in Cambridgeshire and Peterborough; through creating greater synergy and hence efficiencies in the provision of social care and health services, these can better be protected from pressures brought about by increasing demand and reducing budgets. The scale of this transformation opportunity is significant; it is much more than just reducing admissions to hospital. Rather, it is about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary care / community / social care, guided by the goal of living as independently as possible, for as long as possible.

This approach aligns with the principles set out by Government, NHS England and Local Government Association, is consistent with the priorities set out in Cambridgeshire's and Peterborough's Health and Wellbeing Strategies 2012-17. It is also well-supported by evidence that clinical and service integration delivers better outcomes for people, particularly if groups of patients or service users are clearly identified and services for them are joined up around their needs.

Over the next five years we would anticipate, amongst other things, the following changes:

- A transformational shift from what has tended to be an acute hospital-centric system to one which provides timely and appropriate care and support along the whole care pathway, delivered through a variety of service providers and care givers
- Greater emphasis on multi-disciplinary working across health and social care leading to more effective care planning, early recognition of impending crisis and better co-ordination and targeting of resources tailored to the service user's needs
- A transition to 7 day working to enable all agencies to respond in a timely and effective manner

- A more holistic approach to commissioning health and social care recognising the importance of taking into account social, mental health and physical conditions

We anticipate a range of positive outcomes for patients and service users including:

- Greater personalisation of service response to users' needs
- Enhanced support and guidance to carers
- Services which are responsive, timely and pro-active
- A greater emphasis on developing resilience and the emotional wellbeing of communities

Finally, given the system wide working that has recently started as a response to being one of the eleven Challenged Health Economies, it is requested that before moving to the next stage of this procurement urgent consideration is given to ensuring that resources are not allocated which could restrict the scale and pace of transformation or be utilised more effectively in the work being undertaken within the newly formed concordat.

Yours sincerely

Cllr Wayne Fitzgerald
Cabinet Member for Adult Social Care

Peterborough City Council Health Scrutiny Committee

Telephone: [redacted]

Facsimile: [redacted]

E-Mail: [redacted]

Please ask for:

Our Ref: Pf/jc/Olderpeoplescons

Your Ref:

Jessica Bawden

Cambridgeshire and Peterborough Clinical Commissioning Group

[redacted]

Telephone - [redacted]

16 June 2014

Dear Jessica

I am writing to set out Peterborough Scrutiny Commission for Heath Issues response to consultation on **Proposals to improve older people's healthcare and adult community services.**

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) attended the Peterborough Scrutiny Commission for Health Issues meeting on 25 March 2014 to discuss this consultation with Members of the Commission. The minutes of this meeting will not be approved until the next meeting of the Commission which will be on 8 July after the closing date of the consultation on 16 June 2014.

Jane Coulson, Engagement Manager met with the Peterborough Scrutiny Commission for Health Issues Chair, Councillor Rush and Councillor Sylvester on 12 June 2014 to go through the draft minutes from the meeting of 25 March and discuss their response to the consultation. The following are the notes from the meeting held on 25 March and additional comments from the meeting held on 12 June:

- Members welcomed the decision by the CCG to go out to consultation, this was a good course of action as it allowed people to understand what was happening and to have their views listened to.
- Members supported the aims and vision for the proposals and support the proposals for organising services and care around the needs of the patient.
- Members wanted to be clear that joined up working is key to the success of these proposals. Joined up working by health professionals to meet the needs of individuals. That clear lines of communication are needed. Especially around discharge from hospital. Hospital professionals and community professionals need to work in a more co-ordinated way. This also relates to joined up working with adult social care.
- Members raised the issue of coverage of meetings for the Peterborough area at the meeting on 25 March. The Director of Corporate Affairs for the CGG explained that the

public meetings were only a small part of the meetings that they would be attending as part of the consultation.
At the 12 June meeting with the Chair and Cllr Sylvester the Engagement Manager went through all of the meetings that the CCG had attended in and around Peterborough, these were a mix of statutory meetings, sheltered housing groups, coffee mornings, community groups, partnership boards and focus groups, there were 17 meetings in this area in total. Members were happy with this coverage of meetings and felt it was comprehensive in terms of meeting the needs of the Peterborough population and demographic.

- Members were happy with the process of the consultation, they felt the process was comprehensive and gave people the opportunity to have their say.
- Members had asked how rural communities would be able to be involved in the consultation at the meeting on 25 March. Members were advised that documents had been sent to all of the Parish Councils and attended some Parish Council meetings when invited to do so they were pleased that this issue had been resolved.
- Members felt that although large public meetings were good for informing people about what was going on smaller groups should also been contacted. Many people feel better able to contribute in smaller groups than at public meetings, especially vulnerable adults and people who do not have English as a first language. The Director for Corporate Affairs explained that community groups had been contacted and that translations, easi-read versions, audio versions and alternative formats had been developed to ensure that people could access the consultation. At the 12 June meeting the Engagement Officer and Councillors also discussed the work that had been done with focus groups, forums, partnership boards and attending smaller community groups and coffee mornings. Members were happy that this met the needs of people in Peterborough
- Members raised the issue of elderly people becoming socially isolated. Elderly people often lived away from their families and needed extra care not to become socially isolated. Social housing also has a role to play in attempting to allow people to live near to their family, social housing is not always available where it is needed.
- It was important to Members that elderly people were able to maintain independence for as long as they are able.
- Members discussed the call-centre type proposals put forward. They wanted to ensure that all community languages could be provided for as they were for the 111 service.
- Members asked the question of whether this proposed call centre could be linked to the 111 call centre. It was also very important to members that the people working in the call centre were trained health professionals and they were qualified staff.
- Members wanted to ensure that any services procured were able to meet the needs of patients in Peterborough noting that Peterborough's demographic is different to Cambridgeshire.
- Members raised a question about what contingency plans were in place in case of the break-down in services. A breakdown in terms of quality of service but also in the event of contractual breaches. What contingency and resilience planning was in place?
- Finally members wanted assurances that the final bidder would not be selected on the money issues alone. Quality and ability to deliver the right services to Peterborough should be as key to the decision as the finances.

The Commission is supportive of the CCGs vision for more joined up care, better planning and communication, more patients supported to remain independent, and improved community out of hospital services and fewer people admitted to hospital as an emergency, where it can be safely avoided. However we feel the four points below important if this model is to be successful in delivering outcomes for Peterborough residents:

1. The objectives and work streams of the jointly agreed Better care Fund submission must continue to be driven forward as a priority and the funding for these must remain separate.

2. The model of delivery to Peterborough must be tailored to the Peterborough system and demographic. Peterborough has lower life expectancy and higher mortality than Cambridgeshire, which are linked to higher levels of deprivation.

3. Integration of health and care and support services is key to delivering better outcomes. Integrated services should be delivered by all agencies working together and it is vitally important that any new provider recognises Peterborough City Council as a key partner to support and aid in delivery of integration.

4. The local system will be impacted by the Care Act 2014 and any chosen provider must be able to support subsequent changes in Peterborough.

Councillor Rush and Councillor Sylvester wanted to thank the CCG for inviting them to comment further on this very important procurement and trust that comments will be fully taken account of to ensure the right decision is made for the people of Peterborough.

Yours sincerely

P Ford

Paulina Ford
Sent on behalf of Councillor Rush, Chair of Scrutiny Commission for Health Issues
Senior Governance Officer, Scrutiny

Date :	Thursday 17 April 2014
Time :	2 – 4pm
Venue :	Conference Room, City Care Centre

RESPONSES FROM MEMBERS FOLLOWING PRESENTATION BY CHRIS ROWLAND ON OPPB CONSULTATION

4. OPPB Consultation

C Rowland (CR) gave a presentation on the Proposals to improve older people's healthcare and adult community services public consultation which runs from 17 March 2014 to 16 June 2014. To view information on the consultation please go to www.cambridgeshireandpeterboroughccg.nhs.uk.

Responses from members would be fed back to the Engagement Team as part of the consultation process.

Members were encouraged to view the C&PCCG website to review four summary documents alongside the consultation document. Alternatively, contact the Engagement Team who could provide copies for you.

Comments/questions from members were;

Q. Member queried why information on bidders was anonymised as felt the public should know to enable them to make a choice, and there were leading questions in the consultation.

A. The consultation was to obtain the public's views on future solutions for Older People's and Community Services rather than on individual bidder organisations. Anonymised some information which would be commercially sensitive to the bidders. Question 9 asks for other views and members can put comment on individual provider this if necessary. Reiterated that the CCG were looking for comment and feedback on models within the consultation.

Q. One of the objectives was for people not to repeat themselves and queried if the role of the care co-ordinator was linked to the objective and who would fulfil the role of care co-ordinator?

A. It would be up to the lead provider to identify exactly how they will plan to coordinate care, but is likely to be a single process to avoid duplication.

Q. What are vulnerable cases – they would need someone to act on their behalf.

A. The service is for everyone and provider to ensure deliver to meet needs of population. Identify vulnerable people early so anticipate crisis and bidder to demonstrate this.

Q. How share information? Was technical solution part of bid and could the lead provider dictate which information system to use?

A. The lead provider would be responsible how the service is developed. They can sub-contract parts of the system to join up in the envelope of services and require them to work with other areas eg. adult social care, so ensure system joins up. GP Practices and Community use SystmOne and the providers service would need to be able to communicate with that.

Q. Concern of security of system and the security of personal records. Can security be guaranteed if lead provider sub-contracts?
A. There is an Information Governance protocol which everyone will be party to and meet criteria. The C&PCCG will monitor.

Q. Domain 2 Self Care – describe what is self care and how dependent will you be on older people providing self care?
A. Dependent on the individual needs, but assessment would be undertaken by the provider / Social Care as necessary. CR commented on self care and self management of long term conditions as an educational process and to support people to do that. People to monitor how they feel and talk to GP, Health Visitor, etc. Some people do not require intervention.

Member made comment regarding the FIRM and to ensure when discharged late at night the conditions at their home were suitable. Chair advised this did not relate to the Consultation.

Q. Once organisation appointed would Cambridgeshire Community Services (CCS) be part of the new organisation?
A. CCS are not part of the bidders, but services CCS provide would continue to be provided by new organisation.

Q. What does using technology to support people with long term conditions mean?
A. Assisted technologies to help maintain independence eg.handrail, system to help someone take medication. It is a range of technology to help people stay at home longer.
(Dr D Okubadejo arrived)

Member commented on changing of prescription bottles which cause confusion. Some people prefer to talk face to face rather than talking on the phone how they feel.

HM advised that access and technology was one of the ways for people to access information. There are many elderly who use technology. There would be other forms of communication and interaction available. A diabetes programme, DESMOND, was given as an example where the programme was run online and also, if preferred, face-to-face from the Healthy Living Centre.
Member queries how were GPs aware of social aspects of patients if they did not visit them at home?
HM responded that if a visit was required they would. They would also receive feedback from colleagues regarding the patient. Information needed to co-ordinate care.

CR thanked everyone for their contribution and encouraged members to attend future consultation events and to engage through completing the questionnaire.

Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust

Trust Management Board

Meeting held on Friday, 23 May 2014 at 09.00 hours
in the Boardroom at Peterborough City Hospital

M I N U T E S

Present:	Mr Ken Hutchinson, Interim Director of Workforce and OD *(Chair)*
	Mrs Caroline Walker, Finance Director
	Mrs Chris Wilkinson, Chief Nurse and Director of Care Quality
	Mr John Randall, Medical Director
	Ms Lisa Hunt, Interim COO
	Mrs Di Lynch, Deputy COO and GM for E&M
	Mrs Claire McIntyre, Clinical Director , Clinical Support
	Mr Craig Reston, Clinical Director, MSK
	Ms Jo Clapton, General Manager, Cancer and Diagnostics
	Mrs Sue Friend, AGM, MSK
	Mr Peter Baker, Clinical Director, Theatres, Anaesthetics & Critical Care
	Dr David Woolf, Clinical Director, F&PH
	Miss Jane Pigg, Company Secretary
	Ms Kate Hopcraft, General Manager, Clinical Support
	Dr Alfred Choy, Clinical Director, Surgery
	Mrs Sue Friend, Acting AGM, MSK
	Keith Gullidge, MDHU
	Ms Polly Grimmett, General Manager, Theatres, Anaesthetics & Critical Care
In attendance	Mrs Rebekah Pickles, EA to the Chairman and CEO *(Minute taker)*
For item 52.14	Ms Cath Mitchell, Local Chief Officer for Borderline and Peterborough LCGs
	Dr Arnold Fertig, Clinical Lead for the Older People's Programme
	Mr Keith Reynolds, Assistant Director, Strategy and Planning

Presentations

52.14 Older Peoples' Healthcare Consultation

Ms Cath Mitchell, Dr Arnold Fertig and Mr Keith Reynolds attended for this item

Dr Fertig, Clinical Lead for the Older People's Programme, presented an overview on the 13 week public consultation regarding proposals for a five year model to improve older peoples' healthcare and adult community services across Peterborough, Cambridge, Northamptonshire and areas of Hertfordshire included in the CCG's catchment area.

The current provision was underlined as disjointed, lacking in communication and with the wrong focus ie driven by activity levels rather than resources. The services included in the proposals were set out as follows:-

- Community services for older people and adults (eg district nursing, rehabilitation, speech and language therapy, respiratory, diabetes, tissue viability)
- Urgent care for patients aged over 65 including inpatients as well as A&E
- Older peoples' mental health services
- Other services which support the care of older people

A 'lead' organisation would be responsible for joining up care so that different parts of the NHS work better together. Achievement of better clinical outcomes and better patient experience would be linked to payment through a new contract. Approximately 1,500 staff would be tupe'd over to the lead integrator and would retain NHS terms and conditions. Mrs Mcintyre pointed out that the recruitment of staff could impact on the Trust's recruitment programme in 'hard to fill' areas such as therapy services, although it was noted that the intention of the programme would be to reduce hospital pressures for a more efficient organisation.

Dr Fertig pointed out the procurement route to achieve the required scale of change and pace. Four bidders had been shortlisted and consultation feedback would be passed onto these bidders. It was noted that the successful bidder would lead the consortium for an outcomes framework focused on the quality of care for patients. This would be divided into 7 domains such as patient experience, safety and cultural change. Emphasis would be placed on coordinated, multidisciplinary teams in the community with a single point of access and better overall planning and communications to enable early

identification of health problems for avoidable admissions.

The full consultation proposals would be submitted to the CCG in July 2014 for a preferred bidder to be selected in September 2014 with the aim of the new service expected to commence in June 2015. The tight timeframes were emphasised between the selection of bidders and the 'go live' date which was acknowledged as challenging however pace was being maintained balanced with the safe commencement of work.

Dr Woolf questioned why primary care was not being brought into the process. Dr Fertig clarified that bidders would need to demonstrate how they would be expecting to work with primary care in order to understand the alignment of services.

Ms Hunt voiced her support of the concept but questioned the single point of access and whether GP referred patients (to ED) would be turned away. Dr Fertig confirmed that the lead integrator would be financially incentivised to stop inappropriate admissions and treat people in the community where possible. The CCG would be funding work with primary care to move GPs and ambulance control into different ways of working to facilitate shorter patient lengths of stay. The lead integrator would be directly commissioning all emergency admissions for over 65 year olds, excluding elective patients.

Mrs Wilkinson raised concerns over fragmentation of services for patients aged 64 years and below. It was noted that there would be less chance of a coordinated management plan for these people however they would receive improved care information overall.

This programme would also allow an opportunity for acute Trusts to link in with the lead integrator on the supply of services such as end of life care. Income would be attached to the delivery of metrics and the lead integrator would be seeking partners to support them in this delivery as good practice.

Copies of the consultation documents and questionnaires were made available to members of TMB.

Ms Cath Mitchell, Dr Arnold Fertig and Mr Keith Reynolds left the meeting.

Somersham Parish Council

Somersham Parish Council wish to respond to the consultation as follows:

Public Consultation on Proposals to Improve Old People's Healthcare & Adult Community Services

Somersham Parish Council has taken advantage of the chance to consider the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) consultation document to improve older people's healthcare and adult community services. We noted the CCG description of how healthcare services for older people are currently organised currently and how it highlighted the number of providers and consequent fragmentation of the service provision. We also accept that the CCG case for change purports more joined up care, better planning and communication, more support for people to remain independent and improved community services. However, given that the associated questionnaire is directed to individuals in the community rather than to public bodies or other groupings we have elected to provide the following response against the first eight elements of that questionnaire.
((We noted that the themes embedded in the consultation paper include:

i. Ensuring people have good experiences of care and support, with care organised around the patient needs
ii. Providing treatment and care for people in a safe environment and protecting them from avoidable harm
iii. Developing a culture of joined-up working with empowered staff and robust information sharing
iv. Prevention and early intervention for those with complex needs, long term conditions, frailty or mental health needs
v. Rapid response for treatment and/or support during an acute episode of ill health
vi. Long term recovery and sustainability of health
vii. Care and support for people at the end of their lives))

Question 1 How supportive are you of the reasons given for changes?

i. Somersham Parish Council supports the public consultation
ii. We also consider that the template employed is adequately fit for purpose.

Question 2 To what extent do you think the proposals will be in achieving the following?

We believe that good experiences of care and support, with care organised around the patient needs is paramount and this needs to:

i. Target patient needs effectively
i. Be delivered as close to them as possible in the community and
ii. Treat and care for people in a safe protective environment
iii. However, there is no detail on how the likely extra resource would be found

Question 3 Do you currently use the services?

i. Individuals in our organisation do use the service

Question 4 Which is most and which least important of 5 statements about organising care around the patient?

Our take on organised care centred on the patient would require the trust to:

i. Develop joined-up working processes delivering care focused on the patient
ii. Develop enhanced levels of community engagement
iii. Develop better out of hospital provision, planning and communication
iv. Promote prevention and early intervention within the community

v. Support patients to remain independent as long as possible with hospital admission as the last resort
vi. Provide for rapid specialist support during an acute episode of ill health

Question 5 Which is most and which least important of 6 statements about delivering care?

In order to deliver seamless care we believe that it is important to:

i. Have a single point of contact using robust processes and systems
ii. Enable patient records to be readily available via electronic means
iii. Provide adequate staff training to ensure information sharing is reliable and secure

Question 6 Which is most and which least important of 6 statements about supporting older people to stay independent?

Similarly, in supporting older people we strongly believe in:

i. A greater focus on prevention
ii. Providing suitable access to information and services to promote well-being
iii. A robust engagement with the local voluntary services currently delivering support

Question 7 Which is most and which least important of 5 statements about reducing emergency admissions, re-admissions & long stays in hospital?

In order to reduce the pressures on hospital resources we think there is merit in:

i. Promoting community healthcare points
ii. Developing stronger links between community services and the hospital
iii. Developing an urgent care system more able to assess and treat the patient at home

Question 8 Which is most important about end-of-life care?

At this most sensitive of times, we believe that patients deserve their wishes to be well-understood by all the help professionals involved. However, this is predicated on:

i. A well-coordinated team working around the patient's needs
ii. Information about the patient's wishes to die being securely available to all of the healthcare team involved
iii. 24-hour support being made available at the point of delivery desired by the patient even where it might have been more efficient for the delivery to be made elsewhere

The remainder of the survey covers ethnic/administrative data and is not relevant for this body to respond to.

Penny Bryant, Clerk to Somersham Parish Council
[redacted]
www.somersham.org

Community

Twitter [redacted] Facebook [redacted]
Facebook [redacted] www.somersham4u.org.uk

Speak Out Council

Walsh Julia

From: Hodgson Claire

Sent: 12 June 2014 15:09

To: Walsh Julia

Subject: FW: Reasonable Adjustments

From: Alison Fawkes [redacted]
Sent: 12 June 2014 14:31
To: Ellis John
Subject: Reasonable Adjustments

Hi John

I hope yesterday was useful for you – I think that the presentation and questionnaire were excellent, I certainly have a much better understanding of it and all of the leaders were very clear about their answers which shows that they understood it too.

With regard to reasonable adjustments I have spoken with the leaders and the advocacy service manager and we have come up with the following:

Ensure that reasonable adjustments are made with regards to signage, leaflets and all correspondence (including appointment letters, etc.), waiting areas and appointment length flexibility.

The following groups should be considered people with Learning Disabilities, people with Autism or Asperger Syndrome and people with Mental Health difficulties.

I'm sure these are all already considered but I just thought I'd
feedback in case.

Many thanks

Ali Fawkes
Speak Out Council
Co-ordinator Email:
[redacted]
Tel: [redacted] **Mob:** [redacted]
[redacted]
www.voiceability.org

Charity No. 1076630 **Company No**. 3798884 (England and Wales)

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Learning Disability Partnership Board Speak Out Council Q&A feedback

11 June 2014

Q: Where will the money come from to improve community care?

A: By reducing the number of people going into hospital for care. Hospital care is expensive.

Q: What reasonable adjustments would the preferred bidder make for people with learning disabilities?

A: Hospital adjustments are quite good already, not so in community services, so we will be looking to improve on that.

Q: Is it specified to bidders that feedback forms need to be in Easy Read?

A: Bidders will be asked what reasonable adjustments would you make for people with disabilities as part of the final evaluation phase. If you send us a list of what is required, we will use it as part of the marking.

FB: Letters need to be in Easy Read – appointments etc.

Q: Which people will it apply to? Will it apply to those on the autistic spectrum?

A: It will cover a range of disabilities.

Feedback

Questions				
1. Do you think these are good reasons to change things?	YES	YES	YES	YES
2. We want healthcare for older people to be set up around the patient. Do you think this is a good idea?	YES	YES	YES	YES
3. We want to see better planning and communication. Do you think this is needed?	YES	YES	YES	YES

4. We want to see more patients to be supported to remain independent. Do you think this is a good idea?	YES	YES	YES	YES
5. We want to see better community and “out of hospital” services and fewer patients going to hospital as an emergency. Is this good?	YES	YES	YES	YES
6. Do you use services for older people or adults with long term conditions?	YES	NO	NO	NO
A) If you do use services, can you tell us one thing that is good and one thing that you would like to be different about the services you use?		More Easy Read		Easy Read infomormation and letters. Things explained to me in a way I understand.
Good	NOT KNOW			
Different	NOT KNOW			
1. Are you, or any of your close family, users of older people’s services provided by the CCG?	NO	NO	NO	YES
2. Are you a carer for anyone who uses older people’s services provided by the CCG?	NO	NO	NO	NO
3. Are you, or any of your close family, users of adult community health services provided by the CCG?	NO	NO	NO	YES
5. Can you tell us which of the following age bands you belong to? 16-29 years 30-44 years 45-59 years 60-74 years 75+ years	16 to 29 YEARS	16 to 29 YEARS	16 to 29 YEARS	30 to 44 YEARS
6. Are you….				
Male Female	MALE	MALE	FEMALE	FEMALE
7. Which of the following best describes your ethnic background?				
White				
English	X	X	X	X
Welsh				
Scottish				

Northern Irish				
Irish				
British				
Gypsy or Irish Traveller				
Any other white background				
Postcode	CB6	PE28	CB1	PE13

Response to Cambridgeshire and Peterborough Clinical Commissioning Group's 'Proposals to improve older people's healthcare and adult community services.'

Submitted by Stop the NHS Sell-Off in Cambridgeshire and Peterborough June 16th 2014

1) The 'Vision'.

The CCG sets out its 'vision' on page 12 of the document, identifying the following priorities: More joined-up care, better planning and communication, more patients supported to remain independent, improved community and "out of hospital" services and fewer patients admitted to hospital as an emergency where it can be safely avoided. In his Foreword to the Consultation Document Dr Arnold Fertig says: 'Our experience over many years is that services for patients can be fragmented, for example, between hospital and the community, or between physical and mental health services.'

We share the CCG's concern about the fragmentation of services and desire to achieve better outcomes, but nowhere in all the consultation documentation is there any evidence presented to show why their proposed model would deliver this 'vision'.

If the NHS in Cambridgeshire was to work effectively, it would involve commissioners working in harmony with the acute Trusts, GPs, Cambridgeshire Community Services, CPFT as providers of mental health services, and the local authority as organisers of social care.

Clearly the requirement of the Health and Social Care Act for services to be opened up to 'any qualified provider' makes it harder to achieve such an aim. But even acknowledging this, it is startling to see how the CCG has rushed into this huge, untested procurement exercise as a means to achieve its 'vision', rather than drawing on the experience of the existing NHS providers.
The rationale behind this whole exercise is even more questionable when one looks at the activity of local commissioning groups, as described in their report to the June 5th CCG meeting (part of the Annual Report). For example, Isle of Ely and Wisbech LCGs say that much of their work has involved working with CCS to reduce A&E admissions and unnecessary hospital stays; all the other LCGs describe similar activities. These are clearly central to the CCG's stated vision, so why impose their new, unproven model for procurement?

The CCG say that it wants more 'joined-up care', and that it will achieve this by appointing a 'lead organisation' to take responsibility for service coordination and delivery. But in their definition of this (page 21) they say: 'The Lead Provider may be a single organisation, or a consortium made up of several partners…… (which) will employ the community services staff and be responsible for ensuring that they are well supported.' This leaves open the issue of who would actually provide the other wide range of services covered by the contract, i.e. unplanned hospital care and mental health services for over-65s, End of Life care and what the CCG call 'other services for older people'. Presumably these could be provided by a 'sub-contractor', who would have to enter a commercial arrangement with the 'lead provider', which would be covered by 'commercial sensitivity' and so avoiding the kind of public scrutiny so crucial in today's climate of financial constraints and demands on the NHS.

Up to now we have had NHS organisations delivering services which are at least publicly accountable in some way, but now we have the prospect of private companies doing so, protected by 'commercial sensitivity' and no requirement to conform to Freedom of Information requirements. This must place further obstacles in the way of achieving the CCG's aim of 'integrated care'.

We maintain that opening the door to private sector involvement to the huge extent possible under this contract, far from making service delivery more 'joined-up', will make it even more fragmented, as private profit-seeking organisations constantly look for ways to make money from their shareholders, either as 'lead provider' or sub-contractors.

2) 'Funding is not increasing in line with growing demand.'

The CCG says that 'only minimal increases are expected in the coming years'; in fact the position is even worse, with the CCG recording a deficit of nearly £5 million for 2013-14, a failure to meet statutory 'break-even' requirements.

Yet despite this, the CCG is proposing an ambitious programme, including a 24/7 'single point of access contact centre', and a 'single electronic record system and shared protocols' – very laudable aims, but ones which will require considerable investment and some way from what is currently available. This raises a major question: how is this to be paid for?

Current NHS organisations – including CCS as well as the acute and mental health trusts and GPs – could work together to develop these facilities, but that would require investment. We believe that if such investment was made it would reap considerable rewards – financial as well as clinical – in the longer term, as it could make service delivery a lot more efficient.

However, under the CCG's model all this will be expected from quite possibly a private sector organisation which will be looking to make profits for shareholders. Bearing in mind that two private organisations – Serco and Capita – have already walked away from the process on the grounds that they could not see how to make money out of it, it is very hard to see how any serious investment could be made in these proposals. If a private, for-profit company does not make sufficient profit then it will walk away from the contract, as did NHS Direct with the 111 contracts, leaving the CCG with the bill to re-procure the contract.

This raises an important issue not touched on in the documentation: how will delivery of the promised service be monitored? And what happens if the successful bidder does not deliver? The proposed payment method is based on an untested 'Outcomes Framework', with seven 'domains' to be achieved if the contractor is to be paid in full. However the criteria are high-level, and in no way specify how the objectives of the domains are to be achieved. And serious questions have been raised by local Patients Reference bodies, as well as the County Council Scrutiny Committee about the capacity of the CCG to adequately monitor the performance of the 'lead provider' of such an extensive contract.

The Scrutiny Committee, with whom the CCG has a statutory requirement to consult, says: 'It is essential that there is a robust performance management system to ensure that any failures to provide the required levels of care are quickly identified and dealt with, with provision for termination of the contract if the provider fails to deliver.' Yet nowhere in the documentation is there any indication that the CCG has such requirements in place.

So the question of how the service will be paid for, especially if the provider is a profit-seeking private company, remains one which has not been addressed seriously at any point in the consultation; and fears over the capacity to monitor performance suggest that there is likely to be a yawning gap in what the CCG is expecting and what the bidders can actually deliver.

3) 'Good quality services depend on empowering and supporting staff.'

The rationale for the 'Overarching Domain C' of the much-vaunted 'Outcomes Framework' says (page 23): 'Evidence suggests that good staff support and management are fundamental to a healthy organizational culture and are directly related to patient experience of care'. And the 'Clinical Evidence' document published by the CCG in March refers (Page 6) to 'Supporting and empowering staff, and quotes the 2012 Bannister Health Summit reporting 'poor working conditions of nurses, care assistants and home care workers and that caring for older people with complex needs is physically and emotionally demanding and that staff need support'.

All very laudable, but when it comes to what is expected of the successful bidder (page 25 of the Outcomes Framework) there is very scant reference to any actual definitions of how staff will be 'supported and empowered', with just a mention of 'staff engagement survey results and action plan for improvement'. On the following page there is a requirement for a 'mandatory training needs analysis' and for a 'number of eligible frontline staff' to have completed relevant training, but nothing more specific about this vital issue.

Most significantly, there is no mention about pay, terms and conditions of staff, and repeated questions about this during the consultation have failed to produce an answer. This has now become much clearer: on June 5th representatives of the bidding organisations finally met staff and their representatives of CCS, the NHS body most affected by the exercise, and the meeting raised some very serious concerns amongst representatives present.

Only one bidder – the Uniting in Care Partnership – was prepared to make a commitment to maintaining NHS rates of pay and NHS terms and conditions, as well as recognizing established trade unions for negotiating and consultation purposes. Not surprisingly, this is the only bid led by NHS organisations (CUH and CPFT), who recognize the value of stable, nationally-agreed terms and conditions of service, and good relations with recognized staff side organisations. That is because these organisations have long experience of working in this way in the NHS over many years – something which certainly cannot be claimed by the other bidders. One in particular – Care UK – is currently embroiled in a long-running dispute with former NHS staff in Doncaster after cutting their pay. That is not to single Care UK out – any private company will be tempted to make cuts in pay and conditions as a means to make money in a contract which offers precious few other opportunities to do so, for reasons we have already described.

Our concern here is that if staff feel they are being undervalued, as a result of their national terms and conditions being eroded and their organisations denied recognition, then this will inevitably have a knock-on effect on quality of service, as the CCG tacitly acknowledges when quoting the Bannister Summit referred to above.

According to the Francis report, the tragedy of Mid-Staffs occurred when management were chasing Foundation Trust status and putting financial concerns ahead of patient concerns. This scenario will be even worse when those responsible for delivering care have an over-

riding requirement to return a profit to their shareholders, and will be tempted to slash pay and conditions – and likely training and staffing levels - in order to do so.

4) The timetable and consultation.

Throughout this whole exercise strong concerns have been raised by many individuals and organisations, including ourselves, about the way it has been conducted. From April 2013 onwards we have protested about the way in which the procurement was announced, about the timetable (originally the contract was to be awarded in May 2014!), and especially about the lack of consultation – officially there was to be no public consultation until after the contract had been awarded!

Following public pressure, and a threat of legal action by some campaigners, the CCG changed its timetable to the present one, to include the public consultation now taking place. However, we still have major concerns about how effective the consultation has been, how much notice will be taken of it, and how realistic is the timetable for implementation.

Consultation responses are due to be in by June 16th. We are told that the results of these will be given to the bidders, so that they can submit their final bids the following month. We do not believe this is a realistic timetable, as there will need to be a thorough examination of issues raised in the consultation and then some key themes extracted, in order to inform the bidders of what is required. We also believe that the public has a right to be informed about what is being said to the bidders about the responses and themes. To do this in around a month seems highly optimistic at best, and raises a big question about to what extent this is a serious consultation, or one which is being conducted reluctantly to meet the minimum requirements of public demand.

We also have concerns about the way the consultation has been set out and the format of the questions, such as the 'most important/least important' choices given to respondents. This can lead to some bizarre results, e.g. the question 'Named care co-ordinators should be provided, attached to GP practices and community teams' was only cited as 'most important' by 13 per cent of respondents in the CCG report on June 5th, yet the following question 'This named care co-ordinator should co-ordinate and support services from a team of professionals including GPs, nurses, therapists, and other specialists around the needs of the individual' was cited as 'most important' by 34 per cent – making a nonsense of the previous question. It is not surprising that the greatest proportion of 'additional comments' in the questionnaire referred to the 'misleading' nature of the questionnaire.

There are even more serious concerns about the timetable for implementation, which is meant to be from January 2015. As the Patients Representation Group for CATCH (the largest Local Commissioning Group) puts it: 'Analysing the Consultation returns, building points raised into the negotiations with bidders, awarding the contract in September 2014, and the contract starting in January 2015 seems ambitious, if not foolhardy.'

We are very concerned that what will actually happen is that the contract will be awarded in September 2014, and then the successful bidder – having got what they want – will start to dictate terms about deliverability. This would effectively take any real control away from the CCG and place it in the hands of the – possibly private – 'lead provider', thus making a mockery of the stated aim of the Health and Social Care Act to put power in the hands of clinicians.

5) Conclusion.

The Stop the NHS Sell-Off in Cambridgeshire and Peterborough campaign was formed in August 2013 by a wide range of trade unions, campaigners and community groups, to oppose the biggest potential privatisation in the NHS so far. The CCG, which only came into existence last year, by definition could have no experience of a commissioning project on

such a scale. Throughout the campaign we have stressed our opposition to the process embarked on by the CCG, not because we oppose moves to improve and integrate services, but because we believe the model proposed by the CCG is hugely risky, untested, and opens the door to a major takeover by private companies whose main priority will be their shareholders. We have collected around 5,000 signatures on petitions opposing privatisation, and we believe the strength of feeling expressed against the use of private contractors shows the CCG do not have the confidence of the public regarding this exercise, which they are supposed to have in respect of good governance.

For all the reasons outlined above, we call on the CCG to stop this unnecessary process now, and instead work with existing NHS providers to develop the vision of a more integrated, patient-centred service – an aim which we believe is entirely achievable with some goodwill and intent on all sides, much of which is already achieved at local level within the NHS.

We do believe that it is significant that the only bidder to have committed itself to maintaining NHS terms and conditions for staff and trade union recognition, thus ensuring a degree of stability for staff at a very uncertain time which we think is crucial for maintaining quality of service, is the NHS-led Uniting in Care Partnership. CUH and CPFT, who lead this bid, are also organisations deeply rooted in the Cambridgeshire and Peterborough health communities, with long experience of providing health care here – something which can obviously not be claimed by any of the other bidders. These – together with current NHS community services provider CCS – are the organisations to take forward the aim of improving and integrating services, not private profiteers.

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.

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

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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

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

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.

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

[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

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”.

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 Exrcutive 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

Proposals to Improve Older People's Healthcare and Adult Community Services – Joint Response from GMB and Unite

We have serious concerns over the tendering process that the CCG have embarked on with the '*Proposals to improve older people's healthcare and adult community services'* and believe that the procurement has serious flaws. The largest tender in NHS history seems to be being rushed through without due care and consideration for the people of Cambridgeshire.

Consultation

Consultation has been virtually non-existent in any meaningful sense. The exercise that has been embarked upon seems to be a box ticking exercise rather than a serious attempt to engage, learn and possibly alter the proposals in response.

We believe that consultation should have started prior to the CCG inaugural meeting which agreed on the model to be used for the future delivery of the service.

It is this model, the 'Lead Provider' model, which allows a bidder to sub-contract services that should have been subject to consultation. It wasn't and at the inaugural meeting some concern was raised by CCG board members who appeared to want more time and more information. There appeared to be some anxiety that the decision needed to be taken at that meeting, with concerns expressed should there be any delay. We believe that, wrongly, speed is the priority, potentially to the detriment of the general public of Cambridgeshire.

The model and length of contract - 5 years with an option for a 2 year extension - seems to favour the private sector. Profits are not likely to be made early in the contract and investment will be needed, particularly in I.T. systems. The NHS does not have financial resources to draw upon in the same way as the private sector and although Foundation Trusts have the capacity to borrow, this puts private sector bidders at an advantage.

We have been told that there is no ceiling built in terms of how much profit can be extracted which seems a poor way to develop an agreement. This means that public money will effectively be channelled into the private sector organisations, and away from patient care, should they be successful in winning the contract. Despite consistent assurances that this is not privatisation, it is difficult to see this in any other way when taxpayers' money can be diverted via profits to the private sector. To develop a contract with no safeguard for public money seems careless at best.

We have consistently requested information about profits and losses. In particular we have asked what happens to profit that is realised and also where the risk falls should the successful bidder 'go bust' or walk away from the contract. The answers have either not been forthcoming or particularly detailed which is a major source of concern. The fear is that

once again public money would be used to bail out the private sector. Either way, the public are set to lose out.

The CCG document '*Invitation to Submit Outline Solutions'* cites the fundamental aim as being '*to commission an integrated hospital and community service for older people in line with the vision and critical success factors….'*

The model itself seems to lend itself to moving further away from the stated goal of an integrated service. How can this be possible with the ability to sub-contract? Who monitors the sub-contracted parties? As will be outlined in more detail later in the document, the presentations from the private organisations and critical reports from the CQC relating to a particular bidders inability or lack of willingness to communicate with other agencies throws this stated aim into serious doubt. Virgin, one of the short-listed bidders was criticised by the CQC and failed in the standard of communication with other partners - on this basis alone, how did they get through the process?

While the aims of an integrated service seem on the surface to be a worthy goal, there seems to be limited evidence to suggest that it would either produce cost savings or improve health outcomes. [http://www.hsj.co.uk/home/commissioning/where-is-the-evidence-for-promoting-integrated-care/5067408.article#.U57Emtsg_IU]

There does appear to be contained within the proposals a possible move toward lowering staffing costs through reliance on volunteers and the use of tele-health and other technology. Can the CCG commit to maintaining current staffing levels on current terms and conditions as a minimum for the duration of the contract?

The Outcome based payment model that the CCG have decided on for the service provider seems to lend itself to the potential to create perverse incentives in that the criteria used to judge include reducing hospital admissions. It is not clear how the Outcomes based payment model will be measured and by whom? Some of the areas seem to be entirely subjective and the model will only be effective if there is reliable data – how is this going to be managed? It seems that this is open to manipulation from private organisations who will be very adept at ensuring they do not lose money or payment.

For consultation to be meaningful it should be open and transparent. Dialogue should be entered into and alternative approaches or models considered. This has not happened in any meaningful sense. Consultation has been based on only one option. There are not alternative models that are being given as another possible way of achieving the goals. Why is this the case and were any other options considered? If not, why not? If they were, why were they not presented to the public?

The consultation has only really commenced after the key decisions have been taken and with the threat of legal action against the CCG (there was a letter before action presented by Leigh Day solicitors acting on behalf of the Stop the Sell-Off group). The documents that have been released have been heavily redacted to the point of rendering them meaningless and flies in the face of openness and transparency – see Chapter 6 of the '*Invitation to Submit Outline Solutions'* document, pages 58-76. Page 76, 8.12.13 *'Below are the Financial Deliverables required by each bidder'* has been redacted entirely. This completely undermines the principles of openness and transparency, without which a public consultation is meaningless.

Commercial interests should not outweigh that of the public, especially when public money is being spent. We have consistently been denied information on grounds of commercial sensitivity - this appears to be based on a fear of being sued by the private sector organisations as the CCG stated in a public consultation meeting in Cambridge that they were advised they could face legal action from them. In other words, big business seem to be dictating what happens and pulling the strings.

Under Section 14Z2 of the NHS Act, there is a statutory duty to involve service users. We believe that there would clearly be a change in the way that services are delivered at the point they are received and that the CCG may have potentially failed in this statutory duty.

We have never received an adequate response to our questions as to why go to procurement in the first place. Section 75 states that procurement only needs to occur if it is in the best interest of patients. We have asked about this consistently over the past year and the response has been weak - things weren't right beforehand etc. There has been nothing in the way of detailed evidence to support this claim, as we have seen in many other areas of concern.

Guidance from Monitor suggests that CCGs can carry out a review of provision of a particular service and identify the most capable providers as part of that review, negating the need to put the services out to tender.
CCGs are also expected to weigh up competition and patient choice with service integration when procuring services.

Monitor´s draft guidance said: 'It is for commissioners to determine ways of improving the quality and efficiency of NHS health care services, including the extent to which improvements can be achieved through services being provided in a more integrated way, by allowing patients a choice of provider and/or by enabling providers to compete for contracts to provide services.'

'When deciding whether or not to publish a contract notice, commissioners will need to ensure that this decision is consistent with their general objective, when procuring services, to secure the needs of people who use the services and to improve quality and efficiency including through the services being provided in an integrated way.'

This issue has failed to be answered during the process so far. Would the CCG be able to justify the decision to run a procurement and show in detail how this would be in the benefit of patients?

One of the bids for the tender involves Cambridge University Hospitals NHS Trust and Cambridge and Peterborough Foundation Trust in a joint bid. Why was this option not explored fully prior to commencing a costly procurement exercise? Surely this would have been the better option and would have been a more effective use of taxpayers' money. They obviously have the skill and experience to deliver a range of clinical expertise and are current NHS providers.

How much money has the procurement exercise cost and what is the likely total? The CCG must provide details of costings broken down clearly and show where the money has been spent.

The current provider, Cambridgeshire Community Services NHS Trust (CCS) failed to make the short-list. What support was given to CCS to meet the stated goals? We have been told *'believe me, we have tried everything'*, but again there is no concrete evidence to support this. We believe that the 'we have tried everything' argument is not shared by CCS management.

The main question is not being asked - do you want your services run by an NHS provider or a private sector organisation? It is because the answer would be an overwhelming no to privatisation as we have found throughout the process?

Private Organisations/Robustness of Process:

This appears to be highly flawed. We have questioned the process from the beginning and had been assured that the Pre-Qualifying Questionnaire and other further scrutiny and plans that have been submitted will 'weed out' the rogue bidders. This has not happened and we have not been allowed to know what questions are being posed nor how the bids are being judged.

The CCG have been warned about the bidders for the last year and much of the information is not new and is freely available in the public domain.

A quick Google search revealed some alarming information about the bidders and we have compiled a very brief dossier:

Interserve, who are part of the Accord bid were involved in one of the largest Competition Act investigations in history. They were found guilty of Accounting Irregularities and illegal bid-rigging activities and although cleared of doing so, have been involved in allegations of Blacklisting of trade unionists. Their CEO is a Tory peer, Lord Blackwell who is a former policy advisor to *Margaret* Thatcher. He has written anti-NHS pamphlets including '*Better healthcare for all: Replacing the NHS monopoly with patient choice'*. One of their major shareholders are JP Morgan.

Care UK who are part of the Care for Life bid- Bought out by private equity company Bridgepoint in 2010 and have a split ownership and management relationship similar to that of Southern Cross who went bust dramatically in 2011. They are currently embroiled in a bitter dispute with staff in Doncaster who have taken 11 weeks of industrial action following Care UK taking over an NHS contract and immediately cutting pay and terms and conditions of staff by as much as £7,000 per year. This is highly relevant because the CCG have repeatedly claimed that well-being of staff is very important to them.

Most recently, Care UK have run into difficulty in their running of the NHS 111 Call Centre in Suffolk. There have been calls for an independent investigation and the leader of Ipswich Borough Council has called for Care UK to be barred from re-bidding for the contract when it comes up for renewal.

Virgin Care UK- Bought out Assura and have been aggressively expanding in health market. Jeremy Hunt is believed to have forced through signature of a £650 million contract in Surrey which had reportedly been delayed due to 'significant issues' being raised by the Director of Nursing and legal wrangles over issues including staff terms and conditions of employment. A CQC Report into the Urgent Care Centre in Croydon found they had endangered patient safety and there were 4 breaches of standards, including communication with other agencies - given that integrated care is the goal, how have they managed to slip through the process?

Bearing in mind it took a matter of minutes to discover this, we have been concerned that the CCG seemed totally unaware of these issues. When they have been made aware, they have not done anything about it. How robust is the process and how can we have any trust in it when organisations above have made it through the various stages, apparently at odds with the stated aims of the CCG. In fact the only bidder to be excluded has been the current provider, CCS. When we have questioned why they failed to be short-listed we have been told that the information is confidential. CCS are not going to be told themselves until September, once the contract has been awarded.

It is astonishing that these organisations have made it through the process and the current provider has not. We are not being told the reasons why and there is no transparency whatsoever.

Why did CCS, the current provider not make it through the process? To continue to refuse to provide an answer to this only fuels the suspicion that the whole process is one based on ideology.

EqIA/Risk Assessments

We have requested Equality Impact Assessments/Risk Assessment as we believe that it exposes the viability of the both CCS and CPFT as organisations when such a large chunk is taken out and there are obvious concerns for users of the rest of the service, plus those that are subsumed into the new contract - will they get lost in a wider service.

This also needs to be subject to an Equality Impact Assessment on grounds of age, gender, disability and ethnicity. This should be done as a stand-alone.

It took over a year from the first request to the document to be produced. As far as we are aware, there has been a total lack of involvement in the process of those affected i.e. service users, staff or trade unions/professional associations. It appears to have been completed by senior managers within the organisation.

Could the CCG disclose how the EqIA was completed, by whom and what the scope of the exercise was? How long did it take and who did they involve?

The Equality Impact Assessment that has been completed is poor and lacking in scope. The outcomes of 'highly positive' in reference to the changes are extremely concerning and do not show either a basic understanding of EqIA or a seriousness of approach.

We believe that there are significant risks relating to those with protected characteristics under the Equality Act and Public Sector Equality Duty. The most obvious would be age and disability, but also the procurement exposes those who are pregnant, children and other users of the services of CCS as the loss of the services as part of the procurement could impact on them.

This should also be subject to a Risk Assessment, which should be published.

We believe that should the CCG proceed without addressing these issues appropriately that there could be the basis of a legal challenge.

Consultation Document

The document being used as part of the consultation response has been drawn up to elicit a positive response to the proposals. Of course everyone is going to tick yes, they agree to proposals to improve services etc.

It is a bizarre mish-mash of questions with the option to rank unrelated items and to itemise things in order of importance. They don't seem to bear any relationship with each other. The document also uses leading questions pointing to more reliance on voluntary services with no option for NHS providers.

The question that should be asked is whether people want their services run by an NHS or private sector organisation. We have been told that this has not been included as it is not optional. Could the CCG provide evidence for this claim and also publish any legal advice that they claim to have received on this issue?

Timescales

They appear to be extremely unrealistic and we have serious concerns that they are going to be able to have everything in place by January 2015. This has been echoed by members of the community at the public meetings. The TUPE process is not a straightforward one as parts of CCS are bought in by Local Authorities and other organisations who may decide

they do not want the successful bidder providing the service. There are other contracts held by CCS that may need to be renegotiated as a result of the procurement.

A major IT system needs to be operational and this will have to be bought, installed and have staff trained etc. These kind of things take years according to IT experts we have spoken to and even longer when part of major organisational change. Could the CCG explain and publish the advice that they have received in this matter, if any?

Staffside Meeting with bidders

As part of the process, the staffside recognised trade unions in CCS were able to meet the bidders on June 5th at the Menzies Hotel in Bar Hill. Despite the fact that the CCG claim that welfare of staff is important, we think it significant that it was CCS management who insisted that the bidders meet the trade unions, not the CCG. This increased concerns considerably as we were able to question the bidders for the first time and we were alarmed with what we were presented with. In short, the private bidders do not seem prepared to commit to TUPE plus; i.e. protecting long-term T&Cs for staff, new starters, promotions etc. and most had a 'static' interpretation of Agenda for Change in that they 'may not' honour future pay rises or other changes agreed nationally. There was a general lack of understanding of trade unions and we got the feeling that although the bidders claim to have good relationships with staff, they will not hesitate to undermine or de-recognise unions.

CARE FOR LIFE

Lead Provider: Care UK

Sub –Contractors/Partners: Lincs Community Health Services Trust & Norfolk Community Health Care NHS Trust

Bizarrely this bid will lead to there being 3 separate employers and it would depend on where staff worked as to which employer they would transfer in to. We suggested to them that this was a complete mess and would make things complicated for the TUPE transfer, complicated for trade union/staff negotiations and could mean that there would be staff doing the same job under different terms and conditions. Equal pay was questioned and they had a total lack of understanding of what was meant by this. It was incredible as the group we met were senior people within the organisations. We mentioned Equal Pay Audits that should be conducted prior to transfer and they didn't know what was meant by this.

They would have a full-time staff representative to deal with the transition which they anticipate to be 18 months. The staff working for the NHS bidders would have no issue with AfC national T&Cs or the NHS Pension Scheme and they both recognise unions.

Care UK were a different proposition altogether. They do not recognise trade unions and said that they have had legal advice that this does not transfer under TUPE. We argued that their legal advice is incorrect. But notwithstanding legal advice what is their issue with recognising unions? They stumbled through this bit without really answering, mentioned Employee Forums and good relations with staff etc. We then questioned them about their relationships with staff in Doncaster where they have driven down terms and conditions and are in bitter dispute with UNISON members taking indefinite strike action. They said they would come back to this but never did surprisingly.

New starters would be employed under Care UK contracts creating a two-tier workforce. We asked about staff on protected T&Cs and promotions. They confirmed fears that if staff are

promoted they would be moved onto a Care UK contract. They mentioned something about a 'Talent Pool' of employees and that this would break the 'glass ceiling of the NHS'. No detail or substance was given to what they meant by the glass ceiling.

Pensions were a bone of contention and the new Care UK staff as we understand will not be part of the NHS Scheme but a company pension. The nurse who was there said nothing else throughout the whole of the meeting however came out with one of the most memorable lines of the day when she said '*I am so glad when I wake up every day and work for Care UK. We don't need a pension.'* She claimed that nursing staff are not concerned over having a pension.

The 'Care for Life' vision itself offered nothing substantially different from services that already exist e.g. Nurse 24 – a single point of access 24 hours a day, Hospital at Home Palliative Care etc. Again this was very thin on detail and nothing new and innovative.

Accord

When is a 'Social Enterprise' not a 'Social Enterprise'? When Interserve are involved seemingly!

We understand that Accord have now changed their bid and are only focussing on Peterborough/Borderline. This would obviously leave 3 of the lots in limbo and we did not get an answer as to what would happen if they were successful. Could the CCG clarify where this would leave the remaining 'lots' and who would be responsible for running the services? How this bid fits with the CCG aim of 'less fragmentation' is beyond us.

The employer would be Accord which will be established as a Limited Liability 'Social Enterprise' with Provide and North Essex Partnership Foundation Trust.

They had initially bid for all the lots and then changed recently as they said they could focus better on one area and develop from there – we believe that the reality is that this is where the money will be and if they wanted to run the remaining services, this would eat into any profits they would make.

This is not a social enterprise in the classic sense. Provide is the 'social enterprise arm' of the bid. There are two separate parts. It was confirmed that the 'Social Enterprise' and Interserve will split the profits 50/50 with some going to the pockets of the directors. Even the 50% kept by the 'Social Enterprise' could be invested anywhere across the organisation e.g. to bid for other tenders or in other geographical locations.

They stated that they would recognise trade unions however were very flaky about what was meant by this. We were all clear that current arrangements should transfer and that it should only be the unions that are able to negotiate and enter collective bargaining etc. They did not seem to get this at all and we had to repeat what we were saying and explain what this meant.

They would not commit to honouring future pay rises under AfC nor to a TUPE plus type arrangement for the duration of the contract. They were not particularly clear on any of the major issues and kept saying that they were 'looking into that at the moment' and would not commit at present. They said that once they had worked these issues out they would be included in the final bid document.

They mentioned lots of wonderful sounding initiatives about Interserve investing in communities and charities and that some of the money would go into those. They also spoke about Employee Charity funds which we assume exist for staff to receive help from as they are so poorly paid.

Interserve will be investing in I.T. but they seem to be doing so by giving the 'Social Enterprise' arm a member loan which presumably will be paid back to Interserve and could mean that more taxpayers' money will be diverted away from services.

Their vision for delivering the service was thin on detail and amounted to a 'hub and spoke' model based in G.P. Surgeries of which there are around 30. There would be Community Teams and resources based there. They conceded that space may be an issue. Peterborough City Hospital seems to be an issue and they stated that Accord staff would work in the Hospital and vice-versa. They did not offer any detail on this.

CUH/CPFT

The only coherent and detailed bid that we saw throughout the day.

CPFT will be the employer. All NHS terms and conditions will remain as will collective bargaining and trade union recognition.

No staff will be employed by Mitie. Their involvement will be as part of Mitie Home Care which will be a newly developed but small part of the service. The staff will remain NHS staff. Mitie have been involved up to now as they have experience in drawing together bids in a way that CUH/CPFT do not.

IT systems are already in place and they will utilise what already exists – they have System 1 and the others already working and ready to go.

The model they propose makes sound clinical sense and has the backing of clinicians, Hinchingbrooke and Peterborough, GPs and others. The 'Integrated Care Model' would have emergency teams in conjunction with the East of England Ambulance Service, neighbourhood and community teams, wellbeing service, uniting care centre and others. Approximately 18 teams with Community Nurses, Social Care, Mental Health Nurses etc. based in localities.

VIRGIN CARE

Although a standalone bid, they are working with IBM Technology and Beacon Healthcare (MH service providers).

By a distance the worst presentation and discussion of the day, which took some doing considering the other bidders we met!

To be brief, they had no real vision of what they would do if successful in the contract. They clearly do not like nor do they wish to recognise trade unions. There was a lengthy discussion over staff representation and they do not seem to understand the difference between this and trade union representatives, or if they do are not prepared to recognise trade unions as we would expect and we believe they would be bound to do so under TUPE legislation.

They referred to the ‘shackles of the NHS’ and Mid-Staffordshire and the CEO of Virgin Care said that he wanted staff to tell him of concerns and risks so they could deal with them.

Staffside then asked him about Croydon Urgent Care Centre and had a copy of the CQC report which was read from. He was asked about the breaches of standards and putting patient safety at risk and the report stating that Virgin Care had failed in communication with others. How was this compatible with the stated aim of the contract in achieving integrated care?

We mentioned Surrey where Jeremy Hunt had intervened to ensure that the £650 million contract was signed as there were ‘delays’ and the director of nursing had raised concerns over ‘significant issues’ and risks to patients. There had also been legal wrangles over staff terms and conditions.

He responded angrily calling a member of staffside ‘specious’ saying what was said was inaccurate and deliberately so. We responded by stating that it was in black and white, not made up and was in the public domain. We said that he had just told us he wanted to hear concerns from staff yet when we raised a legitimate concern he had called a member of staffside a liar and dismissed it off-hand.

They were quite frankly an arrogant disgrace and we have serious concerns should they get anywhere near the contract.

Conclusion

We appear to be heading down a road that will be very difficult to come back from. This process lacks support from staff or the public and such a major decision should not be hurried or made based on lack of concrete evidence. The process is not robust and should be stopped and at the very least made to rethink and be conducted in a more open and transparent manner, with more detailed evidence and realistic timescales.

We strongly believe that this would be an unmitigated disaster if the plans go ahead and could be costly in terms of legal challenges. Before we get to that stage it would be far better to halt the process and look at alternatives, including investment in currently existing services and collaborative working with CUH/CPFT.

The process seems to be being rushed through without careful consideration of the long-term implications and even certain members of the CCG board do not appear confident in the process. It has been slammed from all quarters - Andy Burnham called it 'the most audacious sell-off to date', the BMA have been critical as have all major health unions. Staff oppose the move and the public/service users do not want it. This appears to be being driven by a select few. The NHS however belongs to us all and they should heed the warnings before it is too late.

Having been involved in the process from the beginning back in April/May 2013 we believe that the procurement is fundamentally flawed for the reasons outlined above. We believe that there would be significant problems arising should the contract be awarded to the private sector and potential issues around patient safety and service delivery. There could be possible legal issues, particularly around staff and we believe that this could expose the CCG/Private Provider to significant risk of equal pay claims and possible cuts to staff terms and conditions.

We have concerns over a potential conflict of interest between senior figures within the procurement team and Older People's programme and Virgin Care Ltd. Involvement in the process. In particular Arnold Fertig, programme lead and Catherine Bennett who resigned as Directors of Virgin Care Cambridge LLP as recently as October 2012.

We remain of the view that the tendering process was unnecessary. However, regardless of that, having now had the opportunity to meet the bidders, GMB and Unite have taken the position of supporting the Cambridge University Hospitals NHS Trust/Cambridge and Peterborough Foundation Trust bid 'Uniting in Care'.

Steve Sweeney

GMB

Ian Maidlow

Unite

WISBECH, MARCH & DISTRICT TRADES UNION COUNCIL

When Adam delved and Eve span who was then the Gentleman

Secretary: Sue Dockett

[redacted]

[redacted]

Phone: [redacted]

E:mail [redacted]

16/06/14

Ms M Donnelly

Lay Chair

Cambridgeshire & Peterborough CCG

Dear Ms. Donnelly

Response to Consultation on Older People's Healthcare and Adult Community Services

I am writing to formally respond on behalf of this Trades Union Council to the consultation.

It is important for me to state quite clearly that this Trades Union Council is not only totally opposed to the proposal to contract out some or all of the services to private contractors but also the way that you have gone about this exercise. Among our membership are present and retired trade union officers who have a wealth of experience of both contracting out of services and best value in the public sector. We have never seen such a dangerous and incompetent process as the one your commissioning group has adopted. In addition we reject your argument that this was the only way to assess best value and wish to make clear that it is more likely not to achieve that objective.

On five occasions members of this Trades Union Council have spent about an hour on each occasion collecting signatures in Wisbech and March market places. On average about 100 signatures were collected in an hour. This, itself, is quite a surprisingly high level of response especially given that neither area is not for a particularly high footfall. Of even more significance was the attitude of the public of all backgrounds and political persuasion who stated quite categorically that they did not want private contractors running their health services. The strength of feeling against their use was overwhelming and is a clear indication of the majority view among Fenland residents.

We believe that you are putting the health care of some of the county's most vulnerable residents at serious risk and have failed to meet the requirements to demonstrate good governance through both public support and the best use of public funds. We fully endorse the detailed response of the 'Stop the Sell Off Campaign' and don't feel we can add any more to that document except to formally request, on behalf of clearly the vast majority of Fenland residents not just our members, that you reject bids from private contractors and keep the services provided solely by direct NHS trusts.

Yours sincerely

Sue Dockett

Secretary