Cambridgeshire & Peterborough Health Services

Let Down by Everyone – A Tale of Incompetence

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Commissioned by Cambridgeshire Keep Our NHS Public

Sponsored by UNITE, UNISON and the NUT

INTRODUCTION
by Cambridge Keep Our NHS Public

IN APRIL 2013, CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP (CCG) CAME INTO BEING; covering a population of about 800,000, one of the biggest in the country. Its intentions were clear from the outset with an 'open day' for private companies to bid for about £1billion worth of contracts.

This was, of course, perfectly in line with the purpose of the Tory-led Coalition government's Health and Social Care Act 2012: to transform the NHS into a huge market for exploitation by the private medical industry.

One of the CCG's first decisions was to set up a huge 'integrated' programme for older people's and adult community services (OPACS), and put it out to procurement by open tender, amounting to £750 million over five years.

That was the biggest potential NHS privatisation in the country at the time. The decision was made with no public consultation or any documentable clinical input.

Cambridge Keep Our NHS Public (KONP) and the unions started campaigns against this, immediately getting a big response from the public. Campaigners lobbied the CCG Board, where the proposals were ratified despite misgivings from some board members.

This was the first of regular lobbies of CCG Board meetings, where campaigners asked questions about lack of consultation, evidence, patient involvement etc.

The central question was why the CCG could not have worked with the existing service providers rather than go out to procurement, and how they had arrived at that decision. Shadow Health Secretary Andy Burnham described the Older People's Programme proposals as 'the most audacious sell-off to date'.

In August 2013, the Stop the NHS Sell-Off campaign was launched on the initiative of KONP, bringing together a broad front of unions, political activists (including the Labour Party), pensioners groups and individuals aimed at halting the OPACS privatisation.

Ten bidders expressed interest in the proposed contract, including Cambridge University Hospitals (CUH – Addenbrooke's) and Cambridgeshire and Peterborough Foundation Trust (CPFT, the Mental Health Trust) who submitted a joint 'NHS bid', under the name of United Care Partnership (UCP), linked to private company Mitie.

In November 2013, after some had been withdrawn and others rejected, five bids went into the initial bidding process. In December 2013 a legal challenge was mounted by Leigh Day, initiated by UNISON and taken in name of Stop Sell-Off campaigners. The challenge was on the grounds of the CCG's failure to consult, to produce documentation, or to publish procurement and engagement strategies.

The CCG was forced to hastily produce procurement and engagement strategies, as well as a (much-redacted) version of the procurement documentation. It was recognised that a legal challenge to the lack of consultation at the start of the process may have been able to stop it altogether, but by now that was too late.

In February 2014, as a result of continuing pressure, the CCG announced a consultation programme running from April to June. The contract start date was moved back to January 2015 (from June 2014). Meanwhile Stop the Sell-Off raised questions with the local authority Scrutiny Committee about the robustness of the process.

The following month the CCG announced four final bidders – Virgin, Uniting Care Partnership (the CUH/ CPFT 'NHS bid') and consortia led by Care UK and Interserve.

Throughout the 'consultation' process, campaigners attended all meetings, challenged the process, collected signatures and raised the media profile of the campaign.

This revealed growing public support for the anti-privatisation stance. Healthwatch, the Scrutiny Committee and local Patient Participation Groups raised concerns, particularly about the timetable.

Detailed responses were submitted by Stop the Sell- Off, UNISON and GMB/UNITE. In June the consultation came to a close with a packed angry public meeting in Cambridge followed by a demonstration. 5,000 petition signatures were submitted to the meeting, with widespread media coverage.

From June to September 2014, the CCG considered the bids. Meanwhile campaigning continued, with GMB and UNITE publishing allegations of Virgin connections to CCG members, as well as an ongoing petition campaign, including public 'stunts' at Virgin shops in Cambridge and Peterborough.

Problems continued to mount, with the start date of the contract put back to April 2015 in response to consultation concerns. Then in September 2014 the Interserve-led bid withdrew, leaving three remaining bidders (Virgin, the Care UK-led bid, and the UCP 'NHS' bid).

In October, the CCG announced the award of the contract to the NHS-led bid UCP. The Stop the Sell-Off campaign claimed a qualified victory by succeeding in stopping the biggest NHS privatisation to that point going to a private contractor. However the deep flaws in the contract itself remained, and this was the contract signed by the 'NHS' bid.

After a further postponement, the contract itself started on 1st April 2015. Eight months later, on the 3rd December 2015, the collapse of the contract was announced, after it had been deemed 'financially unsustainable'. Not only did this expose the whole process as a shambolic and completely unnecessary politically driven marketisation exercise – it also created huge uncertainty about the vital services covered by the contract.

This report seeks to explore the way the scandalous situation was brought about, and who was responsible, and examine its implications for the whole NHS in Cambridgeshire, as well as lessons for those campaigning to defend the NHS throughout the country.

First and foremost, it shows that wherever any services are put out to competitive tender or threatened with privatisation in any way, campaigners have to mobilise to defeat the threat. Only in this way can we defend our NHS and keep it public!

Executive Summary

THIS REPORT ANALYSES the actions and arguments of the many and various individuals and organisations who contributed to the collapse at the end of 2015 of a flagship contract for Older People's and Adult Community Services (OPACS), which had been drawn up by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

The ill-conceived and inappropriate governance framework established in the massive reorganisation of the NHS by the Tory-led coalition government in the Health & Social Care Act played a vital role in this. It ushered in a new amateurisation of NHS management, opening the door for the private sector to step in – as it was intended to do.

The NHS in the East of England has been used for over a decade as a test bed for various unsuccessful experiments like these, driven by the old Strategic Health Authority management, and their creation, the Strategic Projects Team (SPT).

To make matters worse, the financial gap that was threatening to open up by 2019 was estimated at £250m – although at no point since this was announced have any measures been proposed with a chance of making any substantial reduction in that figure.

Predictions and warnings ignored

The chapter of errors that led up to the collapse of the contract was not a series of unanticipated or unavoidable accidents: each one of them was predicted and forewarned by campaigners and the health unions during the long drawn-out and costly process of procurement.

Elementary errors

The contract had elementary flaws that no normal couple buying their first house or commissioning a new conservatory would ever make. Astonishingly there was neither an agreed price – for a contract in the order of £750 million – nor a clear stipulation of what would be provided in return.

NHS England bureaucrats who – in the absence of any public body to replace the abolished Strategic Health Authorities – were supposed to supervise the work of CCGs, instead simply stood by and watched the shambolic proceedings.

The regulator, Monitor, proved itself as myopic and toothless as ever, failing to regulate or pay attention until the project had gone belly-up.

Two mealy-mouthed, half-hearted 'inquiries' have taken place so far: West Midland Ambulance Trust, an internal audit for the CCG[1], and the *NHS England Review of the Uniting Care Contract*.[2]

These two reports are remarkable for what they don't say.

NHS reports put to shame – by the BBC

The most devastating report of all to date has been the January 26, 2016 BBC Radio *File on Four* programme, which is also the only one so far to expose the fact that the entire project was seen by the CCG as a **cost-cutting exercise**.

The BBC report quotes an unnamed private sector source saying they were taking chances, hoping for the best:

> "*Uniting Care was aware that there were risks in terms of whether they'd be able to make it work for the money, but* ***everybody thought they stood a fighting chance*** *of doing it.*" [emphasis added].

Yet at no point anywhere, has the CCG or the Trusts revealed how such savings were supposed to be generated.

The only organisations to have been vindicated in their stance following the eventual collapse of the contract are the Stop the Sell Off campaigners, who had to fight every inch of the way for even the most basic consultation and transparency, and the trade unions, who supported them.

Five years of mounting incompetence

1. **The failed OPACS contract was inescapably a fruit of the new NHS structure as created by Andrew Lansley's Health & Social Care Act (2012).**

The central purpose of the Act was to remove the direct accountability of the NHS to Parliament through the Secretary of State, and institutionalise a competitive market in the provision of an increasing range of health services paid for by the NHS.

The OPACS fiasco is simply an extreme example, since it was seen as a flagship project for others to follow. It is especially important that the lessons of its collapse are known and shared.

2. The underfunding of the contract, and the desperate quest for cost savings flows inescapably from Tory Chancellor George Osborne's unprecedented real-terms freeze on NHS spending since 2010.

The combination of a decade of austerity in health budgets, coupled with the enthusiasm for 'market' style methods and private sector engagement in health services, spawned plans such as OPACS.

3. NHS England has plainly failed to scrutinise or supervise the actions of Cambridgeshire & Peterborough CCG despite its attempt to establish an experimental high profile, flagship contract, which could have been worth up to £750 million over five years.

NHS England now administers a bureaucratic structure of regional offices, with Cambridgeshire assigned to the giant Midlands and East Region. It's not clear what these regional bureaucrats do most of the time: they are accountable upwards to NHS England, but not at all downwards to local people in the patch they cover.

NHS England's own report on this fiasco tries to find ways to blame nobody. It defers any conclusive judgments to the outcome of further 'reviews'.

4. Cambridgeshire and Peterborough CCG itself ignored the concerns of the local public and the warnings of campaigners in its blinkered, single-minded drive to establish this contract. It then ignored warning signs, and signed a contract with more holes than a teabag.

Campaigners from Stop the NHS Sell Off, supported by the health unions, challenged and exposed the secrecy of the whole process. They had to threaten to take legal action against the CCG to force any disclosure at all. The limited consultation eventually began only AFTER all the big de facto decisions had been taken, AFTER the tendering process had been almost completed and AFTER the CCG had already decided how the final stage of tendering would be handled.

Since the original contract collapsed, the CCG has continued to directly commission a range of services for older people – apparently unaware that by doing so they give clear evidence that the whole procurement exercise, and the costly apparatus of the contract were ill conceived from the beginning.

The Sustainability and Transformation Plan for the whole health economy of Cambridgeshire & Peterborough has brought the creation of a new 'Health Executive' to take decisions for all trusts and for social care in Cambridgeshire and Peterborough for the next five years. The new body will be completely unaccountable to local people as it hatches plans in secret aimed at achieving a staggering £250 million additional savings to balance the books by 2020.

5. The Strategic Projects Team (SPT), originally from NHS East of England, now has a variety of costly failures to its name across the Midlands and East of England.

The SPT has also been central to the highly controversial proposals to contract out cancer services to a lead provider in Staffordshire, which is currently under review[3].

6. The Trust boards of the two Foundation Trusts, which won the contract, then went on, without agreement from the commissioners or apparent awareness of the tax implications, to establish a Limited Liability Partnership (LLP), which immediately incurred an annual VAT liability of £5m.

Having made this expensive error, the two trust boards went on to nod through the whole process of the contract. No executive or non-executive director ever questioned the lack of any stipulation of a firm price to be paid to their trust or defining the scope of the services which had to be provided by the trust under the contract.

7. Monitor (now NHS Improvement) is supposed to be the regulatory body checking on the behaviour of foundation trusts, with a specific brief to check on the contracts they sign.

It's not apparent who in Monitor is accountable for the costs of this failure to regulate and to allow the contract to go forward. But key individuals in Monitor, who should have been scrutinising such things, have shown themselves, if not the whole organisation, to be grossly incompetent in the handling of this case.

8. The Cambridgeshire County Council's Health Committee (CCCHC)

Despite campaigners on at least three occasions drawing their attention to the CCG's management of the procurement programme, the Committee, spent virtually no time discussing the OPACS contract in the meetings running up to its launch in April 2015.

The Committee was reliant on the statements, documents and evidence that they received from official NHS bodies and their advisers, lacked any independent view, and was swept along by the general rhetoric for the OPACS project.

Where does all this leave health services in Cambridgeshire & Peterborough?

The prospect is one of continuing cuts and search for 'savings' to remedy a vast financial black hole that has been opened up by six years of austerity-driven underfunding, a costly market system, and several more years of virtual cash freeze to come.

The situation for the CCG has worsened due to the collapse of the OPACS contract, which took the CCG from a projected marginal £0.5m surplus to a forecast deficit of £15.7m for 2015-16.

Cambridgeshire & Peterborough Health Services
Let Down by Everyone – A Tale of Incompetence

THIS REPORT ANALYSES the actions and arguments of the many and various individuals and organisations who contributed to the collapse at the end of 2015 of a flagship contract for Older People's and Adult Community Services (OPACS), which had been drawn up by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

In the event, the people of Cambridgeshire and Peterborough, who depend upon these services, and the thousands of staff who work each day delivering these services and have been subjected to many months of uncertainty and insecurity, have all been let down by people who should know better.

The ill-conceived and inappropriate governance framework established in the massive reorganisation of the NHS by the Tory-led coalition government in the Health & Social Care Act played a vital role in this. It ushered in a new amateurisation of NHS management, opening the door for the private sector to step in – as it was intended to do.

The established professional management structures, created to deliver the commissioning of health care and manage budgets of hundreds of millions, were all swept away in 2012–13, and, in place of Primary Care Trusts, a network of over 200 Clinical Commissioning Groups was established, ostensibly under the leadership of local GPs.

GPs in management

While GPs in general have many skills and strengths, few of them have any training in management or commissioning of services across wider populations, or in drawing up, negotiating and monitoring complex and far-reaching contracts – or monitoring the results. So even had the GPs, in practice, been in control of the Cambridgeshire and Peterborough CCG there is no reason to suppose this would necessarily result in proficient management and organisation of resources. And in this case it certainly didn't.

However it's fair to say that this was not the first time irresponsible initiatives have been attempted in Cambridgeshire's health services, not least the disastrous experiment in privatising the management of Hinchingbrooke Hospital in Huntingdon, with NHS East of England defying warnings from unions and campaigners to hand an unworkable contract to an untested Circle Health, an unsuccessful private hospital company. This also resulted in a swift and messy failure, with the company opting to walk away amid mounting deficits and crumbling hospital performance after just two years of a 10-year contract.

The NHS in the East of England has been used for over a decade as a test bed for various unsuccessful experiments like these, driven by the old Strategic Health Authority management, and their creation, the Strategic Projects Team (SPT), who appear to learn nothing, say nothing and change nothing after their various failed projects.

The main reaction of the SPT to the collapse of the OPACS contract was to insist that they had not been the only advisors, and that they had not had anything to do with the contract in the final period leading up to its collapse. They had simply helped formulate a flawed contract, and made their escape before it collapsed.

This approach – seeking to blame others or external circumstances, rather than accept responsibility and recognise elementary errors, characterises almost all those who were party to this fiasco. The other factor that many of the architects of the doomed OPACS contract have in common is a reluctance to accept any accountability to local people and communities or to consult on plans, which they know are controversial, and to take any note of critical comments.

That's how bad policies are made, and flawed contracts drawn up and signed.

To make matters worse, in 2014, Cambridgeshire was singled out as one of eleven 'challenged health economies' and subjected to even more interventions from management consultants.

The financial gap that was threatening to open up by 2019 was estimated at £250m – although at no point since this was announced have any measures been proposed with a chance of making any substantial reduction in that figure. At least in part, this reflects the historic underfunding of services in Eastern England, exacerbated by the government's austerity squeeze since 2010.

Predictions and warnings ignored

The chapter of errors that led up to the collapse of the contract was not a series of unanticipated or unavoidable accidents: each one of them was predicted and forewarned by campaigners and the health unions during the long drawn-out and costly process of procurement, during the consultation that the CCG tried so strenuously to avoid and throughout the contract negotiations with the preferred provider.

So this was not simply inadequate management, governance and policy-making, it was incompetence on a major scale, with the CCG refusing to heed valid warnings or to take note of the actual situation changing around them.

This report therefore aims to identify the different levels of incompetence that combined to create the contract itself and the circumstances that led to its unseemly collapse.

Elementary errors

The contract had elementary flaws that no normal couple buying their first house or commissioning a new conservatory would ever make. Astonishingly there was neither an agreed price – for a contract in the order of £750 million – nor a clear stipulation of what would be provided in return.

Moreover, the commissioners seem to have been blissfully unaware of exactly who they were commissioning, since they had not taken note of the formation of the Limited Liability Partnership between the two foundation trusts.

The whole shambles was avoidable: indeed there was no need for it ever to have begun, since the CCG could have engaged in a constructive dialogue with local trusts to spell out their ambitions and requirements rather than embark upon the tendering process.

Too many people shaping the decisions were driven by agendas that were not appropriate – whether that be an ideological commitment to the concept of a competitive market, the private sector and its methods to improve health care or an equally ideological commitment to reducing public spending, including NHS spending, as a share of GDP, regardless of the consequences; or whatever confused notions were going through the minds of trust board members and a CCG Governing Body who were hopelessly out of their depth when these flawed proposals were being discussed.

NHS England bureaucrats who – in the absence of any public body to replace the abolished Strategic Health Authorities – were supposed to supervise the work of CCGs, instead simply stood by and watched the shambolic proceedings.

The regulator, Monitor, proved itself as myopic and toothless as ever, failing to regulate or pay attention until the project had gone belly-up.

The people, patients and health workers of Cambridgeshire deserve better. And they deserve more than the two mealy-mouthed and half-hearted 'inquiries' that have taken place so far, from West Midland Ambulance Trust, as an internal audit for the CCG[4], and the *NHS England Review of the Uniting Care Contract*.[5] The official reports so far, although they have revealed something of the chaos that led to the collapse of the contract, have been little more than face-saving exercises.

The "internal audit" team at West Midlands Ambulance seeks to minimise the extent to which the CCG and its actions were fully exposed as incompetent. NHS England has been seeking to divert attention from its own incompetence by blaming almost everybody else.

These two reports are also remarkable for what they don't say:

- **Neither report** explains how the services are being maintained now they have been put firmly back into the hands of the CCG, or discusses any longer term future plan.
- **Neither report** explains how a service that was threatening to bankrupt Uniting Care (the 'limited liability partnership' formed by two local NHS trusts which won the contract) can now apparently be afforded by the CCG.
- **Neither report** even mentions the situation of the staff who have been transferred from Cambridgeshire Community Services Trust to CPFT.
- **Neither report** suggests that the attempt to save over £110 million from the delivery of older people's services in Cambridgeshire and Peterborough must be reconsidered.
- **Neither report** addresses the issues of local engagement and transparency, since supposedly the procurement process implemented by the CCG was 'excellent' – for all but the local campaigners, health unions, community organisations and Healthwatch who found themselves excluded, having to campaign and even threaten legal action to secure a token consultation exercise (from which large amounts of information were redacted).

Nonetheless the two reports do uncover some important aspects of the fiasco, and are analysed in some detail in Appendices One and Two.

The second stage NHS England report will be some time before publication, so it seems there is very little immediate prospect of any more specific and hardhitting critique of the lamentable failures that led to the OPACS debacle.

The National Audit Office report that has just been published is only slightly more hard-hitting and forthright in its conclusions.

NHS reports put to shame – by the BBC

The most devastating report of all to date has been the January 26, 2016 BBC Radio File on Four programme, which is also the only one so far to expose the fact that the entire project was seen by the CCG as a **cost-cutting exercise**. The report, by Jane Deith, edited by David Ross and produced by Ian Muir-Cochran[6], uses far more information and asks blunt questions of the key players in the CCG and Uniting Care (UCP). It quotes an unnamed private sector source as saying "It was obvious as soon as we looked at it, the numbers didn't stack up." But it also points out that the private sector was reluctant to saying this publicly because "We have to keep relations with the NHS warm": in other words it wasn't just the NHS commissioners and providers who remained silent or in denial about the reality of the contract, but the private sector too.

Uniting Care's chief executive refused to be interviewed but one of its directors, Dr Alex Gimson, a consultant at Addenbrooke's Hospital, did speak to the programme, admitting that the whole contract was built on shifting sands:

> *"We found that there were some contracts which were being undertaken by third parties, for which there was no written contract that we could find, but money was changing hands. That lack of clarity, contractual clarity, made subsequent discussions in my view very, very complicated. It primarily failed because we were unable to come to any final conclusion with the CCG about the terms of the contract."*

Gambling for high stakes

The BBC report quotes an unnamed person from UCP saying that they were taking chances, hoping for the best:

> *"Uniting Care was aware that there were risks in terms of whether they'd be able to make it work for the money, but* ***everybody thought they stood a fighting chance*** *of doing it."*

The King's Fund's Professor Chris Ham also summed up the scheme as a gamble:

> *"The NHS providers who together took on this contract underestimated the complexity and the cost of doing so, because effectively these innovative outcome-based contracts, as they are often called, shifting risk from the commissioners of care to the providers of care – the providers are taking a punt, if you will, that if they do take on these contracts and the funding that's on offer they'll be able to run successfully, maybe create a margin, a financial margin that they can then reinvest in the other NHS services they provide."*

The scale of the gamble is also revealed in the BBC report. Referring to a copy of the contract through a Freedom of Information request (a contract that is not referred to in either the Internal Audit or the NHS England report), Deith reveals that the Uniting Care model was forecast to ***save the NHS £117 million*** over the five-year contract – more than 15% of its value.

The savings target is the equivalent of almost £20 million a year, enormous savings even by today's standards from services that are still heavily labour intensive. Yet at no point anywhere, has anybody revealed how such savings were supposed to be generated, not least because the OPACS project was constantly portrayed as a way of improving and integrating services rather than as reducing the cost and quality to fit a predetermined cost envelope.

Having signed the deal, the CCG leaders clearly just kept their heads down, hoping somehow it would work. The BBC report interviews Dr Neil Modha, head of the CCG project, who insists that despite the CCG's efforts to generate hefty savings from the project: *"We had no kind of early indications that the kind of financial envelope wasn't correct …"*

Finger of blame

The BBC's is the only report to clearly point the finger of responsibility at the CCG and its leadership and advisors.

It is also the only report to focus attention on the role of Monitor, the NHS regulator (now transmogrified into NHS Improvement), which is also facing questions and an inquiry. Even though Monitor declined to be interviewed, Jane Deith asks on air:

"Why did it give the go-ahead when there were concerns about the contract?"

Deith goes on to estimate the total cost of the fiasco to the CCG and the two trusts at £20 million. She challenges Modha's claim that the improved model for more integrated services for older people was a product of the contracting process, pointing out that the CCG went into the process with a model, seeking a partner to implement it – and are still lacking that partnership.

Her report in its final few minutes includes Chris Ham arguing correctly that:

> ***"There is no good empirical evidence that having competition within the NHS drives down costs. In fact there's some pretty good evidence it can increase costs, all the transaction costs associated with tendering, writing contracts, monitoring contracts – and, of course, in extreme cases, contracts failing, as in Cambridgeshire****.*
>
> *"So the ideological belief that competition will drive improvements in performance and particularly in efficiency is not well founded, and that's another reason why, at a national level, we're seeing politicians not talk about competition any more. The leaders in NHS England and NHS Improvement are turning their attention to how we can make the NHS work better, more as a planned system rather than a market system."*

Cambridgeshire and Peterborough CCG, continues to put out services to competitive tendering out of fear of potential legal intervention and competition law rather than recognising the need for collaborative work with providers to shape services to meet patients' needs.

The only organisations to have been vindicated in their stance following the eventual collapse of the contract are the Stop the Sell Off campaigners, who had to fight every inch of the way for even the most basic consultation and transparency, and the trade unions, who supported them, and did what they could to challenge the flaws in the scheme and bring the CCG to its senses.

Five years of mounting incompetence

1 The failed OPACS contract was inescapably a fruit of the new NHS structure as created by Andrew Lansley's Health & Social Care Act (2012).

Mr Lansley's massive top down reorganisation of the NHS, announced straight after the 2010 election despite the lack of any reference to its proposals in the Tory manifesto, swept away existing NHS management and imposed 'Clinical Commissioning Groups', which we were told were to be 'led by GPs', who in reality, would be figureheads, while the CCGs would actually be led by managers and /or management consultants. This complex and massive piece of legislation, which only applies to England, and was subjected to limited and belated opposition from Labour, was pushed through the Commons and Lords with the support of the Liberal Democrats.

The central purpose of the Act was to remove the direct accountability of the NHS to Parliament through the Secretary of State, and institutionalise a competitive market in the provision of an increasing range of health services paid for by the NHS. It encouraged foundation trusts (FTs) to generate up to 50% of their income from private medicine or contracts with the private sector. It went far beyond the relatively limited (if costly and ill-conceived) experiments by Labour from 2000 in using private providers to deliver uncomplicated elective surgery and a variety of community health services for the NHS.

CCGs took over in the spring of 2013, and from the outset were expected (by Section 75 of the Act and by the complex series of regulations pushed through the House of Lords) to open up an ever-increasing range of services either to competitive tender, or to 'Any Qualified Provider'.

Enthusiastic privatisers

Of the small minority of GPs in each area who have opted to involve themselves in the running of the CCGs, a disproportionate number have demonstrated their zeal for contracting out health care to private or privately-led providers – giving rise, in some cases, to questions over conflicts of interest, where GPs are also participants or shareholders in businesses which benefit from contracts.

Cambridgeshire is only one example of this type of contracting. Elsewhere, contracts have proved to have serious knock-on consequences for the viability of existing local NHS providers. In West Sussex, a contract to outsource the provision of elective musculoskeletal services to BUPA as lead provider was rejected … by BUPA, since a subsequent report by PwC had shown it could destabilise two A&E departments serving the area.

In Cornwall, NHS Kernow CCG floated the idea of putting non-emergency services out to tender – and potentially bankrupting the county's only, struggling, hospital trust. There are many more tales of potential knock-on effects that have been flagged up by campaigners, who have been ignored by CCGs until too late.

These examples are mentioned to demonstrate that in the management and governance regime ushered in by Andrew Lansley's Act, incompetence at CCG level is an increasingly common problem, not restricted to Cambridgeshire and Peterborough. The OPACS fiasco is simply an extreme example, since it was seen as a flagship project for others to follow. It is especially important that the lessons of its collapse are known and shared.

2 The underfunding of the contract, and the desperate quest for cost savings – often under the guise of 'clinically-led' proposals for 'improving services', flows inevitably from Tory Chancellor George Osborne's unprecedented real-terms freeze on NHS spending since 2010.

The freeze, which has brought the meanest-ever five years of funding increases for the NHS, is intended to last until 2020, reducing year by year the share of GDP spent on health, and reversing the increases in funding from 2000-2010.

Since the McKinsey report for the Labour government, written in the aftermath of the banking crash of 2008, outlined a highly contentious menu of largely unevidenced measures which they claimed could bring NHS 'efficiency savings' of £20bn over 5 years, similar lookalike plans and proposals have been increasingly the mainstay of NHS management.

The McKinsey proposals, and more localised plans based on them, placed heavy emphasis on diverting services out of hospitals, despite little if any evidence that alternative models of care could either reduce the need for hospitals or save any money.

The combination of a decade of austerity in health budgets, coupled with the enthusiasm for 'market' style methods and private sector engagement in health services, spawned plans such as OPACS – which we now know aimed to deliver a very substantial cost saving of almost £120m over 5 years – equivalent to over £20m per year.

In the past 18 months, NHS and foundation trusts (FTs) have run into unprecedented levels of deficit, while performance on many high-profile targets has been consistently falling, in some areas to crisis levels, leaving hospitals on 'Black Alert' (diverting ambulances for lack of beds) and mental health patients facing ever longer journeys for scarce psychiatric beds.

The continued tightening level of financial austerity, while population increases and cost pressures rise for the NHS, makes it impossible to maintain safe and adequate services. The collapse of the OPACS contract is consistent with other evidence that there is now insufficient money available to implement the new plans.

Now the FTs' body – NHS Providers – is warning that up to 50 hospitals could have to be closed if funding levels are not increased, while others, including David Bennett, former chief executive of the regulator Monitor, and US health systems expert Don Berwick, have warned that attempting to run a universal health care system on just 7 percent of GDP is an experiment with unknown consequences.

So the context of the underfunding of the OPACS project and its collapse also serves to question the judgment of the Chancellor and the Cameron government, for whom austerity in public spending is clearly a political choice, resulting in UK health spending lagging way below that of equivalent developed economies and deliberately creating the conditions for privatisation.

3 NHS England has plainly failed to scrutinise or supervise the actions of Cambridgeshire & Peterborough CCG despite its attempt to establish an experimental high profile, flagship contract, which could have been worth up to £750 million over five years.

The Health & Social Care Act (2012) has created a separate management structure for the NHS, which is no longer accountable to the Secretary of State butto regulators, now grouped together as NHS Improvement.

At the top of the NHS management is the commissioning body for England, now known as NHS England, which was responsible for overseeing the creation of CCGs, vetting their constitution and leadership, and has since taken control of the allocation of financial resources and responsibilities.

The old regional structure of Strategic Health Authorities was swept away and in place of these public bodies, which met in public and published Board papers, NHS England now administers a bureaucratic structure of regional offices, with Cambridgeshire assigned to the giant Midlands and East Region. It's not clear to many what these regional bureaucrats do most of the time: they are accountable upwards to NHS England, but not at all downwards to local people in the patch they cover, and they do not hold public meetings or publish their papers.

Now it seems an even more drastic, top-down reorganisation, driven by NHS England, has carved up England's NHS into 44 'footprint' areas, and is designed set to pull together CCGs and trusts into working together as 'health economies'. The objective is to drive cash-saving measures to address mounting deficits and balance the books[7].

But one of their tasks should surely be to oversee major initiatives such as the OPACS contract. This was clearly not done. And now NHS England's own report on this fiasco is a desperately poor effort, again trying to find ways to blame nobody and deferring any conclusive judgments to the outcome of further 'reviews'.

This underlines the lack of managerial competence and accountability in the NHS as presently organised.

4 The Cambridgeshire & Peterborough CCG itself ignored the concerns of the local public and the warnings of campaigners in its blinkered, single-minded drive to establish this contract. It then ignored warning signs, including the withdrawal of private sector bids (in which the companies cited the lack of adequate funding as their reason), and signed a contract with more holes than a teabag.

From the moment that the contract was announced in 2013 through to the early spring of 2014, campaigners had to fight tooth and nail to force the CCG to engage in any consultation or publish any details about their plan to put Older Peoples Services out to tender. Campaigners from Stop the NHS Sell Off, supported by the health unions, challenged and exposed the secrecy of the whole process. They had to threaten to take legal action against the CCG to force any disclosure at all.

The campaigners pointed out that by keeping all the key documents hidden from local people the CCG were preventing any meaningful public engagement in the biggest local tendering exercise so far, and eventually forced the grudging promise that some of the documents would be published. But even then the CCG's eagerness to hide what they insisted were 'commercially sensitive' documents far exceeded their professed willingness to engage with the local community and patients who depend on the services involved.

The limited consultation they eventually did run began only AFTER all the big de facto decisions had been taken, AFTER the tendering process had been almost completed and AFTER the CCG had already decided how the final stage of tendering would be handled.

The Consultation document as it was written gave no opportunity for people to declare their wish to oppose or to stop the CCG taking the community services contracts for Older People and Adults away from the existing high quality NHS provider. Unusually for a consultation document, no actual choices were offered at all, and those who participated were not asked which option they would have preferred: all the decisions had already been taken.

Moreover while the public view was sidelined and ignored, the CCG was even less willing to engage seriously with staff

working in the affected services or the trade unions representing them. Indeed the CCG would not even go through the motions of asking staff views on how best they could work with colleagues in other provider organisations. The divide between purchaser and NHS provider was never greater[8].

This secret process led to a fatally flawed contract, based on inadequate and out of date information and with ***no fixed costs or prices agreed*** – a contract more naïve than even the most elementary house sale or business contract.

As a commissioning body in a marketised NHS, charged with proper use of their £1.1 billion budget for the health care of people in Cambridgeshire and Peterborough, the CCG needs to be proficient in drawing up, concluding and monitoring contracts.

Since the original contract collapsed, the CCG has continued to directly commission a range of services for older people – apparently unaware that by doing so they give clear evidence that the whole procurement exercise, and the costly apparatus of the contract were ill-conceived from the beginning.

Indeed, as soon as the contract had collapsed the CCG seems to have had no trouble negotiating with the service providers to maintain services. Nor, astonishingly, do they even seem concerned to address the financial imbalance that brought the whole Uniting Care house of cards tumbling down.

There seem to be no further plans to re-tender the services: maybe something has been learned after all, though sadly not absorbed or recognised by the CCG. The OPACS fiasco shows that they are not competent as a body to carry out this task, with or without their external 'advisers' who appear equally deficient.

Nevertheless the key mover from the CCG in the OPACS fiasco, Dr Neil Modha, who stepped down from his post to 'rebalance' his life, alarmingly stepped straight back up for a while to take charge of the Sustainability and Transformation Plan (STP).

This creates a new 'Health Executive' to take decisions for all trusts and for social care in Cambridgeshire and Peterborough for the next five years. The new body will be completely unaccountable to local people as it hatches plans in secret aimed at achieving a staggering £250 million additional savings to balance the books by 2020. It's all rather grimly reminiscent of the confidential meetings that took place to set up the OPACS contract.

5 The Strategic Projects Team (SPT), originally from NHS East of England, now has a variety of costly failures to its name across the Midlands and East of England.

Prior to the OPACS contract collapse the SPT had been involved in the failed contracting out of management at Hinchingbrooke Hospital, failed attempts at spreading the same model to George Eliot Hospital in Nuneaton and Weston Hospital in Weston-super-Mare, and a failed £500m tendering exercise for pathology services in the Midlands.

This team dates back to the heyday of the East of England Strategic Health Authority (SHA), which in the mid 2000s set itself up as the high command of the government's efforts to bring more private sector providers into the NHS. The SHA invested substantial public money in the process and established a 'unique Commercial Advisory Board' to drive it, led by Director of Strategy, Dr Stephen Dunn[9], and coordinated by Andrew McPherson, the director of the 'Strategic Projects Team' which was set up in 2009[10].

The project the SPT cite as their landmark success was the controversial 'friends and family test' to rate the perception of NHS Trusts and services, which was eagerly embraced and driven by David Cameron, and introduced throughout England's NHS, although it was strongly criticised and rejected as 'useless', 'meaningless' and 'not appropriate for use in an NHS setting' by expert bodies including the Care Quality Commission (CQC) and the NHS Alliance[11].

More recently, the SPT has also been central to the highly controversial proposals to contract out cancer services to a lead provider in Staffordshire, which is currently under review.[12] According to the BBC's *File On Four* programme, the Department of Health (DH) has described the SPT as 'the gold standard of transformational change'. It would be interesting to see what the less successful teams look like.

The SPT still says it has played a part in the 'ground breaking' OPACS project, even as it tries to keep its distance from the aftermath of its embarrassing collapse[13], insisting that it 'exited' the project 'months before' the final moments. But as advisors to the OPACS project, for which they were **paid £280,000**, they encouraged the CCG to ignore all the warnings, promoted 'innovative' ideas despite the lack of evidence, and were a party to drawing up the flawed contract and attempting to implement it with insufficient funding.

This is not exactly a glittering success by any measure: it's clear that the CCG's failure to secure adequate and competent advice from the SPT or from legal advisors has been a major factor in the swift eventual breakdown of the OPACS contract.

6 The Trust boards of the two Foundation Trusts, which won the contract, but then went on, without agreement from the commissioners or apparent awareness of the tax implications, to establish a Limited Liability Partnership (LLP), which immediately incurred an annual VAT liability of £5m.

Having made this expensive error, the two trust boards went on to nod through the whole process of the contract. No executive or non-executive director ever questioned the lack of any stipulation of a firm price to be paid to their trust or defining the scope of the services which had to be provided by the trust under the contract.

This has clearly demonstrated that the two boards were in this respect incompetent and negligent, with the key directors having led the trusts into this fiasco.

The two major provider organisations which made up Uniting Care – no doubt motivated by legitimate concern to keep the services in the public sector – eventually signed up to a contract which was insufficiently funded to ensure the delivery of adequate, safe and satisfactory services to a potentially vulnerable population of older patients

However, the CCG was seeking to make excessive and unmanageable cash savings by cutting the value of the contract. The lack of adequate funding and the ultimate responsibility for the eventual and inevitable crisis must lie with the CCG and its advisors: it's clear that the trusts should not have been put in this position in the first place.

7 Monitor (now NHS Improvement) is supposed to be the regulatory body checking on the behaviour of foundation trusts, with a specific brief to check on the contracts they sign.

Monitor had already seen the failure of its regulatory function in the local area, when the disastrous PFI contract was signed in 2007 by Peterborough & Stamford Foundation Trust, despite TWO warning letters from Monitor that the Trust could not afford the repayments.

That wilful defiance by the Trust triggered an immediate financial crisis, which has still not been resolved nine years later.

But in 2014, despite have been endowed with substantially increased responsibility and powers by the 2012 Act, Monitor allowed yet another deeply flawed major contract to be signed without adequate intervention.

Monitor's letter to the County Council's Health Committee trying to explain away its failure with the OPACS contract is interesting. The director involved, David Dean, argued that:

"It is important to understand that Monitor's legal role as the regulator of Foundation Trusts (FTs) is to risk assess transactions. We are only able to carry out a risk review into transactions which involve a FT."

By contrast the NHS Improvement website argues that it has a general brief for NHS and FTs and for independent sector providers:

"By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future[14]."

It seems evident that the much narrower definition of Monitor's brief in the OPACS case allowed room for the failed contract to be finalised and signed, and that the regulator in this case has failed to regulate. Mr Dean's letter makes clear that only a limited, 'high level' scrutiny of the position of CPFT was attempted, partly because of the rapid timescale for implementing the contract:

"*Although the transaction was significant, we agreed to carry out a limited, high level, risk review because the view that had been expressed to us strongly from within the local health economy[15] of the patient safety and financial viability risks if the contract was not approved by April 2015. This was not an ideal situation but we needed to find a pragmatic way of completing the first stage of a review to enable this transaction to proceed whilst continuing to review some of the risks we'd identified[16].*"

It's not apparent who in Monitor, in addition to Mr Dean, is accountable for the costs of this failure to regulate and to allow the contract to go forward. But key individuals in Monitor, who should have been scrutinising such things, and most especially checking out high profile contracts like this, have shown themselves, if not the whole organisation, to be grossly incompetent in the handling of this case.

8 The Cambridgeshire County Council Health Committee (CCCHC)

Despite campaigners on at least three occasions drawing their attention to the CCG's management of the procurement programme,, CCCHC spent virtually no time discussing the OPACS contract in the meetings running up to its launch in April 2015.

The Committee had not supported the campaign to force the publication of details of the proposals and public consultation, and there is no indication of any awareness or concern among Committee members that such a large and complex contract was being effectively negotiated and signed behind closed doors, at least not until the contract collapsed.

Then, ever wise after the event, in March 2016[17], the Committee expressed criticism of the limited and ineffectual Monitor scrutiny of the project:

"The Committee expressed concern that arrangements for scrutiny of a proposed contract of this magnitude had not been equal to the task."

At their subsequent May 2016 meeting[18], Councillors on the Committee highlighted several contributors to the collapse, with a significant omission in the roll call of failure:

- NHS England should have taken a much more active role in assessing the robustness of the proposals, especially with regard to the change in corporate structure and its implications for liability for VAT;
- Monitor, the NHS improvement body, should not have been content with a 'high level' review;
- The contract should not have started in such a hurry with so many unanswered questions;
- The CCG should have conducted more thorough due diligence on the Cambridgeshire Community Services handover package before agreeing a final go ahead;
- CUHFT should have alerted other stakeholders as soon as its deteriorating financial position meant that it would be unlikely to be able to bail out any UCP shortfalls; and
- NHS England should not have let what was supposed to be an invaluable pilot go under for a sum that was small in relation to the size of the contract.

The Committee, regardless of its political composition, is certainly far from unique in its limited knowledge, awareness and interest in scrutiny of the detail of proposals.

In this case, it was clear that the Committee was reliant on the statements, documents and evidence that they received from official NHS bodies and their advisers, lacked any independent view, and was swept along by the general rhetoric for the OPACS project. Its effectiveness in scrutiny – other than after the event – is therefore in question, as is its competence in representing the electorate in this key role. This does not bode well for the management of integrated health and social care budgets, relying more and more on commissioning support groups that are increasingly composed of or informed by private for profit companies seeking to expand the role of private care within the NHS. This is a significantly weak link in the already weak accountability chain.

Where does all this leave health services in Cambridgeshire & Peterborough?

The prospect is one of continuing cuts and search for 'savings' to remedy a vast financial black hole that has been opened up by six years of austerity-driven underfunding, a costly market system, and several more years of virtual cash freeze to come.

The CCG's estimate is that the total gap in funding to 2018 across the CCG, and various NHS providers in Cambridgeshire and Peterborough, adds up to a hefty £430m. The situation for the CCG has worsened due to the collapse of the OPACS contract, which took the CCG from a projected marginal £0.5m surplus to a forecast deficit of £15.7m for 2015-16.

This, plus a series of additional cost pressures[19] for the coming year, means that the higher than average uplift in funding received by the CCG will be more than wiped out, leaving the CCG itself to find £44m of savings to balance its own books.

Even if the identified schemes succeed and deliver the promised savings, the CCG itself is still facing a £7m deficit for 2016-17.

The CCG is the body charged by the NHS with the responsibility of driving the development of a Sustainability and Transformation Plan (STP) to balance the books of the whole area. The plight of the Acute Trusts, for which the STP is also responsible, will be worsened by the CCG's efforts to hold down spending and generate £17m of savings from acute services, while 'other programme services' also need to beware of CCG plans to liberate another £13.9m of savings from them.

It seems that even after the failure of its grand scheme to save £117m over the life of the OPACS contract, the CCG has not yet caught on that solving its own budget problems at the expense of local providers is not a way to balance the books overall – it's just passing the buck.

John Lister
London Health Emergency
Summer 2016

APPENDIX ONE

A response to The Internal Audit Report

The Internal Audit Final Report into the procurement, completed swiftly by West Midlands Ambulance Service Trust and published in March 2016, admits that it is narrowly "focused on the processes and mechanisms deployed by the CCG", and that it makes use only of material generally in the public domain (i.e. with no access to the actual contract itself).

It notes in the introduction the rather mundane conclusion that "*The termination of the contract soon after its inception is an indication that there were mismatched expectations of the financial investment required to deliver the service delivery model*".

We hardly needed an inquiry to point out that fact. But the same report goes on to insist that: "*The CCG did have in place controls designed to ensure bids were within the estimated annual contract values.*"

This obviously raises a number of questions. Were the controls adequate? Was the winning bid in some way dishonest or were the bidders deceived? And why has the CCG been so shy over the fact that its 'estimated contract value' over the lifetime of the contract was pitched not so much to secure continuity of services, but rather to deliver cash savings each year, totalling over £110m?

Limited lessons

The sketchy list of 'Lessons to be Learned' skates delicately around the failure of the OPACS contract to stipulate the precise package of services and specifications required, or a clear and finally agreed price. Instead the focus is on more peripheral, if still significant questions

- The fact that even the external lawyers and advisors on procurement failed to take up the consequences of the establishment of the Limited Liability Partnership – or secure appropriate guarantees from the two 'Parent Company' FTs. It sounds here as though problems with the UCP's LLP arrangements are being used as an excuse for the contract collapse, and that CUH and CPFT are being made scapegoats. These are surely basic principles for the negotiation of almost any significant contract and raise questions over both the CCG's ignorance of the process and the quality of the legal and procurement advice and advisors (Strategic Projects Team, along with Wragge, Lawrence Graham & Co). Are any other contracts worth hundreds of millions signed off without fully checking out who the parties are, whether they are reliable, and what their liability might be in the case of a default?
- The purchaser/provider split in the NHS, coupled with the extensive 'business in confidence' exclusion of transparency, which has worsened since the 2012 Health & Social Care Act, meant that the CCG was not able to check out how much the FTs were expecting to secure as income for their part in the project. Had this been known they might have seen at once that the expectations were unrealistic.

But conversely, had the FTs been able to see clearly how much the CCG hoped to save from its contract over the five years, they might have been more sensible, and realised sooner that the deal was not sustainable. The fog of business secrecy has helped deepen the confusion on both sides.

- The Internal Audit report highlights the way in which Uniting Care LLP attempted to diverge from the contract from the very first invoice.
- And it raises concerns over the CCG's delay in raising these issues with NHS England.

Why the inaction?

We might well say that the bigger question is why the Department of Health (DH) and NHS England presided over such a fiasco and were so slow to recognise that there were genuine, terminal flaws in the flagship deal that had been signed – flaws that have since been seen as significant enough to force a halt to another, similar sized and possibly even more contentious contract in Staffordshire[26], pending a review.

It's hard to avoid the conclusion that the DH and NHS England were reluctant to interfere in a project that corresponds with their own assumptions and aspirations. Cambridgeshire was a trailblazer with others preparing to follow. Nobody wanted to find a problem that might set it back: the CCG and Trusts were given the benefit of the doubt.

The Internal Audit report looks at the process followed by the CCG in the procurement, which was widely depicted as a model of its type – right up to the point of its abrupt collapse.

The Report asserts (3.1.3) that the contract aims included: 'delivering recurrent financial balance in a sustainable way'

Had this really been a central concern, it's hard to see why the CCG should have been so unconcerned at the absence of proper costings or a final agreed price.

The Inquiry report also argues that the other objectives included: 'sharing financial risk across the commissioner-provider system'; and 'creating the conditions for investment and delivering a return on investment'.

However the substantial level of savings, which the CCG was seeking to derive from the contract, raises serious questions over both these objectives.

We can now see that in line with current trendy NHS notions of 'lead provider' and 'accountable care organisations', the risk was NOT to be shared with the CCG, but passed firmly over to the providers.

Questions that should have been asked

At the same time, the cost-cutting approach made it next to impossible for the providers to invest in the service or make

any return from their investment – as became painfully obvious when they gave up and pulled out.

The Inquiry mentions the withdrawal of bidders prior to the shortlisting process (3.1.7): but it does not investigate the extent to which these were motivated by the underfunding of the contract itself, although this was widely known to be the case[27].

The entire legalistic pseudo-'business' culture that has developed among CCGs since the 2012 Act, with the potential involvement of the Competition and Markets Authority, NHS Improvement and EU competition laws, has meant that the CCG was excessively concerned to avoid any legal challenge. Indeed the CCG's business expertise seems to have been limited to that one area – of avoiding legal action (3.1.8).

Report section 3.1.9 makes clear that the Strategic Projects Team failed to take note of or address issues arising from the change of legal entity as a result of the formation of Uniting Care as an LLP by the two foundation trusts. Indeed the SPT did not even explore the extent to which the LLP was developed as an organisation, assuming that Uniting Care was the new employer of front line staff, while, in effect, it was little more than a front office employing a relative handful of admin staff.

This is a massive blunder to have been made by the organisation charged with advising the CCG in a highly complex contract. To make matters worse, the CCG (wrongly, it transpired) expected its legal advisers, in drafting the contract, would also undertake drafting a Performance Guarantee for the 'parent' trusts of Uniting Care (3.1.10). The Report does not explain why this did not happen or whose responsibility it should have been: either way this legal clause was not completed or included, which meant that the two FTs and Uniting Care could simply walk away from the failed contract.

Cash savings – and secrecy

The extent to which the CCG approach was focused on cost savings is underlined in 3.2.2, where the Report stresses that: "*The CCG approach to the financial value of the contract was to seek solutions within a cost envelop (sic) that had been derived from examination of the current cost of delivery but also included expectations of cost improvements to be achieved over the contract term.*"

The Report does not inquire into either the scale or practicality of these cost improvements, or what assumptions they might have been based upon – or the extent to which these cost cutting ambitions were made clear to Uniting Care.

It does seem strange that while the CCG requested sight of the Cambridgeshire Partnership FTs' business case as submitted to Monitor – only for this to be declined – nobody seems to have asked for any business case or information about Uniting Care LLP.

This mutual observation of secrecy ensured that the first time the extent of the contradiction between Uniting Care's expectations and those of the CCG emerged was when the first quarter's invoice was submitted – at a figure much higher than expected (3.2.3).

However the Inquiry (3.2.4) does quote some comments from unidentified 'stakeholders' back in November 2014 questioning the viability of the OPACS programme, the issue that brought down the whole house of cards. These comments appear to have been ignored by the CCG and its advisors, as they ignored all external criticism.

No final costings = no contract price

As a result of this attitude, neither the commissioners nor the providers had full costings on the services that were to be provided. The Internal Audit Report notes: "*There was recognition by both sides that the contract sum would need to be amended to take account of the activity outturn for 2014/15.*" (3.2.7)

In other words, with no agreed final price in the contract, neither the commissioners nor the providers were justified in signing it off. It was a recipe for confusion and conflict.

Despite this the Department of Health's *Gateway Report* on the contracting process failed to spot any of the problems, doubts or fundamental flaws and instead praised the 'professionalism of the procurement process', with especially complimentary points on the avoidance of any legal challenge (3.2.8).

For the DH to come to such a conclusion now is equivalent to arguing that the operation was a success but the patient died. Unfortunately the Internal Audit Report is equally reluctant to point the finger explicitly at the CCG and its advisors for their role in such an expensive and high profile failure.

After the contract had been signed there were yet further failures to check out the viability of the new provider organisation, Uniting Care LLP.

Monitor required only one of the two parent FTs to open up its business case for scrutiny. This proved to be the trust with the least serious financial problems, while CUH kept an embarrassed silence. This partial scrutiny may have given Monitor a skewed picture of the ability of the new consortium to absorb the impact of unexpected costs and less than expected income. The regulation of this process once again proved minimal and ineffectual, allowing the flawed contract to proceed.

No agreed view

There is still no coherent, accepted view of what went wrong or who took the crucial decisions (3.3.2). Each is looking for ways to point the finger of blame elsewhere – and the Internal Audit Report merely echoes this without any firm conclusions.

The drawing up of the contract was the job of the commissioners – the CCG and its advisors – while the process of due diligence in checking it and ensuring it would not undermine the viability of their organisations was very much that of the two FTs.

They chose to work through establishing their new Uniting Care Partnership, and it's clear that caused more problems than it was worth.

It was very much the job of the Trusts that formed it to check out in advance whether or not the formation of an LLP would make it liable for VAT and therefore take a £5 million lump out of their combined income. They should have sought immediate guidance on this from HMRC, and, if required, NHS England and/or the DH. They did not and the confusion has proved expensive.

Both sides of the contract failed lamentably to do what was required. Both proved themselves manifestly incompetent at contracting: as, apparently, did their largely passive 'advisors', whose role appeared to be simply watching the foul-up take place.

The contract unravels

The unravelling of the contract went at rapid pace, beginning just one month after it had commenced, when UCP requested a massive additional payment of £34.3 million from the CCG (3.3.3). It took almost three months, until August, before the CCG responded with an offer of an extra £9.3m in the contract, plus another £12m in one-off extra payments: the total offer was £22m extra for 2015-16. Repeated further exchanges between the contracting parties failed to bridge the financial gap of around £10m (3.3.6).

But it was not until mid-October that the CCG flagged up the issues to NHS England (3.3.7). Their belated intervention proved insufficient to solve the financial problems that had emerged.

The Internal Audit report draws to a swift close with a list of issues, which were inadequately discussed and dealt with by the CCG during 2015. Its final cagey comments are that: "*There are gaps in the detail of reporting which may have impacted the Governing body's full understanding of the issues and risks.*"

This lame conclusion sums up the reluctance of the Internal Audit investigation to raise sharp or pointed criticism of the CCG.

The Internal Audit's preoccupation with ***process*** in the contracting seems to have displaced any appropriate concern for the CCG's central responsibility to make absolutely clear the terms of the new, innovative contract: ***what work was to be undertaken, on what terms, for how much, and by whom***. It appears from this report that they did not satisfactorily address any of these responsibilities.

APPENDIX TWO

A response to the NHS England Report

The NHS England Review of the Uniting Care Contract, published a month later in April 2016, is more searching in some respects but also gives the distinct impression they were keen to find as little as possible. Their main points are:

- That 'all parties to the final negotiations' – from the NHS and the ultimately unsuccessful private sector bidders – agreed that it was right for the CCG to attempt a new type of contract seeking an integrated approach to care for the over-65s.
- That the contract collapsed 'for financial reasons', and that this was the result of a number of factors, on which we will comment (in italics):
  - Information gaps around community services.

  But these gaps in knowledge were widened by the competitive contracting process and the fact that existing contracted activity was to be taken from one NHS Trust – Cambridgeshire Community Services (CCS), which had expertise and detailed knowledge of the services – and delivered instead by the eventual winner of the contract. CCS had no interest in passing on information that might assist those taking work and income from CCS.

  - The financial envelope of the CCG for these services could not be reconciled to current expenditure levels.

  The CCG wanted to spend less on the new service than they had been spending previously, in order to deliver cash savings during the 5-year contract. Private sector organisations had already walked away as a result. But NHS England does not explain why the trusts, which eventually won the contract bid, did not do more to explore this before they submitted their bid.

  - There was an additional VAT cost.

  This was a result of establishing UCP as a Limited Liability Company. Again the obvious questions are not raised by NHS England: why weren't the trusts aware of this extra cost or alerted by their advisors before they set up UCP?

  - There was not enough time available in setting the contract in motion to make the planned financial savings that were required in the first year.

  But nowhere are the plans for these notional 'savings' explored: were they genuine savings, or simply cuts, or ways of delivering a reduced or lower quality service? Could they have been achievable on a scale to make a financial difference?

  Or was the CCG, advised by the Strategic Projects Team, following in the inglorious footsteps of the previous Cambridgeshire & Peterborough Primary Care Trust and East of England Strategic Health Authority, who combined to push through a hugely over-optimistic and ill-fated contract with Circle to run Hinchingbrooke Hospital, with the undefined and incredible promise in the winning bid of generating £310m savings on a £1billion contract?[28]

  - The contract value was not absolutely agreed.

  It's hard to think of a more basic schoolboy error to make in a contract (apart from being sure you know who is signing from the other side – which of course the CCG also failed to do).

  - The contract should have been delayed until these issues were resolved.

  Why, then, was this not done? Why throughout the process was the CCG in such an all-fired hurry to set up an untested system that it wanted to press ahead with, without consultation?

The NHS England Report pulls up short of questioning the competence of a CCG and FTs that could make such errors – partly, no doubt, because the oversight of the CCGs is a task of NHS England itself: and far from urging caution or holding back the implementation of the new contract, NHS England was actively urging the commissioners on.

The lead provider (or 'prime vendor'[23]) contract is a variant of the 'accountable care organisation' model advocated by NHS England's chief executive Simon Stevens, who brought this and other ideas back with him from his time as a senior executive with UnitedHealth, the largest US health insurance business.

NHS England is keen to look on the bright side, and list all the 'benefits' that it claims have come from the contracting process, including an 'outcomes framework' and a 'service re-design process' (page 10). But the report does not show why these could not have been achieved through negotiation and discussion between the CCG and the FTs, or whether the outcomes framework, designed to ensure the contractor was paid by results, actually contributed to the collapse of the deal.

Nodding through a flawed contract

NHS England is happy to accept claims that the CCG was unaware of the plans to establish Uniting Care as an LLP. But it does point out that when this was discovered the CCG should have reassessed the bidder 'for capacity, capability, economic and financial standing' – but this was not done.

There were also 'some gaps' in reporting the detail of the contracting process to the CCG Governing body. But it's hard for NHS England to avoid the fact that the members of the CCG's Governing Body were happy to hear general statements, to nod through the contract drawn up by directors and by the CCG's advisors – and trust that somebody else was following the details.

Despite this, the report argues (page 11) that there is no need for the CCG to be subjected to an 'assurance process': the procurement was conducted 'professionally' – regardless of the flaws in the contract and collapse of the resulting deal.

Like the Internal Audit report, NHS England shows no interest in how more than £100m of savings were to be derived over five years from previously underfunded services through the new contract. However the report does make

very clear that the contract represented a full transfer of risk to the successful bidders:

"***All of the risks would be passed to the provider*** *and the provider would determine how services would be delivered in the five-year period in order to deliver the required outcomes within the agreed financial envelope The CCG resisted proposals for a 'risk share'/'gain share' arrangement.*" (page 11) [emphasis added]

Despite having signed a contract in November 2014, Uniting Care demanded last-minute changes to the contract just a month before it was due to begin in April 2015. This was to allow increased payments to take account of actual costs and spending in 2014/15 – and for further additional funding in the event of evidence that the costs of services had been understated. The two FTs, through Uniting Care, also required a procedure on any other issue that might arise during the period of the contract that threatened the financial stability of either party – allowing either side to terminate the contract if agreement could not be reached (p12).

Astonishing ignorance at the top

Incredibly, NHS England reveals its own ignorance on whether the FTs do, in fact, have the power to enter into 'parent guarantees' in relation to the Limited Liability Partnership. If NHS England doesn't know this, and have not been able to find out from Monitor, what chance has anybody else of finding out? Who even decides what powers and rights FTs have in the new restructured NHS?

NHS England is also evasive on the question of the £5 million per annum VAT bill on the contract that arose as a result of establishing Uniting Care as an LLP, rather than delivering services directly and remaining within the NHS VAT group. It seems that whereas this issue was not addressed in the Uniting Care bid, the CCG was aware of it: 'the CCG and Uniting Care agreed to explore with HMRC and financial advisers ways of avoiding this cost' (p 13).

NHS England blandly states that 'this issue was never resolved' but does not say what the position should have been, or explain why neither the CCG, nor the FTs, nor their financial or legal advisers appeared to be capable of checking this out beforehand and establishing the position that would apply. This again would seem to be the basic issue of competence.

No firm figures

It appears from the NHS England report (page 13) that the CCG constructed the contract on the basis of old (2013/14) figures for costs and activity in the services that it was contracting out. Financial advisers were also brought in by the CCG to check out the costs of community services: they clearly failed to do so satisfactorily.

As a result the CCG had no firm figures to go on, but decided to press on regardless, to draw up a contract that was inevitably flawed on this most central question. But they weren't the only parties in the dark. According to NHS England (page 14):

"The bidders also expressed the view that the due diligence report on community services costs did not provide the information/assurance they required."

In fact the CCG had an interest in not discovering the actual cost of the community services it was currently commissioning. The NHS England report makes clear that Cambridgeshire Community Services (CCS), the Trust, which was set to lose some of this work, was in fact spending more than the agreed contract price in delivering some of the services – effectively subsidising the services on behalf of the CCG. This was only sustained by a cross subsidy from other areas of the Trust's activity.

However since this was being achieved by CCS, there seem to be even more questions to be answered on why it made sense to split the services off from CCS and incorporate them in this new complex contract, which meant transferring thousands of staff to a new employer.

Cambridge & Peterborough CCG, in common with many other CCGs, has been happy to pay below the realistic cost of services wherever it can, since this can then be claimed to be an 'efficiency' saving, and limit the pressure on the CCG to find equivalent savings elsewhere. The new contract was seen as a way of securing even larger such 'savings' at the expense of the winning bidders – even though this was never admitted openly.

Plenty to be secretive about

Throughout this entire process, ***all*** of the financial details were obscured from any public view or scrutiny, despite the pressure from campaigners for the process to be made more transparent.

Perhaps one of the reasons this could not be agreed by the CCG was that nobody really had a firm grip on the financial aspects of the contract. According to the NHS England report, at the time the CCG declared Uniting Care to be the preferred bidder, it still had an astonishing 71 outstanding clarification questions, almost half of which were still outstanding when the contract was signed.

NHS England, which now says that when the contract commenced 'there should have been a finally agreed value of the contract the first year' (page 15), concludes that "the lesson to be learned is to obtain this information, and in a robust and accurate way, early in the process, before existing providers become conflicted."

Collaboration needed, not contracts!

Alternatively, and more reliably, commissioners could seek to negotiate changes in services jointly with providers, rather than going through the laborious and unrewarding procedures of drawing up contracts. However the preoccupation of the CCGs and of NHS England with the application of EU (and British) competition law (page 20) is likely to mean that the collaborative development of improved

services will continue to be abandoned in favour of complex and confrontational contracting procedures with equally dubious outcomes.

This further underlines the need for legislation to reverse the competitive market framework established by the Health and Social Care Act in 2012, and reinstate the NHS as a public service delivered by public sector providers, with no role for the private sector, and therefore no basis for the application of competition law.

It appears that the CCG has now accepted that it 'should have done more to brief NHS England earlier in the dispute and request intervention' (page 16), although it's not clear what direction that intervention may have taken – whether to bully Uniting Care into accepting the lower price or get the CCG to see sense.

NHS England implies that in relation to the manifest failure of the SPT and the legal and financial advisers retained by the CCG (and no doubt whoever was also advising Uniting Care), there will be 'a thorough review of the role, function and effectiveness of each of the advisers' in the second stage of its review.

Such a review is to be welcomed, but there will be no review of the flawed system in which the flawed advisers do their work.

The blunt edge of this first NHS England report gives little confidence that the subsequent review will give any decisive new guidance to prevent a similar occurrence at the hands of the same advisers in Cambridgeshire or elsewhere.

Indeed NHS England has also recognised it needs to review the effectiveness of the Gateway review process of the DH (page 20). Perhaps it also needs to note the failure of its own local team in East Anglia to scrutinise this very substantial contract and ensure that things were done properly.

Although self-criticism is largely absent from the NHS England report, it seems that this might be taken on board as a result of the proposal to review 'the current approach of complete delegation to CCG to enter into large complex novel contracts without the need to provide any assurance to NHS England', and the proposal to review 'all current and planned CCG and NHS England contracts and sought as a matter of urgency' (page 21).

NHS England also recommends that CCGs establish 'an accurate financial envelope for the new service procurement model before the procurement commences' so that the financial assumptions in the contract bear at least some relation to the current expenditure levels (page 22).

They must now ensure that the contract value is 'absolutely clear before the contract commences' (page 23): it is truly astonishing to find that at this stage in the development of contracting within the NHS, it is still necessary to spell this out to CCGs.

REFERENCES and NOTES

1 Review of Procurement, Operation and Termination of the Older People & Adult Community Services Contract (OPACS) Internal Audit Final Report: CPCCG15/23, available from http://www.cambridgeshireandpeterboroughccg .nhs.uk/news-and-events/A_PR_3765.htm

2 Stout, D. (2016) NHS England Review of the Uniting Care Contract NHS England Publications Gateway Ref 05072 Available from https://www.england.nhs.uk/mids-east/ourwork/ uniting-care/

3 After a number of private sector bids were withdrawn because of concerns of the inadequate funding of the contract, it was awarded to a consortium headed by Interserve, a support service provider with no clinical or commissioning expertise. Shortly afterwards the University Hospitals of North Midlands, the only local provider of cancer services in Staffordshire, pulled out of the Interserve consortium, warning that there was insufficient money in the contract to maintain adequate quality and safety of services.

4 Review of Procurement, Operation and Termination of the Older People & Adult Community Services Contract (OPACS) Internal Audit Final Report: CPCCG15/23, available from http://www.cambridgeshireandpeterboroughccg .nhs.uk/news-and-events/A_PR_3765.htm

5 Stout, D. (2016) NHS England Review of the Uniting Care Contract NHS England Publications Gateway Ref 05072 Available from https://www.england.nhs.uk/mids-east/ourwork/ uniting-care/

6 BBC *File on Four* 'NHS Contracts: Tender Issues" Tuesday 26 January 2016, transcript available: https://www.google.co.uk/search?q=BBC+PMR604%2F16VQ5740&ie=utf-8&oe=utf-8&client=firefox-b&gfe_rd=cr&ei=lzpDV_ujF8fW-8gfOgZGoDA

7 More details on the formation of the STPs is available from Health Campaigns Together at http://www.healthcampaignstogether.com/financialcuts.php

8 This and the preceding two paragraphs are based on the UNISON Eastern Region report *Fatal Flaws*, June 2014.

9 Dr Dunn was given a special award for "Deal of the Year" by Healthinvestor magazine in 2011 for his role in the (as yet incomplete, and later disastrous) contract to franchise out the management of Hinchingbrooke Hospital to private hospital company Circle http://www.strategicprojectseoe.co.uk/uploads/files/PR333E%20Two%20prestigious%20awards%20(HI%207%20June%2011).pdf

10 http://www.strategicprojectseoe.co.uk/ uploads/files/SPT%20Brochure%20v2%20Sept%2012%20single%20pages.pdf

11 http://www.independent.co.uk/life-style/health-andfamilies/health-news/health-experts-reject-friends-and-family-test-8440238.html

12 After a number of private sector bids were withdrawn because of concerns of the inadequate funding of the contract, it was awarded to a consortium headed by Interserve, a support service provider with no clinical or commissioning expertise. Shortly afterwards the University Hospitals of North Midlands, the only local provider of cancer services in Staffordshire, pulled out of the Interserve consortium, warning that there was insufficient money in the contract to maintain adequate quality and safety of services.

13 http://www.thestrategicprojectsteam.co.uk/cambridgeshire-peterborough-procurement/

14 https://www.gov.uk/government/organisations/monitor/about#our-responsibilities

15 NB: it's still not clear who expressed these views

16 Appendix A available at http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12977

17 http://www2.cambridgeshire.gov.uk/CommiteeMinutes/Committees/AgendaItem.aspx?agendaItemD=12977

18 http://www.cambridgeshire.gov.uk/news/article/481/health_committee_continues_scrutiny_of_ucp_contract _failure

19 A rise in the tariff for trusts, rising population, other cost increases and growing demand for services, the need to establish parity of esteem for mental health patients, more for Child and Adolescent Mental Health Services contributions to the Better Care Fund, the GP IT programme, the costs of additional A&E patients above target, a 1% reserve, and the CCG's share of the risk of extra costs for community health care.

20 http://www.hsj.co.uk/sectors/commissioning/nhs-england-to-investigate-12bn-staffordshire-contracts-following-cambridgeshire-failure/7003841.article

21 http://www.healthinvestor.co.uk/ShowArticle.aspx?ID=3091&search=cambridgeshire

22 http://www.theguardian.com/public-leaders-network/2015/jan/12/hinchingbrooke-hospital-circle-outsourcing-nhs

23 See NHS England report page 8

Keep Our NHS Public (KONP) fights for a National Health Service that is publicly funded, publicly provided and publicly accountable and against attempts to marketise and privatise the NHS.

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