Health Committee

Oral evidence: Integrated Care Pioneers, HC 560

Tuesday 14 October 2014

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Andrew George, Robert Jenrick
Barbara Keeley, Andrew Percy, Mr Virendra Sharma, David Tredinnick, Valerie Vaz

Questions 68 - 291

Witnesses: **Dr Giles Maskell**, President, Royal College of Radiologists, **Professor Chris Ham**, Chief Executive, The King's Fund, **Jan Sensier**, Chief Executive, Healthwatch Staffordshire, and **Val Lewis**, Healthwatch, Stoke on Trent, gave evidence.

Q68 Chair: Thank you for coming. Welcome to this session on the Integrated Care Pioneer in Staffordshire on transforming cancer and end of life care. I would ask at the start for each of you on the panel to introduce yourselves, for the record.

Dr Maskell: I am Giles Maskell, a consultant radiologist in Truro in Cornwall. I am also President of the Royal College of Radiologists, which is a professional body for radiologists who diagnose and treat cancer with x-rays and scans, and also clinical oncologists, who are cancer doctors who deliver all the radiotherapy and most of the chemotherapy in this country.

Professor Ham: I am Chris Ham. I am Chief Executive of the King's Fund.

Jan Sensier: I am Jan Sensier, Chief Executive of Healthwatch Staffordshire.

Val Lewis: I am Val Lewis, a manager of Healthwatch, Stoke on Trent.

Q69 Chair: Thank you very much for coming today. I want to start with an opening general question on what the panel feel the risks and benefits are of this prime provider approach to transforming cancer and end of life care. Perhaps I could start with you, Dr Maskell.

Dr Maskell: The ambitions are unarguable. Joining up care over a larger area than usually provided by a traditional NHS organisation, and hopefully integrating hospital and community care by different providers, is an ambition shared by almost everyone who works in the health service, if not absolutely everyone.

The objective is absolutely right. The question is whether this is the right or the best way of going about it. The concerns that we have are, first, is this the right place to be doing it? This is an area of the country which is really struggling in the aftermath of the Mid Staffordshire debacle and the imminent dissolution of the Mid Staffordshire Foundation Trust. Is it the right way to go about it? Is it something, with its 10-year span, which we run a risk of being locked into and which, if it turns out not to be working well, will then be impossible to dismantle once it is under way? Is it potentially going to get in the way of any other projects locally?

I have already alluded to the fact that the main provider of cancer services, the University Hospital of North Staffordshire, is fully occupied at the moment with trying to sort out the mess that was left after the Mid Staffordshire problems. Is this, in essence, the best way to go about integrating cancer care in the area?

Professor Ham: The benefits are, potentially, better integration of care around the needs of individual patients and populations; delivering better outcomes of care with higher-quality and safer care; and better value for potentially a large sum of the NHS budget in Staffordshire.

The risks, largely, are around the fact that this is uncharted territory. Staffordshire is not alone. There are other areas of England that are testing out a similar approach to how you can commission and fund services differently to deliver more integration with the benefits that I have enumerated. Nobody has yet done that. To anticipate, we do not have any evidence from the NHS one way or another that this will deliver the benefits, or indeed that it will all fall over.

This innovation is welcome from our point of view at the King's Fund. It needs to be properly evaluated. We need to be mindful of those risks. If I may add, I think the devil is in the detail in getting this right. It is making sure that the definition of the services to be covered by this commissioning approach is right—not too broad and not too narrow—and that there is a realistic budget put in place. Frankly, nobody knows how much is spent on end of life care or cancer care in any county in England at the moment, including Staffordshire. It might be too generous and, equally, it could be not sufficient.

There is a lot of work to be done around defining the outcomes that the commissioners and the providers involved want to work towards. That is not a trivial thing either. There is a whole bunch of technical issues around the kind of contract and the vehicle that would link the prime provider and the others working with that prime provider to deliver on the ambitions of the commissioners. Because nobody has done this successfully before, that is quite a risky thing to do, but in our view it is a risk worth taking as long as it is a calculated risk and there is proper evaluation to see if patients and populations really do achieve the improvements in outcomes that we all want to see.

Jan Sensier: The benefits have been well articulated. From a Healthwatch Staffordshire point of view, we absolutely understand that there are problems with the way in which services are delivered at the moment, in terms of lack of integration. We have heard patients' stories that articulate that for us very well. We also agree with the objectives of better outcomes and better value.

The risks have also been well articulated. The question of whether Staffordshire is the right place is one that is worthy of thought. There are reasons why it could be a very good place to do it in. In some ways you could say that things in Staffordshire need a fresh look and a change, because what we have been doing has not worked well over the past few years. There are also risks, because we have a lot else on our plate as a distressed health economy and with what is happening around the dissolution of Mid Staffordshire.

Going back to the devil in the detail, as long as the programme works alongside those other things that are happening, and the thinking around the programme is integrated into what else is happening, then it could be a good time.

Another risk would be a lack of patient involvement. We think the programme is doing very well to involve patients in designing, every step of the way, but it is really important to not just involve patients but communicate with the public. The public at large—not just those patients who are involved in the programme—need to understand what is happening. They need not to be alienated from the programme. That is a key risk. The public in Staffordshire, to be quite honest, feel quite battered in terms of their health services. People in the county town of Stafford, for instance, will always argue that they feel as if they have been punished twice through poor care in the first instance and through dissolution of their trust in the second. It is really important that those people are not alienated by this programme but feel it is working to their benefit in the longer term.

Val Lewis: I would echo much of what my colleague Jan has said, but I think if you always do what you have always done, you will always get what you always got. There have to be times when we do take risks to make changes. Healthwatch in Stoke on Trent does hear patients' stories about when things are not working well on the cancer and end of life pathways. We know that there need to be some changes to improve integration.

I would also echo the risks of the massive number of different initiatives that we have going on, not just in Stoke and Staffordshire but elsewhere across the country at the moment, if they are not integrated and they do not complement each other, in terms of the different integrations of care in the community, hospital integration, the implementation of the Better Care fund, our cross-economy transformation agenda and the KPMG recommendations from the distressed health economy. All those things are happening, and it is really going to be so important that (a) this does not get lost in the mix but runs alongside it, is complementary to it and works with all the changes that happen, and (b) that the other partners at the party make sure that that does happen, so that we get a truly integrated, patient-centred service that is much improved.

Q70 Chair: Before we move on to the detailed questions about what is happening locally, I would ask the panel: what made you decide to go down this route, rather than looking at best practice elsewhere? As we have heard, this has not been tried anywhere else in the country, but presumably there are examples around the country where end of life care and cancer care are working very well. What made you decide to try something completely new, rather than adopt an existing model?

Professor Ham: I should have said right at the beginning that my colleague Rachael Addicott at the King's Fund is on the advisory group helping Staffordshire CCGs in this work. I am not from Staffordshire, but my understanding, knowing something about this particular example from outside Staffordshire, is that there is experience in the old PCTs of trying to commission in this innovative way, not least in Birmingham, where, around end of life care, some of the people involved in Staffordshire had two or three years' experience, which in the end did not come to fruition, partly because of the hard work involved in writing a contract in commissioning in this very different sort of way. That experience will have influenced the decision to go down this particular route.

My understanding, too, is that Macmillan Cancer Support has been very closely involved. It has given its resources and support to the local CCGs in taking this forward with the involvement of Healthwatch and other organisations. I suspect it may not have happened in Staffordshire unless that connection had been made. It is a very expensive thing to go through this kind of work. I imagine that sums in the millions of pounds have already been spent, even ahead of agreeing how a contract should be let and over what period of time. I imagine that a number of things came together.

Q71 Chair: But the question specifically was whether you looked at examples of best practice elsewhere in the country before deciding to take this route.

Dr Maskell: I think that is probably a question more for the people coming after us.

Chair: All right; I will leave that to the next panel.

Q72 Barbara Keeley: This is a question for Chris Ham. It may be that you have already answered this in part. The King's Fund more generally has published evidence that questioned the wisdom of taking a disease-specific approach to integration, instead of just a risk-based population approach. Although you said you welcome the innovation and that the definition is in the detail, do you believe it is wise for the Staffordshire pioneer to focus explicitly on cancer care and end of life care?

Professor Ham: It is a good challenge and a very fair question, if I may say so. If we lived in an ideal world, I would focus much more on how we commission for whole populations. If you go down a disease base or a care group line, as they are doing, for example, in Cambridgeshire around commissioning for older people's services in a very similar parallel initiative, the risk is that you integrate around the disease or the care group, but all you are doing is creating new silos to replace the old silos you are seeking to move beyond. That is another of the real risks here. But we do not live in the ideal world; we live in the world as we find it. Moving in this direction, as one approach, is certainly worth while, but subject to what I said earlier about proper evaluation.

Q73 Barbara Keeley: The Chair has already touched on this to a certain extent, but is there evidence either domestically or internationally that contracting a prime provider, in the manner proposed here in Staffordshire, can help to improve patient outcomes? There are two things: one is whether there are examples, but there is also the sheer scale of this. First of all, are you aware of any precedents or examples?

Professor Ham: I mentioned that the former PCTs did some work that is closely related to this but not on the same scale. There was a study I undertook with colleagues about four or five years ago that included looking at the example of end of life care in Birmingham. We found half a dozen other small-scale examples. I think they were in Somerset, Liverpool and I cannot remember exactly where. They were much less ambitious than the one we are talking about here. This is of a different order.

Outside the UK, I am aware that in New Zealand's healthcare system they do not use the prime provider/prime contractor route, but they certainly have experience of using alliance contracts. Alliance contracts are a close cousin of these. The work we have done in the King's Fund looking at that in Canterbury in South Island is generally positive about their experience of working in this way.

Q74 Barbara Keeley: Obviously, one of the key things would be if any suggested system or approach helped clinicians in secondary care work more closely and effectively with general practice and community care.

Professor Ham: Exactly.

Q75 Barbara Keeley: Do you know of examples where that was the outcome in any of the things you have touched on?

Professor Ham: Yes. I can refer to another piece of work that we are about to publish precisely on examples in England of hospital-based specialists who are working across hospitals in the community to achieve much more clinical integration. The examples relate to care of older people, the children's service, rheumatology, diabetology and a couple of other specialties. But they are not based on this innovation in contracting that we are talking about for this inquiry. They have largely come about because you have clinical champions and hospital specialists who have taken the initiative with the support of their GP colleagues, and often with the support of commissioners, to say, "Our future as specialists lies much more out of the hospital, supporting the primary care teams and doing much more of this routine chronic disease management to reduce the reliance on people coming to the hospital." There are different routes to a similar destination.

Q76 Barbara Keeley: You said earlier that you think it is risky but possibly a risk worth taking. How much extra risk is there in just the scale and the fact that there are no precedents for doing this on this scale?

Professor Ham: On this scale, obviously, the risks, by definition, are much bigger. As Jan said just now, the risks of not doing something like this should also be recognised. Staffordshire has had its fair share of well-known problems in the recent past. It is not as if it is starting from a very high base in either cancer care or end of life care, as far as I understand. Therefore, there is a risk of going backwards rather than forwards. It is a calculation of the balance of risks and benefits, in both the status quo and in this option.

Q77 Valerie Vaz: That is a hell of a risk to take with taxpayers' money, is it not? It is £1.2 billion.

Professor Ham: Indeed, it is a risk to take with taxpayers' money. CCGs have to make the judgment, given that they are the custodians of the taxpayers' money in different parts of the country, as to the best way of delivering value and outcomes.

Q78 Valerie Vaz: But you are not convinced that that is going to happen, are you?

Professor Ham: I have not said I am not convinced, but nor am I convinced. None of us can sit here and say that this is going to deliver huge benefits, or indeed is going to take us backwards. We need more evidence, but unless we try things, there is no possibility of getting that evidence.

Q79 Valerie Vaz: Part of our role when something like that happens, and when there is not a positive outcome, is that you and the next panel can all sit here and say, "Why are we going down this route? Why are the contracts already out?" We are already halfway down the road on procurement, aren't we?

Val Lewis: We are; yes. I suspect that part of the reason why we are sitting here is the adverse publicity that has been around it from the lobbying groups concerned with the fear of privatisation. That does not make it any less of a thing that we ought to consider doing. The patient is telling us—and telling the project, I believe—that there are gaps in the service, that the service does not flow, and that pathways do not work. If they are not working for patients—and I can speak from personal experience with a close family member and from the patients' stories that we have coming to us—it says that there is a need for some shift in the way that we operate. We have such a service that operates in many different silos. We have a drive towards care in the community, which is right, but if we shift more care into the community, it shifts more responsibility to people in the community who perhaps do not have that experience and yet that patient still has the same issues.

Q80 Valerie Vaz: I understand that. You are talking about silos, but to me this system seems like it is going to be a silo, because there are going to be prime providers for breast cancer, lung cancer and all the other different cancers. Is that right?

Jan Sensier: My understanding is that there is going to be one prime provider for cancer, and one for end of life.

Q81 Valerie Vaz: I had read somewhere that there were going to be different types of prime providers. Let me turn to consultation, because you have given us personal experience of what you have. What sort of consultation have you had? You talk about lobbying groups, but have you consulted the people of Stoke? Presumably, you're part of the consultation process, aren't you?

Val Lewis: Healthwatch's role, certainly in Stoke-on-Trent, has been to support the programme in promoting their consultation process. We have not ourselves consulted. The programme has been interviewing quite a few thousand people to understand what their experience of the pathway has been, what has worked well and what has not worked well to inform the design of the programme that is designed going forward and will be delivered by the prime provider. Healthwatch in Stoke-on-Trent has certainly facilitated many of the events, in terms of promoting them through our newsletter, website and e-mails to our network of people within the city. We have regularly asked the programme to explain and update us on their progress.

Q82 Valerie Vaz: What is coming back? You say there is lots of adverse publicity, but there is only adverse publicity because people do not want it to happen, I presume.

Val Lewis: Again, this is a view from my own perspective. A lot of the adverse publicity that we are seeing that has rocked the press in the last few months has been around the lobbying groups that have been inferring, I suppose, that this is privatisation on a massive scale. I feel that the programme has not perhaps been as strong as it could have been in putting a balanced point of view about what they intend to do. That has resulted in a fairly high level of fear in Stoke-on-Trent among patients and members of the community that what they have and know is going to disappear, and they are not going to have anything in its place.

Q83 Valerie Vaz: I am trying to focus on this. Rather than saying that people are against it in programmes going on, I am trying to work out—from both of you as Healthwatch with your brief—what sort of consultation you have had with Mrs Smith or Joe Public. How many meetings have there been? How many responses? How many in favour and how many against?

Jan Sensier: We have not conducted a consultation on the programme because it is not our job to conduct consultations for other people. Our job is to advise on what they are doing with their consultations. It is up to the programme to own the consultation and our job is to advise. What I know Val has done consistently, as we have in Healthwatch Staffordshire, is advise that the communications be stronger in terms of the programme. Right from the very early days of the programme, both Healthwatch bodies have been asked to supply patient champions to work with the programme. We have both done that. We have had the ability to nominate people to go to the workshops and the design events that have been held, and to take part on a regular basis.

One of my champions from Healthwatch Staffordshire, who is a patient herself and has experienced that fragmentation of the cancer pathway, is involved in the procurement workstream. I have spoken in the last few days to several of the champions that we have who are involved with the programme. What we have come to understand through that is that the patients who have been involved are very excited by the work that is being done, and feel that it is potentially of great benefit. They want to get involved and stuck in. They are not uncritical of some things. They have told me, for instance, that they have recently been commenting on leaflets that have been produced. They are very much engaged and involved. What has been lacking has been that wider engagement and involvement. That is something that the programme has now understood, and it has begun to produce more and more information and literature. Our job, as Val has said, is to promote that. Our job is not to conduct the consultation on the programme's behalf.

Q84 Valerie Vaz: I am not suggesting that is your job. You are the guardian, so you need to be satisfied that the local population has been consulted in an appropriate way, not through fear that there is a gap in the system and the process and therefore you are going to fill it. What I am hearing from you basically is, "We are pleased that something is going to be done. There is a risk to it. It does not really matter what the risk is, but something is going to be done." That leads me to think, why do you go down a risky route and why do you support people down a risky route rather than one where, for example, clinicians are involved? Dr Maskell, I know you have written in *The Guardian*, but do you know whether clinicians have been involved in this consultation?

Dr Maskell: I understand that clinicians in the community were involved from an early stage, but I can say that the hospital-based clinicians were not involved. In fact, some of our colleagues have told us that the first they saw was when the advert went out. That really was the first they knew about the programme.

Q85 Valerie Vaz: What is your view on that?

Dr Maskell: It is an unfortunate way to kick off something which is supposed to integrate primary and secondary care. If you are not asking the secondary care clinicians for their input and advice from an early stage, it gives the impression that there is something to hide, or that there is some threat or whatever. Whether there is or not, it creates a perception of poor communication and perhaps something that they would rather not hear.

Q86 Valerie Vaz: Presumably, clinicians will be involved, won't they, if there is a difficult issue like, for example, operations? Presumably, this scheme does not do the operations and the difficult cancers.

Dr Maskell: We touched on this a little bit earlier. One of the difficulties here is ring-fencing what is a cancer service. Your whole emergency surgical service, for example, will deal with some cancer patients and some non-cancer patients. As a radiology service, we will do hundreds and hundreds of chest x-rays to find one patient with cancer. How can you tease out the cancer element of the whole service, and is it the sensible thing to do? That is a different concern.

Q87 Valerie Vaz: Presumably, as part of this process, you need to have a multi-disciplinary team. So shouldn't the clinicians be involved?

Dr Maskell: Very much so. The glue which holds the system together at the moment between the two sectors is the cancer nurse specialists, who do cross between hospital and community. In most places where the system works well, they do function as a very effective glue. There are not enough of them and they do not have a standardised role or job description, which would be a good thing to have. For someone working with patients on the front line, it always seems that, if we are going to spend millions and millions of pounds on cancer care, we might get better value from a few extra nurse specialists, rather than this very complex legal and contracting process.

Q88 Valerie Vaz: I have one last question on consultation. I was a bit concerned to read that someone called John Sneddon is on the board of Healthwatch. What is his role with TCEOL?

Val Lewis: He is a non-executive director of the programme.

Q89 Valerie Vaz: How can he have two hats on? You are either in Healthwatch or you are on this board. Presumably there is a conflict there, is there not?

Val Lewis: We have always been aware that he has been in that role. He joined the Healthwatch board from the LINk, the local involvement network, as one of two who came across from the LINk to Healthwatch. He has always separated it out. If it is discussed at our board, he has declared an interest. He has given two presentations to our board of information that I believe goes out generally to the public when they do presentations. If we have asked any other questions, we are referred back to the main programme board staff to answer those, because that would compromise his position. From our point of view, it is quite helpful in some ways to know that someone is involved with Healthwatch and on that group. It is giving us the opportunity to understand the general activities of that programme as well, which is quite helpful.

Q90 Valerie Vaz: That is great, but where is the patient and the average person in Stoke and Staffordshire? My colleagues—Rob Flello and Joan Walley, the elected representatives—are very concerned about this. They have direct links to ordinary people. I hate the words "ordinary people," but Joe Public. They have concerns about it. I know you are satisfied that John Sneddon can sit on both and it is helpful, but I think that is a serious issue.

Jan Sensier: As I explained before, the representation that Healthwatch was asked to provide was very much through patients with real-life experiences. I quoted from one of the patients who we put forward from Healthwatch Staffordshire. We certainly do have that contact with ordinary people, and with people who have experienced the services and are therefore able to bring that experience to light when they are involved in the programme.

Q91 Valerie Vaz: Perhaps you could let us know how many people have been involved in the consultation. That would be great.

Jan Sensier: Yes.

Q92 Rosie Cooper: I have two points. First of all, picking up on the point that Valerie makes regarding the Nolan principles, have you taken any advice on this duplicity of roles in an individual?

Val Lewis: We have a standard process within our board for conflicts of interests. This has not arisen as one, until raised today.

Q93 Rosie Cooper: Good grief. Should you not have noticed? I think you need to take advice. The Nolan principles are based not just on what is happening, but on the perception of what is happening. If you have not noticed what obviously a great body of people are worried about, then I fear the judgment within your organisation.

Val Lewis: I would rebut that, in that the whole of our Healthwatch management board are very committed to ensuring that the patient voice is heard and supported as widely as possible in the delivery of this process for this programme. We are very passionate about the patient's voice being heard, and have worked very hard in Stoke-on-Trent to enable that.

Q94 Rosie Cooper: I will be very brief, but describe to me the difference between a patient and a member of the community. Is it only patient voices? A member of the community could be your patient tomorrow. Do they not have a view? Are you listening to them?

Val Lewis: Every member of the public is potentially a patient at some point or other. I am sorry, but I am not quite clear what you are asking me.

Q95 Rosie Cooper: In essence, you keep on talking about consulting with, and listening to, "patients." That was the word you used. Yet the wider community is consulted, and when people ask you about that, you say you see it as a failing. When people express a view that they are not happy, you talk about it as "adverse publicity from lobbying groups." Then you do not see a conflict of interest under your nose. That makes me worry.

Val Lewis: I understand what you are saying now; my apologies. I do believe that every member of the public has the right to be consulted. We know that patients have been consulted in the early part of the programme to understand what their pathways are and to ensure that the programme, as we understand it, is fully informed about what the issues are. The wider public consultation will be something that we hope Healthwatch will be involved with, once the description of what the programme is going to look like is understood. We hope we will be involved in helping to ensure as wide a consultation as possible with all groups who may be impacted.

With regard to your comments about John Sneddon, I will go back to my board and take some advice from them about what we should do.

Q96 Rosie Cooper: It might be helpful to go beyond your board. I want to ask you all one question and then I probably will not speak again. What is the role of Macmillan in this process?

Dr Maskell: Macmillan are coming on the panel after us.

Q97 Rosie Cooper: I know that, but I want to understand from you.

Val Lewis: From my perspective, I have commented a number of times that I think Macmillan's role has been too much in the back seat. We have not really understood what their position was.

Jan Sensier: My understanding is that they provide some funding for the programme and some of the support. They have made it clear that they will not bid as a prime provider and that the reason why they are involved is because, from a strategic point of view, they believe that services are insufficiently joined up and they think this is a chance to try something out. Beyond that—which I am sure any of us could have read—I would not like to comment.

Professor Ham: I cannot say much more than Jan has just said. I think it is because Macmillan believes integrated care has to be part of the future of our cancer services. We often have fragmented care at the moment and this is one way of trying to overcome that. As I understand it, they have been generous in offering some financial support to this part of the country to test that out.

Dr Maskell: That is my understanding as well.

Q98 Barbara Keeley: I am not sure how many people Healthwatch would say are the community of current and former patients that you consider are people who should be consulted. My colleague asked a question about the general public and that is fair, but I was trying to get a sense of this, and I didn't from the way you answered Valerie Vaz earlier. Is it 10% of people who should know about this who do know about it or have been consulted? Is it 5% or 70/30 or 60/40? You must have some sense of the reach of the information.

Jan Sensier: There are two different issues, and that is what I tried to make clear in my opening remarks. One issue is how many patients is the right number of patients to get involved in the actual detail of the programme, the design, the champions and what we have described. I understand there are about 50 patients involved, which is a small proportion but actually quite large compared with the involvement of patients in other health services.

Q99 Barbara Keeley: That is 50 out of how many overall?

Jan Sensier: I do not know the exact population covering the four CCG areas, but I would imagine it must be about 500,000 or 600,000 and it would probably be more than that. It is a very small proportion.

Q100 Barbara Keeley: I am trying to get a sense of the percentage. How many of those 500,000 or 600,000 of the population would be cancer patients at any one point in time?

Jan Sensier: I do not have the answer to that; I am sorry.

Q101 Barbara Keeley: I suggest, given that this is disease specific, you need to know that.

Jan Sensier: Yes; that is a very fair point. What I was going on to say is that that is about people who are giving up a lot of their time to get very actively involved in the programme. We cannot expect that to be a large percentage of the population, but what we can expect is for a much larger percentage of the population to understand what is going on and to be informed about what is going on. That is where I do think that the programme has not performed as well as it should have done. As I said in my opening remarks, that is where work has to be done. We do need to ensure that the public at large understand what has happened and that needs to reach a much wider audience.

Q102 Barbara Keeley: There is a secondary point on that. You have talked about Macmillan, which was referred to earlier. Maybe we should ask them what the scale is of the funding they have put in. My concern is that, in reaching out to patients, Macmillan would be an organisation that is in the closest contact with the patient.

Jan Sensier: Absolutely.

Q103 Barbara Keeley: It seems to me that if they have this very substantial vested interest, in that they are funding the work, then that gives you a problem with disseminating information to patients. I join with my colleagues here. I do not think you can be on both sides of this. If you have invested in it and you want to drive it forward, then you are not necessarily the vehicle for dealing with people who might be sceptical about it, and quite rightly so.

Jan Sensier: That would be something you need to put to Macmillan because obviously, as Healthwatch, we have not invested in it.

Q104 Barbara Keeley: I think it is an issue for you as well, in that it is okay having patient champions, but it is right to represent people who are sceptical.

Jan Sensier: Absolutely. I completely agree with you. All I was saying is that we have not invested in the programme.

Q105 Barbara Keeley: No, but in any dissemination, if you take a large area like this, who would be the organisations in touch with cancer patients? It would be Macmillan and Marie Curie, wouldn't it? If they are heavily invested in it, they have too vested an interest.

Jan Sensier: You feel they are compromised and therefore that we should be taking up that and making sure—

Q106 Barbara Keeley: That is a choice for you, but somebody needs to.

Jan Sensier: I agree with you and we do, as Healthwatch, absolutely have a complete role to play in helping that. That is something we need to take forward in conjunction with the programme.

Q107 Rosie Cooper: Have you yourselves decided that this is the right thing to do? Anybody who does not agree or objects does not seem to be represented by you.

Jan Sensier: No.

Val Lewis: No, no.

Q108 Rosie Cooper: That is what's coming over—

Val Lewis: I apologise if that is the impression that I have given. Healthwatch's position is that it cannot take a position on whether it is the right or the wrong thing to happen. Its position is that it has to enable the public debate to happen so that as many people as possible can make contributions to support the final decision of what sort of pathway is agreed and designed.

Q109 Rosie Cooper: I want to test that. How many of those people you describe as lobbying against have you talked to?

Val Lewis: Let me put this into a context. We have had a number of events in Stoke-on-Trent that have protested against privatisation, with this programme as the theme. Having attended those events, it has been worrying to see how distressed people have become because they have believed that it was all about privatisation of their service, when in actual fact, for me, this is a much bigger programme about improving the patient pathway and supporting people.

Q110 Rosie Cooper: So you have not really engaged with those people either?

Jan Sensier: I would add an example to that. At the Healthwatch Staffordshire AGM, one of those groups came and had a stand at the AGM. They asked questions in public about this programme. As a result of that, my chair committed to, and then followed through, raising this and promoting their concerns to Healthwatch England, which he did at their committee meeting.

Q111 Rosie Cooper: Macmillan are on NHS England's board, are they not?

Jan Sensier: I am sorry; I do not know. I was not talking about Macmillan.

Rosie Cooper: The point I am really trying to make to you is that that group came to you. You did not go and talk to those groups if you were bothered. I will stop there.

Q112 Andrew Percy: I have a quick question on this. I hear all this and obviously, as soon as there is mention of providers, people get very excited. It upsets people because they equate an outsider or private provider with it not being NHS care. Of course the word "privatisation" makes people very nervous.

Is there anything different about the way in which the consultation for this is occurring compared with other reconfigurations or changes to the provision of health services in your local area? Is the process that has been followed, in terms of public engagement and consultation, different or the same?

Jan Sensier: Given that we have had some very large-scale changes in Staffordshire, the public consultation—the public communication and engagement—has not reached the scale that it should have as yet, as I said before. I take for instance the dissolution of Mid Staffordshire and the Trust Special Administration process that we have had in Mid Staffordshire. Healthwatch Staffordshire provided the independent chair to all the consultation events last year, and between them around 3,000 people turned up to those consultation events. They were run by Ernst and Young as the TSAs, but we provided the independent chair to those. As Val said, we do not take sides, but what we firmly believe is that we are there to facilitate as much public engagement as possible. No, it has not reached that scale, and it does now need to really push on to get much greater engagement.

There is a crowded market in Staffordshire at the moment. That dissolution of Mid Staffordshire is still going on. Val and I have been working with the University Hospital of Staffordshire to help facilitate their own engagement about the transition and the integration of services now taking place. We are running three large-scale events for the University Hospital of North Staffordshire over the next few weeks. There is a lot going on. One of the things we would be very keen to talk to the programme about is how they now step up their public engagement to a much greater level.

Q113 Valerie Vaz: The concern is that the contracts have already gone out. You are already down the way to procurement. You are talking about engagement after it has all gone out. That is the bit I find slightly odd. You are trying to allay people's fears, but actually you are saying, "They do not know what is going on, but it has all gone out." The point about it is that people are concerned because they do not know who the provider is. They know who their GP is, but they do not know who their consultant is. That seems to me a seamless way of doing business, rather than palming it off on a provider that they do not even know.

Jan Sensier: I do not think we are trying to allay people's concerns. I think we are trying to give people a voice. I just want to make that clear. It is not our job to say to the public, "Don't worry. It is all right; it is fine." It is our job to ensure—

Q114 Valerie Vaz: That is what you are saying to us.

Jan Sensier: No. That is not our job. It is our job to ensure that the public has—

Q115 Valerie Vaz: That is what you are saying to me.

Jan Sensier: I am sorry you got that impression, but we are very clear that that is not our job. Our job is to ensure that people have the ability to engage. That is what we push the programme to deliver and try and ensure ourselves. At the beginning of this session we were asked to give our opinions on the risks and benefits. Maybe in doing so that made it sound as though we were trying to allay public concerns. We were not. We were giving our assessment of the risks and benefits. Our real job, out there in Staffordshire and Stoke on Trent, is to ensure that people have a voice.

Chair: We do need to move on to Andrew's questions. We have the second panel to come as well.

Q116 Andrew George: In terms of the outcomes of cancer and end of life care services within the four commissioning areas that we are looking at, could I ask you, Dr Maskell—because you have no doubt spoken to your colleagues in the area and looked at the outcomes in recent years—how much worse or better the outcomes were for patients in this area, in comparison to other areas?

Dr Maskell: I am sorry, I do not have detailed information on that so I will not try and pretend that I do.

Q117 Andrew George: Can any other of the panel comment on that?

Professor Ham: No.

Jan Sensier: No.

Q118 Andrew George: What was it that was broke that needed fixing here? Dr Maskell, I know you are sceptical of this as the fix, but in terms of the weaknesses of the system itself, it would be helpful to know certainly in my own mind, and, if someone is coming up with a new whizz-bang solution to something, it is useful to have a clear idea of what is broke about the system that needed fixing. Can anyone offer any advice on that?

Jan Sensier: Val and I both have anecdotal evidence from patients who have described fragmentation in the way in which they have received services.

Q119 Andrew George: They saw fragmentation?

Jan Sensier: Yes.

Q120 Andrew George: A lack of continuity of their care?

Jan Sensier: Yes. I have a story that one of our patients has shared with me about her own journey through breast cancer care and the disconnect between the hospital and community service—and, actually, the disconnect within hospital services as well. She was advised one thing by, as she puts it, Dr B, another thing by Dr K, and then something else by the district nurse.

Q121 Andrew George: Is this any more so than exists in any other health economy anywhere else in the country?

Jan Sensier: The trouble with anecdotal evidence rather than quantitative evidence is that you cannot answer that question particularly. It is certainly a start.

Q122 Andrew George: Is the quantum of fragmentation in this particular arena—in this particular specialty, in this area—greater than you are aware of anywhere else in the health economy?

Jan Sensier: I do not think I can answer that. I do not know is the answer to that.

Professor Ham: To answer that question, you would need to have an agreed measure of the extent of integration, either in Staffordshire or compared across the country. Sadly, there is no such agreed measure.

Q123 Andrew George: I just wanted to be clear in my own mind as to why you appear to have snatched at a pioneer project. It seems to be on the back of anecdotal information and stories. Is that right?

Jan Sensier: No, I do not think that would be true to say at all.

Q124 Andrew George: That is all you have told me so far.

Jan Sensier: None of us has made the decision to go down this route. What we are involved in now is supporting the public engagement with the route that has been chosen. I think the question would have to be asked of the programme, because they will have the evidence about why they have chosen to go down this route, which they have explained. Obviously, in the leaflets and work that I have seen, it has been explained at a very high level. I cannot give you quantitative measures. They do tell us that the outcomes were worse in Staffordshire and Stoke on Trent than in the country as a whole. I have taken that at face value. I have not dug deep into the statistics to verify that. The programme should be able to give you that.

Q125 Andrew George: But you have both been persuaded that it is worth while.

Jan Sensier: No; I have not said we have been persuaded. Our job is to get involved in making sure that the public and patient engagement is there.

Q126 Andrew George: I understand that. Dr Maskell, you have written in *The Guardian*, as has been referred to already. Your opening remarks also indicate a level of scepticism about this project. Is that fair to say?

Dr Maskell: Yes.

Q127 Andrew George: From a clinician's perspective—and presumably you are talking about secondary clinicians—there is not only a lack of consultation, which you have enlightened us about today, but a level of scepticism that this is the solution and a concern that the time scale, from what I have understood you to say, will close off the possibility of other solutions coming along in the meantime. Is that a fair reflection?

Dr Maskell: Professor Ham may correct me on this, but the concern is that tying into a very long-term contract runs the risk that, if whoever is the provider decides at a point along the journey that it is not working out to their satisfaction, and that they have no interest in prolonging it beyond the period, you will find yourself tied into a contract which is not working for anybody—neither the provider nor the local patients. There is a risk that you might see the quality of service deteriorate in that situation. That has been the experience with one or two other procurements.

Q128 Andrew George: What do you think are the implications of having a primary provider? Are you persuaded that this will result in greater integration than exists at present from a clinician's perspective?

Dr Maskell: No, I am not persuaded that it will, but I accept that we should all be looking for better ways to integrate care. I do accept that this is a valid model, which deserves testing. Whether it should be tested on this scale in this area of the country is what I am questioning.

Q129 Andrew George: In answer to a previous question, you indicated that appointing more specialist nurses might provide the necessary glue to paper over the cracks of the fragmentation which currently exists. Is that a reasonable reflection of your view?

Dr Maskell: Again, there is an expert on my left. If you could do the controlled trial whereby you implemented something like this prime provider model in one area, and then in an adjacent or other area where you simply invested in more front-line staff, it would be absolutely fascinating to see which one ended up with better outcomes, but I do not see how you could ever do that.

Q130 Andrew George: Professor Ham, do you have any comment on that? Have you, from the King's Fund perspective, reflected on whether there should be a less "throw it all up in the air and start again" approach, and whether bringing in some specialist nurses in this case might provide the solution?

Professor Ham: I want to go back to where we started and then come on specifically to your question. There is a choice with these innovative forms of how you commission integrated care. You can start very small, and therefore minimise the risks, because the risks are real, as I said right at the beginning. That is what some parts of the country are doing. For example, one of the case studies we looked at was musculoskeletal services. It is a much smaller budget with a much more defined group of the population. If you are going to make any mistakes, you could argue that making mistakes with a service like that will mean that the damage, if it goes wrong, will be much less than taking cancer services across the whole of a big county like Staffordshire.

The counter argument would be that, given the scale of the financial and quality challenges facing the NHS and social care, now is the time to be bold. If I can use the royal "we" here, the NHS is not going to address those challenges by small-scale, even if well-intentioned, innovations around relatively limited services like musculoskeletal care. If you are going to do that and be bold, then clearly the risk appetite has to be high and you need to be very confident. I am sure you will want to ask the CCGs this because at the end of the day they are in the driving seat. What is their plan for managing risk over the period of a contract like this? What reviews have been built into that 10-year period? What data will they be requiring from the chosen provider, assuming they go ahead with this—that is not a given, as I understand it? How, from a commissioner point of view, can they give this Committee and the population of Staffordshire the reassurance that I am sure everybody would like?

Q131 Andrew George: I have one further question for Dr Maskell. In relation to the Royal College's trade union role on behalf of radiologists, for want of a better expression, could you reassure me in respect of the extent to which your scepticism is the product of a protection of your members' jobs? Is one of the potential outcomes of this new model that some of your radiologists would be made redundant by the introduction of a new primary provider that would not include the current provider's service?

Dr Maskell: Thank you for asking, but no, that is not a concern on two counts. The Royal College is not a trade union.

Q132 Andrew George: No; I know that, of course.

Dr Maskell: It is a charity and a professional body. With around half as many radiologists in the UK as the rest of the western world has, we have no shortage of work to do and there are no shortages of opportunities for radiologists anywhere in the country, including in Staffordshire. I do not think there is any serious risk. Certainly, one of my concerns is not a shortage of jobs for radiologists.

Andrew George: That is very helpful; thank you.

Q133 Chair: I want to ask a question on behalf of Andrew Percy, who has had to slip away. He was going to ask whether the procurement process should be halted because local circumstances make it difficult for some of the local NHS providers to make a competitive bid. Do you think that is a fair comment?

Dr Maskell: I do not work in the locality, so I cannot give you detailed local knowledge. I do think that part of the rationale for setting this up and conceiving it in the first place was the multiplicity of different contracts and providers. Conceivably, with the dissolution of Mid Staffordshire Foundation Trust, that has been rationalised to a degree already, or is being rationalised. Perhaps some of that rationale is not there to the extent that it was when it first started.

Professor Ham: If anybody had any certainty as to when things will be stable in Staffordshire around the provider landscape, then that would be a perfectly good question.

Jan Sensier: Just to add to that, the fragmentation in Staffordshire means that something has to be done to try to bring the various commissioning bodies and the various provider bodies together. If this is a pathway for doing it, there are risks about fragmentation into other silos, but anything that helps bring those various bodies together and working better together in Staffordshire is to be welcomed.

Q134 Valerie Vaz: That is what the CCGs are supposed to do—not give it out to somebody else like a prime provider, whoever that is.

Jan Sensier: We have six CCGs in Staffordshire and Stoke-on-Trent.

Q135 Valerie Vaz: Well, give them a chance. There is an implication for Walsall as well.

Professor Ham: The CCGs can answer this better than I, but my understanding is that there are about 30 separate contracts at the moment for end of life care in Staffordshire, which I think speaks volumes about the extent of fragmentation around how those services are currently commissioned.

Q136 Barbara Keeley: I have a final question about the overall financial viability of trusts if they get into the position of no longer being commissioned to provide cancer care to patients in their local area. What hit might an NHS trust take if that is the case?

Professor Ham: A very big one. This can only be speculation. It is back to Andrew's question, if I may. With these big ambitious innovations in commissioning and contracting, I think, nine times out of 10, it is highly likely that an NHS provider will emerge as the chosen prime provider, because I cannot see private companies coming into the market wanting to take on that role with the expertise, the track record and the ability to do so. The incumbent NHS providers are so much better placed. I may be wrong, and please call me back in a year's time when all this is done and dusted and I will give my fulsome apology, but if you look at what is happening in Cambridge and Peterborough, their preferred provider around their older people service is precisely one of the local NHS providers. It will also mean that the chosen lead provider will then have to arrange sub-contracts with others—the hospices, the voluntary sector and maybe the private sector if they have expertise—to help it deliver on that prime contract. If, in one case out of 10, the local NHS acute trust in particular loses its role in that, then financially it will suffer a significant penalty.

Q137 Barbara Keeley: Would that be an intolerable hit? I do not know what proportion cancer patients would represent for an acute trust, but it is presumably substantial.

Professor Ham: It is, but again if you have a hospital in Stafford and a hospital in Stoke which is the local hospital that the population looks to for its specialist cancer care, if your local acute provider is not the prime provider, the chosen prime provider will almost certainly have to sub-contract with those local acute hospitals. One way or another, it seems to me that it is highly unlikely that they are going to lose the business, even if they are not in the driving seat in winning the contract to do so.

Q138 Barbara Keeley: Do you know if they are worried about this? Are other boards of the acute trust sitting around really worrying about this at the moment?

Professor Ham: Yes, they are, because this, as the Coalition intended, is a market kicking in around how money flows around the system. It is a competitive threat, and that creates a degree of concern and anxiety.

Chair: Thank you very much for coming today. We appreciate your time.

Witnesses*:* **Andrew Donald**, Chief Officer for Stafford and Surrounds and Cannock Chase CCGs and Chair of the TCEOL Programme Board, **Dr Jonathan Shapiro**, Macmillan Director of Clinical Engagement, and **Barry Attwood**, Non-Executive Board Member, TCEOL, gave evidence.

Q139 Chair: Welcome to the second panel. Could you introduce yourselves to everyone in the room, please?

Barry Attwood: I am Barry Attwood. I am a non-executive board member and I therefore represent the public voice, as well as the patient. I do quite a lot of the engagement of the public and patients. If you have any questions about that, please address them to me and I will try my best to answer them.

Chair: I am sure there will be plenty; thank you very much, Mr Attwood.

Andrew Donald: I am Andrew Donald. I am the accountable officer for Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups. I am the senior responsible officer for the transforming cancer and end of life care programme.

Dr Shapiro: I am Jonathan Shapiro. I am variously known as the Clinical Director or the Director of Clinical Engagement. My career has spanned researching and commentating on policy. That has been based on a clinical career as well as a career in management, in academia, on the non-executive side of the health service. It makes me a jack of all trades.

Q140 Chair: I will start by asking whether you can clear up an issue that was raised in questions to the previous panel. Where are we in the procurement process right now?

Andrew Donald: We have been through the prequalification questionnaire. That is a standard questionnaire that is sent out through all procurements, where we identify whether the bidders are fit and proper to go through to next stage of the process. We will be announcing the bidders who got through that PQ process in the middle of November, round about 7 or 8 November. The end result is that the decision on a prime provider will not be made until June 2015.

Q141 Chair: But you are well on the route in this process.

Andrew Donald: We are in the first part of it. The second part of it is what we call a competitive dialogue with a number of providers and groups of providers. We are hopeful that we will work with consortiums of providers, and not just an individual organisation.

Q142 Chair: I have one other technical question before we move on to David Tredinnick's questions. It concerns the position of South East Staffordshire and Seisdon Peninsula CCG and the East Staffordshire CCG. Could you clarify whether they are incorporated into this programme and what will be the position of patients in those areas?

Andrew Donald: Certainly. They are outside the programme. They are out of scope of the programme. They took an individual decision for various reasons not to be in the programme.

Q143 Chair: Do you know why that was?

Andrew Donald: Yes. Most of South East Staffordshire and Seisdon's provision is outside Staffordshire. They work with Good Hope Hospital, in the Heart of England Foundation Trust, and with services on a far wider footprint.

Q144 Chair: So they are facing in another direction.

Andrew Donald: Exactly. East Staffordshire, which is Burton, were in the programme and decided not to continue in the programme. We had a lot of discussion with them about that. They felt that in terms of priorities this was not a priority for them in relation to what they were already doing around other work that they got, and therefore they took a decision not to be in the programme. The actual programme covers 876,000 people.

Q145 Chair: But patients from those areas will be affected by these proposals.

Andrew Donald: They will and they will get the benefit, even though the CCGs are not in the programme. The potential is that they will get benefits from the outcomes and experience that we improve.

Q146 Chair: But, likewise, if there are not benefits and if it goes the other way, they will—

Andrew Donald: Correct, obviously.

Barry Attwood: I would add there that some of our patient champions, with whom we are engaging and designing the programme, are from that area.

Q147 Rosie Cooper: Mr Attwood, reading the notes, I see that they say you are a volunteer for a cancer charity, or that you were.

Barry Attwood: Yes. I was.

Q148 Rosie Cooper: Which one was that?

Barry Attwood: Roy Castle.

Q149 David Tredinnick: When deciding how to improve cancer and end of life care, what other models did you examine and reject in favour of the prime provider model?

Andrew Donald: This goes back two and a half years so I will try and keep the story fairly brief. The first thing was that we wanted to understand what the problem was. There is no reason for coming up with a solution if you don't understand what the problem is. We spent two and a half years talking to lots of different people—patients, the public and clinicians—to understand what the challenges were with the system in which they worked. We are not trying to make a judgment on the care people receive; it is a judgment on the system of the health service, which seems to be bounded by organisational boundaries.

We understood the problem. What people were saying was about continuity of care, poor communication, and not being able to navigate the system, and it led to really poor outcomes for some patients and poor experience. There are lots of patients who talked to me who have had really good outcomes. We have to learn from that.

We then looked at the evidence and said, "Right, what models would help us try to drive and commission better outcomes and experience for patients?" We used the work of the King's Fund because, as Chris said earlier, the evidence is pretty limited on the different types of models. We could have just used a traditional commissioning model, but we did not think that would work. We looked at the prime provider. We looked at alliance space contracting. We looked at two or three models. Alongside a bit of evaluation that we got from the Office of Public Management, we came to a conclusion that the prime provider model, or service integrator model, would be the one that we would want to explore further and start to move down a procurement route with, which is about one organisation taking responsibility for multiple contracts and multiple providers to develop an approach to integrating care. That evaluation has continued, so we continue to learn through the pioneer programme and adjust our approach as we move through the programme.

Dr Shapiro: If I can add to that, I joined the programme fairly recently. Given that I have done quite a lot of evaluations, I was able to almost do a bit of internal consultancy and get a bit of the story. The thing that emerged for me was, first, there is a long history of dissatisfaction amongst patients and the public about the degree of integration and the experience that they have.

Somebody asked about Macmillan's input into this. There is a starting point long before this. The feedback that Macmillan was getting nationally was that patient experience is not very good and there was room for an experiment, and in some way to try a different model. That led them, if you like, into this arena. There were also poor outcomes. Again, somebody asked about the figures. The reality is that the incidence of most cancers is higher in Staffordshire than nationally. The spend is higher than most places nationally and the outcomes are poorer than most places nationally. In terms of somewhere that needs something doing, it is clearly very strong.

The evidence is that some of that is to do with deprivation in the sort of population it is. Quite a lot is a British phenomenon: we tend to go to services late. Part of what we want to do is to get in much earlier with primary and secondary prevention.

Q150 Rosie Cooper: We have just heard from Healthwatch Staffordshire that there is a disconnect between primary and secondary care, and that there needed to be something new. Why would you construct a new system that did not engage with the secondary—

Dr Shapiro: Could I finish the story, if I may? The context is that there is a need. There is also a growing demand. We know that the epidemiology of cancer is going to get greater over the years. There will be more patients suffering with cancer as time goes by.

Just to answer one of the other queries, we know that at any one time there are about 22,000 people with cancer alive in Staffordshire. We also know that our consultation has involved upward of 10,000 people, so it is quite a large consultation by NHS standards, albeit mainly with patients. That is where you get back the most evidence. If you ask members of the public about something that they do not know much about, they tend to give you less of an informed view than if you ask people who are very involved.

Turning to the models, different ones were considered, and it was before my time. We stopped using the term "prime contractor" because that does raise images of one provider doing most of the provision. We see it as a service integrator—someone who will hold the ring on co-ordinating all these different providers. That is the reason for putting the contract through that organisation, so that they will then sub-contract with their providers.

Q151 David Tredinnick: You are saying that the other models were before your time. Does that mean you did not look at them and evaluate them as possibilities?

Dr Shapiro: Not me personally. There is a list here of many that we went through.

Q152 David Tredinnick: What I am trying to bear down on is this: why did you reject the other models in favour of what is essentially a radical scheme? What evaluation did you do of the other ones? Convince the Committee, please.

Andrew Donald: I have been a commissioner probably longer than I remember—about 20-odd years. I have seen every commissioning change since 1990. One of the ways I describe it is that over the last 15 or 20 years I have felt a bit like a commissioning electrician. We would commission parts of services and then the commissioners would spend the next 10 years wiring it all together. We had a debate about how we could get an organisation to work with CCGs—they remain the commissioner statutorily—who have the experience to do that wiring of those providers to work together effectively. We have used as much evidence as there is available, but actually we are creating new evidence because there are lots of questions in this process to which we do not know the answers. As part of the pioneer programme, that is the learning bit. We have to make adjustments as we move along, but that is where we came from with this. It was about patients not getting a good deal and not getting a good outcome. If you are in Cannock and you have cancer, you die early and we spend lots more money than anywhere else, but you do not have a good outcome and experience.

Q153 David Tredinnick: Much of the work of this Committee has been looking at integrated healthcare. We have been looking at the Health and Social Care Act and the authorities that govern the different medics and the organisations therein. There is another meaning of integrated healthcare prior to that, and that is integration of mainstream allopathic medicine and complementary medicine. I happen to have chaired the group on integrated healthcare, alias complementary medicine, here for many years and been a member since 1988.

My experience of talking to cancer patients over the years is that they have been helped enormously by, for example, reiki, therapeutic touch and healers. The National Federation of Spiritual Healers does a lot of work. There are aromatherapists, reflexologists, homeopaths and herbalists. In this new integrated model, are these people, who alleviate suffering at end of life so effectively, getting proper representation?

Andrew Donald: That is the opportunity. One of the things we know about end of life care is that many people who die do not get a choice of where they die. Significant numbers of people die in a hospital bed when they wanted to die at home. That is a significant cost to the NHS. One of the things that we know is there are major gaps in service provision in end of life care. If you talk to members of the public and to patients they will tell you what those gaps are. With some of the services that you are talking about, particularly in end of life care, there is an opportunity to fill some of those service gaps with services like that. At the moment, we do not get that.

Q154 David Tredinnick: A lot of the ones I have mentioned are very cost-effective options and they are very popular. What you were saying about care out of the home is a different issue. I am talking about the availability of treatments which are non-mainstream and which particularly help those who are at the end of their lives.

Dr Shapiro: It may be worth rehearsing the procurement process. It is rather akin to procuring PFI, when that was still around. We procure on the basis of outcomes. We can tell our potential bidders, “These are the outcomes we want clinically: better survival, better patient feedback, better experience” and so on. What we do not do—and by the procurement process we are not allowed to do—is prescribe the mechanism. In the next phase—the competitive dialogue phase—the potential bidders will come up with ideas that we will then discuss with them. We will hone and refine their ideas, but, in essence, the difference between old commissioning and new commissioning under this idea—and it is not just the prime contractor—is that you procure for the outcome. The bidders then will tell you some of the mechanisms, and you agree the mechanisms with them. If they come up with complementary therapies, we can discuss it. It is not for us to prescribe.

Q155 David Tredinnick: I understand your point about prescription, not to be confused with prescriptions in this instance. Going back to Mr Donald’s point about care at home that I rather moved away from, this is linked to my next and last question. One of your stated objectives is a significant decrease in occupied bed days. That sounds brilliant, but I do not see anything here about a specific target that the prime provider must achieve. It is the sort of thing you might see in a manifesto document, not from my party of course, but perhaps from one or two others. Can you be a bit more specific?

Andrew Donald: Yes. The reason it is not in a document yet is because that will be part of the negotiation of the contract through the competitive dialogue. Let me give you some statistics that might be helpful to you. We know, for example, that in University Hospital of North Staffordshire about 2,700 people die every year in the hospital. A significant proportion of those—something like 75% of those individuals—would have been known to services and yet they still do not get the choice of where they die. Their average length of stay is seven to eight days in their last emergency admission. They have probably had two to three emergency admissions before that. That is at a cost of about £20 million.

If we could give people more choice, and more services at home and in the community, and release that resource, that would allow us to plough more money back into the NHS for better services for people at the end of life. That is the sort of statistical stuff and the sort of thing that will go into a contract on end of life.

Q156 David Tredinnick: If I were to talk about personal budgets, would that ring any bells?

Andrew Donald: Yes, absolutely.

Q157 David Tredinnick: The early trials showed that, if you give patients their budget, not only did the patients use the money more effectively and have a much better quality of life but the providers were more empowered and the costs to the health went down. Are you taking an interest in that?

Andrew Donald: People asked about the contract. There are two parts to the contract. The first two years will be about understanding what we do not know. As Professor Ham said, there are issues about understanding what things cost and how the pathways work. As part of that, the prime provider will produce what is called a set of commissioning intentions. One of the things that we want the prime providers or the organisations to do through the competitive dialogue is come up with innovative ideas about how they use public policy to drive change. I think personal health budgets are a good way of doing it.

Q158 David Tredinnick: In summary, if I am talking to my constituents in Hinckley and Bosworth this weekend, what reassurances can I give them, having talked to you this afternoon, about your work?

Andrew Donald: You can give them reassurances that what we are trying to do is improve the outcomes and experiences of patients. We are trying to do that through a new mechanism called a prime provider or a service integrator. I think the language is a little unhelpful, but the CCG retains responsibility for commissioning and will ensure that throughout this programme patients and the public are involved in ensuring that there are checks and balances on the prime provider to make sure that we hit the outcomes and experience that we want, and avoid the number of unintended consequences that could occur with a programme on the size and scale of this one.

Q159 Valerie Vaz: So you put a contract out and you are allowing this provider to decide or convince you about what they need to do to get certain outcomes—which are what?

Andrew Donald: They will come along to the CCG every year and say, "Here is what we want to achieve."

Q160 Valerie Vaz: So they get the contract first, and then they come back.

Andrew Donald: They get the initial contract for two years.

Q161 Valerie Vaz: But they don't know what it is that they are supposed to be doing; they come back and tell you, even though they have the contract.

Andrew Donald: No, no.

Q162 Valerie Vaz: But that is what you said. Tell us properly.

Andrew Donald: We produce a prospectus as part of the procurement process. That prospectus sets out the outcomes that we want.

Q163 Valerie Vaz: Which are what?

Andrew Donald: For example, in cancer care, the outcomes are about more people being diagnosed earlier so that they get better and quicker treatment and survive. We want to improve the survival rate for people in the four tumour groups that we are talking about. Instead of being only in the top 30 in Europe, we want to be in the top three in Europe. There are outcomes around the experience, so that people can tell us, "We are having a really good experience and we don't have to explain five times who we are and what our disease is," because we get lots of messages back on that.

On end of life, there is the outcome around choice of place of death. There is the outcome about more services in the community, out of hospital. All of those are measurable. What we are trying to do in the prospectus is set out those things. What we then do through the dialogue is have debates and proposals from providers about how they would meet those outcomes.

Q164 David Tredinnick: So this is pre-contract.

Andrew Donald: This is pre-contract. Then, once we have gone through the competitive dialogue, we stop the dialogue and there is then a formal set of proposals that would come from the bidders about how they will then deliver the service and the costs of those services. Then the decision will be made on the preferred provider, which will be in June 2015.

Q165 Valerie Vaz: And you are telling me that 876,000 people in Stoke and Staffordshire want this.

Andrew Donald: No; I am not at all telling you that.

Q166 Valerie Vaz: Yes, you did. Do you think they understand this?

Andrew Donald: I do not think they do.

Q167 Valerie Vaz: Do you think you should go ahead and waste public money and put this process in that nobody understands?

Andrew Donald: No; there are two things. In relation to the public money debate, we have Macmillan as a partner and we have to be really respectful of that. They have put the resources in to support this programme. In terms of use of public money, there is a very limited amount of public money going into this programme. It is probably about £150,000.

Q168 Valerie Vaz: When people go out and come back in again, are they paid for all this? What are the transaction costs in relation to the contract going out and people coming back and you picking the provider? No one is going to do it for nothing, are they?

Andrew Donald: No, not at all.

Q169 Valerie Vaz: So what are the transaction costs?

Andrew Donald: For the prime provider, there will be what is called a management fee.

Q170 Valerie Vaz: How much is that?

Andrew Donald: That is commercially sensitive because it is part of the procurement process. If we give a figure out, then every bidder will bid to the figure. We are in the middle of a procurement process, so I cannot answer that.

Q171 Valerie Vaz: I am just trying to work out why you are here explaining something to us when you are in the middle of a commercial process. You are actually saying to us that it is already happening and already down the line, and there is nothing anyone can do to stop this, even though the people in Stoke don’t want it.

Andrew Donald: No, no.

Q172 Valerie Vaz: Explain it to me.

Andrew Donald: There are thousands of people with whom we have engaged, including clinicians I might add, who say that this is the right thing to do and they want us to work with them to develop this approach. There is another group of people who say that this is the wrong thing to do. Both Jonathan and I have gone to big meetings of those people. We were at one in Stoke town hall a few weeks back. There were 300 people there who clearly did not want this to happen. Our job is to listen to what they are telling us. As a commissioner my challenge is, do I deal with the 7,000 or 8,000 people who say, "We want this," or do I go with the 8,000 people who don't want it?

Q173 Valerie Vaz: Can I just stop you there? You actually mentioned that there were many responses. Is there any way you could publish all those responses?

Andrew Donald: We have published it.

Q174 Valerie Vaz: In favour and against?

Andrew Donald: We can publish all the information of all the groups and all the people we have spoken to. Clearly, we cannot produce the individuals because there are all sorts of information given to us.

Q175 Valerie Vaz: I just want numbers.

Andrew Donald: There are 33 pages of detail about the people we have engaged with. We can also give you information about the people who are not as happy about this. There are two groups. One is a group around an ideology about the method we are using. They do not disagree that they want us to improve outcomes and experience; they disagree on the method by which we are doing that. There is another group who already believe they get good care. I was with the north Staffordshire moles group, which is the melanoma group. The melanoma group told me lots of stories about how they get really good continuity of care led through the system and it works for them.

The challenge for us is that if we have 4 million people by 2030 with cancer—and we only have 2 million now—how can we make sure that everybody gets that level of service?

Q176 Valerie Vaz: What sort of engagement have you had with the local MPs in the area and what is their view?

Andrew Donald: I have met with a number of MPs and my colleagues have met with a number of MPs. The Labour MPs have clearly said to us that this is privatisation of the NHS and that they do not agree with it. That seems to be an ideology thing. We debate that with them. I have had debates with Joan Walley and others.

Q177 Valerie Vaz: And you are saying it is not privatisation.

Andrew Donald: We are being absolutely clear it is not privatisation.

Q178 Valerie Vaz: It is not privatisation?

Andrew Donald: No. It is about choosing an organisation or a group of organisations to help us integrate care.

Q179 Valerie Vaz: I just want to go on to the governance. You have this prime provider who is—what? Is it a public limited company?

Andrew Donald: We do not know. It could be private sector, public sector, voluntary sector or a group of them. It could be three or four of them together.

Q180 Valerie Vaz: I keep getting really confused about this. There is £1.2 billion of public money going out somewhere but you don't know who it is and you can't tell anybody.

Andrew Donald: No, it is not.

Q181 Valerie Vaz: You have this prime provider but you don't know who it is. You do not know the entity. They can sub-contract to other people; is that right?

Dr Shapiro: In the end, by this time next year, there will be—

Q182 Valerie Vaz: Can they sub-contract to other people?

Dr Shapiro: Yes.

Q183 Valerie Vaz: Right. So they can sub-contract to other people. What sort of accountability line is there from these other people right back up to the CCG and right back up to the Secretary of State?

Dr Shapiro: That is the key link. At the moment, the CCGs are managing 60 different contracts, all of which are relatively small in the scheme of things. They will now manage one contract with a service integrator.

Q184 Valerie Vaz: I have asked you a question about accountability. I understand all that. What is the line of accountability?

Andrew Donald: The line of accountability is through to CCGs, the governing bodies; through to the two local authorities, Stoke-on-Trent and Staffordshire county council; through to the regulators, which for us is NHS England; and through to the Secretary of State.

Q185 Valerie Vaz: So if I ask the Secretary of State about this contract, what will he do? Will he turn round to me and say, "I can't; it is commercially sensitive and it is up to the local groups"? Is that right?

Dr Shapiro: He will today, but next June, when this process is finished, it will then all be public. We are talking in the middle of a process where there are a number of bidders. We do not actually know who the bidders are, because we are not part of the procurement process. That is deliberately so, because we are having this sort of conversation. There are a number of different bidders, we think, who will then come up with a model. During the next phase, that model will be clarified in each case. The number of collaborators, the consortiums and all those sorts of things will then be formed. By the time the contract is let, which is about this time next year, that will all be completely transparent.

Q186 Valerie Vaz: What if the prime provider is a limited company? Does the public have access to any of its accounts or anything else, or can they FOI them and find out what they are doing? Is there accountability?

Andrew Donald: As part of the first part of the process, any organisation that puts forward a proposal to bid has to set out all its company accounts through the pre-qualification questionnaire. One of the things we need to make sure of is that whoever applies not only has the skills and expertise but the appropriate financial backing to ensure that they are good enough to go forward to the next stage. If there were any doubt about that, they would not proceed to the next stage.

On about 7 November, we will announce the bidders for cancer and end of life: the two programmes. The interesting challenge for us is that the bidders do not have to reveal at this stage who they are working with. We have encouraged the bidders, through bidder days, to actually work together. My view is that I do not believe that just one organisation can do this piece of work. I believe this could be about the NHS working with the third sector and working with the private sector.

Q187 Valerie Vaz: I want to go back to your consultation. You said you had consultation with clinicians. Could you say who they are?

Andrew Donald: I cannot give you the names.

Q188 Valerie Vaz: Could you write to us and tell us?

Andrew Donald: Yes. I can tell you which clinicians we have met, because I was involved in some of the meetings. At Mid Staffs, I remember I met 10 clinicians on that day. I remember explaining what we were trying to do. I remember the clinicians actually agreeing that—

Q189 Valerie Vaz: Just tell me. Is the University hospital happy with this process?

Andrew Donald: No; the chief executive is not.

Q190 Valerie Vaz: What are you doing to allay his or her fears?

Andrew Donald: I work closely with the chief exec because of the Mid Staffs dissolution. I am explaining to him what we are trying to do here, but I am aware—because he has put it in the newspaper—that he is one of the bidders.

Q191 Valerie Vaz: The chief executive is not happy with it. Say there is a big important thing, like someone needs an operation. Where do they go then with these prime providers? Would they be going back to hospital?

Andrew Donald: I do not believe, in this model, that the hospital that is providing cancer care will not be the hospital providing cancer care in 10 years' time. I believe this is about trying to get the hospital, community services and voluntary sector to remove their boundaries and start working together for the benefit of patients.

Q192 Valerie Vaz: Will they be going back to the hospital?

Andrew Donald: Yes.

Q193 Valerie Vaz: So you are not engaged with the hospital; the hospital does not like this; but you will still be using the hospital for difficult things. Is that right?

Andrew Donald: No. We are engaging with the hospital and we continue to engage with the hospital because we commission services from them other than cancer care and end of life care. If you ask the chief executive of UHS, he would say that we are doing exactly the right thing on end of life but he does not like the cancer one.

Q194 Valerie Vaz: Can I just focus on the cancer one? Cancer covers a lot of areas. I do not agree with you because I think breast cancer has actually come down a huge amount because of the screening. Certainly, that is the case with prostate cancer. It is not the case that cancer care is getting worse. It is getting better in certain instances. Where would that fit into your little set-up?

Dr Shapiro: We have included screening as part of the package. We have the involvement of the specialised commissioners, which was really quite helpful and surprising, so that we can include some of these more regional services in there. They will be within the system basically from diagnosis right through treatment. For the individual patient, which was where you started from, the experience will not be that different, except to improve.

The reality is that we cannot contest radiotherapy. The NHS provide it, and they are going to carry on providing it. There is a little bit of ginger in the system because there is a bit of contestability. We are encouraging them to talk in a more complete way, whoever "they" happen to be, with the community, with the GPs, with the hospices and with whoever, so that the whole package, orchestrated by this service integrator, becomes much more seamless. If you want my personal view, I think the GPs need to be absolutely at the centre of this. Someone earlier said that, where cancer ends, another disease starts, so the GPs need to be included. We are encouraging the GPs to try to come in with some of the bidders. Again, it is encouragement in a non-specific way. I am not allowed to go and tell them any more because I do not know any more.

Valerie Vaz: My colleague is anxious to come in so I will pick up where I left off later on.

Q195 Andrew George: I want to come back to a question I asked the previous panel, which was what was broke that needed fixing. I saw in the corner of my eye a lot of body language indicating that there was a desire to answer that question off to stage right. Now you have the opportunity.

From what you were saying earlier, Dr Shapiro, it seems to me that you were saying that cancer outcomes were worse. Mr Donald, you were indicating that there were a lot of patients who died unnecessarily in hospital. I was slightly concerned about you assessing that in terms of money rather than the quality of patient care. Are those the two bases on which you are saying that the system is broke and why you want to mend it?

Barry Attwood: Can I answer that, Mr George? A lot of patients feel that they are falling through the system and through the gaps. You get the scenario where a little old lady is suffering some sort of illness and she goes to the hospital. She cannot get transport there because that is not integrated. The ambulance turns up five hours early and she is sitting around at the hospital. We get stories like this all the time. People are coming to us all the time and saying to us, "The communication is terrible. We are not being told about our condition or what happens next. We are not getting any information about what we should do now, where we are going now and what the outcome might be." In my view, that is scandalous.

What we are trying to do is fix that. We are trying to bring the whole system together. Ms Vaz said earlier that we have all these little silos of different cancers. That is wrong. That is not what we want. As Andrew said earlier, we are trying to wire them together.

I will tell you something now. I used to build sewerage works. It is quite a good subject. You cannot stop the flow into a sewerage works. I suppose you could give the whole of the population a cork each and hope for the best, but you cannot stop that flow. When we are designing the sewerage works, we have to build in for anything that might go wrong in that system. That is what we are trying to do. That flow is going to keep going. Patients are just like the sewage in my sewerage works. They are coming all the time.

Q196 Chair: I am not sure that is the right analogy, but we get the point.

Barry Attwood: Sorry, but at the end of that example there is clean water going into a river.

Q197 Valerie Vaz: We are talking about sick people here.

Barry Attwood: I know, and you cannot stop the flow of the sick people. All I am saying is that it is like that.

Q198 Andrew George: I can understand your point about integration. I can hear the headline writers in your local newspapers playing on those words, so be careful. Clearly, the purpose behind setting the pioneer up was not on the basis of the anecdotes that Mr Attwood has just described. It is on the basis of statistical assessments of poor outcomes and greater cost to the service for those who are assessing the cost, and patients not dying in the place that they choose.

Andrew Donald: I do not think it is about the greater costs, actually.

Q199 Andrew George: Everyone wants to be a pioneer and not a laggard so one can understand why you want to be a pioneer. In terms of what it is there to achieve, what is broke that needs to be fixed? That is what I fully need to understand beyond the anecdotes and beyond the sewerage system.

Andrew Donald: We have an NHS system that is totally and utterly focused on delivering what the system wants. The NHS does not focus on the individual citizen. What we are trying to get here, through integration is—I apologise for the jargon—a person-centred approach. What patients and the public tell us is that the system does exactly what the system does. This is not anecdote but real evidence. A lady with breast cancer unfortunately had a mastectomy. The day she went to the hospital and said, "I've now got a lump in my other breast" she was told that she had to be re-referred through the system to see somebody again. So she had to go right back to her GP. That is the system working for the rules of the system. It is not the system working for that individual patient. Those are the sorts of things.

Dr Shapiro: Another way of putting it is that the system focuses on throughput. It is just churning people through. It is not patient-friendly and it leads to worse outcomes. Both of those points are right. I would not discount the anecdotal bit. Yes, there are lots of stories around, but, again, with Macmillan's involvement in this, they have had thousands and thousands of patient contacts, albeit nationally, saying that patients are unhappy. The anecdote is really important. If you combine that with disproportionately poor outcomes in the area, then you get something that is broke.

Q200 Andrew George: But the anecdotes Mr Attwood was referring to before he invited us to look at the sewerage system were—

Barry Attwood: I am sorry; it was meant to be a joke.

Q201 Andrew George—those of transport arrangements. To what extent are transport arrangements a part of this integrated service?

Andrew Donald: It is all part of it. I go back to two and a half years' work gathering intelligence and information from a large range of people in Staffordshire about the system.

Q202 Andrew George: So transport providers are involved in this pioneer project.

Andrew Donald: All providers. We have multiple contracts. Somebody said earlier, "Why can't the CCGs do this?" It is a good question, but the reality is that we have 60-odd contracts across end of life and cancer.

Dr Shapiro: The procurement process won’t mention this per se; it will say that we want a seamless service. A bid that does not include the transport is going to be disadvantaged over one that does.

Q203 Andrew George: In terms of measuring the outcomes, when you look at the outcomes of this new service, what will be your ultimate measure of outcomes? Will it be numbers of patients who die in hospital?

Andrew Donald: To keep it simple, there are five outcomes. What is the outcome for the organisations involved? What is the satisfaction outcome for the patients, the public and clinicians? What is the clinical outcome—so, survival rates, better treatment? What is the activity-based outcome—that is, what is now happening that was not happening before that is of benefit to those patients and individuals? What is the resource utilisation outcome, so are we using the money that we have in the NHS better than we were using it previously? Those are the five rounded outcomes.

We then overlay on that the Macmillan nine outcomes. Macmillan have an outcomes frame that they have worked on about the way people are treated, the way they are communicated with, etc.

Q204 Andrew George: Those are evaluations, but would you be saying, for example, that you reduce avoidable emergency admissions?

Andrew Donald: Yes.

Q205 Andrew George: Is that one of your five outcomes?

Andrew Donald: Yes; that would be an outcome.

Dr Shapiro: What Andrew has mentioned as the outcomes are what we want the work to produce. The fact that we are a pioneer needs to be mentioned. We try to learn as we go through evaluation of the process, addressing some of the criticisms that you are making, and questioning. Saying, “Is this the best and what can be learned at every stage?” is really important.

Q206 Andrew George: Who will be undertaking that evaluation?

Dr Shapiro: A number of people.

Q207 Andrew George: Independently?

Dr Shapiro: Yes. There are a number of agencies involved—probably too many. There is room here for really rigorous evaluation.

Q208 Chair: I want to clarify one point. Could one criticism of this be that you are shifting your own responsibility as commissioners commissioning this integrated pathway, and that you are handing that over to a prime provider and saying, "You commission it all over again"? In other words, we have two layers of people commissioning and deciding the service. Listening to this, that is what is sounds like.

Andrew Donald: It could be, but it isn't. The CCG has to retain its statutory responsibility as the strategic commissioner.

Q209 Chair: Yes, indeed. You retain your responsibility but you are outsourcing it to someone else to commission an integrated pathway.

Andrew Donald: We are working with them. That is because we cannot do it ourselves. We are not big enough. We have a limited level of resources to do that. We looked at the model and asked, could the CCGs do this? We did look at the evidence for that.

Q210 Chair: But joining together as a group, you would have one person in the CCG taking responsibility for the other CCGs, as other CCGs do.

Andrew Donald: Even that. I have a total budget of £351 million. We have hundreds of contracts. The Francis report, if you look at recommendation 130, was very clear that we had to manage contracts more forensically than in the past. The CCGs are not big enough to be able to do that, and they need help and support to do it.

Dr Shapiro: One of the things we are going to be looking at very strongly is the capability of the CCGs to manage this. It makes it a much stronger, much more strategic accountability. Going back to the competitive dialogue, when we are discussing with potential bidders the accountability mechanisms, what will be reported on, what is an operational target and what is an outcome target will be negotiated at that stage, before the final bid is let.

Q211 David Tredinnick: Dr Shapiro, you have talked a lot about the structures of the organisation. I want to ask Mr Attwood whether he is content with the way things are going. You have come out of retirement and got involved, as I understand it and according to the notes I have here, because you believe "that it was possible for people to have a say in the way we are treated by becoming part of the decision-making process." It says that you are "an advocate of putting the patient at the centre of care, seeing a patient as a person, not as a disease or condition and…a believer in the patient voice as an effective agent for beneficial change."

I have heard a lot about structural change in the form of centralisation through the prime provider service integration model. I am slightly concerned that I have not heard a lot from you. I would like to be convinced that, in your involvement as a non-executive director of transforming cancer and end of life care, you are content with the way this process is going. My colleague here has questioned some of the accountability aspects. How does it feel for you, as somebody who is primarily there to stand up for patients?

Barry Attwood: We have two organisations where we officially feed in information. We have patient champions. To get these patient champions, we went and stood in market squares in the snow and in supermarket foyers. We handed out leaflets to people and interviewed people. We asked them for their stories and people came forward and gave us their stories. When we asked these people, “Would you like to be a patient champion?” some refused and others did not. They came and we meet every month. They all come together and usually about 25 people turn up at our monthly meetings. We have a further 30 people or more who are in touch with us by e-mail all the time. They are constantly feeding us their stories and information. They are talking to other patients. We are trying all the time to recruit more people by going out and having our roadshows, going to little community groups and so on. We want to get these people to come in and talk to us and tell us what their experience is. This is to somehow find a way of improving the system.

The information from them is then taken by us, the non-executive board members, to the board and we bring it into the programme. We also have a forum of various organisations throughout the county. They are pressure groups, if you like, and various community interest groups who come along. Healthwatch are independently involved, apart from Mr Sneddon, in this. They come along and discuss the same things. We get information from them and we feed that back to the board. We feed it back all the time into the team. We go out all the time and talk to community groups anywhere. In Stoke on Trent, we have something called Community Health Voice. I shall be there on Thursday evening. We go and talk to people there. About 30 people regularly turn up there. They feed me the information because I am a member of it and I bring it back.

We go and talk to PPGs. We talk to any number of groups. We try to get this information and feed it back to the team so that this information is part of the design process. Furthermore, the patient champions are part of the procurement process. We have just done the pre-qualification questionnaire. The questions that came back from the bidders were looked at, not just by professionals but by these patient champions and other members of the community. We can look at this and get a fair assessment of what it is that people need. That is all part of the design process. I think you must take this into account when you are thinking about what we are doing. It is very much the patient voice.

Chair: Thank you very much, Mr Attwood. I am quite keen that we now move on to Barbara’s questions.

Q212 Barbara Keeley: There is a question around the relationship between the prime provider and primary care, particularly GPs. I do not know how many GPs there are in the area of the contract, but will the provider have any control of a GP activity, performance or remuneration? In terms of context, you have said a number of times about more choice in end of life care being one of the outcomes. Since I have been an MP, I have had at least two very catastrophically bad end of life care situations. It was very poor care and catastrophic for the person left behind. This whole thing about choice to die at home is not just the honeyed thing that can go all right and be a wonderful blissful end for people. If it goes wrong because the GP is under pressure, because the district nurse service is under pressure or because all those local and community services are under pressure, then it is a choice people end up wishing they had not made and their families wish even more so that they had not made because the burden falls entirely on family carers. It might be cheaper and you might be meeting choice but, if it goes wrong, it is terribly wrong.

Given that there are, in my experience, GPs who get it wrong and sometimes hospital doctors who get it wrong, and that you aim to improve the outcome, how can the prime provider really control GP activity and GP performance and remuneration? In the most recent example I have had, the GP failed to prescribe in the last few days the pain control that the patient needed when she moved into severe pain for her last few days. We still have the remains of concerns about that. It is the second time as an MP that I have had a catastrophic end of life care failure because of failure to prescribe pain control. A lot will hinge on the GP. What is that relationship going to be?

Dr Shapiro: There are two elements. GPs are doing what GPs do and that, as you know, is not under CCG control at the moment. Again, as a commentator I have misgivings around that. That is still under the area team. With the advent of co-commissioning, it may be that we can get a much closer relationship with the area team and the CCGs will begin to have a say in how the delivery of primary care itself is—

Q213 Barbara Keeley: Just to be clear then, only "may be." You are going into a situation of contracting with prime providers and you do not control what the GPs do.

Dr Shapiro: We do not control what they do as GPs in primary care. If the service integrator decides that part of the model, with our agreement, is to do more in the home and to pay GPs to provide more than what normal GPs do, then it is perfectly in their gift to pay them to do that. We have been approached by many GPs who say, "You are expecting us to do an awful lot more for no more money," and we are not. They carry on doing what GPs do under the GP contract, but under the cancer contract—and that is why I am encouraging them to be involved—it will be a much more collaborative and concrete relationship between the service integrator and the GPs on an enhanced payment. If and when co-commissioning comes in and we can control general practice as well as the specialised thing, then we will have much more control, and the real weaknesses in general practice that have always been there can perhaps be controlled better than they are at the moment.

Andrew Donald: The interesting bit of this is, of course, that GPs are commissioners as well. The GPs were involved in developing the programme because it is about clinically-led commissioning, not management-led commissioning. The really interesting bit of this is, do we know who the people are who might unfortunately die in the next 12 months? The answer in Staffordshire is that we don't. At the moment, it is 0.02% of people who are on end of life care registers. We do not really know who anybody is.

Q214 Barbara Keeley: Just to be clear about offering more choice, people would be limited in their choice if you were not sure or if you did not have a contracted GP at the end of the line. These failures that I have talked about—and I am sure they happen in lots of parts of the country—are where somebody lets the patient down in terms of no pain control and they die in agony. That is a dreadful experience. Choice would be limited, depending on whether the GP was in the contract and being paid and directed or not.

Andrew Donald: Not necessarily.

Q215 Barbara Keeley: How would it work then?

Andrew Donald: One of the big pieces of work we have to do is to have integrated information. One of the things about end of life care is that information is not shared across boundaries with different organisations and with GPs. Therefore, some of the problems we have and some of these issues with pain is because people cannot get hold of a single record to tell them about the patient and what is required. One of the parts of this programme which we are developing in Staffordshire and in Shropshire is an integrated care record. It is through a big project called the text project. That will be about giving better information to clinicians, GPs and acute providers.

Q216 Barbara Keeley: From the examples I have seen, I do not think information is the source of the issue. I just don't think it is. I worked for many years in IT, so I would not hang your faith on that.

Andrew Donald: But patients are telling us that.

Dr Shapiro: I think you raise a really valid point around the variability of standards, particularly in general practice, around the country. That is a wicked issue and it has been around for very many years. My guess is that, except in very isolated areas where there is only one GP, the service integrator will work with the GPs who are more interested and who are better and there will be some choice. In the end, you are right, and we should be able to manage all general practice. At the moment, that is not in our gift.

Q217 Barbara Keeley: We understand that GPs are under a lot of pressure. I know that in the example that I quoted the district nurse service is under pressure too. I want to ask a final point because I did not have a chance to ask it earlier. It has been quoted that Macmillan have invested £4 million in Staffordshire and Stoke-on-Trent over a five-year period. Is that the case?

Andrew Donald: That is not the investment in this programme. I understand that is correct for Macmillan, through Macmillan nurses and other projects, but they do that across the country, obviously.

Q218 Barbara Keeley: You said earlier that the spend was minimal on this integration project from the NHS because Macmillan had put in so much.

Andrew Donald: Correct.

Q219 Barbara Keeley: We have heard two or three times in this session how much Macmillan were putting into this in terms of resources. If you do not know the figure, we would appreciate having it later.

Andrew Donald: We can give you the figure. There are two separate things here. Macmillan do what Macmillan do already in all local communities where they provide resources through nurses and others to hospitals and community services. What Macmillan are doing with us is providing us with resources for infrastructure, for the programme team. That cost is round about £1 million over the life of the programme. There is then ongoing discussion with Macmillan about being part of funding the first two years of the prime provider contract, because Macmillan want to help to transform health services. They know that the health service itself is really tight in terms of its NHS finances and cannot do these sorts of transformation projects. That is the reality. There is not any spare resource to do that.

Q220 Barbara Keeley: I am confused. I think it was said earlier that Macmillan would not be taking over contracts. We have been concerned in this session to hear of some conflicts of interest. You have just said that Macmillan do what Macmillan do and they have nurses and so on.

Andrew Donald: In their normal charitable business.

Q221 Barbara Keeley: So they are putting resource into this because they believe in developing integration, but Macmillan will not themselves be any part of the provision.

Andrew Donald: No; absolutely not.

Dr Shapiro: Traditionally, Macmillan have worked on a very small scale. It is about Macmillan nurses; it is about coffee mornings and so on and so forth.

Q222 Barbara Keeley: I had one a few weeks ago.

Dr Shapiro: In recent years, as I understand it, they have gone for much more strategic projects because they want to help change in the NHS where the NHS cannot oil the wheels itself. We do not have the headroom in most areas. This is providing some headroom to try out a new way of doing things. Their only interest is to try this out to see what happens.

Q223 Barbara Keeley: It may be that you cannot answer this, Dr Shapiro, but I have to say, as a person who did run a coffee morning for Macmillan a few weeks ago, that I think this is a risky thing for Macmillan's reputation. As we have heard in this session, there are groupings of local MPs who are not happy with this. You have talked about hundreds of people at meetings who were not happy with this. This is seen as privatisation. As a charity, it seems to me that Macmillan is taking a lot of risk in making what sounds like a very substantial investment into a model which an awful lot of people who might have been your supporters don't agree with.

Dr Shapiro: It is not for us to represent Macmillan, because we are not Macmillan.

Q224 Barbara Keeley: But you are listed as being—

Dr Shapiro: I am a Macmillan appointee, if you like, but I work for the CCG.

Rosie Cooper: Hang on, this is more doublespeak.

Q225 Chair: What does that mean?

Dr Shapiro: The reality is that, because I am a non-exec director in a trust, I am not allowed to be employed by the NHS so I am employed on a contractual basis through the CCG by Macmillan.

Q226 Chair: So, in other words, Macmillan pay you to sit on the CCG board.

Dr Shapiro: They pay me to do what I am doing to facilitate the medical engagement and to help the project.

Chair: So that is part of the cost.

Q227 Barbara Keeley: So you are employed by Macmillan.

Dr Shapiro: I am actually a freelancer.

Q228 Barbara Keeley: But you are employed by Macmillan.

Dr Shapiro: I am not sure, technically. I am paid by the CCG, but the money comes from Macmillan.

Q229 Chair: Are we allowed to know how much that would be in total?

Dr Shapiro: It is what you might expect to get as an ex-GP.

Q230 Chair: When you say what you might be expected to get, for charities that can be anything from virtually nothing to something quite eye-watering. I do not want to put you on the spot, but if you felt comfortable to tell us what that was then that would be helpful. As I say, it is a matter for you.

Dr Shapiro: My fees are included in the fees of running the team and all the team are on salaries. We are not voluntary.

Chair: I know, but that was not what I asked. What I am hearing is that you are not comfortable to share it with us, which is fine because I do not want to put you on the spot.

Q231 Rosie Cooper: Hang on, it is absolutely not fine. Last Friday, a friend of mine whose father died of cancer had a coffee afternoon. I spent five or so hours dishing out tea because I believe in Macmillan. Are you telling me that my friend is still going to want to raise £1,000 thinking it is going to Macmillan nurses and to be used in that sort of charitable avenue, when actually she is propping up “strategic projects to help change the NHS”? I do not think all those little people out there raising money for cancer and for Macmillan to have Macmillan nurses will be happy to know that it is going on your salary, via whatever means it is—and you are not prepared to say what it is—and that Macmillan are hosting you. This is ridiculous.

Dr Shapiro: Again, we are not apologists for Macmillan. You need to address those questions directly to Macmillan. What I would say is that they are not being opaque about this. People know that this is a strategic project. If people do not want to support them, then that is up to them.

Rosie Cooper: I do not think the average person understands this at all.

Q232 Chair: What we would like to know is whether Macmillan is prepared to say exactly how much of fundraisers' money is going into this. That would be helpful to know.

Dr Shapiro: Yes, I am sure.

Andrew Donald: The answer, Chair, if you do not mind me saying so, is that we have to be respectful of the contribution Macmillan makes to helping us transform services, but the significant majority of what Macmillan does is what Macmillan does around charitable donations, nurses and things like that.

Q233 Rosie Cooper: Dr Shapiro has just said that Macmillan is going to go more into strategic projects to help change and transform the NHS. I wrote it down and it will be on the record. That is not what people are raising money for.

Dr Shapiro: This is what Macmillan is doing. I have just been told by the person behind me from Macmillan that they are putting £867,000 into the project.

Q234 Rosie Cooper: That is a hell of a lot of coffee mornings and a hell of a lot of hours where people have dished out coffee and raised £200 or £300. My friend raised £1,000. She had loads of people coming to her house. Would she do that next year? I'm not so sure she would.

Dr Shapiro: But at the same time Mid Staffordshire is an absolute disaster so we need to change the way the NHS does things. The NHS does not have the headroom to do it itself.

Rosie Cooper: So raise the money on that basis; do not raise the money by having people going out raising money for Macmillan nurses. This is duplicitous, as is the way you are paid and all the rest of it. It is silly.

Q235 Andrew George: On the basis of this project, it would be helpful to know from one of the 14 pioneers. I just wondered what the additional departmental budget is for the project for being a pioneer, or is there no additional budget at all given?

Andrew Donald: The original application for pioneer was on the basis of no resource backing from the Department. There have been small amounts of resource released to all the pioneers. It might be about £80,000 or £90,000 to help with the development process. As far as I am aware, there is no significant amount of resource behind the pioneer programme. It is much more about learning and sharing learning across the pioneers.

Q236 Andrew George: So it is development funding rather than project funding/

Andrew Donald: In effect. That is correct.

Q237 Andrew George: How will the project integrate with other services that are seeking to integrate in Staffordshire?

Andrew Donald: That is a really good question. If you take end of life care, for example, one of the debates is where does end of life care start? We know where it finishes but where does it start? Somebody with a long-term condition, say a respiratory disease, when do they become part of the end of life care system, so to speak? We had a debate about the last 12 months of life. We decided that that was not a good proxy. We decided to work with primary care—and this comes back to the point that was made earlier about primary care—to identify people as they reach that point and then make sure that they are on an end of life care register so that the services that are available to them are connected together. That is what we are trying to do.

Dr Shapiro: Andrew has skipped over a really important statistic. If there are 100 people who are going to die, there are about 25 of them that we do not know are going to die in any one year. They may fall under a bus, have a heart attack or whatever. There are 75 that we do know about.

Q238 Andrew George: When you say "people who are going to die," do you mean people who are going to die of cancer?

Dr Shapiro: No; of any illness. There are 25 that are unexpected and 75 are usually expected. We are formally recording those that we expect to die in this year and hence providing services, and it is well below 1%. It is one in 100. One of the things we want to try and correct, for people dying not just from cancer but from many other chronic diseases such as COPD, heart failure, motor neurone disease, Parkinson's and all those sorts of things, is to try and improve the end of life care for them. It will not happen all at once but that is part of the aims of the project.

Q239 Andrew George: In Staffordshire, I understand that there is an effort, just like everywhere else in the country, to better integrate the health economy with the social care economy.

Dr Shapiro: Yes, there is.

Q240 Andrew George: To what extent does your project integrate with the social care economy and to what extent are you integrating with the integrations, as it were?

Andrew Donald: You are probably talking about the Better Care Fund. The two councils—the county council and Stoke on Trent city council—are part of the pioneer programme. Social care, of course, does not look at people with diseases. It looks at people who require help and support, whether that is free to them or whether they have to pay for it. We have been working through with them how we make sure that they are part of this project, and it adds value.

The bigger integration is the fact that in my opinion there are too many organisations in Staffordshire and, perhaps, it will be argued, there are too many commissioners. Over a period of time, how do we now look at integrating those and use this perhaps as a catalyst for getting better integration of organisations working together? For example, community services needs to work in conjunction with the acute trust. At the moment, they are two separate organisations that really do not seem to work effectively together across boundaries. That is not because the people who are giving care are not doing a good job; it is the way the system is constructed.

Q241 Andrew George: But unless all of a patient's care is fully funded through continuing care—and these days you have to be virtually on your last legs to be entitled to continuing care, as we all know—being integrated to adult or children's social care is clearly going to be important, and, yet, if that is failing and the care and support available is not there, then those patients are going to find their way back into hospital avoidably. Therefore you need to integrate with social care.

Andrew Donald: Absolutely. There is already a list of areas of service where we are looking at integrated commissioning between health and social care in Staffordshire.

Q242 Andrew George: As part of your project.

Andrew Donald: No, outwith of that. My job is to ensure that I understand what we are doing within systems, this project and other programmes, and making sure those things work together effectively. That is the challenge. You are quite right, and one of the risks that Professor Ham highlighted was that in integrating services you could create more fragmentation. One of the challenges for us is to ensure that that does not happen.

Q243 Andrew George: In terms of potential unintended consequences, so you are bringing a lot of the services that are necessary for this full pathway of care for cancer services together—one understands that—have you assessed the potential for it to have a detrimental impact on the current NHS providers by effectively withdrawing the need for services?

Andrew Donald: My personal view is, yes, we have. I do not think this will have a detrimental effect on an acute hospital because they will still be the provider of care. What it will do is, hopefully, mean that double the number of people who are going to appear with cancer in the next 10 to 15 years can actually receive the level of service that everybody else is receiving, in an integrated way. I do not think we are talking about moving lots of providers around here and people around organisations. If we are doing that, we have probably failed. This is much more about how you get people to work more effectively together. That is the real challenge here. I was talking to the trades unions about that the other day. They were concerned about whether we were going to be moving people around.

Q244 Chair: Coming back to the point I was making earlier, effectively the prime provider is actually the prime commissioner. That would be a better description. They will be commissioning services from themselves effectively.

Andrew Donald: No. The language I would use is "managing agent."

Q245 Chair: Oh, my goodness. So we have the prime managing agent.

Andrew Donald: We need to find the right words.

Q246 Chair: You are using the term "prime provider" but it is actually a misnomer in a way, isn't it?

Andrew Donald: Yes, it is.

Q247 Chair: That body, whatever term you try to put on it, is effectively going to be commissioning services from itself. Andrew's point is, what if it is in their interests to shut down an existing service and commission themselves? There is genuinely a risk of conflicts of interest here, are there not?

Andrew Donald: There is.

Q248 Chair: How are you going to deal with that?

Andrew Donald: We have already been very clear, before we get into the discussions with people through the dialogue, that, if there is a provider of services already, we have to put safeguards into the contractual arrangements with that provider. For example, hospices have said to us, "In this model we could be eaten up by a big provider." That would be a bad unintended consequence of this. Therefore, if we are aware of that, we ensure that what is in the contract protects that from happening because that would not be good for patients or the public. The way we contract is really important here. That is why I have said all along that, if you can get a consortium of organisations working together as the prime provider, then you have checks and balances there between those organisations. You are absolutely right that that is one of the consequences we have to avoid in the way we set the contract.

Q249 Chair: Is this not just a co-commissioning model? Wouldn't you be better to look around the country to where in the country is the best model for providing cancer services and end of life care? What was to stop you from looking at the very best models and the best outcomes around the country and saying, "We are going to look at what they are doing there and we are going to have a co-commissioning body"? As you say, it is all about scale and each individual CCG is too small.

Andrew Donald: As we go along, we continue to gather information and intelligence from different parts of the country on what is going on. The evidence we are getting is that there is not what anybody can describe as a model like that. What people describe to us is a continuing fragmented system of care. People get good care in the individual interventions but it does not fit together.

Q250 Chair: What do other parts of the country do about that?
Andrew Donald: They just do what we do at the moment, which is commission by numbers. We basically commission activity.

Q251 Chair: The point is that, where it happens well and you get good integration, it is usually because you get good relationships between people working together.
Andrew Donald: Absolutely.

Q252 Chair: Do you need to have this very complex structure in order to make those relationships happen? Is your view that it cannot happen in any other way?
Andrew Donald: That is the question I continue to ask myself.

Q253 Chair: That is the big question.
Andrew Donald: The answer to that is that, if we had got that working across the NHS now, we wouldn't be looking at this sort of model, would we? Chris Ham said there was not a lot of evidence around what is happening.

Q254 Chair: But there are parts of the country where you have good cancer care.
Andrew Donald: Yes, absolutely. I would agree.

Q255 Chair: The other issue that has been brought up is that this is going to take place over a very long period of time.
Andrew Donald: Yes.

Q256 Chair: If it all starts to go badly wrong and people decide, "Actually this is not working," how will you be able to pull out of this? Do you have plan B?
Andrew Donald: Within the contractual framework, there will be appropriate breaks in the contract. Even though it is a longer-term contract, there are appropriate breaks in the contract year on year. We are taking advice through the—

Q257 Chair: Who will make those decisions?
Andrew Donald: It will be the CCG, as the commissioner.

Q258 Chair: So the CCG can say, "This is not delivering what we thought; we're out."

Andrew Donald: Correct. There are lots of things we don't know. That is why we are using Monitor, NHS England and the Department of Health to help us with this. We do not have all the answers. That is the really important point.

Q259 Rosie Cooper: How often do you see the breaks appearing?

Andrew Donald: In the two-year contract, there will be a break at the end of two years. During the eight-year contract, there will be the normal year-on-year breaks.

Q260 Rosie Cooper: So that contract could be broken each year.

Andrew Donald: It could be, yes.

Q261 Rosie Cooper: I want to ask you one thing that has been puzzling me all afternoon. I know the CCGs are the overall body, but where do you come from? You talk about being a board and you talk about non-execs, but appointed by whom?

Andrew Donald: We are a programme board that brings together the four CCGs, the two local authorities, specialised commissioning—

Q262 Rosie Cooper: So you have appointed yourselves.

Andrew Donald: No. It has come together under a memorandum of understanding which the governing bodies of those organisations have signed off. They have said, "We want our representative to be Andrew Donald on that programme board."

Q263 Rosie Cooper: So you have appointed yourselves, then. This is the target. How did you choose your non-execs?

Andrew Donald: We recruited them. We went out and advertised publicly.

Q264 Rosie Cooper: How many people applied?

Andrew Donald: I think about 70 to 80 applied. I remember because I did the—

Q265 Rosie Cooper: And you function as a board; i.e. five, five and a chair.

Andrew Donald: I can give you the details, but not now.

Q266 Rosie Cooper: Is it a normal NHS-type board?

Andrew Donald: No, it is not. It is a programme board that sits under the governing bodies of the organisations.

Q267 Rosie Cooper: I know it is not an NHS board; I am trying to understand the thinking that you are operating under. I have one final thing and then I really will shut up. Will you please write to us and explain your employment and convoluted contractual arrangements?

Dr Shapiro: I do not have to write to you. It is not that convoluted. I have to be a contractor because I am a non-exec in the NHS and therefore cannot be employed by the NHS. I am contracted with a CCG and the money comes from Macmillan, the same as everybody else from the team. I get the equivalent of what a GP would get for two days a week.

Q268 Rosie Cooper: Why would Macmillan pay you to do this while you are a non-exec on NHS England?

Dr Shapiro: I am not on NHS England.

Rosie Cooper: Okay, forget it.

Q269 Barbara Keeley: Obviously we have touched on some issues with Macmillan. I do think there are issues there and it might be that we will want to write just to clarify some of the points that were made. I understand that people on the panel cannot necessarily answer that. Presumably, you have some private companies bidding for these contracts.

Andrew Donald: I cannot answer that because I am not involved in the procurement process. I will not know until 7 November. I know what I read in the papers.

Q270 Barbara Keeley: It is likely then, is it?

Andrew Donald: My intuition tells me that it is likely.

Q271 Barbara Keeley: Could we explore that in this question? Clearly, one of the overriding objectives of the private companies bidding to become prime providers is to make a profit from the provision of care. That is why they exist in the private sector. How do you think that profit motive can be squared with the objective of improving cancer care and end of life care for patients in Staffordshire? We seem to slip between efficiency improvements and quality and that type of thing. It is as if this programme thought you could get it all; that you could improve all the outcomes; you could integrate the working; you could reduce emergency bed admissions; and then somehow on top of all this you could move outside the NHS and pay companies to make a profit. How is that going to work?

Andrew Donald: It is part of the discussions about the contract. If, for example, one of the preferred bidders is a private company and they are on their own and not working with others, there is going to have to be a conversation about the contract and the issue of profit. There will have to be a debate about that because there will have to be protection, for me, for the public purse around it. Undoubtedly, if they are a private company, yes, they are in business to make money.

Q272 Barbara Keeley: What protection could there be? If they are a private company and they exist to make money—

Andrew Donald: We could limit it. You have to remember that these two programmes are very different. What we see in cancer is getting more integration, being more efficient and more effective with the resources that are in the NHS. We do not think we are going to get any more money for the NHS at the moment. Therefore, we know there is a train coming down the track with more people who have cancer. We need to make that money go further. The idea of the prime provider is to use integration to make the resources go further for the more people who need it; so more efficiency.

On end of life, there is an opportunity to repatriate resources which probably are being used appropriately at the moment because they are to do with emergency admissions; but actually that money could be used better. Again, we are not going to get any more money from anywhere else, so it is how we use that money better to fill service gaps and to pay the contract of the prime provider. It will be a management fee and the challenge for that individual organisation or group of organisations is to make that management fee that they get self-financing within two years. Again, we do not want to put more pressure back on the NHS.

Q273 Barbara Keeley: So you are going to somehow limit the profit if you end up with a private provider.

Andrew Donald: You can within a contract.

Q274 Barbara Keeley: What do you believe you might limit it to?

Andrew Donald: I am not the expert on this. I do not know at the moment. In some contracts in the past in the NHS, where we have had private providers, we have asked them about profit and we have limited it to a percentage, but I cannot say what it is.

Q275 Barbara Keeley: What sort of percentage?

Andrew Donald: Honestly, I would be guessing.

Q276 Barbara Keeley: Could you let us know?

Andrew Donald: Yes; sure. What I cannot do is say what the negotiations are going to be with the organisations. Obviously that—

Barbara Keeley: I have to say that I am a cynic, but I do not believe that all of this extra efficiency, better choice, more integration and the profit for a private provider is at all feasible. I just don’t buy that.

Q277 Valerie Vaz: I have a final question based on what you and other people have said. You have mentioned here that you are going to adjust the contract and that there are lots of uncertainties. Chris Ham gave evidence earlier; I do not know if you heard it or not.

Andrew Donald: Yes, we did.

Q278 Valerie Vaz: He basically said, "This is a risk. This has never been done before." Can I ask you why you are proceeding with this contract the way it is when you have just sat there and told us a lot of unknowns?

Andrew Donald: Because there are thousands of people who we have engaged with who are basically saying that we could do better. As an NHS commissioner and as a public servant, my job is to try and do better for the populations that I serve.

Q279 Valerie Vaz: But you can do that without wasting £1.2 billion worth of public money.

Andrew Donald: Again, it is a myth. That £1.2 billion is the cost of end of life services and cancer services over a 10-year period. That money will be spent anyway on services for patients. That is not going to go to the private company.

Q280 Valerie Vaz: I understand that but I am saying this is a risk. All I have heard this afternoon from you is, "I don't know. I'm going to adjust the contract. It's going to come in. There is going to be negotiation." There is no certainty about this, so why are you proceeding with this?

Andrew Donald: There are lots of certainties. The certainties are that we need to improve outcomes and experience for patients. Once we have got into the detail of negotiating the contract, which is the next stage, we will have a lot more information available to people to be able to say, "We have safeguards in place to ensure that we are going to get the best results for patients and the best result for the public purse."

Q281 Valerie Vaz: We are running out of time and I just have a few questions. Let me move on to the next bit. Will you still be dealing with the population of the two CCGs that are not involved?

Andrew Donald: We said that earlier.

Q282 Valerie Vaz: You said lots of things earlier.

Andrew Donald: If the individuals go to the organisations that evolve, which they will do, they will get the benefits, yes.

Q283 Valerie Vaz: Is the value of the contract based on the number of people who are projected to get cancer? What if the figure goes up? Will they be coming back for more money?

Andrew Donald: No, they won't. That is a fixed fee for them. The challenge for us in the NHS now—forget about this model—is how we provide for all the people who are going to get cancer. That is one in three of us, unfortunately. How do we provide with the money we have available to us now? We have to use that differently.

Q284 Valerie Vaz: So there is the same pot of money for an increased population.

Andrew Donald: Yes.

Q285 Valerie Vaz: I have one last question, because you mentioned it, Dr Shapiro. Could you say who the strategic project team are within the NHS and how you have been working with them?

Dr Shapiro: They are based in CSU in East Anglia, as I understand it.

Andrew Donald: Yes; the commissioning support unit, which is part of the NHS.

Dr Shapiro: They are doing the mechanics and the logistics of the procurement process. They are the ones who tell us what we have to do in a legal sense and a financial sense.

Q286 Valerie Vaz: Are they part of NHS England?

Dr Shapiro: Yes.

Q287 Valerie Vaz: So they have been helping you to—

Andrew Donald: They do many projects across the country.

Q288 Valerie Vaz: Could you just give me a breakdown of what their expertise is? Are they management consultants, doctors or clinicians?

Andrew Donald: They obviously have procurement expertise. They provide financial expertise and links to legal expertise as well. We need all of those things as part of European law.

Q289 Valerie Vaz: They have been probably helping you and you are just—

Andrew Donald: In effect, we have procured them to help us do that work, yes.

Q290 Valerie Vaz: You pay for their services?

Andrew Donald: We have to pay for their services, yes.

Q291 Valerie Vaz: How much is that?
Andrew Donald: The contract is about £250,000 over the life of the contract.

Chair: On that note, thank you very much for coming today.