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Transforming cancer and end of life care
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Staffordshire & Stoke-on-Trent
Transforming Cancer and End of Life Care Programme

Cancer Care Procurement

Memorandum of Information

June 2014

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1 Executive Summary

1.1 North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups and NHS England, (all the „Commissioners") jointly on behalf of themselves and with the support of Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England launched the Transforming Cancer and End of Life Care Programme in April 2013 (the „Programme").

1.2 This Programme comprises two separate Procurements, being the Procurement for a Prime Provider for End of Life Care Services and this Procurement for a Prime Provider for Cancer Care Services.

1.3 The Commissioners wish to shift their approach to the delivery of care from a series of treatment episodes to a model which is delivered via whole pathways built around the patient. This shift will enable an outcomes-based transformation in service design, and delivery focussed on the patient. The Commissioners believe a Prime Provider model of care will deliver this transformation.

1.4 The Commissioners see the appointment of a Prime Provider for Cancer Care Services as an opportunity to modernise and target services that best meet the needs of the local population. Based on engagement with the local population to date, it is evident that the public want responsive services that are centred on the needs of the patient, in a holistic manner.

1.5 Commissioners recognise that the move to a Prime Provider model and the paradigm shift of commissioning focus from providers of care to patients as service users is so significant that improvement will take time. Facilitating such fundamental change requires a stable and managed change environment. Accordingly Commissioners consider that an initial period of time (which they have assessed as two years) is needed to enable the Prime Provider to understand and plan for the scale of transformational change required.

1.6 The Commissioners" approach to procurement is one of engagement with providers from the outset, leading to competitive dialogue, on the basis that this is likely to produce the most sustainable and innovative solutions.

2 Introduction

2.1 Vision

2.1.1 North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups and NHS England, (all the „Commissioners") jointly on behalf of themselves and with the support of Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England launched the Transforming Cancer and End of Life Care Programme in April 2013 (the „Programme").

2.1.2 The aim of the Transforming Cancer and End of Life Care Programme is to support health and social care commissioners to shift the focus of practice from providers and individual interventions to one that encompasses the whole patient journey, is fully integrated and puts the patients" needs at the centre for both Cancer Care Services (prevention through to survivorship) and for End of Life Care Services (for all long term conditions).

2.1.3 There are three key aspects for the Programme within the Region:

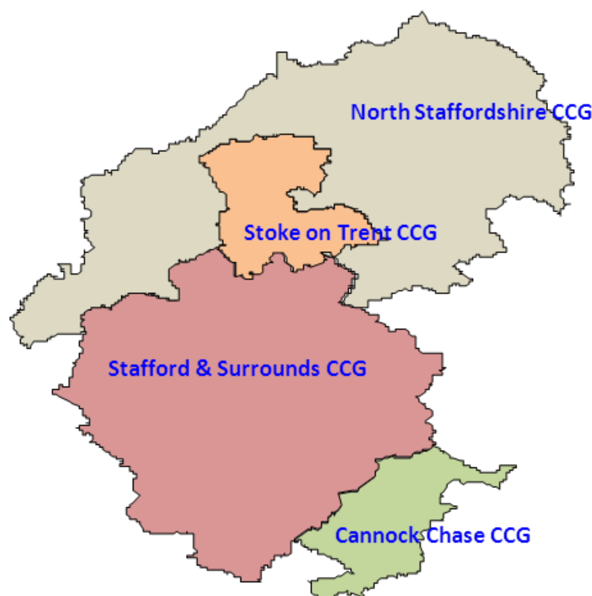
- To achieve the best possible outcomes for patients and carers so that there is sustained improvement in survival rates for the Region, firstly to get to be the best in England, and secondly to achieve rates equivalent to one of the top three Countries in Europe;
- To improve the patient experience and quality of care for cancer patients and their carers; and
- To reduce the fragmentation of care provision so that there is seamless, integrated and personalised care, when and where people need it, so that no patient or carer will get lost in a complex system.

2.1.4 The Commissioners wish to shift their approach to the delivery of care from a series of treatment episodes to a model of care which is delivered via whole pathways built around the patient. This shift will enable an outcomes-based transformation in service design and delivery truly focussed on the patient, which Commissioners believe a Prime Provider model of care will deliver.

2.1.5 The Programme is one of the fourteen Department of Health National Integrated Health and Social Pioneer initiatives.

2.2 Local Context

2.2.1 The four Clinical Commissioning Groups (CCGs) have 127 practices, with over 471 GPs serving a combined population of over 771,500 people.



2.2.2 The current approach taken by Commissioners to procuring services for cancer patients focuses on episodes of care in a variety of different settings. In some cases detailed pathways are procured through tariff and form part of block contracts. This makes shifting investment more difficult and prevents real innovation. A range of cancer care services are procured separately by Commissioners from the same providers through separate contracts.

2.2.3 NHS England have a responsibility for the population of England (patients registered with an English GP) and for commissioning specific parts of the pathway. Therefore, rather than contracting for specific populations the contracts held are for all patients that are accessing the service, irrespective of geography.

2.2.4 CCGs are responsible for commissioning services for their own local population and for other parts of the cancer pathway. The result is that no single Commissioner, organisation or individual can or is held accountable for the totality of a cancer patient's journey.

2.2.5 The vision for the Transforming Cancer and End of Life Care Programme is aligned and underpinned by the principles outlined in the five-year plan for Staffordshire and Stoke-on-Trent (2014-2019), the Commissioning intentions, and the local Health and Wellbeing Strategies. Namely, a vision for an integrated health and social care system as one which is centred on individual needs, more personalised community-based care and support, and one which recognises the wider determinants of health.

2.2.6 Innovation and having a responsive health and social care system across the Region, which meets patient and carer expectations is fundamental. The attributes of such a system are:

- designed by the public, personalised to their needs and preferences;

- provides access to services 24/7;
- reflects a modern model of integrated co-ordinated care between providers and sectors;
- provides exemplary cancer diagnostic and treatment options, giving the best clinical outcomes and reflecting patient choice;
- provides health, wellbeing and self-care programmes;
- exemplifies integrated systems and pathways based on quality of experience; and
- supports people in living with and beyond cancer, and enables independence, choice and control.

3 The Case for Change

3.1 The cancer story is changing, the way people with cancer are supported must change as well.

3.2 Currently most cancer care services focus primarily on cancer as an acute illness with little support provided following the end of treatment and within primary and community care. However the cancer landscape is changing and the picture is becoming more complex. While some people with cancer still die within a year of diagnosis, advances in treatment mean that those with incurable cancer can live for years and experience similar illness patterns to those with long-term conditions, with many suffering from complex co-morbidities. Even for people considered cured of their cancer, returning to normality is fraught with difficulties, as the consequences of the disease and treatment impact on the individual not only physically, but also psychologically, financially and socially. The consequences of treatment can occur soon after treatment but serious effects can also be experienced years later. There are also known barriers to early diagnosis, despite it being known that people with cancer are more likely to survive longer if they present earlier and are diagnosed earlier.

3.3 With cancer prevalence predicted to increase by 2 million to 4 million by 2030 in the UK, the Commissioners recognise the need to create more integrated care in the Region. The incidence rate of cancer for the CCGs is similar to the England average, with the exception of Cannock Chase and Stoke-on-Trent CCGs where the overall rate of cancer incidence is significantly higher. The incidence of prostate cancer is particularly high in Cannock Chase and Stafford and Surrounds CCGs. Lung cancer and upper gastro-intestinal (GI) rates are high in Stoke-on-Trent CCG.

3.4 Additionally, cancer incidence is on the increase. Between 2008 and 2010 (latest data available National Indicator Set (provisional), Social Care and Mental Health Indicators) there were 13,240 new cases of cancer (6,900 males and 6,350 females); an average of just over 4,400 per year. Breast, colorectal, prostate and lung cancers make up the biggest proportions of cases.

3.5 The cost of service provision is incrementally rising year on year and with diminishing budgets across health and social care there is a demand for the radical transformation of the way services are delivered. Nationally, expenditure on cancer has increased from £3.19 billion in 2003/4 to £5.50 billion in 2011/12.3 which is broadly in line with the overall increase in NHS expenditure. The share of total expenditure was 6.5% in 2004/05 and 6.6% in 2011/12. This share of total expenditure peaked in 2009/10 at 6.8%.

3.6 Within the Region there is significant variation in both the clinical outcomes cancer patients may expect (in terms of both morbidity and mortality), and also the quality of their experience during their cancer journey. These variations differ from other parts of the UK but the most significant variations can be found when comparison is made to other countries, not only in Europe, but elsewhere in the world. It is intended to achieve clinical morbidity and mortality indicators for cancer that will rank alongside the best three countries in Europe. This requires behavioural and cultural change but the intention is to substantially improve these outcomes over the duration of the Contract.

3.7 There is large variation in expenditure levels between the Commissioners. The highest spending organisation spends more than twice as much per person than the lowest spending organisation. It is unclear how much this variation can be explained by variation in the incidence and prevalence of patients with cancer and other factors.

3.8 Patient and carer experiences across the Region are variable for cancer patients and their carers.

3.9 From community feedback gained during a range of engagement events across the Region, including clinical and public input, it is known that there are pockets of excellent care. For cancer, this means that people are not always being diagnosed early and often find it difficult to know where to go for information and support. Care can often feel disjointed due to a lack of co-ordination and communication between different health professionals, and with other support services. This means that patients very often report a negative experience. This is unacceptable and needs to change.

3.10 It is intended through this Procurement to make the experience of care for cancer as seamless and joined up or „integrated" as possible. The approach of procuring a Prime Provider will enable this to happen as well as ensuring sustained patient choice. At the moment, cancer care services are organised around the needs of care providers. This needs to change so that it is organised around the needs of patients, becoming truly person-centred care. The care and support services that patients and carers receive should be personal to them, regardless of where they live.

4 The Commissioners' Approach

4.1 The Commissioners have identified that the current service model for cancer patients has serious shortcomings which can cause people to experience real problems with their care including: poor information and communication, unnecessary delays (some due to systems and processes); lack of compassion; dignity and respect; no coordination across services; people having to give their details repeatedly; lack of effective care planning with little/no involvement of the patient or carer in that care planning. All engagement activities to date evidence that local patient and carer experiences of cancer services is that of a fragmented, poor quality, unresponsive service that sees patients „falling through the gaps" at transition points and leaves patients and carers feeling unsupported.

4.2 The range of services relevant to the cancer pathway are shown in the diagram below.

4.3 The Commissioners intend to commence this transformation of Cancer Care Services in four tumour sites initially (breast, lung, bladder and prostate) and introduce the remaining tumour sites by Year 5 onwards.

4.4 The Commissioners see the appointment of a Prime Provider for Cancer Care Services as an opportunity to modernise and target those services that best meet the needs of the local population to provide responsive services that are centred around the holistic needs of the patient. Potential Bidders are expected to provide truly integrated, dynamic services, with the patient and carer at the centre.

4.5 Change and improvement on the scale required cannot occur overnight and requires a stable and managed change environment where providers of care know what is expected

of them. This will require the development of further or changed services for some, and disinvestment for others where it is considered that services are best provided elsewhere or there is a planned shift in activity in the patient's journey.

4.6 In addition to the outcomes and Cancer Wait Time targets required nationally, there is the expectation that the appointment of a Prime Provider through a ten-year contract will deliver the following outcomes:

4.7 sustained improvement in survival rates to the top three in England by year 10 and demonstrating continuous improvement;

4.8 all cancer patients have an excellent and equitable experience of care and support, with care organised around them;

4.9 all cancer patients receive appropriate care and support to enable them to live the best possible life during and following completion of their cancer treatment;

4.10 integrated care that is centred around the patient with access to local services and provides continuity of care where appropriate;

4.11 early detection and intervention to support improved survival rates;

4.12 care and support based on holistic needs of patients;

4.13 treating and caring for people in a safe environment and protecting them from avoidable harm; and

4.14 where clinically appropriate, cancer patients are able to self-manage or to receive supported management of their condition at home.

4.15 Commissioners consider that the success of the Prime Provider model and delivery of the desired patient outcomes will depend upon establishing key building blocks, including:

- a clear business case and strategy for change;
- new models of Cancer Care Services co-designed with services users, carers and clinicians;
- clear and measurable expectations of the Prime Provider and in turn the providers of services within the care pathway; and
- establishment of outcome based performance contracts that hold to account the Prime Provider and providers of services within the care pathway to deliver the expectations.

4.16 The Procurement will enable a shift in service delivery from the acute to the community, (community based services and social care settings) with an increase in the range and volume of services being provided in patients‟ homes and elsewhere in the community. Bringing together the various contracts across the Commissioners should also help to reduce duplication of services in the system.

4.17 Macmillan Cancer Support is supporting the Commissioners and other partners by providing expert advice on all aspects of service development, design and delivery, across the whole cancer pathways. The organisation will contribute to the Programme‟s funding in the first two years of the Contract to encourage service re-design and transformation and will work with the Commissioners on monitoring performance thereafter.

4.18 The Prime Provider will be expected to deliver Macmillan‟s nine outcomes, namely:

I was diagnosed early	I understand, so I make good decisions	I get the treatment and care which are best for my cancer, and my life
Those around me are well supported	I am treated with dignity and respect	I know what I can do to help myself and who else can help me
I can enjoy life	I feel part of a community and I'm inspired to give something back	I want to die well

4.19 The Commissioners do not intend to specify in detail how the outcomes should be achieved, but wish to stimulate dialogue with Bidders, through this Procurement, to discuss and develop the required innovative delivery models.

4.20 The use of local high-level outcomes and the Macmillan nine outcomes reflects the new approach to commissioning which the clinically led Commissioners wish to pursue. The emphasis is on delivering measurable improvements in specified outcomes. It will require a holistic approach which encompasses entire patient pathways and signals the need to think beyond traditional organisational demarcations in and outside the NHS.

4.21 The Commissioners are in the process of developing an outcomes framework that will be part of competitive dialogue in the Invitation to Submit Outline Solutions stage.

5 Programme Governance

5.1 The Programme is overseen by a Transforming Cancer Care and End of Life Programme Board, The Programme Board includes Non-Executive Board Members, local clinical GP representatives, Commissioners, Senior CCG Finance Officers, Public Health England, NHS England, Macmillan Cancer Support, Social Care and the programme team. Its role is to oversee the Programme including this Procurement and the Procurement for End of Life Care Services. In addition a Procurement Group has been established under the Procurement Board to offer procurement advice and recommendations to the Programme Board.

5.2 Public and clinical engagement and involvement is at the heart of the Programme and the three Non-Executive Board members bring the patient voice to the Programme. They oversee engagement and are working with a cadre of patient champions across all localities. A partnership group ensures the voice of local organisations such as, Healthwatch and local patient and carer organisations is heard and that these organisations can add to their understanding and experience of services and their aspirations for the future.

5.3 Public and clinical engagement has been carried out through large-scale workshops, where clinicians were able to give an overview of current services and shared their aspirations for future service provision and members of the public shared their experiences of current services and their aspirations for future services.

5.4 Further Programme engagement included community roadshows, surveys, one-to-one interviews with members of the public and clinicians, case studies, and visiting established support groups. Throughout the process, people, carers, families, communities and clinicians are and will continue to be actively involved in the design, development, procurement and appointment of the Prime Provider. They will continue to work closely with the successful Prime Provider following contract award and for the lifetime of the Contract, in order to continue to co-produce Cancer Care Services across the Region.

6 Transaction Structure

6.1 Prime Provider Model

6.1.1 The Commissioners wish to enter into a ten-year agreement with a Prime Provider for the delivery of all Cancer Care Services commissioned by the Commissioners.

6.1.2 The Contract will be in two parts. Part 1 will last for two years and Part 2 will last from years three to ten.

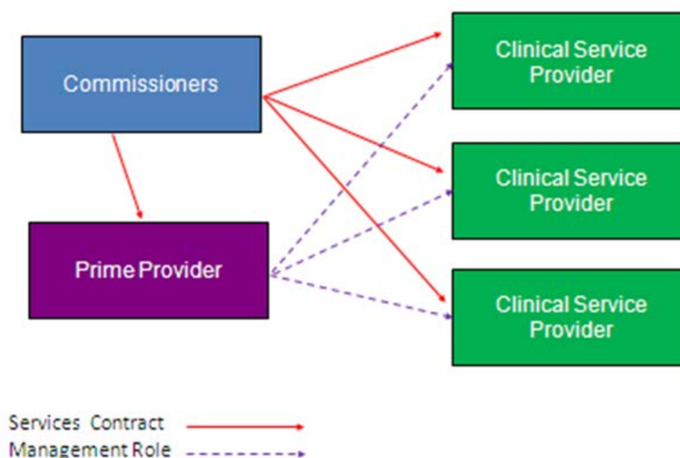
6.1.3 Commissioners recognise that the move to a Prime Provider model and the paradigm shift of commissioning focus from providers of care to patients as service users is so significant that improvement will take time. To facilitate such fundamental change requires a stable and managed change environment. Accordingly Commissioners consider that an initial period of time (which they have assessed as two years) is needed to enable the Prime Provider to understand and plan for the scale of transformational change required. In particular Part 1 of the Contract is required to ensure quality, accurate data and information around the activity and costs of current service provision. During Part 1 of the Contract, Commissioners require the Prime Provider to dramatically improve the capture of real time activity, cost, performance and patient experience data along the whole patient journey to facilitate improvements.

6.1.4 During Part 1 of the Contract the Prime Provider‟s role and responsibilities will be to manage the existing provider contracts, details of which will be provided at ISOS. The role will be akin to a „Prime Provider Integrator‟ model whereby all the current contracts between the Commissioners and the existing providers, all of whom contribute towards the delivery of the integrated service, will remain in place and the Prime Provider will assume responsibility for the co-ordination and management of the integrated service. There will be no contracts in place between the Prime Provider and existing providers of Cancer Care Services during Part 1 of the Contract and all staff and other assets will remain with the respective existing provider organisations. Risks and rewards will be allocated between the Commissioners and the Prime Provider in the Contract in relation to the co-ordination and management function.

6.1.5 During Part 1 of the Contract the Prime Provider will be required to:

- manage and improve data quality and collection to establish and agree detailed real time information needed to proactively manage work streams to predict demand;
- understand patient and payment flows;
- achieve a set of service outcomes that focus on improving the patient‟s experience of the service and ensuring equality of access and treatment;
- maintain and attain, where applicable, all National Indicators relating to cancer waiting and access times; and
- gain an in-depth understanding of cancer pathways.

6.1.6 The contractual arrangements between the respective parties during Part 1 of the Contract are best illustrated by the following diagram:



6.1.7 Part 2 of the Contract will last for years three to ten and is anticipated to take the form of a more traditional Prime Provider model whereby the Commissioners will be commissioning the entire delivery of the Cancer Care Services from the Prime Provider who will have full responsibility for the delivery of the Cancer Care Services.

6.1.8 The provisions of Part 2 of the Contract will allocate risk and reward in relation to the provision of the integrated Cancer Care Services between the Commissioners and the Prime Provider.

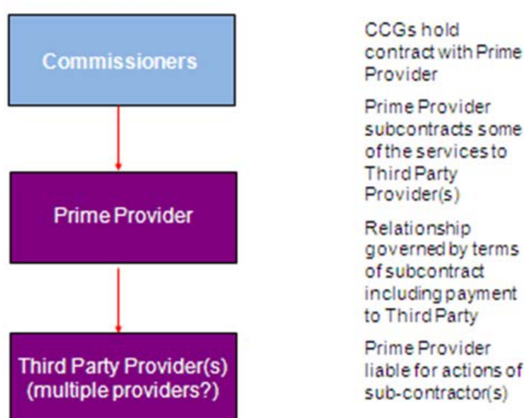
6.1.9 During Part 1 of the Contract the expectation is that the Commissioners and the Prime Provider will agree what steps need to be taken in terms of existing contracts with existing providers. This will be driven by the Prime Provider‟s model of service delivery for Part 2 of the Contract. Steps may include the Commissioners decommissioning services with existing providers and putting into effect a series of individual sub-contracts between the Prime Provider and selected providers of services.

6.1.10 The Prime Provider will not be required to accept the novation or assignment of existing provider contracts en masse.

6.1.11 It is anticipated that the Prime Provider will sub-contract specific roles and responsibilities (and allocate risk associated with their performance) to its sub-contractors. One of the Commissioners‟ key drivers for this Procurement is to replace their management of multiple existing providers with the ability to hold a single Prime Provider to account for the delivery of the entire service and for the co-ordination of its „supply chain‟ (i.e. its sub-contractor providers). The Prime Provider can be, but does not need to be, a provider of healthcare or clinical services itself and it could sub-contract all

but the co-ordination role. It is expected however, that they will have an understanding of cancer pathways, including treatment options and also have an appreciation of/recognition of potential future developments in cancer treatments.

6.1.12 The Commissioners recognise that depending upon the form the Prime Provider takes there may be VAT considerations that drive the form of the Bid model and Contract structure. The Commissioners will adopt a flexible approach to the structure of the Contract to facilitate a VAT efficient model, subject to the other drivers. This can be discussed during dialogue. The Commissioners intend to review the Bid model, Contract structure and proposed contractual arrangements between the respective parties for overall VAT efficiency, including any impact on the third party providers. Bidders should explain the VAT implications of their proposals. Currently, the Commissioners anticipate that the contractual arrangements between the respective parties during Part 2 of the Contract could take the form illustrated by the following diagram:



6.2 The Procurement Requirements

6.2.1 The Commissioners have identified that the current model of commissioning Cancer Care Services has serious shortcomings including: fragmentation; non-aligned incentives; focusing on the measurement of specific processes rather than outcomes; is subject to local variations such as, high hospital occupancy rates and challenges around sharing information.

6.2.2 The Commissioners wish to transform the way services are commissioned and delivered for people with cancer to ensure that patients and carers receive a seamless integrated pathway across health and social care providers, which provides continuity of care.

6.2.3 Through integrated service transformation there is an opportunity to make significant improvements and to introduce innovative solutions.

6.2.4 The Commissioners are mindful of the obligations under the Equality Act 2010 not to discriminate on unjustifiable grounds in the provision of services and public functions. They are also mindful of their obligations as public sector bodies to have due regard to the need to eliminate any conduct prohibited by the Equality Act, advance equality of opportunity, and foster good relations between those with protected characteristics and those without. The Commissioners have had due regard to these matters in identifying their strategic priorities and developing their service visions for this Procurement and this will remain under review throughout. A copy of the Commissioners" Procurement Strategies can be found at their respective websites (www.cannockchaseccg.nhs.uk; www.staffordandsurroundsccg.nhs.uk;www.northstaffsccg.nhs.uk; www.stokeontrentccg.nhs.uk). These will remain under review as the process unfolds.

6.2.5 The Commissioners do not intend to specify in detail how the transformation outcomes should be achieved, but wish to stimulate provider dialogue, through the Procurement, to lead to innovative delivery models.

6.2.6 Section 6.1 of this MOI describes the Prime Provider approach to the Contract and refers to the intended structure between Years 1 and 2 and 3 to 10.

6.2.7 Specifically the Commissioners intend to incorporate in Contract Years 1 and 2 the requirement that the appointed Prime Provider works with the Commissioners, Local Authorities, patient groups and stakeholders to:

- Develop and agree integrated pathways for the first four tumours, Breast, Lung, Bladder and Prostate;
- Agree future dates for transfer of the remaining tumour sites, Agree NHS standard commissioning contracts or sub–contracts based on the NHS standard contract for the period commencing contract Year 3 onwards, with appropriate “flow-down” of the Prime Provider obligations to sub-contractors;
- Agree a Procurement and Organisational Strategy to incorporate all new contracts to enable an effective service commencement in Contract Year 3;
- Develop and agree a data collection/patient record system with the Commissioners that is fit for purpose from Contract Year 3 onwards to reflect the needs of integrated pathways and Commissioners intentions;
- Update the Outcome Measures to incorporate the requirement to facilitate continual service improvement for patients and other stakeholders; and
- Work with the Commissioners to reduce costs in Contract Years 1 and 2 and to agree how the services can offer better value for money and remain affordable from Contract Year 3 onwards.

6.2.8 From Year 3 the appointed Prime Provider will be responsible for the entire service and will assume the risk for delivery of same.

6.2.9 In order to achieve the requirements listed above the Commissioners will centre the evaluation of bid submissions on how improvements can be made on/in:

- The internationally recognised cancer standards, for example waiting times and survival rates;
- Patient experience;
- Data collection and analysis;
- The submissions/proposals made on the four tumour sites;
- The agreement of the outcomes based approach;
- Innovation and joint working;
- Organisational structure and inclusion, covering joint working with commissioners, patient groups and other stakeholders; and
- How the Prime Providers fee for managing and providing Cancer Care Services can be "self-funding " whilst ensuring that the services are value for money and affordable.

6.2.10 To meet these needs the procurement process involves three main stages: Pre-qualification (PQQ), Invitation to Submit Outline Solutions (ISOS), and Invitation to Submit Final Solutions (ISFS). An indicative timetable is given in the PQQ.

6.3 **Consortia Arrangements**

6.3.1 A Potential Bidder is the organisation, which is submitting a response to the PQQ and can be a stand-alone organisation, a consortium or other collective arrangement (e.g. joint venture, partnership, use of a subcontractor). Where the Potential Bidder is a consortium there must be a Lead Bidder (the organisation proposed to enter the Contract) which will be deemed to be leading the bid. All other organisations within that consortium regardless of their role or status are known as Relevant Organisations for the purpose of this MOI and the PQQ. The Commissioners do not require the consortium to form a legal entity or enter into a binding legal arrangement at this stage, although it may be required to do so prior to the award of a Contract for Cancer Care Services. The Commissioners may require evidence that the collective arrangement has the resources necessary to perform the contract(s) and may require a guarantee or undertaking to that effect.

6.4 **Anti-competitive behaviour**

Where a Bid involves entities working together or coming together to provide the Cancer Care Services and those organisations currently provide similar services there may be requirements to ensure compliance with competition law. In particular Chapter I of the Competition Act 1998 prohibits agreements between competitors which restrict competition unless exempted, such as joint sales agreements, sensitive information sharing agreements and agreements to share markets or customers. Further, Commissioners will need to be satisfied that any proposed arrangement is not anti-competitive in the context of the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (the so-called „s75 Regulations").

6.5 **Merger control**

6.5.1 Potential Bidders will also be aware that if their bid involves entities working together or coming together to provide the Cancer Care Services and those organisations currently provide similar services there may be requirements to ensure clearance under competition law as it applies to mergers.

6.5.2 Monitor has published guidance on the respective roles of Monitor, the Competition Markets Authority (CMA) (previously the OFT and the Competition Commission) in relation to mergers involving NHS trusts and NHS foundation trusts and other „enterprises" as defined by section 129 of the Enterprise Act. The term merger is used to refer to all types of arrangements that may give rise to two or more enterprises ceasing to be distinct. Two enterprises will cease to be distinct if they are brought under common ownership or control. Such arrangements will generally include mergers, acquisitions and some joint ventures and, possibly of more relevance for Potential Bidders" intended arrangements under this Procurement, other arrangements such as the transfer or pooling of assets, hosting arrangements, management contracts, shared management arrangements and other integrations involving all or part of an organisation.

6.5.3 The Preferred Bidder will be required to collaborate with the Commissioners in any pre-notification process, formal notification to the CMA and any subsequent review or investigation by them and will be required to bear their own costs of such review and investigation.

7 Financial overview

7.1 Current expenditure on Cancer Care Services

7.1.1 The Commissioners have carried out an exercise to identify the current costs of all cancer services including the specific costs for the four main tumour sites of breast, lung, bladder and prostate. These costs are based on 2012/13 data.

7.1.2 As data is not currently collected in the required format, a number of assumptions have had to be made in compiling the cost data. This includes a number of cost allocations across categories where data is not currently recorded against the specific categories. It is therefore expected that, whilst total costs are representative, the allocation of costs between categories needs to be refined.

7.1.3 The above position is reflected in the two-part stage approach to the Contract, whereby during Part 1 of the Contract, Commissioners require the Prime Provider to improve data capture, managing and reporting systems necessary for the effective and efficient delivery of the Cancer Care Services.

7.1.4 The total cost of Cancer Care Services in 2012/13 across the Region was approximately £68.7m of which £20.7m related to the four specified tumour sites. The total costs broken down by pathway are shown in the table below.

Cancer - Detailed Pathway by Cancer Site

PATHWAY	DETAIL	ALL CANCERS (£)	SPECIFIED SITES				
			BREAST (£)	LUNG (£)	PROSTATE (£)	BLADDER (£)	TOTAL (£)
Prevention & Promotion	Screening	3,272,581	2,550,578	0	0	0	2,550,578
Prevention & Promotion Total		3,272,581	2,550,578	0	0	0	2,550,578
Prescribing	Drugs	4,988,478	537,737	0	351,191	515,859	1,404,787
Prescribing Total		4,988,478	537,737	0	351,191	515,859	1,404,787
Suspected Cancer	New OP Clinic	3,514,422	955,416	184,644	142,335	209,073	1,491,468
(Cancer Specialties)	Diagnostic Tests	0	0	0	0	0	0
	Follow Up OP Clinics	704,216	215,655	33,341	37,968	55,771	342,735
Suspected Cancer Total		4,218,638	1,171,071	217,985	180,303	264,844	1,834,203
Test Positive - Medical Treatment	New OP Clinic	1,170,593	87,198	73,547	35,054	51,491	247,290
(Oncology / Radiology)	Follow Up OP Clinics	2,807,392	207,059	176,938	84,773	124,521	593,291
	Outpatient Procedures	386,687	31,035	23,566	10,774	15,826	81,201
	Other	0	0	0	0	0	0
Test Positive - Medical Treatment Total		4,364,673	325,292	274,050	130,601	191,838	921,782
Test Positive - Surgical Treatment	Pre Assessment Clinic	253,770	49,224	35,910	8,064	7,296	100,494
(Cancer Specialties)	Inpatient (Elective & Day Case)	20,761,029	1,864,785	886,302	536,520	1,105,179	4,392,785
	Inpatient (Non Elective)	7,834,805	119,778	889,044	225,638	200,386	1,434,846
	Patient Appliances /Prosthetics	0	0	0	0	0	0
	Follow Up OP Clinics	513,148	92,049	26,024	20,843	14,564	153,480
	Post Year 1 Follow Up OP Clinics	995,745	207,233	86,040	53,937	48,801	396,011
	Diagnostic Tests	2,408,921	0	345,604	0	0	345,604
	Other	0	0	0	0	0	0
Test Positive - Surgical Treatment Total		32,767,418	2,333,069	2,268,925	845,002	1,376,225	6,823,221
Specialised Services	High Cost Drugs	10,291,722	2,550,624	1,109,206	110,497	233,658	4,003,985
	Radiotherapy & Chemotherapy	8,793,728	1,692,330	991,232	156,951	331,891	3,172,406
Specialised Services Total		19,085,450	4,242,954	2,100,438	267,449	565,550	7,176,390
TOTAL		**68,697,237**	**11,160,702**	**4,861,398**	**1,774,545**	**2,914,315**	**20,710,961**

7.1.5 The tables below also show the costs broken down by CCG.

All Sites

PATHWAY	TOTAL (£)	NHS NORTH STAFFORDSHIRE CCG (£)	NHS STOKE ON TRENT CCG (£)	NHS CANNOCK CHASE CCG (£)	NHS STAFFORD AND SURROUNDS CCG (£)
Prevention & Promotion	3,272,581	795,667	1,097,510	628,072	751,331
Prescribing	4,988,478	1,499,000	1,754,492	789,977	945,009
Suspected Cancer	4,218,638	1,238,822	1,473,107	667,652	839,057
Test Positive - Medical Treatment	4,364,673	1,170,665	1,418,825	781,335	993,848
Test Positive - Surgical Treatment	32,767,418	9,240,640	10,899,003	5,653,231	6,974,544
Specialised Services	19,085,450	5,483,356	6,616,551	2,894,578	4,090,965
TOTAL	**68,697,237**	**19,428,149**	**23,259,488**	**11,414,845**	**14,594,754**

Breast, Lung, Prostate & Bladder Only

PATHWAY	TOTAL (£)	NHS NORTH STAFFORDSHIRE CCG (£)	NHS STOKE ON TRENT CCG (£)	NHS CANNOCK CHASE CCG (£)	NHS STAFFORD AND SURROUNDS CCG (£)
Prevention & Promotion	2,550,578	552,760	763,079	562,203	672,536
Prescribing	1,404,787	399,821	420,603	266,073	318,290
Suspected Cancer	1,834,203	478,403	619,757	348,494	387,549
Test Positive - Medical Treatment	921,782	231,935	317,820	163,745	208,281
Test Positive - Surgical Treatment	6,823,221	1,880,369	2,399,399	1,157,049	1,386,404
Specialised Services	7,176,390	1,928,622	2,925,674	880,653	1,441,441
TOTAL	**20,710,961**	**5,471,911**	**7,446,332**	**3,378,217**	**4,414,500**

7.1.6 The Commissioners are currently in the process of refreshing and refining the above information in respect of 2013/14. This will be provided with the Invitation to Submit Outline Proposals.

7.2 Future planning assumptions

7.2.1 The Commissioners current financial planning assumptions, as they relate to Cancer Care Services, for 2014 and beyond are summarised below.

- The public sector faces unprecedented financial and demand pressures which are expected to continue for the foreseeable future. Through service re-engineering the appointed prime provider will be expected to deliver the outcomes of this project within the identified cost envelope. In addition the prime provider will be expected to release savings to the Commissioners reflecting their respective financial positions which will vary between commissioners.
- At the end of year 2 when actual pathway costs are known the prime provider will be expected to deliver all improvements agreed in the contract within the then agreed cost envelope. It is expected that this approach will require a form of gateway to enable benefit/risk sharing
- Potential Bidders will be expected, at the end of year 2, to have agreed a cost envelope which will be „self-funding" and meets the demand for services.

7.3 High level financial principles

7.3.1 It is currently envisaged that the financial arrangements for the Contract will be based on the following:

Contract stage	Years	Basis of payment
Part 1	1 and 2	Fee based payment for the services provided in managing the contracts with service providers on behalf of the Commissioners.
Part 2	3 to 10	Fixed element and performance based payment based on the delivery of specified outcomes.

7.3.2 The payment mechanism for years 3 to 10 will be the subject of dialogue during the procurement process. However, it is currently envisaged that there will be a fixed element and a performance-related element based on the delivery of specified outcomes.

Annex 1 – Glossary

Glossary and Explanation of Terms	
Bidder	means an economic operator that has been short-listed through the PQQ evaluation process and been invited to participate in the Procurement.
Cancer Care Services	means the services being procured by this Procurement and which will become the subject matter of the Contract.
CCG	means a Clinical Commissioning Group.
Clarification Question Template	means the template for candidates to use to submit any clarifications or queries they have ahead of the PQQ submission date.
CNST	means the Clinical Negligence Scheme for Trusts.
Connected Person	means a legal person within the meaning given in sections 993 and 994, Income Tax Act 2007; and sections 1122 and 1123, Corporation Tax Act 2010.
Consortium	means an association of two or more individuals, companies, organisations or governments (or any combination of these entities) with the objective of participating in a common activity or pooling their resources for achieving a common goal.
Contract	means the contract to deliver Cancer Care Services.
CSF	means a Critical Success Factor.
Commissioners and/or The Authority	means NHS North Staffordshire CCG, NHS Stoke-on-Trent CCG, NHS Stafford and Surrounds CCG, NHS Cannock Chase CCG and NHS England.
Competitive Dialogue	means a competitive dialogue process pursuant to regulation 18 of the Public Contracts Regulations 2006 SI2006/5 (as amended**).**
CQC	means the Care Quality Commission.
DH	means the Department of Health.
Eligibility Requirements	means the requirements set out in regulation 23 of the Public Contracts Regulations 2006 SI2006/5 (as amended).
EOI	means an expression of interest in respect of this Procurement.
FOIA	means the Freedom of Information Act 2000.
FT	means a Foundation Trust .
Guarantor	means a person or entity that agrees to be responsible for another"s debt or performance under a contract, if the other fails to pay or perform.
ICT	means Information and Communications Technology.

Invitation Documents	means the ISOS and the ISFS documents
ISOS	means Invitation to Submit Outline Solutions.
ISFS	means Invitation to Submit Final Solutions.
Lead Bidder	means the lead member of a Consortium.
MOI	means this Memorandum of Information.
NHS	means the National Health Service.
NHS Act	means the National Health Service Acts of 2006 and 2012.
NHS England	means NHS England established by Section 14 of the 2006 Health and Social Care Act.
OJEU	means the Official Journal of the European Union.
PID	means the Project Initiation Document – the document describing the governance arrangements for the Procurement.
Potential Bidder	means an organisation submitting a response to this PQQ.
Prime Provider	means the organisation with sole responsibility and accountability for the delivery of Cancer Care Services.
PQQ	means the pre-qualification questionnaire set out at Part D of this MOI.
PQQ Response	means a response to this PQQ.
PQQ Return Date	means the final date (& time) by which Potential Bidders can return submissions; submissions received after this date & time will not be accepted.
Preferred Bidder	means the Bidder selected as the preferred Bidder for the Procurement.
Procurement	means the procurement for the delivery of Cancer Care Services.
Procurement Rules	means the Public Contract Regulations 2006 SI2006/5 (as amended) and the general principles of the Treaty of the Functioning of the European Union.

Programme Board	means the Programme Board established as part of the wider governance arrangements established for the Programme.
Region	means the geographical coverage of the four CCGs; NHS North Staffordshire CCG, NHS Stoke-on-Trent CCG, NHS Stafford and Surrounds CCG and NHS Cannock Chase CCG. .
Relevant Organisation	means an organisation(s) or person connected with a response to a PQQ and / or connected with a bid submission including (without limitation): (i) a Potential Bidder; (ii) a Lead Bidder; and (iii) a member of a Potential Bidder Consortium.
Service Commencement Date	means the date when the Prime Provider begins the delivery of the Cancer Care Services pursuant to the Contract.
Type A Organisation	means a Non-NHS organisation.
Type B Organisation	means an NHS Organisation.
TUPE	means the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI/2006/246).
VfM	means Value for Money.