House of Commons

Committee of Public Accounts

UnitingCare Partnership contract

Twenty-fifth Report of Session 2016–17

Report, together with formal minutes relating to the report

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The Committee of Public Accounts

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Committee reports are published on the Committee's website and in print by Order of the House.

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Committee staff

The current staff of the Committee are Dr Stephen McGinness (Clerk), Dr Mark Ewbank (Second Clerk), George James (Senior Committee Assistant), Sue Alexander and Ruby Radley (Committee Assistants), and Tim Bowden (Media Officer).

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Summary

In December 2015 an £800 million contract for UnitingCare Partnership to provide older people's and adult community services collapsed after only eight months because it ran into financial difficulties. Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) attempted to design a more integrated and improved service for patients in the area. But, in contracting out responsibility for commissioning local health services, it lost sight of its own commissioning responsibilities. The procurement exercise was undermined from the start by poor commercial expertise, a lack of realistic pricing, and weak oversight. The CCG accepted the lowest bid on the table, without seeking proper assurance that the two trusts, which had combined to form the UnitingCare Partnership, could deliver for that price. It was then grossly irresponsible of the trusts and the CCG to rush ahead with the contract without having resolved significant differences in their understanding of the contract price or indeed the scope of services that were included in that price. The catalogue of failures resulted in unforeseen costs and losses, and services for patients in Cambridgeshire are likely to suffer as a result. Following the collapse of the Hinchingbrooke franchise, this Committee made a specific recommendation that the NHS should improve its commercial skills, yet it still lacks the expertise to ensure that patient services are procured effectively. This is all the more worrying as local initiatives proposed in sustainability and transformation plans may still include CCGs using new or untested contracting arrangements. With the NHS budget so stretched, innovative solutions are likely to be part of attempts to make the NHS financially sustainable. NHS England and NHS Improvement must improve the oversight and supervision of contracting arrangements and avoid such catastrophic failures in future.

Introduction

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) needed to change the way its older people's and adult community services were provided, as it faced a funding shortfall of £250 million in the five years to 2018–19. It wanted to provide a better and more integrated service to patients, while at the same time making efficiencies through reduced hospital admissions. In November 2014, following a competitive tendering process, it awarded a five-year contract for £726 million to UnitingCare Partnership, a limited liability partnership, to provide these services in Cambridgeshire and Peterborough. The partners in UnitingCare Partnership were Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust. The contract began in April 2015 but was terminated in December that year after only eight months, because of a failure to reach agreement on contract cost. The termination led to unfunded costs incurred by UnitingCare Partnership totalling at least £16 million, which had to be shared between the two trust partners and the CCG, worsening their financial positions and reducing the money now available to provide patient services in Cambridgeshire and Peterborough.

Conclusions and recommendations

1. **By putting the contract for older people's and adult community services out to tender, Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) tried to outsource its own responsibility to commission local health services.** In an attempt to transform service delivery, the CCG signed a contract in November 2014 with UnitingCare Partnership, a limited liability partnership, to commission a more integrated approach to older people's and adult community services in Cambridgeshire and Peterborough. But the contract collapsed after only eight months because it ran into financial difficulties. The CCG now accepts that it cannot outsource the difficult decisions that come with trying to integrate services in challenging financial circumstances. It acknowledges that it needs to manage future risks collectively with the trusts rather than trying to transfer them to providers. It recognises that shared management of risk, with a focus on good outcomes for patients, will be important if it is to succeed in implementing its sustainability and transformation plan.

   Recommendation: ***Local commissioners should take responsibility for designing more integrated systems of healthcare themselves, drawing on skills from within the NHS. They must not abdicate commissioning responsibilities to a body which is not clearly accountable to the taxpayer.***

2. **There was a fundamental mismatch between what the CCG expected to pay for the contract and what UnitingCare Partnership expected to receive.** At £726 million, UnitingCare Partnership's bid was significantly lower than its competitors which helped it to win the contract. But the bid did not make clear that UnitingCare Partnership expected to negotiate a 20% funding increase from the CCG through contract variations as the project progressed. The lack of transparency meant that the CCG could not assess all the bids it received on a level playing field. The CCG was then naïve in failing to assess properly the viability of the UnitingCare Partnership bid or to challenge it on the costs and level of contingency it had built in. Instead, it accepted the lowest bid on the table. As part of its attempts to improve its oversight of complex local procurements, NHS England is preparing a checklist for CCGs to follow in future. Even without a checklist this lack of basic scrutiny is cause for concern.

   Recommendation: ***NHS England's new checklist for CCGs should set out the minimum steps that CCGs should take to assess the realism and viability of bids.***

3. **It was grossly irresponsible of the trusts and the CCG to rush ahead with the contract without sufficient clarity on the costs and the risks.** Fearing that delays in the timetable would impact on staff and patients, the CCG and UnitingCare Partnership signed the contract before they had reached agreement on many important contractual issues. The CCG did not have a full understanding of the current cost of the services being provided, nor had it provided a complete list of the scope of services to be included in the contract. Notably, neither party was clear on who would pay some basic costs, such as any VAT liability incurred through the contract. As a limited liability partnership UnitingCare Partnership was outside NHS VAT arrangements. This meant that its subcontractors were no longer able to recover VAT on these services, as they had previously when providing services

directly to the CCG. The Partnership had not factored these additional costs into its contract price, and nor was the CCG expecting to foot the bill. Despite these clear warning signs, both sides pressed ahead and signed the contract without resolving the outstanding issues.

Recommendation: ***NHS England and NHS Improvement need to introduce safeguards so that CCGs and trusts cannot start a contract unless they have agreed the cost and scope of the services to be provided.***

4. **Services for patients in Cambridgeshire are likely to suffer due to this failed contract.** The contract's failure worsened the finances of an already struggling local health economy, leaving unfunded costs of £16 million to be shared between local trusts and the CCG. The CCG is now in deficit, and has not been able to afford to bring in all of the service improvements it had planned. It is costing the CCG more to commission services than it expected to have been paying UnitingCare Partnership, and it cannot afford to commission all of the services that were promised under the contract. Furthermore, the contract collapse meant that £178 million of expected efficiency savings have not materialised, leaving even less money available for other health care services. Through its sustainability and transformation plans, the CCG is trying to work out what services it can afford from its reduced resources, and it is considering closures or reorganisations of other health services such as the minor injuries unit in South East Cambridgeshire.

   Recommendation: ***In its sustainability and transformation plan the CCG should be clear about the impact of this contract failure on its ability to deliver health care services to the people of Cambridgeshire and Peterborough.***

5. **This contract collapse is yet another case of the NHS lacking the commercial skills to procure patient services effectively.** The astonishing array of errors in this contract shows that the health sector is still not getting the commercial basics right. The procurement adviser on this contract, the NHS Strategic Projects Team, proved not to be fit for purpose and NHS England has since abolished it. NHS England told us that one of the seven key lessons arising from this contract is that it needs to improve its commercial expertise, which is currently spread too thinly. In the meantime the CCG is still relying on consultants and is about to sign a £800,000 contract with McKinsey for advice on how to improve its financial position. We are concerned that the health sector has still not improved its commercial skills, as we recommended in our session on the failure of the Hinchingbrooke franchise more than 18 months ago. If it does not do so urgently then more money will be wasted.

   Recommendation: ***By April 2017, NHS England should report back to us on what specifically it has done to improve the quality of commercial skills available to local NHS bodies, as identified in its seven key lessons for the future.***

6. **The elaborate contract set-up exposed gaps in regulatory and oversight arrangements which, if not addressed, may reoccur in local initiatives proposed as part of sustainability and transformation plans.** Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust chose to form a limited liability partnership to hold the contract with the CCG. This arrangement reduced the risk to the two shareholder trusts.

But it also meant that there was a new private sector body which did not fall within existing health sector oversight arrangements and for which accountability to the public and to Parliament was not clear. NHS England and NHS Improvement accept that there were gaps in their oversight of this contract but it is worrying that such fundamental mistakes are still being made. Sustainability and transformation plans will encourage more innovative and integrated ways of providing health care so we are concerned that NHS England still plans to allow CCGs to use novel contracting arrangements in future, given the failings of this contract.

Recommendation: ***Before local areas start to implement their sustainability and transformation plans from April 2017, NHS England should report back to us on how it plans to ensure that any innovative arrangements for providing services can be scrutinised by the full range of health oversight bodies.***

1 The contract collapse

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from NHS England, NHS Improvement, the Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG), Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust about the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough.[1]

2. In November 2014, the CCG awarded a five-year contract to provide older people's and adult community services in Cambridgeshire and Peterborough. It wanted to address a funding shortfall, of £250 million in the five years to 2018–19, by contracting with one provider to design a more integrated service that would provide better outcomes for patients while making efficiencies through reduced hospital admissions. The successful bidder, with a bid of £726 million, was UnitingCare Partnership, a limited liability partnership of two local trusts, Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust. UnitingCare Partnership subcontracted with a range of bodies, including the two trusts themselves, other NHS providers and private sector and voluntary organisations. The contract began in April 2015 but was terminated in December that year after only eight months, because of a failure to reach agreement on contract cost.[2]

The CCG's commissioning responsibility

3. We asked the CCG why it had decided to contract out the commissioning of services to a third party, given that the commissioning of services is the role of the CCG itself. The CCG explained it had hoped that by commissioning one organisation for all of the services, that the organisation would find ways of integrating pathways of care to get the best outcomes, which the CCG had failed to do until that point.[3] The CCG acknowledged that it had tried to outsource the responsibility for transforming care pathways. It accepted now that CCGs should not outsource difficult decisions that they should be taking themselves, and that the commissioner is responsible for the NHS services for their local populations.[4] The CCG confirmed that it believes it is now able to fulfil the commissioning role and is investing in developing the organisation to be fit for purpose to do so.[5]

4. The CCG explained that, following the contract's collapse, it has developed relationships with providers so that they now collectively own the risks and challenges in the system, "rather than seeking to transfer that risk back and forth across the commissioner-provider divide."[6] We noted that this shared risk management will be particularly important in developing and implementing the sustainability and transformation plans, for which the CCG is the lead organisation.[7] We challenged NHS England and the CCG about why it was necessary to set up complicated arrangements to deliver these services.[8] NHS England told us that there may, on an exceptional basis, be a need to bring separate organisations

1 C&AG's Report, *Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough*, Session 2016–17, HC512, 14 July 2016
2 C&AG's Report, paras 1–4 and summary para 1
3 Qq 58, 59
4 Qq 81–83
5 Qq 59–63
6 Q 63
7 Qq 64, 84
8 Qq 98–99

together as a shared endeavour again in future. It also told us it has identified seven lessons to learn from this particular procurement before any similar arrangements are put in place:[9] We summarise how it described those lessons to us as follows:

i) Design the service properly from the outset, rather than developing it during the procurement;

ii) Insist on transparency from legacy providers, including open book access to cost data;

iii) Increase the NHS's commercial capability so that basic mistakes can be avoided;

iv) Get complete clarity about the role of external advisers and how their individual inputs should be brought together into coherent advice;

v) Do not change the terms of the procurement part way through the process

vi) Do not go live until all issues between commissioners and providers are resolved; and

vii) NHS England and NHS Improvement should work better together, rather than regulating in organisational silos.

Bidding for the contract

5. We asked why the CCG had set its budget for the contract at £752 million. The CCG explained that a budget of this level would create the efficiency savings it needed to close the CCG's budget shortfall. The CCG told us that it had based it on its existing spending and on efficiencies being delivered in other parts of the country. It agreed that its budget did reflect the financial pressures it was under but it told us that it thought the budget had been planned alongside the new service model.[10] We asked the CCG and the trusts whether it had been reasonable to expect to make a 10% efficiency gain over the five years of the contract. The trusts explained that their expected savings had been based on projects that had been tried elsewhere, just not all together and not on this scale. The CCG commented "In retrospect, I think that that [the 10% efficiency gain] may well have been a flawed expectation". NHS England took the view that as the contract was terminated after only a few months, nobody could know whether the expectation of savings due over five years had been realistic.[11]

6. UnitingCare Partnership submitted a bid of £726 million, which was considerably cheaper than other bids.[12] The trusts both wanted to win the contract: Cambridgeshire and Peterborough NHS Foundation Trust was concerned about the viability of its other services if it did not win the contract, but told us that it believed its bid to be appropriate, based on the limited available data.[13] Cambridge University Hospitals NHS Foundation Trust told us that it had bid primarily because it wanted to look after the local population better in the right part of the hospital and to reduce disruption in secondary elective care,

9 Qq 86–90, 100
10 Qq 101–102, 113
11 Qq 111, 112, 117
12 Qq 119, 120
13 Qq 97, 113

planned surgery and tertiary services.[14] We asked whether adequate contingency had been built into the bid given that there was uncertainty about costs, or whether UnitingCare Partnership had effectively bought the contract, hoping to make good any deficit through later contract renegotiation. The trusts denied that they had deliberately undercut other bidders.[15]

7. Despite its bid of £726 million, UnitingCare Partnership's business case assumed that it would receive more than 20% above that amount in additional funding from the CCG over the five year life of the contract.[16] Both trusts told us that they had assumed they would be able to negotiate more income after signing the contract because of gaps in cost data and in the service specification.[17] The trusts had a specific agreement that the CCG would update the contract value to reflect actual spending in 2014–15. But both trusts accepted that they had not informed the CCG that they had assumed so much additional income in their business case. The CCG confirmed that it was not aware of the trusts' expectations for additional income above the bid price.[18]

8. The CCG told us that it had challenged UnitingCare Partnership's bid price, and asked it to confirm that it could provide the services for that sum.[19] At the time of the procurement, the Cambridge University Hospitals NHS Foundation Trust's deficit was not as large and clear to the CCG as it became shortly after the contract was awarded.[20] NHS England commented that it will be issuing a checklist from October this year for any CCG embarking on such a project. This will look at four areas, including whether the provider is actually capable of managing the contract and the risk involved.[21]

Starting the contract without resolving all the issues

9. There were a large number of unresolved issues about the cost and scope of the contract when the CCG chose UnitingCare Partnership as its preferred bidder in October 2014. The contract began in April 2015, but only one month later UnitingCare Partnership requested £34 million of extra funding for the first year.[22] Cambridgeshire and Peterborough NHS Foundation Trust told us that they had faced great pressure to press ahead to start addressing the financial constraints, to improve patient care and to give greater certainty to the 1,200 staff who would transfer to a new employer under the contract. The trust agreed that in retrospect it would have been better to resolve the outstanding issues before signing the contract.[23]

10. The CCG accepts that it did not have an adequate understanding of the costs of service provision from Cambridgeshire Community Services NHS Trust before the contract had started. It told us that it had thought that the money it paid the trust covered the costs, whereas that was not actually the case, commenting that "… so there was an unknown cost, post-transaction [when the contract was signed], that was a surprise".[24] The trusts

14 Q 121
15 Qq 120, 168, 169
16 Q 118, C&AG's Report, para 12
17 Qq 115–116, 122
18 Qq 122–128, 183; C&AG's Report, para 12
19 Q 114
20 Q 72
21 Q 172
22 C&AG's Report, para 11, 14
23 Q 97
24 Qq 70–71

also told us that the full costs of the services being provided were not known when they signed the contract.[25] There were a significant number of areas where the information wasn't clear so they had sought either specific agreements or conditions in the contract. This uncertainty meant that both trusts expected to be able to negotiate further over the contract price.[26]

11. One of the most significant cost issues outstanding was the VAT liability arising from the UnitingCare Partnership arrangements. As a limited liability partnership, UnitingCare Partnership was not itself an NHS body and so fell outside the NHS VAT arrangements. This meant that its subcontractors could not recover VAT on services they provided to UnitingCare Partnership as they had done when those services had been provided directly to the CCG.[27] Cambridgeshire and Peterborough NHS Foundation Trust told us it sought advice on whether VAT would be payable given that the partnership was formed from NHS trusts but that the answer from HM Revenue & Customs was not clear.[28] The CCG subsequently stated that the Trust had received advice on the potential VAT liability in October 2014, before the contract was signed, although HM Revenue & Customs did not make a formal decision until December 2015.[29] The trusts did not factor the potential VAT cost into their bid price, but told us that they had managed the risk through discussing this with the CCG.[30] The CCG had not factored the cost in either, but acknowledged that it should have made absolutely explicit in the tender documents that it expected the provider to pay any VAT liability.[31] NHS England pointed out that the VAT rules are quite complicated but stated that this issue should have been resolved before the contract started.[32]

Impact of the contract's collapse

12. Local health services in Cambridgeshire already faced significant financial challenges before 2015, but the collapse of the UnitingCare Partnership contract has worsened the finances of the local health economy.[33] After only eight months of the contract, UnitingCare Partnership had already spent £16 million more than the CCG had agreed to pay it, a position which forced it to terminate the contract. The partner trusts and the CCG shared the costs of the contract's collapse but doing so has worsened their financial positions.[34] UnitingCare Partnership's business plan estimated that the new services would create £178 million of savings by 2020. In addition, the CCG told us that patients had really endorsed a more joined-up model for older people's and adult community services.[35] But the potential benefits of the UnitingCare Partnership model did not materialise before the contract collapsed.[36]

25 Q 69
26 Qq 115, 116, 122
27 C&AG's Report, summary, para 4
28 Qq 174–178
29 Cambridgeshire and Peterborough CCG, (UCP0003)
30 Q 180
31 Q 181
32 Qq 177, 186
33 Qq 169, 188–193, C&AG's Report, summary paras 1, 16
34 Qq 188, 189; C&AG's Report, paras 15–16
35 Qq 74, 86
36 C&AG's Report, para 16

13. The CCG could not say exactly how much it is paying for its older people's and adult community services now. But it estimated that for the current year it is paying more than it would have done at UnitingCare Partnership's bid price, but less this year than the Partnership would have ultimately wanted.[37] Despite paying more than the contract value, the CCG has not been able to bring in all of the model's planned services for 2016–17 because it cannot now afford to commission them itself.[38] The CCG now needs to establish how to make the efficiencies it needs to get its finances back on track. The CCG told us that it is having to look across all of its services to work out how it can live within its resources, and is cutting its cloth accordingly. As part of this it will continue to redesign its services for older people and adults in the community and it is trying to accelerate these changes. However, there are some concerns about the continued viability of services such as the minor injury unit in South East Cambridgeshire. The CCG is looking to find different models of provision for urgent care as part of its sustainability and transformation plans.[39]

37 Q 169
38 Q 201, C&AG's Report, paras 16, 1.17
39 Qq 188, 190, 191

2 Commercial skills and oversight

Improving commercial expertise

14. In our 2015 report on the failure of the Hinchingbrooke franchise we concluded that public bodies will not achieve value for money from their contracts until they become more commercially skilled. We recommended that the Department should report back on the steps it was taking to develop the necessary skills within the service.[40] In July 2015, the Government agreed with our recommendation and set out some of these steps, including strengthening its central commercial function to provide guidance and oversight on procurements.[41]

15. However, lessons do not seem to have been learned on improving commercial expertise, as the number of basic errors in this Cambridgeshire and Peterborough procurement shows us. There was still a significant lack of appropriate skills to deliver the contract effectively, as evidenced by the review commissioned by NHS England into the role of the external advisors. The review found that the Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) engaged several consultants to advise it during the procurement, but there were failures in the way the advice was brought together.[42] Separately, NHS England conducted an internal review and decided to disband the Strategic Projects Team, which had advised the CCG on the procurement, because it was not satisfied with the quality of the team's work.[43]

16. NHS England acknowledged that its commercial expertise is thinly spread. It told us that it needs to standardise some of its approaches to procurement so people do not have to hire their own external advice to get some of the basics right. But it also recognised that it needs to ramp up its commercial expertise in areas such as negotiating drugs prices with individual pharmaceutical companies.[44] Nevertheless, the CCG is still relying on external consultants to help it turn the organisation around and plans to pay McKinsey approximately £800,000 to do this.[45]

Improving oversight

17. Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust chose to form a limited liability partnership for the contract with the CCG. This arrangement reduced the risk to the two shareholder trusts, neither of which was in a position to become the lead provider. But it also meant that the CCG contracted with a private sector company which did not fall within any health sector oversight arrangements. We asked NHS England who was responsible for

40 Committee of Public Accounts, *An update on Hinchingbrooke Health Care NHS Trust, Forty-sixth Report of Session 2014–15*, HC 971, March 2015
41 HM Treasury: Treasury Minute: Government response on the forty-sixth report from the Committee of Public Accounts: Session 2014–15, Cm 9091, July 2015, paras 5.1 and 5.5
42 UnitingCare Partnership procurement review, PricewaterhouseCoopers, September 2016
43 Qq 90, 140–141
44 Qq 210, 211
45 Qq 133, 136

the contract, and who Parliament could hold to account. NHS England told us that the statutory boards of the CCG and the two trusts were accountable but did not identify one single accountable officer.[46]

18. The C&AG's report noted that the regulators and oversight bodies acted in accordance with their statutory roles but ultimately regulatory checks on individual bodies' risks did not ensure that the contract was viable.[47] We asked why the seven safeguards set out by NHS England had not been in place during the UnitingCare Partnership contract and asked who should have been responsible for checking the resilience of these partnerships and their commissioning and contracting arrangements. NHS England stated that if there are to be more of these kinds of arrangements, the NHS will have to evolve the way it works nationally, as well as putting in safeguards locally.[48] This will include ensuring that NHS Improvement is clear about the extent to which a limited liability partnership should be regulated itself, rather than as the two statutory bodies that form it, and that the Care Quality Commission is clear on its role.[49] NHS England told us that it and NHS Improvement will create a joint assurance process to start to address this. In the meantime NHS England has already reviewed some procurements taking place in other parts of the country either to stop them altogether or to amend their approach.[50]

19. Under its sustainability and transformation plans, the CCG told us that it still intends to put in place the same model of care in place as had been specified in the contract that collapsed. It said that patients had really endorsed the model and that there had been concern from patients and the public since the contract collapsed that the model would be lost; the CCG's commitment is that it would not be lost. It further explained that a huge effort with patients and the public went into designing the model and "It is the one thing that we definitely need to keep from this."[51] We asked the CCG who was accountable, given that sustainability and transformation plans rely on agreement from local health sector organisations. The CCG stated that it and its partners would focus on what gets the right outcomes for patients and what gets the best use of all resources, both financial and staff resources.[52]

46 Qq 93–95, 200; C&AG's report, summary paras 4 and 18
47 C&AG's report, para 21
48 Q 171
49 Q 94
50 Qq 172, 210
51 Q 74
52 Q 85

Formal Minutes

Monday 7 November 2016

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon	Kevin Foster
Philip Boswell	Kwasi Kwarteng
Charlie Elphicke	Nigel Mills
Chris Evans	John Pugh

Draft Report (*UnitingCare Partnership contract*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 19 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twenty-fifth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 14 November 2016 at 3.30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 14 September 2016	*Question number*
Simon Stevens, Chief Executive, NHS England	Q1–57
Simon Stevens, Chief Executive, NHS England, **Stephen Hay**, Executive Director of Regulation/Deputy Chief Executive, NHS Improvement, **Tracy Dowling**, Chief Officer (Accountable Officer), Cambridgeshire & Peterborough Clinical Commissioning Group, **Roland Sinker**, Chief Executive, Cambridge University Hospitals NHS Foundation Trust, and **Aidan Thomas**, Chief Executive, Cambridgeshire & Peterborough NHS Foundation Trust	Q58–213

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

UCP numbers are generated by the evidence processing system and so may not be complete.

1 Cambridgeshire Community Services NHS Trust (UCP0006)

2 Dr Arnold Fertig (UCP0005)

3 Healthwatch Cambridgeshire (UCP0001)

4 NHS Cambridgeshire and Peterborough Clinical Commissioning Group (UCP0002)

5 NHS Cambridgeshire and Peterborough Clinical Commissioning Group (UCP0003)

6 NHS England (UCP0004)

List of Reports from the Committee during the current session

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2016–17

First Report	Efficiency in the criminal justice system	HC 72 (Cm 9351)
Second Report	Personal budgets in social care	HC 74 (Cm 9351)
Third Report	Training new teachers	HC 73 (Cm 9351)
Fourth Report	Entitlement to free early education and childcare	HC 224 (Cm 9351)
Fifth Report	Capital investment in science projects	HC 126 (Cm 9351)
Sixth Report	Cities and local growth	HC 296 (Cm 9351)
Seventh Report	Confiscations orders: progress review	HC 124 (Cm 9351)
Eighth Report	BBC critical projects	HC 75 (Cm 9351)
Ninth Report	Service Family Accommodation	HC 77 (Cm 9351)
Tenth Report	NHS specialised services	HC 387 (Cm 9351)
Eleventh Report	Household energy efficiency measures	HC 125 (Cm 9351)
Twelfth Report	Discharging older people from acute hospitals	HC 76 (Cm 9351)
Thirteenth Report	Quality of service to personal taxpayers and replacing the Aspire contract	HC 78 (Cm 9351)
Fourteenth Report	Progress with preparations for High Speed 2	HC 486
Fifteenth Report	BBC World Service	HC 298
Sixteenth Report	Improving access to mental health services	HC 80
Seventeenth Report	Transforming rehabilitation	HC 484
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Twenty-third Report	Universal Credit and fraud and error: progress review	HC 489
Twenty-fourth Report	The Sale of former Northern Rock assets	HC 632

HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: UnitingCare Partnership Contract, HC 633

Wednesday 14 September 2016

Ordered by the House of Commons to be published on 14 September 2016.

Watch the meeting

Members present: Meg Hillier (Chair); Mr Richard Bacon; Philip Boswell; Chris Evans; Caroline Flint; Kevin Foster; Stephen Phillips; Bridget Phillipson; John Pugh; Karin Smyth.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Robert White, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-213

Witnesses

I: Simon Stevens, Chief Executive, NHS England.

II: Simon Stevens, Chief Executive, NHS England, Stephen Hay, Executive Director of Regulation/Deputy Chief Executive, NHS Improvement, Tracy Dowling, Chief Officer (Accountable Officer), Cambridgeshire & Peterborough CCG, Roland Sinker, Chief Executive, Cambridge University Hospitals NHS FT, and Aidan Thomas, Chief Executive, Cambridgeshire & Peterborough NHS FT.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough (HC 512)

Examination of witness

Witness: Simon Stevens.

Q1 **Chair:** Welcome to the Public Accounts Committee on Wednesday 14 September 2016. We have two sessions today. We will come to our main session in a moment, on the UnitingCare Partnership and what happened in Cambridgeshire, but I wanted to use the opportunity, while Simon Stevens, head of NHS England, is here, to ask him about the accounts that were laid before Parliament on 21 July. I think yours came later that evening, on Parliament's last day, so this is our first chance to talk to you about those accounts. You may have seen that we asked Chris Wormald about that last week, and we gave you notice of this for today.

Mr Stevens, you have sat in front of us eight times this year—it might even be nine. You have promised that all the issues that we have looked at—mental health issues, specialist commissioning, what is happening with the provider deficits—will be solved by the £10 billion of funding that you have got to 2020. You shake your head; well, that it is going to make a major contribution to it, and the five-year plan on the transformation of the NHS will contribute as well. But the accounts show that you are on a very sticky wicket, don't they?

Simon Stevens: Yes, they do show that we have a huge challenge in front of us, and I think that would be consistent with everything I have said to this Committee. As it happens, NHS England in 2015-16 was able to generate a £599 million underspend to contribute to pressures elsewhere in the NHS and the Department of Health group, but let there be no doubt that this is an incredibly financially challenging period for the national health service.

Chair: So you have less money, but you still have to deliver all the things that you have to deliver, and the expansions. We have talked, for instance, about specialised services; there is a growing demand there. There is a clear Government commitment on mental health parity, which I think we discussed the last time we saw you. You have less with which to deliver.

I will quote the Comptroller and Auditor General, and you can tell me if you agree with him. He says: "the NHS faces an unprecedented financial challenge which requires long term strategic measures to address." He goes on to say that, when he looks at elements of NHS England's performance report and the Five Year Forward View, there are three challenges, which you would acknowledge and have identified, including

the funding and efficiency gap, and says: "if the NHS fails to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments." Do you agree with that?

Simon Stevens: Were you quoting Sir Amyas or me there?

Chair: I was quoting Sir Amyas.

Simon Stevens: Because I agree with that entirely. I wasn't sure whether that was one of my quotes.

Q2 **Chair:** You can agree with the Comptroller and Auditor General; I am sure he will be delighted. Then we have NHS Providers coming out again this week, saying that they have not got enough money to do their job. You have previously talked about social care, which I think is a bit of a "get out of jail free" card, frankly, because you are relying on that to help with some of the pressures on the NHS budget.

You say there are challenges. In all of this, do you think you can deliver what you have to deliver under the mandate with the money that you have?

Simon Stevens: Well, it would be helpful if we could, for the avoidance of all doubt, clarify what we requested and what we have got.

Chair: You are anticipating my questions.

Simon Stevens: As it happens, we have set this out carefully for the Health Committee as well, in something called the recap briefing, which is available on its website. It details all the funding settlement for the NHS. At the time the Five Year Forward View was drawn up, we set out a set of ambitions for the NHS. In terms of the spending review settlement that we achieved, that was for five years beginning this year, 2016-17, up to 2020-21. We got, broadly speaking, what we asked for this year, 2016-17: a kick-start to the funding for the NHS. On that back of that, that will enable us to absorb nearly £1 billion of extra pension costs, cut provider deficits by more than two thirds, as compared with last year, and get going on the agenda for mental health, primary care and other services. So that is year 1.

For year 5, the Forward View said that we estimated that the NHS funding requirement, net of efficiencies, would be somewhere between £8 billion and £21 billion. The spending review settlement that we obtained was within that range—at the lower end, but within that range. That is year 1 and year 5.

We did not get what we originally asked for years 2, 3 and 4—namely, 2017-18, 2018-19 and 2019-20. Whereas it is right that at the end of the five years, the annual funding for the NHS will be within the range that was set in the Forward View, in the intermediate years we have a bigger hill to climb than was first envisaged. That is why it is so important that

we take measures to drive efficiency and get control of cost this year, to put us in the best position going into next year and the year after.

Q3 **Chair:** I won't rehearse what you know and what we know of all the measures taken to make the books balance, but given what has happened in the accounts, you have set yourself a very stiff task with NHS improvement and transformation to change systems to deliver these efficiencies in a year. Is that really possible?

Simon Stevens: In a year?

Chair: Not all of them in a year, but you need to do a lot in this next year to ensure you don't have the same shenanigans over the accounts as happened with the ones that were laid before us on 21 July.

Simon Stevens: I don't think "shenanigans" is a term that would be recognised. Given that these are unqualified accounts for NHS England, I don't think the Comptroller and Auditor General would use the term shenanigans, either. The fact is that, yes, the financial performance of the NHS this year will obviously have a big impact on how we go into next year and the year after. Let's be clear: there are going to be significant challenges, choices and controversies on the back of it. The question you began with was on our ability to fund the mental health improvements and specialised services in other areas, and we will obviously do so in accordance with the funding available.

We have set out in incredible detail what the year-by-year growth in mental health services will be on the back of the fact that the cash available to the NHS is going up from £100 billion last year to £119 billion in 2020-21. This is not the land of milk and honey, but it does provide us with some opportunities.

Q4 **Chair:** Ministers have said repeatedly that they have given the NHS what it has asked for. You have just told us very clearly—and I think most of us knew—that you did ask for more. Do you disagree with Ministers?

Simon Stevens: As I say, it is correct to say that for 2020-21, which was the year that the Five Year Forward view talked about—the annual funding increase that the NHS would require—the funding settlement that was available is within that zone. But in the years up until then, we have got a lot of work in hand because we did not get what we originally asked for.

Q5 **Stephen Phillips:** You say that you asked for between £8 billion and £21 billion. That is quite a large range. When you were in negotiations with the Government during the spending review, what did you say they would get for £8 billion and what did you say would happen if they managed to find £21 billion? Let us clarify the base as well. You managed to get £10 billion. Is that right?

Simon Stevens: Yes, I think the Government would record it as £10 billion. The Health Committee recorded it a little differently—

Q6 **Stephen Phillips:** You asked for between £8 billion and £21 billion. It is a massive range. What is the difference between a health service in 2020 with an extra £8 billion and one with an extra £21 billion?

Simon Stevens: Well, it is a pretty substantial difference in terms of the expansion of services and the improvements that the public would see, but the reality too is that the three scenarios in the Forward View were contingent on the different efficiencies that the health service was able to deliver. Notwithstanding your point, Chair, about social care, we did say that the three dependencies here were a well performing social care system that kept up with rising social care need; continued availability of preventive health services, including local government; and enough capital to lever in the changes.

Q7 **Stephen Phillips:** Let me suggest this to you, Mr Stevens. You have already said that the health service is facing, in your words, an incredibly financially challenging period.

Simon Stevens: Yes.

Q8 **Stephen Phillips:** £10 billion is not enough to stand still by the end of this Parliament, is it?

Simon Stevens: Yes, it is enough to stand still, and do more than stand still. By comparison with the historical rates of growth available to the national health service, obviously this is an unprecedentedly extended and deep period of slowdown in funding growth in the NHS, particularly in the middle of the SR period.

Q9 **Chair:** In the decisions you have had to make, have you ever sought a ministerial direction as a result of funding challenges?

Simon Stevens: No, because the mandate that the Government set for the NHS is framed to take account of the resources that are available. That has been the case for this year. In reality, of course, there is a discussion and a negotiation. The asks that are being made are to some extent calibrated to the funding available. That is a legitimate choice for elected Governments to make. Of course, the NHS would want to set out its stall and we would use funding well, but there are other calls on public resources, and it is not the NHS that makes those choices but Governments.

Q10 **Chair:** You acknowledge, as one could say, the bleeding obvious: you have to cut your cloth according to the money that you have got. Yet you have been in front of us eight or nine times so far this year. We have looked at specialised commissioning. Let us take that as an example. That is 14% of your budget.

Simon Stevens: On specialised commissioning, we have budgeted a 7% increase this year, a 5% increase next year, 4.8% the year after and 4.5% the year after that. That is within the funding envelope that we have with SR.

Q11 **Chair:** Fine. That's the money. But the need, the demand, is going up

faster than the increase that you have just projected.

Simon Stevens: There are always choices to make at the margin. If there were more, we could do more, but it is not unreasonable for us, as you said in your Report on specialised commissioning, to make sure we are driving maximum value out of the £15 billion we are currently spending. Could we do more with another £500 million in specialised commissioning? Of course we could, but that is £500 million that is juxtaposed with other calls on the public purse. Ultimately, those are decisions for the Government to make.

Chair: Isn't the danger, though, that you are firefighting at one end rather than coming up with a transformation plan that stops and prevents issues in the first place? But maybe I'm going a bit too far on that one. Perhaps I should not have posed it in quite that way. We will move on to Karin Smyth and then I will come back to Mr Phillips.

Q12 **Karin Smyth:** I think we know that the end of this year is quite important. You have repeated that, without capital investment, the social care problems and the problem of prevention will not be dealt with, but the Comptroller's statement says that the Committee is concerned that the Department does not have a coherent plan to get through this problem. Chris Wormald last week was very clear that the pressure is on the money, that the Department comes in under the line and that through the mandate there is a plan for the STPs. Are you confident that the STPs will be delivered within the timeline, in order to help you deliver that plan?

Simon Stevens: I cannot answer that question in the abstract, because people have not finished drawing up their proposals for these STPs, and they won't have done until the end of October. We can certainly say that people are grabbing the bull by the horns. They understand that we have to think in the round about the funding available in different parts of the health service and, indeed, the social care system in each part of the country. As to what that implies about the pace of change and the ability to drive some of those local efficiencies, that is what people are working on right now. When you think about the so-called £22 billion of efficiency to deal with the gap between rising demand and available funding in 2020, of that, we estimate that about £15 billion—£14.9 billion, to be precise—will be delivered through local change processes and efficiencies, and the rest will be done through national programmes. Precisely what that £14.9 billion-worth looks like in each part of the country is the exam question that people are working on right now.

Q13 **Chair:** On the figures, when you wrote to the Health Committee in May this year, you set out that £7 billion would be delivered nationally and £15 billion would be sourced locally. You just said £14 billion—I want to be clear.

Simon Stevens: It is £14.9 billion locally—£15 billion, rounded up.

Q14 **Karin Smyth:** To go back to your words, it's not in the abstract, because the vehicle to deliver that is the STPs. So they're not in the abstract,

because if they don't deliver realistically within the timescale that has been set out, they do not deliver. Is that right?

Simon Stevens: I think that's a syllogism.

Q15 **Karin Smyth:** Does that mean they are not going to deliver?

Simon Stevens: Well, I think your question was, "If they don't deliver, they're not going to deliver," to which the answer is, "They won't have delivered."

Q16 **Karin Smyth:** They will not deliver the savings required that you are talking about delivering for years 2, 3 and 4 of the five year Forward View.

Simon Stevens: What we are going to see from these is that there are some changes people can make pretty quickly, and there are some that are going to take much longer. One of the unknowns at this point is what capital investment we need in order to bring about some of these service changes and investments, including beefing up primary care and out-of-hospital services. There will be a process where we will see what people are telling us they would need in order to make some of these efficiencies. We will then have to compare that with the level of capital and infrastructure investment we have, rank that in some way and see what it leaves us. I do not expect that, come the end of October, we will have peace in our time in every part of the country for every year, and everything's tickety-boo. I do not think that at all.

Q17 **Karin Smyth:** But will we have it by the end of March?

Simon Stevens: For 2017-18, 2018-19, which is where I think you're leading us to—

Q18 **Karin Smyth:** I am going to years 2, 3 and 4, because you have been very clear elsewhere that year 1 is okay and year 2 looks more promising, but years 2, 3 and 4 are the problem.

Simon Stevens: Yes. That is why we are bringing forward the funding and contracting around 4 next year and the year after and, indeed, will be issuing our planning guidance for every part of the health service next week on that. We normally issue that on Christmas eve. We are asking people to make these choices about divvying up the money in each local area as best as they are able by Christmas, rather than what usually happens in the annual cycle, as you know, which is theoretically the end of March but often spills over into May or June. That is going to force people to focus on these difficult choices and say, "What is it going to take for us to make this work in our area?"

Q19 **Karin Smyth:** So we will be very knowledgeable by November.

Simon Stevens: Yes.

Q20 **Karin Smyth:** We had a discussion last week about the raid on capital done by the Department of Health in order to bring their accounts within the expenditure limit. We asked in this Committee last week whether

they were concerned about the disincentives in the system and the continuing development of the estate in terms of the raiding on capital. I don't have the evidence in front of me, but my memory is that they were not particularly concerned about that. Your plans depend on capital coming forward, so are you concerned about the raid that has been made on capital?

Simon Stevens: I think the Department of Health said when they were here last week that for last year, part of what they were able to do is use the fact that some projects were running slow and that there was under-use of the capex, and convert that into revenue. But certainly if that were to continue year by year, it is going to be a substantial problem. I think there will be more of that in the current year, and less of it the year after, but the truth is we are very capital-constrained—to a greater extent than we hoped when we began this process.

Q21 **Karin Smyth:** It is also true that the providers, to save some of their money, have individually in the provider sector raided some of that capital, which would then be outside the scope of the STPs to use going forward. Is that right?

Simon Stevens: Yes. For last year, I think it was in the order of £1 billion to £1.2 billion of capital to revenue transfer. I think it is going to be a little less this year but it will be in that sort of zone, then tapering in subsequent years. We've got a lot of latent need for infrastructure investment.

Q22 **Karin Smyth:** My final question is, if the STPs don't start to deliver those sorts of savings, which we will see quite quickly, what is plan B?

Simon Stevens: Put it this way: next year is our year of growth in the NHS. It is just not growth at the historical rate and will be relative to what the unmitigated demand is likely to be. On the '17-18 and '18-19 position, we will see what people say they need to do within the next several months when they bring that forward, for the reasons I have given. On the profile of what those savings will look like, it will differ in different parts of the country depending on the size of the service redesign that people envisage is necessary.

Stephen Phillips: Now answer the question, Mr Stevens.

Simon Stevens: Rephrase it for me in a way that makes it sufficiently—

Q23 **Stephen Phillips:** If the STPs don't work, what is plan B?

Simon Stevens: Well, plan B will be dependent on what it is that isn't working.

Q24 **Stephen Phillips:** Let's say they deliver £7 billion-worth of savings rather than £14.9 billion-worth of savings by the end of this Parliament. You will be £7.9 billion short. What is plan B?

Simon Stevens: Under those circumstances, if the NHS is required to live within the limits that have been set, obviously we will be able to expand

treatments at a slower rate than we want to and we will see other offsets in the availability or quality of care.

Q25 **Stephen Phillips:** If they don't work, there will inevitably be cuts in NHS services, will there not?

Simon Stevens: The health service will still be bigger at the end of this period than it is now, treating more patients and doing more things.

Chair: You say this every time. We know that.

Simon Stevens: But it's true.

Chair: Yes, it's true, but there is also demand and the job is to treat the population and the demands they have.

Simon Stevens: Yes, I'm being very frank about that. I am not in any way sugar coating that.

Sir Amyas Morse: I just want to come back to the question of capital budgets. I was listening closely to what you were saying about years 2, 3 and 4. You were making the point that there is a difference between your numbers and perhaps the numbers we are hearing from Ministers, because of transfer between capital and revenue. Presumably it would be helpful to be clear in your mind and to have a clear expression of what the level of capital expenditure actually needs to be across the system in order to move things forward, rather than thinking that this is an open door between the two. That really is quite unhelpful in some ways as a principle, I suggest.

Simon Stevens: It is precisely as you say, Sir Amyas. That's exactly what we need to do, and that is why parts of the country are now looking at what they need to do to redesign care to generate efficiency and what their capital needs will be, and we will have that within the next six weeks or so. On the back of that we will be able to rank what we can do with the money available.

Sir Amyas Morse: As I listen to you, and bearing in mind some of the public statements by the hospital associations on the level of distress they are expressing on their ability to operate within their budget, you sound like it is all under control and moving forward. Are they overstating their case?

Simon Stevens: I think you are putting words into my mouth. I don't think I've said any of those things about—

Chair: You tell us then.

Simon Stevens: If Jim Mackey was sitting here—who is, as you know, the chief executive of the hospitals' regulator—he would say that, actually, the provider trust sector delivered its Q1 financial goals for the first time in five years. I think he would argue that hospitals are on track to cut their deficits by more than two thirds this year. None of that is denying that there are substantial pressures but, if that forecast is right, the provider

sector will end this year in a much stronger financial position than it did last year.

Q26 **Chair:** What is "much stronger"? There were so many of them in deficit that it wouldn't take much to be stronger than last year.

Simon Stevens: When you do the bottom-up analysis, which they have done for individual hospitals in the £580 million mark, and they are trying to go further than that, anything in that range compares with the £2.45 billion deficit last year, so that would represent a substantial improvement.

Q27 **Chair:** Time and again we see hospitals set their staffing to fit the budget and then, during the year there are highly predictable pressures. They then need to provide more staff so they go to agencies. We are not talking about the rate of agency pay but about the volume of vacancies they carry, which we hear all around our constituencies and from colleagues from around the House. It sounds to me as though you are being very optimistic and you are going to stick to that—that they are going to be in a much better financial position by the end of the year.

Simon Stevens: That is what NHS Improvement are saying, based on the data available to them, and I have no reason to think that they are wrong. But equally—let's be clear—in order for hospitals to be able to deliver that performance, they are going to have to make some tough and difficult choices and, in some cases, service changes. That goes with the territory of cutting their cloth according to the funding that will have been made available to them. This is not a straightforward exercise, and I think NHS Providers were right to draw attention to the fact that there will be controversy along the way.

Q28 **Chair:** You just talked again about potential service cuts—

Simon Stevens: Changes.

Q29 **Chair:** A man who doesn't like to use the word cuts. They are reductions in the services available to patients—I would say cuts, and you would say changes. What will push you to go back to the Treasury and ask for more money? How far do you have to go before you have to go and ask for more money?

Simon Stevens: The programme of change that will be happening across the national health service will be clear for everybody to see. It does not require anybody particularly to go back. In fairness, despite the fact that we are probably the cheapest high-quality healthcare system in the world, we still—

Chair: We can go through the adverts, but this will just take longer.

Simon Stevens: Nevertheless, we still have efficiency opportunities in front of us. We have rehearsed these in the past. We have significant inefficiencies in procurement. We have variable quality of care. We have underused assets—

Chair: Which we have covered in several Reports this year.

Simon Stevens: What the national health service has to do is actually get going, in a serious way, on all of that, so that nobody can turn around and say that we're not doing our part.

Q30 **Chair:** Okay, but you must acknowledge that the sustainability and transformation plans and other reorganisations are sapping a lot of energy from a system that is also going to be trying to transform.

Simon Stevens: No, I don't think the STPs are sapping energy; I think they are creating energy. People are, in all honesty, now sitting round having pretty profound, open conversations about how services could be better—recognising that yes, some of this is driven out of financial necessity, but even if it were not for that, the truth is that a lot of how the health service has historically provided care is now no longer the way in which care should be provided. There is a pretty wide consensus about the need to redesign around patients with long-term conditions, to join up primary and hospital services, to get the health and social care piece working better and to be more assertive on prevention. That is the consensus, almost regardless of the economic envelope.

Q31 **Chair:** I will make one comment before I pass to Richard Bacon. You mentioned social care. The sustainability and transformation plans have 44 geographical footprints that bear no relation particularly to anything. My own area is boroughs that do not necessarily connect. You have that going on, but it does not take account of the pilot work going on in devolution with some local authorities, for instance, so you could end up with a transformation plan that has no regard to the social care—

Simon Stevens: I'm not sure that's quite right. If you take Greater Manchester, which is the single biggest act of devolution and decentralisation—that is one of the 44 footprints. The truth is that these are not the be-all and end-all. They are just a set of spaces where the right people can come together and have conversations. It is not a new administrative layer. It is not a reorganisation. It is a space where local health and government leaders have said they need to solve a problem. So we will also need to solve a problem at borough level, at county level and at regional level—all that is true.

Chair: There are so many questions about the governance and role of these, which are not really the remit of this Committee, but our sister Committee is watching what we are doing, and we are working with it.

Q32 **Mr Bacon:** Last week, Mr Stevens, when we were looking at the accounts, the NAO was kind enough to provide data on a constituency-by-constituency basis. In the financial year before the last complete one, South Norfolk clinical commissioning group, which is one of five CCGs in my area, was given £248 million and spent £250 million. Then, in the last complete financial year, according to the figures, it was given £268 million—a significant increase—and spent £269 million. We all understand that people are living longer. In 2004, this country had 60 million people; it now has 65.5 million. We all understand there are more people. We all understand that drugs cost more—all of that. But when I look at health

expenditure, which I have been doing for 15 years, I have come to the conclusion that there is no amount of money that would be enough. In the first five months of last year, prior to the election, you were saying—this was widely supported by all the political parties—that we need £8 billion extra for the national health service. I must have blinked, because somehow this £8 billion morphed into £10 billion as the standard number that people were talking about.

Simon Stevens: That is only because the Government have chosen to add in a year prior to incremental planning. There is an apples and pears issue there.

Q33 **Mr Bacon:** I know. You said we have rehearsed these themes in the past and indeed we have. We looked at delayed discharges recently, and we looked at the subject in 2003—13 years ago. All the same old issues came up. It became apparent that Northumbria NHS Trust, which runs adult social services in Northumbria, has zero delayed discharges and had 51 visits in the year from people trying to find out how to do it better. One of the three acute hospitals in Norfolk alone has 80 every night at £303 each, which is about £8 million a year. Times that by however many acute hospitals we have got, and the figure is probably high hundreds of millions or low billions.

You talked about capital. You can buy a perfectly good, functioning IT system for a big acute hospital and run it for five to 10 years for £15 million to £23 million. In Addenbrooke's they spent £200 million, and it crashed the hospital and caused it to go into special measures. You have had money hosed at you for 50 years, and I am not convinced that you collectively—I mean "you" second person plural—are good at spending it. I am really not. We have rehearsed these themes in the past until we are blue in the face, and yet we still see money being spent at a rate of knots as if it is going out of fashion.

I know you are trying to juggle a whole series of very difficult things. However, when I write, for example, to you and to Ministers saying that the Royal Devon and Exeter is about to make the same mistake that Addenbrooke's made by buying an American system called Epic, which we know does not work and crashed the hospital, they say, "It is nothing to do with us. It is down to them." Don't you think you have got to do rather more to impress the public and Parliament that you have really got a grip of this?

Simon Stevens: I think both these things are true at the same time. I have quite explicitly not come here today, or on any previous occasion, and said that the NHS is making maximum use of every pound at our disposal and there are no further opportunities for efficiency. Far from it—that is absolutely not the case we are making. Indeed, the proposition that we are currently seeking to deliver has a ratio of about £2 of efficiency for every £1 of extra funding. I think that is pretty darn impressive if we get anywhere near delivering it, but it is not inconsistent with the proposition that we also spend a relatively modest amount in this country on publicly funded health services compared with many others. I personally think *The Economist* editorial got it right this week when it said that over time as a

country we probably, one way or another, want to spend more on healthcare, but the NHS has got to change in the process. I think both of those can be true at the same time.

Mr Bacon: Unfortunately on that point, although it is in your favour, it was F. Scott Fitzgerald who said that the ability to retain two opposing thoughts in one head at the same time and still retain the ability to function is the sign of first-class intelligence—

Chair: That's the best you're going to get, isn't it? Now, a question—

Q34 **Mr Bacon:** But why is it that everybody, including magazines of the quality of *The Economist,* is so obsessed with input measures? Why do we talk about input measures as if somehow some mythical benchmark of what they are doing in Norway, Bolivia or Sweden is what we ought to be aiming at? Really what we ought to be obsessing about is five-year cancer survival rates, not the pounds, shillings and pence involved in achieving those.

Simon Stevens: We are obsessing about cancer survival rates, and that is why it is so good that the cancer survival rates increased from 59% to 69% over the last 15 years.

Mr Bacon: I meant cancer survival rates as a proxy of output measures generally.

Simon Stevens: Sure, so with our cancer improvement plan for the next five years, the ultimate test will be: do we save 30,000 more lives? It won't be: do we have this many clicks of the turnstile or this number of diagnostic tests? However, in order to get that, we have got to get early diagnosis, which means we need faster testing, in particular for colorectal cancer and lung cancer, and we need to upgrade our radiotherapy machines, which I am hopeful that we can do quite soon. There is a relationship between the care on offer and the outcomes you get, but we have clearly framed our cancer improvement plan in terms of outcomes.

Q35 **Karin Smyth:** Can I take us back to the accounts? Our erstwhile colleague Mr Mowat has appeared in the Department of Health and—

Chair: They wanted him on the inside, rather than the outside.

Karin Smyth: They did. He has mysteriously found £170 million for community pharmacy, as I understand it. Where has he found that money from?

Simon Stevens: When you say he has found £170 million—

Karin Smyth: There is a reprieve or a delay for community pharmacy cuts that were in the forward budgets for next year. They have now been delayed and community pharmacy, we read, has been saved.

Simon Stevens: I certainly hope that last statement is true, but the costs of that delay are a further budget pressure on NHS England this year, which I am having to manage.

Q36 **Karin Smyth:** How is that notified to you from the Department of Health?

Simon Stevens: Obviously, these are decisions for Government. We have a conversation about our ability to manage in these circumstances, and a decision is taken.

Q37 **Karin Smyth:** So would that be another raid on NHS England by the Department of Health?

Simon Stevens: No, I don't think that would be the right way of saying it.

Q38 **Karin Smyth:** But it was not a negotiated point with you for these—

Simon Stevens: No, I think that is trying to put daylight where none may exist. There are some legitimate considerations here about how to deal with the fact that community pharmacy is hugely valuable in this country, but we also have a situation where we are spending something like £2.8 billion in order to dole out £8 billion-worth of medicines. There are efficiencies to be made in every part of our cost structure, including that.

Q39 **Karin Smyth:** But it just doesn't give confidence, does it, that, as I alluded to earlier, there is this plan? To be fair to everybody—I made this point to the permanent secretary last week—there are real problems and real pressures. But this movement in year on people is not helpful, is it, and it does not give us confidence that there is an overall plan that people are sticking to? That is a statement rather than a question.

Stephen Phillips: Do you agree with it?

Simon Stevens: Well, you have chosen one particular example, but in any given year there are ins and outs. But let's be clear: yes, in order to deliver against the funding that we have, we are going to have to be resolute on some often quite controversial decisions.

Q40 **Chair:** You are a frequent flyer with this Committee. It would be very helpful if you could set out to us in a letter exactly what your responsibilities are, which picks up Ms Smyth's point about announcements made by Ministers and then you having to adjust your plans to fit the announcements sometimes. There are all sorts of other pressures.

Simon Stevens: Our responsibilities, and my responsibilities as your accounting officer, are set out very clearly in the governance statement of our annual report, on page 81 and subsequently, in inordinate detail, so I would refer you to that.

Q41 **Chair:** That is absolutely fine. When Chris Wormald, the permanent secretary at the Department of Health, was in front of us last week, he said: "We expect NHS budgets to remain challenging." He talked about the financial reset that you are doing. He said: "it is a tough plan. It is a difficult plan, and it is a challenge for all NHS commissioners and providers to meet." It sounds like he is saying it is down to you to deliver this tough, difficult—these words are all in one sentence, I stress—plan, so do you think your neck is on the line?

Simon Stevens: I don't think that is what Chris said, but the piece you have quoted from him is clearly right: it is incredibly challenging and it is going to be a team effort. There are some things that the Department of Health is going to have to do—

Q42 **Chair:** I have quoted him, so what I have said is right, to be clear.

Simon Stevens: What you put in quotations I agree with, but your editorialising subsequently that therefore—

Q43 **Chair:** I am asking you: do you think your neck is on the line if you do not deliver this?

Simon Stevens: I think all of us want to deliver this, because ultimately it is about trying to improve care for patients across the national health service and to do the best we can with the resources we have. That is why we are all doing the roles we have chosen to do, but is it a—

Q44 **Chair:** But the hole is getting bigger. Is it an impossible task, Mr Stevens, to do this with the money that you have?

Simon Stevens: It is an extremely challenging task. At some level, we are all volunteers, as it were—

Chair: I think everyone has agreed the word "challenging".

Simon Stevens: It is difficult; of course it's difficult. Anybody who thinks it isn't does not know what they are facing, but—

Q45 **Stephen Phillips:** "Extremely challenging" seems to me to come very close to being, "We hope we can achieve it, but at the end of the day it may be impossible."

Simon Stevens: We are going to move heaven and earth to do the best we can—

Q46 **Stephen Phillips:** Mr Stevens, I think you would do yourself a lot of favours if you would just agree with me. No one is suggesting that you are not moving heaven and earth and no one is suggesting that it is not extremely challenging, but I think that the descriptions that you and the permanent secretary are giving to the task mean that, with luck—with a fair wind—maybe we can do it, but equally, and perhaps even more likely, we might not be able to. I think you agree with that and you would do yourself some favours if you indicated that to the Committee now.

Simon Stevens: Well, it is going to take enormous effort on the part of many, many people right across the national health service. I have been absolutely clear about this and I think it is consistent with what you have just said, Mr Phillips. In the 28 years since I started working in the NHS, this is clearly—by far and away—the most challenging extended period for the NHS.

Chair: And you are in charge—lucky you. We will now hear from Mr Foster and then Ms Phillipson.

Q47 **Kevin Foster:** It was interesting to hear, Mr Stevens, the comment a few moments ago about how these plans can energise discussion at local level. I think it is safe to say that since April, when part of the plans for Devon were unveiled in my area, that has certainly energised debate. But the other half wasn't; that was leaked last week. How do you see the balance between delivering your national goals and objectives and, at a local level, ensuring these energising debates are not just, bluntly, foregone conclusions?

Simon Stevens: There are two things to say about that. First, it will be very important that there is full engagement with communities, with staff and with patients about the proposals that are developed through this process. Where necessary, as a result of major service change, there will need to be formal public consultation, with all the legal protections that go with that. We will publish directions to the NHS next week making that crystal clear. However, it also seems not unreasonable that before you do that, you have developed a set of potentially viable proposals with which to discuss and engage, rather than flying kites on proposals that may not actually make any sense. So that is the circle that people are trying to square. In many cases, things that are described as being fresh out of the STP process have been in the works and people have been talking about it for a very long time, so they are further along. In other cases, there is more discussion required.

Q48 **Kevin Foster:** Obviously, it is all very interesting. Full engagement can be summed up as a few meetings and a questionnaire at one extreme. In terms of STPs being delivered, who takes the ultimate oversight in terms of ensuring that they actually deliver the very challenging goals you keep talking about and that, in your own words, you are resolute in delivering? Whose responsibility is that? Is that yours or that of the local areas?

Simon Stevens: The statutory accountabilities are not changed through this process. Individual boards and organisations, increasingly working together rather than at odds with each other, will have that responsibility in each part of the country but, in order to give them their best chance of success, obviously NHS England and NHS Improvement want to work with them to ensure that these are robust and implementable plans.

Q49 **Bridget Phillipson:** You said that you will make this work in terms of the financial settlement, but at what point will you go back to the Treasury if it does not work? If, having moved heaven and earth, it is still not possible, at what point will you go back to the Treasury and say, "This can't be done"?

Simon Stevens: A month before the 2015 spending review settlement, not only unusually but probably uniquely for somebody doing my job—none of my predecessors had done it—I went public and said I did not feel that the SR was on track to get us going on the journey that we wanted. So I will go back as and when circumstances require but, by and large, I think the task in front of us right now is to try and formulate sensible plans and to get going with the efficiencies that, as Mr Bacon pointed out, the NHS still has available to us. There may be subsequent decisions that

would be for the Government, not for the NHS, but we will cross that bridge when we get to it.

Q50 **Bridget Phillipson:** There will be a question of either additional funding or reductions in services at some point.

Simon Stevens: Or other ways of driving efficiency that have not previously been undertaken.

Q51 **Chair:** Mr Stevens, you keep talking about efficiencies when you come here. We are the Public Accounts Committee, so we love efficiencies, but there is a point at which efficiencies come at too high a cost to patient care. The line between efficiencies and cuts in services is often quite a fine one. I don't think I need to repeat Ms Phillipson's question. When will the point come? You have used up political capital once going and asking—

Simon Stevens: I understand why you are posing the question, but you will also understand that it is not a question in the abstract I can answer.

Q52 **Chair:** You say you have done it once. You didn't actually say you would be prepared to do it again.

Simon Stevens: I don't think it helps to go around making threats. The point is that—

Q53 **Chair:** Not threats. You run—is it bigger than the Chinese army?—one of the largest employers and biggest health services in the world, and the most important to us anyway. It is your job to make sure that you can deliver to the mandate, and it is your job to call out Ministers if you do not think that is going to be possible, bearing in mind all your professional knowledge and all the information you have at your fingertips. Will you be prepared to call on Ministers and tell them you cannot deliver to the mandate if you do not have enough money to do that?

Simon Stevens: Ultimately, of course. As I say, I have done that in the past, but let us be clear. We have got a frontloaded funded settlement for this year. There are many moving parts between now and 2020. There are many moving parts between now and 2020. I do not think viewing this purely through the lens of 2020 is necessarily the right way into this conversation.

Chair: I don't think we're doing that, Mr Stevens.

Simon Stevens: The reality is that since 23 June, there have been many moving parts across the economy, the public sector and many other things, so it would be quite unreasonable to expect all of these things to be resolved here and now. Let's see how we go. I think I have been remarkably frank with you here this afternoon about the issues in front of us for next year, the year after and the year after that, and I do not think I have anything further to add.

Chair: Okay. I'm going to see whether Caroline Flint can winkle one more

response out of you.

Q54 **Caroline Flint:** I'll try my best, Chair. Just referring back to Ms Smyth's question about interventions by Ministers—that was in relation to a delay in the cut to community pharmacies; we have yet to see whether that actually happens—how often do you get interventions on specific issues by Ministers outside the planning process?

Simon Stevens: Very infrequently.

Q55 **Caroline Flint:** You have been here since April 2014. Can you give us an idea of how many times that has happened? It is just over two years.

Simon Stevens: I think this is a team effort, where people are all trying to achieve the same results. It implies almost that it is some kind of arm-wrestle, and the truth is it isn't.

Q56 **Caroline Flint:** No, no. I am just interested, because you are in charge of the overall planning of a huge sum of money, and we all agree it is really tough. When you get to a settled view, how often you get interventions from Ministers, who maybe put pressure on from elsewhere, is probably quite important to the stability of how everyone is planning for the future and all the challenges you have. Let's just say in the past 12 months: how often have you had specific interventions by Ministers outside of the planning process?

Simon Stevens: As I say, I have worked in and around the national health service on and off for 28 years. I would say the ability of the national health service to get on with the job that we have been tasked with doing, without those kinds of processes, is greater now than it has been at any time in my recollection.

Q57 **Chair:** I will bring in the Comptroller and Auditor General for a final word, but I just remind the Committee—I am sure you do not need reminding, Mr Stevens—of the Department of Health announcement in November last year about the £10 billion that you have. I will just list some of the things—this is not even a complete list—that it said that would allow the NHS to offer: "5.5 million more outpatient appointments," which is an input, as Mr Bacon has rightly highlighted; "deliver a truly 7-day health service"; "5,000 extra doctors…in general practice"; "£4.8 billion in capital funding in every year of the Spending Review". There is a long list of promises set out for you already, spending that money, yet the demand is going up. My simple question to you is: isn't the hole just getting bigger, and isn't your position going to be untenable soon?

Simon Stevens: We could talk about any one of those, because it is really not very meaningful to have the conversation in the abstract. You talk about the £4.8 billion of capital. We have talked about that—the capital/revenue issues. You refer to the outpatient increases. Yes, I think we will see that, but at the same time, we want to redesign the way outpatients works, because a lot of patients are referred by their GP for a consultant review. Actually, in the best parts of the country, including places like Tower Hamlets, the GP consultation and the outpatient specialist advice are all integrated into the same encounter, often in real

time. You talk about the 5,000 extra doctors in general practice we want. We need that as part of the—

Chair: You may be saved by the bell. Just finish your sentence.

Simon Stevens: For all these things, we are going to have to phase them according to the availability of the extra funding, and for some of them, that is going to be back-ended towards 2020, because that is when the pick-up in the funding occurs.

Chair: Labour Members are abstaining in this vote. Perhaps I should not declare that publicly, but it is too late. Are other members of the Committee content for us to continue while you rush off, vote and come back? Mr Stevens, I will give the Comptroller and Auditor General a final opportunity to emphasise his concerns.

Sir Amyas Morse: I will just touch on some of Chris Wormald's words, since you have obviously studied the hearing. I felt we had a pretty good understanding of where we need to go in terms of not being in a position of having to find as many ad hoc ways of getting the budget into balance at the end of next year as we seem to have this year, and I think the Committee was satisfied with that. He did say that that would be improved because of a reset in the budgetary posture. Can I just understand what you take that to mean? What is the nature of the reset, exactly?

Simon Stevens: I take that to mean the contents of this document that we published on 21 July.

Sir Amyas Morse: No more than that. That is fine.

Simon Stevens: If we can do this, that would be quite sufficient.

Sir Amyas Morse: So if you carry that through, we will not be in a position at the end of next year where you are having to scrape round looking for adjustments to make to stay within the spending limits.

Simon Stevens: There will not be the same pressures as there were last year.

Sir Amyas Morse: There will be pressures, of course, but yes, okay. Thank you very much.

Chair: Thank you for your patience. We did not expect the session to go on quite so long, but as you will appreciate, all members of this Committee—in fact, all Members of this House—have real concerns. We recognise that you have a big challenge running a very important service in this country. We wish you well in it—it may not have come across in our questioning—but we will be holding you to account for it, of course. We will now pause, as we have to rearrange chairs or something to do with the cameras.

Examination of witnesses

Witnesses: Simon Stevens, Stephen Hay, Tracy Dowling, Roland Sinker and Aidan Thomas.

Chair: Welcome to our panel for our main session this afternoon. We have a number of witnesses relating to the National Audit Office's investigation into the UnitingCare Partnership contract. Our witnesses from my left to right are Tracy Dowling, the chief officer and the accountable officer for Cambridgeshire and Peterborough CCG; Simon Stevens, the chief executive of NHS England and a regular visitor to our Committee; Stephen Hay, who is the executive director of regulation and the deputy chief executive of NHS Improvement; Aidan Thomas, who is the chief executive of Cambridgeshire and Peterborough NHS Foundation Trust; and Roland Sinker, on the far left, who is also from Cambridge University Hospitals NHS Foundation Trust. That is Addenbrooke's. I know Addenbrooke's; the new title confused me, Mr Sinker. Our hashtag for anyone who is following this on Twitter—possibly lots of people in Cambridgeshire—is #unitingcare.

This is an extraordinary Report—well, not such an extraordinary Report, but a sad story of £16 million spent on a project that lasted for eight months. It was intended to deliver benefits for patients and a joined-up service, but it actually delivered no obvious benefits for patients. It seems to us that the taxpayer and patients lost. What we want to probe today is what on earth happened that got it to this stage and allowed it to continue when clearly there were really big warning signs that things were not going to work. Is anything salvageable from this so that patients in Cambridgeshire can get any benefit from the taxpayer money that has been poured into it?

Q58 **Karin Smyth:** Welcome, everybody. Ms Dowling, why did the CCG decide to contract this commissioning to a third party?

Tracy Dowling: The CCG and previously the primary care trust had been trying to innovate and change models of care, particularly for older people. They were not able to get those pathway changes to really embed and happen in practice to improve the management of frail older people and people with long-term conditions and have an impact on reducing the demand on acute hospital admissions. They felt that, by commissioning an organisation with responsibility for the total budget for those older people, that organisation would find ways of integrating pathways of care and working differently with providers to get those outcomes. It was very much an outcomes-based rather than input-based specification of care. It was also a long-term contract. Recently we have been contracting on an annual basis with providers. This was putting out to the market a five-year contract with an optional two-year extension, to give providers the time to transform services and make those changes.

Q59 **Karin Smyth:** But commissioning is your role, so why is that someone else's role and not yours?

Tracy Dowling: What the clinical commissioning group was seeking to do through that third-party organisation was for that organisation to bring about the transformation of service delivery.

Q60 **Karin Smyth:** So why can't you do that as a CCG?

Tracy Dowling: I think we can, and I think that is what we are doing now.

Q61 **Karin Smyth:** So is the lesson, then, that you are fit for purpose to do that commissioning role? Is that the lesson?

Tracy Dowling: I am relatively new in post in developing the organisation to be fit for purpose to do that transformation.

Q62 **Karin Smyth:** My question is: you decided to outsource that commissioning role to a third party to integrate, because the CCG felt it could not do that role. Do you now think the CCG can fulfil that role?

Tracy Dowling: Yes, I do think the CCG can do that role.

Q63 **Karin Smyth:** What is the difference?

Tracy Dowling: The difference is accepting, first of all, that that is our responsibility. I think there is a difference in the way in which our relationships have developed with the providers, because actually we have been through a very difficult time together and I think we have come out of that much stronger. We collectively own the issues and challenges in our system, and I think we are collectively owning that we need to find those solutions, implement them together and collectively manage the risk in our system, rather than seeking to transfer that risk back and forth across the commissioner-provider divide.

Q64 **Karin Smyth:** Forgive me—I do not know the geography well enough to answer this question, but are you the lead organisation for the STPs?

Tracy Dowling: Yes, and I am the lead executive for the sustainability and transformation plan.

Q65 **Karin Smyth:** May I ask—sorry, it's a three-way go now, isn't it? To Ms Dowling, Mr Thomas and Mr Sinker: do you accept that the money that was available to fund the transformation—the £10 million—was inadequate?

Tracy Dowling: I think the cost of transforming services was more than that £10 million. The CCG did not have a view that that was the only funding that the accountable provider would be putting into transforming services, and I think that is one of the areas where there was a difference of opinion between the commissioner and the UnitingCare Partnership.

Q66 **Karin Smyth:** Does anybody else want to comment?

Aidan Thomas: The transformation moneys that were agreed were in addition to resources that trusts like mine already had. We already had services on the ground and, for example, we had things like programme management support because we had done lots of other major changes prior to that. I think at the time we were not of the view between us—between the CCG and UnitingCare—that the transformation moneys were inadequate.

Q67 **Karin Smyth:** You weren't? You thought it was adequate?

Aidan Thomas: Yes. Sorry for the double negative.

Q68 **Karin Smyth:** So you thought it would be adequate.

Aidan Thomas: We thought at the time they were adequate, and we had in fact done—I have to say that by the time UnitingCare shut down, the transformation that had started was going to plan. I think in retrospect we did not see that necessarily as a major issue.

Chair: It is very warm in here. We don't want to get started on the "air conditioning or no air conditioning" argument, but you are very welcome to take your jackets off if you are warm, and if you need more water please flag it to one the team.

Aidan Thomas: Thank you.

Q69 **Chair:** Mr Sinker?

Roland Sinker: Two observations from the Addenbrooke's and Rosie point of view. First, given that we didn't have absolute clarity around the full costs of the services being provided between the CCG and the providers at the time of signing, everybody had a slightly different view as to how much money was available and therefore whether the £10 million was sufficient for transformation. If the core costs had been better understood, we would have a clearer view as to whether the £10 million was adequate.

My second observation would be that as we plan together going forward, we are very much thinking about open book accounting between us, and that we really have to understand the costs of services. We have to understand in detail what our patients need and how we can cut the cloth accordingly to get the right service. A big part of that will be some element of double running between hospitals and community services and some real investment in transformation. That is very much what the three of us are planning for at the moment in the STP, the transformation programme that we have signed up to.

Q70 **Karin Smyth:** Ms Dowling, given that you are the commissioner and both trusts were in deficit, it should not really have come as a surprise, should it, that that funding was inadequate? As we have heard, the trust might not have had full sight of the whole picture, but you would have had full sight of the whole picture.

Tracy Dowling: I think that the CCG didn't have a sufficiently adequate understanding of the costs of service provision from Cambridge Community Services. The CCG did think that the budget it was spending on those services was covering the costs. I think that the work that was done through the diligence after the contract was signed has demonstrated that that was actually not the case and so there was an unknown cost, post-transaction, that was a surprise.

Q71 **Karin Smyth:** What does post-transaction mean? Post the date of the

signing of the contract with UnitingCare?

Tracy Dowling: Yes.

Q72 **Karin Smyth:** Okay. But running up to that, in the two or three years before that, you would have had oversight of all your providers' costs and a knowledge of the level of deficits that they were carrying. You would have had those conversations, so it still shouldn't have been a surprise.

Tracy Dowling: Cambridge Community Services were not running with a deficit and neither were CPFT—they had resolved their deficit. At the stage of doing the procurement, I don't think Addenbrooke's was as large and as clear as it then became shortly after the contract signature.

Roland Sinker: That's right.

Q73 **Karin Smyth:** Do you think that is a failure of the oversight process locally, that it became clear afterwards?

Tracy Dowling: I think an improvement in the oversight process since then is that we are much more openly being open book and sharing—

Q74 **Karin Smyth:** So that's a yes to that particular question. I think we will come back to oversight generally in a short while. Thank you.

We agree that the model itself and the coming together and everyone talking to each other and working together co-operatively for the system is, lo and behold, a good thing. It seems that patients thought that that was good. Which part of that do you feel that patients felt was a good thing?

Tracy Dowling: Patients really endorsed the model of care and there was a tremendous amount of stakeholder engagement in designing the model of care that went out in the specification. There has been a lot of concern since the contract collapsed from our patients and our public that we are going to lose that and our commitment is that we won't.

Since then, we have held a number of events with patients, the public and their representatives, to hear about the parts of the model that they particularly want us to keep. We have been very open about the elements that we have got in place and the elements that we can't afford to put in place yet. Our sustainability and transformation plan still intends to put the same model of care in place. A huge effort went into designing that, with patients and the public, and the evidence behind that is that it is a really good model of care that is outcomes-based. It is the one thing that we definitely need to keep from this.

Q75 **Chair:** Ms Dowling, pain was gone through to set up this contract as a new organisation to run the services, but it seems like you have just worked out between yourselves that you are going to do it anyway. Are you not tendering this? Is that not a requirement?

Tracy Dowling: No, we're not and I don't believe that that is a requirement.

Q76 **Chair:** But you tendered it the first time. Why did you need to go through all of this pain setting up a new vehicle and all the rest of it?

Tracy Dowling: The decision to tender it the first time was about changing provider and having some competitive dialogue with different providers about how they would provide this model of care and deliver these outcomes. The winning proposal from UnitingCare, from CPFT and Addenbrooke's Hospital as the two main NHS hosts, was the best quality bid and the staff did transfer—

Q77 **Chair:** We will get into the fact that it didn't stack up financially.

Tracy Dowling: The short answer is that we don't need to, to retain that.

Chair: You don't need to. That makes us wonder why you did it in the first place.

Q78 **Karin Smyth:** So, you don't need to go to a third-party provider.

Tracy Dowling: And we don't need to retender the services.

Q79 **Karin Smyth:** The individual services?

Tracy Dowling: Yes.

Q80 **Stephen Phillips:** I know you weren't in charge at the time—you were in the CCG but you weren't chief executive—but it does lead to the question, why did you go forth? Why did the CCG form the view that this was the appropriate way forward?

Tracy Dowling: I wasn't in the CCG at the time that it took that decision. I think the CCG took that decision at the time because it had not been successful previously in the primary care trust at getting the changes of service model and service delivery that it had wanted to through separate and bilateral contractual negotiations with different providers.

The CCG's view was that to commission a service from an organisation with that responsibility to integrate across the different providers would get that change, because they would be contractually obliged to deliver that change.

Q81 **Karin Smyth:** Doesn't that tell us that the CCG was trying to outsource some of the difficult decisions that would come about as a result of trying to integrate those services within a very challenging financial envelope?

Tracy Dowling: Yes. I think the CCG felt that a different organisation would be able to bring about that change in a way that the PCT had not been able to do previously.

Q82 **Karin Smyth:** So, did they in fact outsource difficult decisions?

Tracy Dowling: They outsourced the responsibility for transforming care pathways and change, which can be difficult to achieve.

Q83 **Karin Smyth:** Would you accept that CCGs cannot outsource difficult

decisions; that they ultimately have to take them themselves?

Tracy Dowling: Yes, I do accept that because I think that is the commissioner's responsibility—to be responsible for the delivery of all of those NHS services for their population and the outcomes, therefore, for that population.

Q84 **Karin Smyth:** So, when it comes to the STPs—you have explained that you have learned those lessons and that is what you are trying to do—the responsibility for that decision-making process will fall to you.

Tracy Dowling: So that will fall to me as the lead of our health and care executive, which is our six-chief-executive governing body for our Sustainability and Transformation plan.

Q85 **Karin Smyth:** But, of course, in governance terms that does not fall to you, does it? Because you can't force all the other people within the footprint to be part of that decision.

Tracy Dowling: I think we have not to use force but be driven by what gets the right outcomes for patients and what gets the best use of all of our resources—both financial and staff resources. That is what is driving us: to find different ways to deliver services that deliver those better outcomes than those we have been able to deliver to date.

Q86 **Karin Smyth:** Thank you. Mr Stevens, it is a good example of people perhaps trying to come together, isn't it? What lessons do you think have been learned nationally from what has happened here, with the way that the CCG has commissioned this project?

Simon Stevens: I think there are seven lessons. In order to get into that, it is worth being clear about my reading of what people were trying to do across Cambridgeshire and Peterborough when they did this. They were trying to do four things in good faith.

First, they were trying to integrate different services, which is not just about passing the buck as to who is making the difficult decisions or who is doing the commissioning. They were saying, "We have got Cambridge community health trust, these other organisations, ambulances, GP surgeries and all the rest of it. It is a bit of a hotch-potch and we want to try to bring this together to create a more person-centred care for some very vulnerable people across Cambridgeshire." That is why this service model is so popular.

Secondly, they were trying to provide multi-year certainty. They were trying to say, "Instead of the annual arm wrestle around short-term contracts, we are going to set out what five years' worth of funding would look like, to give people the ability to reshape services within that."

Thirdly, they were saying, "We are not going to pay for clicks at the turnstile. We also want to link some of the funding to improved outcomes." That picks up Mr Bacon's earlier point.

Fourthly, they were saying, "In the process, we want to drive some real efficiencies." The business plan that set out to do that envisaged £178 million of efficiencies by 2020. Even if it were a third or two thirds of that, it is still worth having.

Those were four good reasons why this group of people got into this process but it did not work. So here are the seven lessons and what we are doing about them.

Q87 **Chair:** Please answer the question.

Simon Stevens: First, you have got to get the service designed right at the outset. I think it is apparent reading this that some of the service design questions were being iterated as the procurement process was going through.

Secondly, you have got to get transparency from legacy providers. As I read the NAO Report, part of the problem was that the data from the previous community health provider—Cambridgeshire Community Trust—were not available to the new folks and therefore they did not know what the costs of service genuinely were. That is why we need open book.

Thirdly, we have got to increase the commercial nous where these kind of arrangements are embarked on. There are some pretty basic things here around parent company guarantees which, if they had been insisted on, would I believe, based on what the NAO found, have forced the conversation about whether this level of risk transfer was viable. The same would be true for the VAT issue—that should not have been still in play after the contract started.

Q88 **Karin Smyth:** So, would you still see this sort of third-party model as being a good way forward?

Simon Stevens: I don't think it is a third-party model; it is a combination model. It was two NHS trusts doing it together instead of a hotch-potch of different providers each with different, separate contracts. So I do not think that was an ignoble ambition for what was trying to be done in Cambridgeshire.

Q89 **Karin Smyth:** That was not quite my question. What you were starting to stay was that the way of contracting, with the overhead parent company type of model, has got inherent problems. I have read this to say that that is absolutely not the way to go forward, but I think you are saying it is still viable.

Simon Stevens: It is only a viable way forward if you force the issue on things like parent company guarantees, in that—Stephen will come in later on—that would then drive the hard conversations about, "Have you guys really thought through what this looks like in three, four or five years' time?"

Q90 **Karin Smyth:** Because they cannot do it by themselves?

Simon Stevens: There are other ways of achieving the same result: alliance contracting. I think what the CCG, as I understand it, was trying to do was not be the piggy in the middle for all the different service providers, so it was arbitrating between them. It was saying, "Guys, you've got to come together and figure this out yourselves," which, in this case, because they did not get these commercial basics right and other things I am going through, it backfired. But that does not mean that intrinsically it always would.

Those are the first three of the seven. I think the fourth is that we have got to have complete clarity about the role of external advisers. It is pretty clear that at best the different strands of advice were not brought together into a coherent whole and the leadership of the decision-making bodies did not register perhaps what should have registered from some of that advice. In the case of one of the three external advisers, having looked at what they had been up to, NHS England has taken the decision that they should be disbanded: the Strategic Projects Team.

Fifthly, I think it is clear that if this is going to work, you cannot change your mind halfway through the procurement process about the terms that you are engaged on. That happens all too often. It is then unfair to the level playing field that was established early on.

Sixthly, do not go live until you have got your issues sorted. And, seventhly, NHS England and NHS Improvement together have got to do a better job rather than it being regulated down the organisational silo. That is a rather long answer, but I have alluded to this very carefully. Those, it seems to me, are the seven habits of highly effective service redesign that we have got to get right if this kind of thing is not going to be repeated.

Chair: Mr Stevens has been reading his management books.

Simon Stevens: Airport fiction.

Q91 **Karin Smyth:** It is not just about service redesign, is it, though? It is about the model chosen to deliver it. My first question to Ms Dowling was about whether the CCG has essentially abdicated or outsourced its responsibility as a commissioner and you seem to be saying that using this model, with the parent company taking that decision, suggests that the commissioner is not really fit for the task it has been set. Would you agree?

Simon Stevens: No. I think what they did instead was make a commissioning decision as to five years' worth of outcomes and value that they wanted with a redesigned service underneath that. For all the reasons we have just gone through—those seven reasons—it did not work, and that cannot be repeated and has to change across the NHS.

Q92 **Karin Smyth:** But they are not piggy in the middle as you said earlier, because they are not providing; they are commissioning. That is their job: to get other people together to provide the service within the specification. You can say that the specification was ill-defined and so on—people will come back in on that—but essentially what is the point in

having a commissioner if they outsource that to someone else who is not a thing accountable directly to the public and cannot, for example, be here in front of us today?

Simon Stevens: No—I think it is perfectly legitimate to decide where the division of labour should sit between different parts of the provider structure. I will give you this example, to make it very tangible: in about a third of the country I think acute hospitals are also running their community services. We call that integration; we do not call that an abdication of the CCG's responsibilities to buy things separately.

Q93 **Chair:** No, but sorry, Mr Stevens, to pick up on Ms Smyth's particularly pertinent point about governance, if there is a problem with community services and a hospital in my area, on those issues I can go to the chief executive of the hospital. There is a board and a chair. What about answering Ms Smyth's question about why Uniting Care partnerships is not a thing that is sitting in front of us today, directly responsible? Who is responsible now?

Simon Stevens: There were two NHS trusts involved in this thing, so we know who they are and their chief executives are here today, and there was a CCG, and the CCG is here. So it is not a very complicated picture. It is the three organisations that are doing this.

Q94 **Chair:** So where did the buck stop? If it had continued and there had been an issue—let's say an MP gets a bit of casework about something in the Uniting Care partnership—who would they go to? Where is the accountability?

Simon Stevens: There are three statutory boards. In the event that these kinds of structures, which will be by exception—there are some downsides to them. Nevertheless, if we are going to have these kinds of things, we need to ensure that NHS Improvement is clear about the extent to which they are regulated as the combined vehicle, rather than the two statutory bodies that form it, and that the CQC is clear what the quality oversight looks like. In some parts of the country, for better or worse, private providers are doing this so it is not just statutory boards.

Q95 **Chair:** But when it comes to the oversight—Ms Smyth was very clear in her point—who is in charge? If Uniting Care Partnership was here now, who would we be challenging about this?

Simon Stevens: It would be the same three people that you have in front of you here: Roland and Aidan, who are the two providers; and Tracy, who is the Clinical Commissioning Group holding the contract and accountable for how they are doing.

Chair: So, exactly. It is three organisations.

Simon Stevens: So they are here.

Q96 **Chris Evans:** Mr Stevens, Monitor has had 34 outstanding issues in negotiations on the contract. It was not signed off until the day it was signed. I am looking at paragraph 1.8 of the Report, which says that

Cambridge and Peterborough NHS Foundation Trust wanted to win the contract because they feared that a "reduction in its income might reduce its viability as a foundation trust in future." Was that a consideration even though there were 34 individual problems with the contract, which was yet to be negotiated?

Simon Stevens: Aidan Thomas, the chief executive of the trust, will obviously respond to that.

Q97 **Chris Evans:** But I want to know why the contract was signed when there were still 34 problems, which was a large amount.

Simon Stevens: I think it is clear that it should not have been.

Chair: Okay, but on the point about the budget—Aidan Thomas.

Aidan Thomas: From our trust's perspective, the point about the continuation of the trust—particularly the viability of the other services that we ran, because we are a mental health provider for adults and children as well as providing community children's services in parts of the patch—was important. In our view, it was important that we did our best to win the contract. That is reflected in the NAO's Report.

On your question about how many outstanding issues there were when we signed the contract, it was a concern for everybody on the provider side. I am sure that it was a concern for the CCG too. There was pressure in the system at the time to get the thing going and get the whole thing running. That was partly because there was a need for the economy to deal with its financial problems—if this contract had been allowed to work, it should have dealt with some of that—and because there had been a long period of uncertainty for more than 1,200 staff. There was pressure to get it done.

I think we would all agree with Simon Stevens that, in retrospect, it would have been much better to have got those things sorted before the contract was signed.

Chair: To state the bleeding obvious.

Q98 **Karin Smyth:** I am heartened to hear Ms Dowling say that the commissioner would now lead this and take that responsibility. I am slightly disheartened to hear that the model of having this third party is still preferred. I do not see, given the lessons we have learned, why you would need to set up a complicated vehicle to deliver the programme.

Tracy Dowling: Sorry, may I clarify? The model we are retaining is the clinical model of service delivery. We have no intention to continue to have a third party.

Q99 **Karin Smyth:** I know, but Mr Stevens's point is about problems with the third-party parent, getting the governance checked and checking whether you pay VAT. Whereas, actually, the lesson of this is: why complicate it by setting up a different vehicle?

Tracy Dowling: We are simplifying it in our system.

Q100 **Karin Smyth:** Okay, but I guess that, across the country, Mr Stevens, we will see different models.

Simon Stevens: Here's the answer: if this scope was a bit wider—if it included GP services and ambulance services, which it might well have done, and possibly some social care—and if you are saying that you can only have a single statutory body doing it, the implication is that you either have to nationalise general practice left, right and centre or you cannot have ambulance trusts and so on. There may need to be ways of bringing separate organisations together in a shared endeavour. I think, for the reasons we have set out, that this kind of approach with an SPV is likely to be exceptional rather than the rule, but if it were ever to be applied, we would need to make sure that the seven safeguards I discussed are fully met.

Q101 **Chair:** Tracy Dowling, we know now that the budget was unrealistic. We have heard from Simon Stevens that certain data was not available. So how did you go about testing the £752 million budget to check that it was viable in the contract that was being discussed?

Tracy Dowling: I think that the CCG looked at its existing spend. It looked at what different models of care in other parts of the country could deliver in terms of efficiency and gain. I also think that it looked at what its future budget would be and the pressures on the budget, and it was seeking that that efficiency would deliver some of the financial gain that will be needed in our system over the next five years.

Q102 **Chair:** So which came first: the budget pressure or the service model? If you have a budget and you are trying to get efficiencies, it is tempting to set the efficiencies to meet the gap in the budget. Is that what happened in reality?

Tracy Dowling: I think the two came at the same time.

Q103 **Chair:** You say "I think." Let's just be clear. You have been chief executive of the CCG for, what, the last 12 months?

Tracy Dowling: Since May this year.

Q104 **Chair:** But you worked for the CCG before.

Tracy Dowling: I worked for the CCG from January of the previous year, which was after the contract was signed.

Q105 **Chair:** Okay, but where were you working before that?

Tracy Dowling: Before that I was with NHS England.

Q106 **Chair:** In Cambridgeshire?

Tracy Dowling: In East Anglia, covering Cambridgeshire.

Q107 **Chair:** So you have had oversight. You have been aware of all the negotiations of this contract.

Tracy Dowling: Yes. When the CCG was first formed, one of the strongest requirements from general practice, leading commissioning, was

to sort out the provision of care for older people. That is because of an ageing population, and the ageing population is growing—the same as is seen nationally. Also, the rate of hospital admission and readmission was crippling in terms of the financial position and was crippling hospitals in terms of being able to deliver the standards of access and care, particularly for that client group. I think it was a primary clinical priority for GPs coming into commissioning.

Q108 **Chair:** But it is an expensive clinical issue.

Tracy Dowling: Yes, a very expensive clinical issue. In the forward planning that it was doing at that time, the CCG was absolutely clear, both managerially and clinically, that getting a fundamental shift and change in the delivery of care for older people and for people with long-term conditions was so fundamental to ever getting the CCG and the outcomes for patients to be where they should be.

Q109 **Chair:** Did you never, at any point, contemplate—you are providing co-ordinated care—having people with greater knowledge, having access to certain services in people's homes or having interactions with patients? There might actually be more demand out there than was apparent from the acute hospital end.

Tracy Dowling: I don't know if that was considered at the time.

Q110 **Chair:** Would it not have been sensible? If you were there now, would you think that would be a sensible thing to consider?

Tracy Dowling: Yes, I think so. I think that some of the evidence around improving the management of long-term conditions is that, in the short term—the first two years—you often see demand increase because you are finding cases that have not been managed.

Q111 **Chair:** Okay, but you had this expectation—all three of you were involved—that there would be a 10% cost reduction in efficiencies across the course of the contract. Why did you believe that that was possible if you had such poor data on which to analyse the contract?

Tracy Dowling: In retrospect, I think that that may well have been a flawed expectation.

Q112 **Chair:** It clearly was. "It may well have been" is very generous. It was, and it is clearly the case that in the overall—

Simon Stevens: With respect, we don't know because the thing got canned after just a few months. It was for five years.

Q113 **Chair:** Okay, fair point. We will allow the "may," but 10% was a very neat number. We are a bit nervous about neat numbers on this Committee because it seems like it is retrofitted to the budget curve that you've got. Aidan Thomas, you said earlier that "it was very important that we did our best to win the contract" in response to Ms Smyth's question about your budget deficit. But didn't this £752 million help you to meet your budget deficit? Was that the reason for the figure that was being put forward to run the UnitingCare Partnership for clinical services?

Aidan Thomas: We put forward what we thought was an appropriate bid. We were trying to win the contract and that was an appropriate bid. There were lots of caveats because there were, as you know from the NAO Report, a lot of things we didn't have enough information on.

Q114 **Chair:** May I say, Tracy Dowling, it was cheaper than other bids—quite a lot. There was a challenge back, but then you just accepted the figures.

Tracy Dowling: Yes, there was a challenge back from the CCG to the provider about the price and being clear about all assumptions on what had to be provided for that sum. UnitingCare clarified that it could provide the services for that sum.

Q115 **Chair:** So, Mr Thomas, before you answer the other point, and Mr Sinker too, did you assume that you would get more money if necessary and if there was a problem?

Aidan Thomas: As we have heard, there was a significant number of things in the contract where the information wasn't clear and where we had either specific agreements or conditions precedent in the contract that meant we were expecting to negotiate or have clarity over those.

Q116 **Chair:** With respect, you went into a contract with a figure and an efficiency target and both of you expected, after the contract was signed, to negotiate over price issues during the lifetime of the contract.

Aidan Thomas: Yes.

Q117 **Chair:** Mr Sinker.

Roland Sinker: Yes.

Aidan Thomas: May I clarify the efficiency point? You raised the question earlier, Chair, about the potential savings. When the model around UnitingCare was originally designed, as bidders we tested different elements of it with people like the King's Fund to try to find out which and what was possible. In fact, if you look at the model as a whole, it is largely made up of things that have been tried in part elsewhere. They just haven't ever been tried together. That's what we based it on.

Q118 **Chair:** But the King's Fund, much as I respect it, is a long way from patients on the ground in Cambridgeshire. At that date, you were assuming in your business case that you would be able to negotiate 20% of additional funding for the CCG. So you had a low bid, but you believed you would get more money. Isn't that right?

Aidan Thomas: We made a bid to win the contract, of course, but we also—

Q119 **Chair:** I am listening to your words very carefully. To win the contract you needed to have a low bid, so did you bid low to win the contract?

Aidan Thomas: We bid as low as we thought—

Sir Amyas Morse: The term is "low ball".

Chair: Okay. The Comptroller and Auditor General makes a technical statement.

Aidan Thomas: We bid as low as we thought we could reasonably do, but we also knew that there were caveats because there was a range of things, as you know from the Report, that we didn't know about.

Q120 **Stephen Phillips:** If you look at paragraph 3.6 of the NAO's Report, it says: "At the final bid stage, the other shortlisted bidders submitted bids at the CCG's maximum value of £752 million, but UnitingCare Partnership"—the joint venture between your trust and Mr Sinker's trust—"made a tactical decision to submit a lower bid of £726 million to achieve a more favourable financial evaluation score." So you deliberately underbid the contract between the two trusts because you needed the work that the CCG was going to deliver to your trusts. That's right, isn't it?

Aidan Thomas: No, I don't think it is right. We didn't deliberately underbid. We bid to try to win it. If you look at the way the gap—

Q121 **Stephen Phillips:** All right. That is your answer. What is Mr Sinker's?

Roland Sinker: We bid to win the contract. We bid to win it for probably two or three reasons. First, obviously, these are the people we are both looking after with both mental and physical health needs. I think we then had slightly different drivers in the mental health trust and the acute trust. The big driver in the acute trust was to look after this population better in the right part of the hospital and ensure that our secondary elective care, our planned surgery and our tertiary services could be provided without cancellation or disruption, and to make good use of taxpayers' money.

Q122 **Stephen Phillips:** In order to reach this low figure of £726 million, which no one else could reach and indeed on which the CCG pushed back, you made some assumptions in the business case, didn't you? One of the assumptions your two trusts made between them was that in fact you could negotiate a 20% additional payment to the joint venture vehicle in relation to those services for which prices were not yet agreed. That is also in the Report and the Report is agreed. Is that right?

Aidan Thomas: It is in the Report and I have no problem with the Report, but I would add that there are a number of areas where I think it would be have been impossible to be clear when we bid exactly how much we would get out. To give you an example, the contract was let before the end of the financial year and due to start in the April. As part of that, it was not clear what the out-turn from the acute hospitals would be. The contract included buying the acute hospitals capacity in the area. That is a good example of where it would not be possible to be clear.

I have been clear that signing a contract without all those things being clear is not, in our view, the right thing to do for the future; Simon Stevens is absolutely right.

Q123 **Stephen Phillips:** Mr Sinker and Mr Thomas, did you make the CCG aware that far from £726 million, you were in fact going to be asking

them after the contract had been signed for another £144 million at some point?

Aidan Thomas: The CCG—

Stephen Phillips: It is a very easy question, to which the answer is yes or no.

Aidan Thomas: The answer is that in terms of the specific amount, no, but in terms of the quantum of the various issues, there was discussion.

Q124 **Stephen Phillips:** Right. Mr Sinker, did you tell the CCG that you were going to need another £144 million in order to deliver the contracted-for services?

Roland Sinker: We dealt with the risk of that by putting the caveats and the additional due diligence in place, and used that as the vehicle to say that we were going to have to come back to this—

Q125 **Stephen Phillips:** I will ask my question again, Mr Sinker. Did you tell the CCG that you were going to need another £140 million-plus in order to deliver the services for which the joint venture was contracted?

Roland Sinker: My belief is that we didn't give them the exact number, but we—

Q126 **Stephen Phillips:** Do you want me to ask the question again, or are you going to answer it? Did you tell the CCG that in order to deliver the services that the joint venture was contracted to provide, you were going to need in excessive of another £140 million?

Roland Sinker: No, we did not give them the number of £140 million.

Q127 **Stephen Phillips:** Right. Ms Dowling, were you aware that they were going to need another £140 million at any stage?

Tracy Dowling: No.

Q128 **Stephen Phillips:** And now I think we might have identified why this catastrophic contract fell apart. Let's move on. Ms Dowling, you have been in post for how long?

Tracy Dowling: I have been in post as accountable officer since May this year.

Q129 **Stephen Phillips:** And you are paid in excess of £135,000 a year. Is that correct?

Tracy Dowling: That is correct.

Q130 **Stephen Phillips:** What was the additional payment into your pension this year?

Tracy Dowling: The payment into my pension—I am not entirely sure.

Q131 **Stephen Phillips:** Would £140,000 into your pension by the CCG sound correct?

Tracy Dowling: No, that does not sound correct. I think that's the cash equivalent sum of the change in the pension. That is not a payment into my pension.

Q132 **Stephen Phillips:** What is the annual budget of the CCG?

Tracy Dowling: It is roughly £1 billion a year.

Q133 **Stephen Phillips:** Your CCG has a budget of £1 billion a year. You have employed some consultants recently, haven't you?

Tracy Dowling: We are just in the process of employing some consultants to help us turn around the organisation.

Q134 **Stephen Phillips:** How much are you paying McKinsey?

Tracy Dowling: We have yet to agree the final contract, but it will be a net sum of—

Q135 **Stephen Phillips:** Sorry, have you not learned your lesson? You haven't agreed a final contract, and they started a consulting project last week.

Tracy Dowling: No, they didn't start a consulting project last week. They have not yet formally commenced the consulting project.

Q136 **Stephen Phillips:** Right. How much are you going to be paying McKinsey to come into your CCG and try to turn it into a functioning organisation?

Tracy Dowling: We will be paying them a net figure of somewhere in the order of £800,000.

Q137 **Stephen Phillips:** You have also got some more consultants. You have been employing Deloitte—is that right?

Tracy Dowling: No.

Q138 **Stephen Phillips:** Someone else? Is it not Deloitte?

Tracy Dowling: There has been a review of the CCG's finance and governance capability, which was commissioned by NHS England. That was undertaken by PricewaterhouseCoopers this year.

Q139 **Stephen Phillips:** And how much did that cost?

Tracy Dowling: I don't know. That was not commissioned by the CCG.

Q140 **Stephen Phillips:** If we go back to this contract, Mr Stevens, what was the organisation that you said has subsequently been disbanded by NHS England? Remind me what it was called.

Simon Stevens: It is called the Special Projects Team.

Q141 **Stephen Phillips:** Why did you disband that team, which gave advice on this procurement between the CCG and Cambridge University Hospitals Trust and Cambridgeshire and Peterborough Trust?

Simon Stevens: Because we were not satisfied with the quality of the work.

Q142 **Stephen Phillips:** There was a report earlier in the year published by a gentleman by the name of Mr Salt—is that right?

Simon Stevens: Mr Stout—David Stout.

Q143 **Stephen Phillips:** As part of that report, he suggested that a second report on the behaviour and performance of the external consultants be carried out. That work was carried out, and the second report was produced, wasn't it?

Simon Stevens: Yes. I think it's in draft form and is about to be finalised, but it does not, as far as I understand it, detract from the benefits of the decision we took to disband the Special Projects Team.

Q144 **Stephen Phillips:** That's very interesting. If we look at an answer that was given by Lord Prior in the House of Lords in response to a question from Lord Hunt, he said that the decision to disband the SPT was following an internal review. Is that the second report, which you are saying has yet to be finalised?

Simon Stevens: No, the second report is an external review. This was an internal look, basically drawing on the work of the NAO and of David Stout, our own inquiries into what had gone on here and various other matters. We took the decision that this lot should go.

Q145 **Stephen Phillips:** None of this information—the internal review and the second review, which is in draft—has been shown to the NAO. Is that correct?

Simon Stevens: I don't know. Certainly the first one has, and I think the second one is still in preparation or is nearly there.

Q146 **Stephen Phillips:** Can I have your undertaking that both the internal review and the second report will be shown to the National Audit Office and to the local Members of Parliament who have asked for it?

Simon Stevens: Sure. We published the David Stout review, and we will publish this one, absolutely.

Q147 **Mr Bacon:** I have got the House of Lords answer in front of me. It says: "Following an internal review and the NAO report, NHS England identified concerns about the work of the SPT." You have just said that it was not as a result of the second report.

Simon Stevens: No, I think we are talking about two separate—

Q148 **Mr Bacon:** Can I just finish? There are two reports. You said that it was not because of the work of the second report that you took the decision to close the SPT. You said that it was because of the first report. The first report is not the one that focused on the SPT; that was the second report, wasn't it?

Chair: Can you be clear about which report you mean, Mr Stevens?

Simon Stevens: There are four separate things here, Mr Bacon: one is the NAO Report; two is the David Stout report; three is an external review that we commissioned of the advice from the three sets of advisers, which is more or less done, but as yet has not been published—

Q149 **Chair:** So that includes the SPT.

Simon Stevens: That includes the SPT. The fourth, which I think is what the reference to the House of Lords is, is to some work that we did ourselves—regardless of these independent reviews—looking at what has been going on with the SPT and deciding whether or not they should be disbanded.

Q150 **Stephen Phillips:** Because there were other things for which they were responsible.

Simon Stevens: Exactly. On the back of that, we decided they should go.

Q151 **Mr Bacon:** Just to be clear, who did the third report—the external review that you referred to?

Simon Stevens: That is being done by PwC, I believe.

Q152 **Mr Bacon:** Forgive me in case I didn't catch that, but how much is that report costing?

Simon Stevens: I can find out for you and let you have that.

Q153 **Mr Bacon:** Is it that report, or the fourth report that you just mentioned—I will just refer to Mr Stout's report. In recommendation 1 on page 20, he states: "Follow up this Part 1 review with Part 2 in the form of follow up investigations specifically on the role of external advisors to the procurement, the effectiveness of the Gateway review process, and the role of the CCG executive leadership, Governing Body and related audit functions throughout the procurement and contract period." What is the report of the four you just mentioned—it obviously cannot be this one—that is referred to there? Is it the third one—the external one by PwC—or the fourth one?

Simon Stevens: Yes, the fourth one, but I said them in the wrong order. To be clear, the temporal order was that first, when this all fell apart, we commissioned the David Stout report and published it. We commissioned it in January and published it in April or May—something like that. In parallel with that, two Members of Parliament asked the NAO to begin its investigation, and it did that. Thirdly, we ourselves did a look internally at the work of the SPT, and on the back of that we decided that they should be disbanded. The remaining piece is the bit that David Stout recommended, which was that there should be a review specifically of the quality of the advice to the CCG from Deloitte, the lawyers and the SPT, and the extent to which the CCG used the advice wisely.

Q154 **Mr Bacon:** And that is the last piece of work that PwC is doing that you are saying is still in draft form.

Simon Stevens: Yes, but I think it will be published very imminently. There are no surprises in there.

Q155 **Mr Bacon:** Okay. Here's my concern, because I did not read out the rest of the parliamentary answer. There is an instrumental part of the answer. It says: "Following an internal review"—that is one that is already done—"and the NAO report, NHS England identified"—past tense—"concerns about the work of the SPT. As a result, the SPT will close". So the report that this answer is based on was already completed, was it not?

Simon Stevens: Well, when you say the report, our internal look—

Q156 **Mr Bacon:** I said "an internal review and the NAO report". I am just reading from a parliamentary answer.

Simon Stevens: So the internal review was clearly complete, and that is what led us to decide to disband the SPT.

Q157 **Mr Bacon:** In other words, because of concerns about the SPT. That is what it says: "As a result, the SPT will close".

Simon Stevens: That's right.

Q158 **Mr Bacon:** But my point is that the report that the "NHS England review of UnitingCare contract" talks about refers to another review: "Part 2 in the form of follow up investigations".

Simon Stevens: That's the PwC report.

Q159 **Mr Bacon:** Which you have described as the third and sometimes the fourth, depending on which order you decide to put them in. That report is still not complete, so we do not yet know what the conclusions of that report are—

Simon Stevens: As far as I understand it—

Q160 **Mr Bacon:** If I could just finish my question. It is correct, isn't it, that we do not yet know, and nor does the NAO know, what the conclusions of that report are about the role of the external advisers to the procurement? That is correct, isn't it?

Simon Stevens: As soon as that report is finalised—

Q161 **Mr Bacon:** Sorry, but is that correct?

Simon Stevens: Well, it has not been published yet, so therefore it is correct.

Q162 **Mr Bacon:** It would be helpful if you answered my question, rather than a different one. Is that correct?

Simon Stevens: Well, since it has not been published, of course that is correct. It will be published—

Q163 **Mr Bacon:** Sometimes people are shown draft reports. It does not have to be—

Simon Stevens: I do not know the answer to that question, and I do not know whether Sir Amyas has or has not—

Q164 **Mr Bacon:** No, the NAO has not seen it. So we do not yet know, and nor does the NAO, what Part 2—the investigation recommended by Mr Stout, specifically on the role of the external adviser to the procurement—says. And I think it is rather germane information, isn't it? And, by the way, it was not just the external advisers, it was the role of the CCG executive leadership as well. We need to know this stuff, and we need to know it soon. When will it be finished?

Simon Stevens: I think it is pretty much there, so I would have thought we can get it to you if not this week, then next, but let me check that.

Q165 **Mr Bacon:** This Report was published in July, 14 July—the NAO Report was published in July. How extensive is this PwC report? It has got some terms of reference, it is fairly clear—we need to know about the effectiveness of the gateway review process, the role of the external advisers, the role of the CCG executive leadership and also governing body and related audit functions throughout the procurement of contract period. It does not sound like rocket science. Five heads of additional inquiry.

Simon Stevens: Let us hope it is a useful addition to the literature on this topic.

Mr Bacon: One would hope so. I would like to suggest, Chair, that we await this report before we reach our own conclusions, and that we allow the NAO to take a look at it, because we cannot really form a full conclusion otherwise.

Chair: I agree.

Simon Stevens: Perfectly reasonable.

Q166 **Karin Smyth:** What has happened to the team? They have been disbanded—what has happened to them?

Simon Stevens: As I understand it, there were 21 people in this team; 20 of them have left, gone—

Q167 **Chair:** Retired, made redundant?

Simon Stevens: I think 19 of them were on short-term contracts, and there were two permanent employees, and of those two permanent employees, one has gone back to clinical practice, as I understand—she was a nurse, and has gone back to clinical nursing—and the other, last remaining person leaves next month.

Chair: We might come back to that.

Q168 **Philip Boswell:** I have two questions to Mr Thomas and Mr Sinker. You intimated in answer to Mr Phillips's earlier questions that risk management was indeed carried out. If so, why? Unlike your competitors, was adequate contingency not included in the bid? Secondly, given your

stated keenness to win the bid and the disparity, did you effectively buy this contract hoping to make good any deficit using variations of subsequent renegotiation?

Aidan Thomas: No, we did not buy the contract. I want to add to what Roland said earlier is that the other thing is that we wanted to make the contract work. We were actually very proud of the model, and UnitingCare had done a lot of work even prior to the contract award to work with local people to get the contract ideas sorted and to get engagement. So from that perspective, we did not buy the contract, and I want to state that very clearly.

Will you just remind me of the first part of your questions?

Q169 **Philip Boswell:** If risk management was carried out, why then was adequate contingency not included in the bid?

Aidan Thomas: We of course did look at risk, and that was actually one of the biggest parts of discussion we had with Monitor about the contract itself and the trust's position in relation to that. There would have been a slightly different process, I think, for Addenbrooke's, but we certainly did look at risk and we did look at contingency. We were aware of the risks to the trust in it, as well as the wider risks.

I do not want to give the wrong impression either from what I said earlier. I think the savings potential in the contract was there. I personally, in a long career in the NHS, have seen some of the things in that contract work, on a different scale. So I firmly believed that it could work. What I would add, though, is that it has never been done on the scale of this, and that is the bit that is untried.

Roland Sinker: I agree with everything that Aidan said. My only build would be the contingency that Addenbrooke's had available to support the contract was eroded as our financial position deteriorated during the course of the financial year and we became in support of liquidity funding from the Treasury.

Aidan Thomas: Can I add something? The other thing on risk management, which I didn't say before, is that of course part of the risk management were the conditions that were put in the contract. So that was part of how it was handled.

Chair: We will go back to that in a moment.

Sir Amyas Morse: I just want to ask a question about the future, so I should ask Ms Dowling, I guess. How much are you paying for these services now? So we've now got this collaborative, open, sharing way of working, which you described and which sounds very good. Over the same five-year period, what are you now going to pay?

Tracy Dowling: I'm sorry; I don't have that figure with me. What I—

Sir Amyas Morse: I'd like to know what it is. Is it more or less than the range of bids you had before? In other words, I'd just like to be clear

whether the net net of being able to do all this is that you are actually paying more. What's the answer to that?

Tracy Dowling: I think that, in terms of the next five years, that's what we're working through as part of our sustainability plan. In terms of this year, we are paying less than the amount of money that UnitingCare would have wanted this year, but we are paying more for these services than the CCG would have expected at the bid price. That is because we are paying at full payment by results tariff for the admissions into hospital and we have increased our investment in the services that UnitingCare had set up. So we have not taken away any services that had been established by UnitingCare.

Sir Amyas Morse: Just to make sure that I've understood that, when you talked about what UnitingCare "would have wanted", is that the £887 million number that we are talking about, which they actually had in their internal costings as what they should have charged in the first place and what they needed to get from you? You are saying you are not paying quite as much as what they thought they needed to have to cover the costs, but you are paying more than the £726 million that they actually bid. Is that right?

Tracy Dowling: Yes, that is right and that is one of the reasons why we have financial challenges in our system.

We do not now have one contract for these services. We contract separately now with the acute hospitals for attendances and admissions for older people, and with the mental health trusts for community services and third sector organisations. The totality of that is less than for this year—less than the amount that UnitingCare were saying they would need—but it's more than the bid price. So, the financial position of the CCG is less favourable than it would have been had the services been able to be provided at the bid price.

Sir Amyas Morse: Okay. So it would be very helpful to understand that in specific detail for the next five years. Thank you.

Tracy Dowling: It would be marvellous to do, and that is part of what we are working through with our sustainability and transformation plan—

Q170 **Chair:** If you could send us the detail that you have now, that will inform our report.

Q171 **Caroline Flint:** We have heard from Mr Stevens that he has got seven safeguards to prevent this from happening again. Why weren't those safeguards in place already, and who is responsible for that? Is it NHS England, or is it NHS Improvement, which once was Monitor, and Monitor was also supposed to be looking into checking the resilience of these partnerships, and their commissioning and contract arrangements? Whose job is it?

Simon Stevens: I think the NAO's answer to the question is on page 10 of its Report, which is, "CCGs and foundation trusts have significant

statutory freedoms to make their own decisions. The regulators and oversight bodies acted in accordance with their statutory roles". The point is that if we want more of these kinds of changes, we will have to evolve the way we work together nationally, as well as putting in these safeguards locally. We will have to evolve our systems to deal with these kinds of issues.

Q172 **Caroline Flint:** When's that going to be completed by?

Simon Stevens: From October, we will publish a checklist that will have to be gone through for any CCG wanting to embark on these kinds of service changes, and NHS England and NHS Improvement will create a joint assurance process that, for any part of the country that is going through a big thing of this nature, will answer four questions.

First, can we be convinced that the clinical model—the service model they are talking about—will actually produce net benefits to the health service across the whole economy? Second, is the provider—whoever they are—actually capable of managing the contract and the risk that is involved? Thirdly, have people thought through the consequences for other providers? That is not to say there is a veto on change, but nevertheless in the real world there may be consequences for other providers, so what are you going to do about that? Fourthly, as we talked about earlier, does there need to be any change in the regulation that NHS improvement has for that provider or providers and the Care Quality Commission as well? Those four tests would have to be applied to any of these kinds of arrangements in future.

Q173 **Caroline Flint:** What is worrying for the public is that in different guises we have had strategic oversight with different names. NHS Improvement was once called Monitor. Before NHS England we had the strategic health authorities. The oversight of what PCTs and then CCGs are meant to do has been around for quite a long time, but we constantly hear that there is not enough expertise in the system to make sure that silly mistakes are not made. For example, on the establishment of a limited liability partnership, who is responsible for not giving the advice that if you set up a limited liability partnership you are not open to the VAT privileges that you have if you are an NHS entity? Who would have been responsible for informing the CCG or someone of that?

Simon Stevens: The parties to the agreement are responsible.

Roland Sinker: What I'd add to Simon's comments is that at least half of Simon's seven lessons learned are exactly the sort of things that foundation trust boards should be thinking about. Both Aidan and I, our boards, have carried out quite extensive reviews—Aidan, I know yours has just completed—into how we make decisions.

Q174 **Caroline Flint:** Sorry to interrupt you, Mr Sinker. Yes, you are absolutely right that the foundation trusts should have been thinking about these things, but if you are setting up a particular partnership, why wouldn't you seek the correct advice from whomever to say, "Can we be absolutely clear what we will and will not be liable for by setting up this

partnership—this type of LLP?"

Aidan Thomas: On the VAT issue we did seek advice—that's the one you mentioned. We took advice from different companies on the tax implications, and we—

Q175 **Caroline Flint:** Who did you take advice from?

Aidan Thomas: At the time—hang on a second.

Chair: Did you take advice—

Aidan Thomas: We took it from KPMG and HMRC. I think it is fair to say that—this links to a point earlier made by Ms Smyth—if you look at what was happening, this was NHS money going through an LLP but into NHS services. It wasn't clear from HMRC at the time, and it still finally isn't, what the VAT relations were.

Q176 **Chair:** Sorry, you say it finally isn't—

Aidan Thomas: My understanding—

Chair: But the NAO report is pretty clear that the VAT was not reclaimable.

Aidan Thomas: It's still not finally clear from HMRC.

Q177 **Chair:** We are seeing HMRC in a few weeks, so I just want you to be really clear on this.

Aidan Thomas: I think I am talking in general terms.

Simon Stevens: Maybe we could get you a combined note on what the current issue is, as we see it—or as the team sees it—on VAT. Obviously, the VAT Act 1994 is quite complex—

Chair: It is extraordinary. It may be complex but you have HMRC and lots of clever, highly paid tax advisers and I am sure that someone could have got this right.

Q178 **Caroline Flint:** I think this goes to the heart of the concern about the assumptions made of what you would be liable for and therefore, the costs of running the contract, and to what Mr Boswell said—did you say it was a lowball, Auditor General?—about doing a bid that was far too low in terms of what you could expect to have to pay out for and what you could expect in terms of additional funding from the CCG. It all adds to a sense that you were not really clear about what it was all going to cost.

Aidan Thomas: I think this goes back to the point that Simon Stevens made earlier; it is very clearly in one of his seven recommendations. I agree that the right thing in future, and the thing we are all mindful of, is that we should not be agreeing contracts where we have large numbers of outstanding uncertainties. We did take advice on VAT; it's just that it wasn't clear.

Q179 **Caroline Flint:** All right, you're saying that you took advice on VAT but it

wasn't clear whether or not you would be liable for VAT. But you still decided to go ahead on the basis of the contract you set up.

Aidan Thomas: Well, we managed—

Q180 **Caroline Flint:** You made a huge assumption.

Aidan Thomas: No, we didn't. We managed the risk that was associated with it. As I answered to Mr Boswell, it was included in discussions we had with the CCG about how the contract was run.

Caroline Flint: Managing the risk sounds like you are shoving it under the carpet to me. These are very serious matters.

Q181 **Chair:** Perhaps we can just ask Tracy Dowling whether the CCG was aware that, one, the management of this VAT risk was there, and two, that the CCG would fill the gap if the VAT ruling went the wrong way.

Tracy Dowling: No, I don't think the CCG was aware that it would have to manage the gap on that. I think what the CCG should have done is made sure it was absolutely explicit in the tender documents where the responsibility for VAT would sit; and given that with procurement of this type we could receive bids from any kind of organisation I think the tender documentation should be really clear that any organisation that has a VAT liability would be responsible for putting that cost, and that risk, within their bid submission; and I don't think our documents were sufficiently clear on that. Hence the uncertainty afterwards.

Q182 **Chair:** Yours weren't, at your CCG; Mr Stevens?

Simon Stevens: For a nano-second of role reversal could I ask a question, which is did the other two bidders include VAT?

Tracy Dowling: I would need to go back and check to give an absolute answer.

Simon Stevens: From stage left we are hearing yes as the answer to the question. But that ends my attempts to usurp the Committee's remit.

Q183 **Chair:** It's always useful to know that we do not all know what is going on. I think it is pretty obvious from some of what has happened. It all just beggars belief, really.

We had this issue with the CCG not knowing and not having the right contract documentation. Across NHS England—maybe this is for Mr Hay—across the piece, is that normal? Is that the norm or was the CCG in Cambridgeshire and Peterborough an outlier?

Stephen Hay: I think from the research I have done into this case that the CCG and the providers knew there was a pretty material contract risk, and it is £160 million to £170 million. It is in a board paper that was submitted to us by Cambridge and Peterborough at the end of January, and as far as we are concerned that contract gap was raised with the CCG and was also in our bid.

Q184 **Chair:** The question was is this a common problem across the NHS, that the contract arrangements do not require the bidders to make it clear what the VAT liability is. Twenty per cent. is a big issue, a big difference.

Stephen Hay: My view is that this was quite a unique situation, this particular joint venture.

Q185 **Chair:** So you don't know the answer. Tell us if you don't know.

Stephen Hay: I haven't come across this particular issue before.

Q186 **Chair:** Mr Stevens, I hope it is on your agenda.

Simon Stevens: I think usually it is explicit, but the VAT rules are quite complicated as between type of bidder; so one of the complaints is that in some ways there is not a level playing field, in that if you are an NHS bidder you have a different VAT look-through than if you are not, and different types of cost within a contract are subject to different VAT rates; so it is not just 20% across the board, in or out. It is more complex than that. I think we should get you a note ahead of your discussions with the Revenue, but this is the Value Added Tax Act 1994. A lot of case law has developed but it is not as simple as one might think.

Q187 **Chair:** If you take, also, pensions on some of these subcontracted or contracted out services, there are different pension liablities; there is a marketplace now, in the NHS, but these are issues that I am sure our sister Committee will be looking into. I am going to let Caroline Flint finish off; then Mr Phil Boswell; then Karin Smyth.

Q188 **Caroline Flint:** I understand there are something like £16 million of unfunded costs as a result of what happened. At PMQs today the MP for South East Cambridgeshire, Lucy Frazer, raised concerns about the continued viability of the minor injury unit in her area. Could you maybe outline what impacts this is going to have on some of the other service provision within this CCT area? Who is going to pay the cost? Who will pay the price?

Tracy Dowling: As the CCG, we do have a deficit position this year and are having to take action to look at all of our services—not just the minor injury unit services—in terms of best value for money and cutting our cloth and living within our resources. In terms of the minor injury unit we are also reviewing them against the draft Keogh standards for urgent care centres, and looking to find different models of provision—not just minor injury but other urgent care services. That is an area that we are reviewing as part of our STP.

Q189 **Caroline Flint:** Okay, but, given a difficult area, do you agree with the figure of £16 million of unfunded costs resulting from what has gone on wrong here. Is that agreed?

Tracy Dowling: Yes.

Q190 **Caroline Flint:** So where are you going to find that money from?

Tracy Dowling: We are currently spending more money than we have got. We have got to look at all of our services, and part of continuing to redesign these services for older people is to get those efficiencies that will get our finances back on track.

Q191 **Caroline Flint:** But in the short term?

Tracy Dowling: In the short term, we are looking at a whole raft of other efficiencies. We are looking at accelerating some of these changes. We are one of the first in the country to do integrated urgent care.

Q192 **Caroline Flint:** I understand that everywhere is doing that across the country, but is it fair to say that if this process had been better managed, and there had been better knowledge and oversight, the existing difficult situation for Cambridgeshire wouldn't have been further worsened by an extra £16 million of unfunded costs?

Tracy Dowling: I don't think we know, because we do not know how this would have played out had it continued. What we have to do now is to—

Q193 **Chair:** Sorry, so it might have been worse?

Tracy Dowling: We don't know. The reason why the contract terminated is that it was clear that it was not affordable for those costs to continue.

Caroline Flint: Goodness knows how much more it would have been if it had carried on.

Chair: I am going to bring in the Comptroller and Auditor General while Caroline Flint and I roll back gobsmacked.

Sir Amyas Morse: I just want to understand a bit about the circumstances, Ms Dowling. You came from NHS England.

Tracy Dowling: Yes.

Sir Amyas Morse: So you were the new broom to sort things out, right? What happened to the previous CEO of the CCG? Are they still working in the NHS? Have they disappeared along with the special projects team? In other words, was this part of a bit of a clean-up? I would just like to know. You were the person who was parachuted in to sort this out. Is that right?

Tracy Dowling: I was already within the CCG. Dr Neil Modha was a GP accountable officer, and he resigned that role in January this year and is just practising as a GP.

Sir Amyas Morse: And did he resign it because of anything to do with this contract?

Tracy Dowling: No. He had done four years' tenure in his post, and he had planned that after four years he would step down to focus on the priorities within his practice.

Q194 **Chair:** Mr Sinker and Mr Thomas, you are still around, and you were around then overseeing this debacle—let's be honest, that's what it was.

Ms Dowling, who else in the CCG was responsible for the contract, apart from the CEO? He was a GP so he had a different set of skills.

Tracy Dowling: We have also had a change of chair at governing body level, and I have restructured the executive team to make sure we employ executives who have the capability to transform services. I believe that that is the CCG's responsibility.

Q195 **Chair:** So what happened to the people who were responsible for this? You have changed chair and the GP chief exec has gone back to being a GP. Who else? Not names, but was there a finance director looking at this?

Q196 **Caroline Flint:** Ms Dowling was actually the chief operating officer at the CCG during this time, I think.

Tracy Dowling: I was the chief operating officer last year.

Q197 **Chair:** That is after the contract was signed.

Tracy Dowling: After the contract was signed, yes. The chief strategy officer who had responsibility for this is now working in another part of the NHS, and the director of finance has retired.

Q198 **Chair:** We're just puzzled—I raised accountability earlier—where the buck stops with this. In other jobs, if you do not perform you get demoted or you get some sort of rap. It seems like everyone's still working. What's been the consequence?

Simon Stevens: Does it really feel like that? I think, actually, Tracy's just described a pretty big clean-up.

Chair: It doesn't quite sound like that.

Q199 **Caroline Flint:** One's gone to work somewhere else in the NHS.

Simon Stevens: One's gone back to practice, one's retired and one's left.

Q200 **Chair:** But there other people in the other constituent parts—a couple of them are in front of us here—who were involved at the time. My point is not about individuals but about who is responsible when you have got, as is increasingly going to be the case, these multiple-party contracts? Who is in charge? It still isn't clear from the previous answer you gave me.

Simon Stevens: As we discussed, there were three bodies—two trusts and a CCG—and here they are. They are in charge.

Chair: That's the problem.

Roland Sinker: What Tracy articulated is very much the position at Addenbrooke's as well. There have been a number of changes to the executive team and board over the course of the past 12 months that are very well known.

Q201 **Philip Boswell:** Supplemental to my earlier questions on the contracting strategy, you stated, Mr Thomas, that the difference here was scale. I

thank you for your earlier answer. You have seen some of the mechanisms included in this bid work previously in respect of projected cost savings. Can you give one example of a service provision strategy or cost-saving mechanism included in this bid that has worked before, but was caused by the scale, in this instance, to fail?

Aidan Thomas: The first thing to say is that none of the schemes in this bid has failed this time, because either they have been implemented and are starting to work, or they have not yet been implemented because we cannot afford them. So there is no question of them failing this time—I think that is an important point—and, in fact, we are working hard to make them work now. I can give you some examples from my previous history, if you are interested.

Q202 **Philip Boswell:** I just wanted to know why you would then attribute the failure of this project to its scale, rather than to the mechanisms themselves.

Aidan Thomas: I think we need to be clear that what failed was the contract, not the services. That is the important point to make. The services are not what failed. It is a very important point to make, because there is evidence that some of the things that we are implementing jointly and working together on are working. That is a very important point to make on behalf of the staff involved in all of that.

Karin Smyth: That leads me neatly on to my point. I think that's right. You clearly have a model that works, that we would want to replicate elsewhere and that the patients we hear feel is good and should be used. I think there are two questions about that. First, as I said earlier, why can't that be done by yourselves without a third vehicle? Also, is it not the case that this is a very sad and sorry tale of multiple reports? Between us, we cannot really get what comes first or what they are telling us. The use of special projects and several large, reputable consultancy firms, at quite phenomenal cost to the taxpayer; and this hearing, follow-on hearings and a lot of things attached—all of that is a result of the requirement in the Health and Social Care Act to undertake some kind of competitive tendering process, and to do this differently. I can see Mr Stevens is looking at me.

Simon Stevens: Raring to go.

Karin Smyth: My question is first of all to Ms Dowling, though. We would not be here, would we, if not for the drivers in the Health and Social Care Act?

Tracy Dowling: I think we wouldn't be here if the contractual mechanism had worked through all of those—

Q203 **Karin Smyth:** You wouldn't have used a contractual mechanism like this without being forced to by the provisions of the Health and Social Care Act.

Tracy Dowling: I think the CCG might have done. I couldn't say whether the CCG would or would not have done. They may have done, because it would have been an option open to them.

Q204 **Karin Smyth:** Did people feel under pressure in that system—

Simon Stevens: Just to put some factual context on it—

Karin Smyth: Okay, but do you feel that people felt under pressure to do something innovative or different, or where they were uncertain about the environment, in order to test something which has proved to be highly risky?

Tracy Dowling: I think people were actually really enthusiastic about doing something different, because it was really clear that the historical way those services were being delivered wasn't going—

Q205 **Karin Smyth:** Not in terms of the model. We all agree the model is good, but the vehicle for delivery is the problem. Were they enthusiastic about the vehicle?

Tracy Dowling: Yes, I think they were, and I think there was enthusiasm for the intent to get some different approaches to creative service redesign. As Aidan has said, where this went wrong was in the contractual oversight and the commercial capability, and in the understanding of the different vehicles.

Q206 **Karin Smyth:** But it wasn't just in the contractual oversight, though, was it? It was in the establishment of the contract.

Simon Stevens: Just on the very specific point about the requirements in 2012, as I am sure you recall, it was actually in 2009 that community health services were split off from primary care trusts, and the biggest move to outsourcing community health services occurred prior to 2012 as part of that separation, so I don't think one can attribute these kinds of procurement exercises to the 2012 Act per se. However, I do think we have an opportunity as part of our Brexit negotiation to see whether we cannot have a smarter version of the Public Contracts Regulations 2015, so we have more flexibility in these kinds of matters in future.

Q207 **Karin Smyth:** So you would say it is the EU procurement rules, as opposed to whether—

Simon Stevens: The EU procurement rules predate the 2012 Act, and frankly it is the public procurement rules from the EU that have driven a lot of this, when overlaid on the decision to separate community health services from what primary care trusts were doing.

Q208 **Karin Smyth:** Would you accept, then, that the 2012 Act added a layer of complexity that perhaps people didn't understand locally about what they did and didn't have to go to procurement on?

Simon Stevens: It certainly added complexity.

Q209 **Chair:** Well done, Ms Smyth. That's as far as you're going to get with an

experienced operator like Mr Stevens.

I just want to rattle through the last questions—I am aware of the time and I want to finish in the next few minutes. Mr Stevens, in this sorry saga, you have disbanded the special team that was set up to deal with these projects. Do you think there is enough commercial expertise in the health service, given the climate we're in?

Simon Stevens: The SPT was actually set up in 2009 as a creature of the East Midlands Strategic Health Authority, and was then inherited by the successor bodies including, ultimately, the East Midlands CSU.

Q210 **Chair:** Do you think you've got enough commercial expertise now?

Simon Stevens: What we've got to do, given that it is thinly spread, is to standardise some our approaches so that people aren't having to reinvent the wheel. We are going to memorialise those seven tests and processes so that people do not have to get their own external advice or hire their own people to get some of these basics right, and we will have that operating across the system. It is also why NHS Improvement and NHS England are together going to put a supervisory structure on top of these. As evidence of that, on the back of what has happened here, we have already reviewed some of these procurements that were bubbling up in other parts of the country and have asked the CCGs and others locally either to stop them altogether, for example in South Warwickshire, or, in a number of other cases, to substantially amend the approach they are taking.

Q211 **Chair:** You say you are standardising it. Do you need to recruit more commercial expertise? We have an issue across Government that there isn't enough commercial expertise, as you can probably pick up. Whitehall is doing work to resolve that. Have you got enough resource already?

Simon Stevens: Actually I think we do need more, but I think we can solve these kinds of issues through the approaches that I have described. I think there are some other areas where we are going to ramp up our commercial expertise. We talked before we got going on Cambridgeshire about specialised commissioning, for example. We are taking on more responsibility for negotiating drugs prices with individual pharmaceutical companies and are having some success in doing that, but that means we are going to need to increase our commercial bandwidth in areas like that.

Q212 **Chair:** Okay, well I think you will be in competition with lots of other people after Brexit.

Can I just ask another couple of quick questions? The Cambridgeshire MPs have been very vocal and interested in this issue. Stephen Barclay MP has been in the hearing this afternoon, although I think he may have now left—I should have acknowledged him earlier. The others are equally concerned and interested. Will you agree to meet those Cambridgeshire MPs to talk about what has happened, the lessons learned and their concerns about services in Cambridgeshire?

Simon Stevens: Certainly. I am joined by NHS colleagues from across Cambridgeshire. I think we have had a very thorough airing of the issues and I don't think anybody here is trying to pretend all is well, but we have got a clear plan to deal with these problems going forward.

Q213 **Chair:** We have a constitutional role here as the Public Accounts Committee but they, as local Members of Parliament, have concerns about their local population. I know you are a busy man, but I think for a failure this catastrophic, which is costing patients and taxpayers in the area dear, if you could agree to that meeting, that would be very good.

Simon Stevens: I'd be happy to.

Chair: Thank you very much. I think that is everything I had to ask. Thank you very much indeed for your time. I can only apologise for the heat, which we have all been suffering with—we can't control everything on the Public Accounts Committee.

Simon Stevens: We have the same sensation.

Chair: Our transcript will be out in the next couple of days. It might be published before the weekend—it is published straight away on the website uncorrected. If there is anything majorly factual that has been somehow misinterpreted, let us know, but we don't otherwise change it.

Simon Stevens: I will check where that other one is and get that to you within the next week.

Chair: We have a list of things to ask of you—various reports and finding figures, particularly from Ms Dowling. Our Report will be slightly delayed while we are waiting for that further information. We are very concerned about what happened here, because if it has happened here, it could be happening elsewhere. I'm heartened that you've stopped some bad programmes, Mr Stevens. We're not a Committee that will stop innovation and value for money, if it is appropriate, but this was a dog's breakfast. We are glad it's over, but it is still costing patients in Cambridgeshire. Thank you very much indeed for your time.