



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough

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Department of Health

Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

12 July 2016

Cambridgeshire and Peterborough clinical commissioning group commissioned an innovative integrated contract with a budget of about £0.8 billion to provide its older people's and adult community services from UnitingCare Partnership (a limited liability partnership formed from two local NHS foundation trusts). The five-year contract started in April 2015 but was terminated after only eight months because it ran into financial difficulties. This investigation examines the design, procurement and operation of the UnitingCare Partnership contract, and the events that led to its termination.

Investigations

We conduct investigations to establish the underlying facts in circumstances where concerns have been raised with us, or in response to intelligence that we have gathered through our wider work.

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What this investigation is about

- 1** In November 2014, following a competitive tender process, Cambridgeshire and Peterborough clinical commissioning group (the CCG) awarded a five-year contract to provide older people's and adult community services in Cambridgeshire and Peterborough. The services included all community care for adults over 18 years old, acute emergency care for those over 65 years old, and older people's mental health services.
- 2** The successful bidder was UnitingCare Partnership LLP, a limited liability partnership, set up to fulfil the requirements of the contract. The partners in the organisation were Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust. UnitingCare Partnership then subcontracted with a range of bodies to provide the services, including the two trusts themselves, other NHS providers and a number of other private sector and voluntary organisations.
- 3** The new contract aimed to bring previous health services together to give patients a clear and more integrated pathway of care. It planned to increase capacity in community support, deliver care closer to home, reduce emergency attendances and acute admissions, and discharge patients more quickly into community settings. This integrated approach aimed to make efficiencies through reduced hospital admissions, and to deliver a better service to patients. The CCG intended to commission for outcomes, and to create financial incentives to deliver better services. The contract is in line with NHS England's Five Year Forward View, which advocates for integrated patient-focused services, networks of care and an increased focus on out-of-hospital care.
- 4** UnitingCare Partnership's bid was for a contract costing £726 million over five years, with a budget of £152 million in the first year. The contract value reduced over the following four years because it was assumed that the new model of working would result in efficiency savings. The contract went live in April 2015 but was terminated in December that year after only eight months. This was because of a failure to reach agreement on contract cost. The termination led to unfunded costs totalling at least £16 million, shared between the two trust partners in UnitingCare Partnership and the CCG.
- 5** Following correspondence we received on the topic, we conducted this investigation to set out the facts about the design and procurement of the services, the operation of the contract and the contract's termination. There are several other reviews about the failure of this contract either under way or already published. This investigation will provide an independent view of what happened and set out the main factors leading to the contract's collapse. We do not evaluate the decision to use this particular design for the model of care, or the value for money of the services provided by the contract.
- 6** Appendix One lists our methods, which included reviewing documents and interviewing organisations involved in the contract's design, procurement and operation.

Summary

Key findings

The service model

1 The clinical commissioning group (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. The Cambridgeshire and Peterborough CCG is one of the most financially challenged in the country. Despite recent funding increases it remained more than 3% below its target funding allocation in 2015-16, with significant financial challenges and an ageing population. The CCG's model aimed to improve outcomes for patients by increasing and better integrating out-of-hospital services, while achieving savings.

2 There was significant support from stakeholders for the contract's design, which provided a new model of services based around the patient. We heard a consistent view that the new model was innovative and ambitious, requiring a significant amount of reconfiguration of existing services. The approach had strong potential to join together all bodies in the local health economy and to deliver better patient care. The new approach was popular with patients, staff and providers alike.

3 Although the successful bidder, UnitingCare Partnership, was only just starting to reconfigure and transform services, stakeholders were encouraged by early progress. UnitingCare Partnership's business case set out total estimated net savings of £178 million to the local health economy by 2020, mostly by reducing inappropriate emergency hospital admissions and emergency attendances. Although it was too early to see whether the new model would deliver these savings, stakeholders were positive about the benefits of new services such as the joint emergency teams.

Commercial expertise: designing the contractual terms

4 The trusts chose a limited liability partnership to meet the CCG's requirement for contracting with a single entity, but neither UnitingCare Partnership nor the CCG made proper arrangements to fund the ensuing VAT liability. Based on legal advice, the trusts chose to form a limited liability partnership to hold the contract with the CCG. This arrangement reduced the risk to the two shareholder trusts, neither of which was in a financial position to become the lead provider. However, this resulted in problems because as a separate legal entity, UnitingCare Partnership was not itself an NHS body and was outside NHS VAT arrangements. Therefore NHS subcontractors were no longer able to recover VAT on the services provided to UnitingCare Partnership that had previously been recovered when they provided the same services to the CCG. The partnership had not factored these additional costs into its contract price.

5 The contract included a £10 million transformation sum to help redesign the service, but other bidders thought this was insufficient. Bidders highlighted the small amount of transformation funding and the short mobilisation period allowed. The CCG told us that it expected the provider to invest its own funds up front to assist with service transformation, but this was not a requirement in the contract, and UnitingCare Partnership told us that it disagreed with this expectation.

6 The contract included an estimated 10% cost reduction over the term of the contract from reconfiguring services. Some stakeholders told us this cost reduction profile was optimistic. They indicated that they had concerns about the financial viability of the contract.

7 There were important gaps in the specialist procurement advice to the CCG. The CCG engaged the Strategic Projects team, as procurement advisers for the contract, as well as specialist financial and legal expertise from Deloitte LLP and Gowling WLG.¹ The procurement advisers conducted a limited assessment of the viability of UnitingCare Partnership's bid. They accepted UnitingCare Partnership's assurance about the viability of its assumptions. The CCG's legal advisers highlighted a need to secure performance guarantees (incorporating parent guarantees) in the contract. However, while this advice was attached to the procurement adviser's summary report evaluating the bids, it was not mentioned in the text and its implications were not drawn out. The CCG did not go on to seek such a guarantee.

8 The final contractual terms left the CCG exposed to significant unintended risks and potential costs. The CCG designed a service model that intended to transfer much of the risk to the service provider. But additional contractual and termination clauses added during contract negotiation passed significant financial risk back to the CCG as the commissioner. The CCG and UnitingCare Partnership differed in their understanding of the extent that the contract clauses allowed UnitingCare Partnership to negotiate additional funding after signing the contract. In addition, the CCG's failure to secure a parent guarantee from UnitingCare Partnership left it vulnerable to having to fund any contractual losses.

¹ The Strategic Projects team is a business unit within a commissioning support unit hosted by NHS England.

Commercial expertise: negotiating the contract price

9 Bidders faced significant difficulties in pricing their bids accurately due to limitations in the available data. For example:

- it was difficult to determine accurately the number of patients, the services provided and the costs of providing services from block contracts, particularly from the incumbent community services provider. This difficulty forced UnitingCare Partnership to assume when pricing its bid that the cost of the services was the same as the amount the CCG paid to the supplier for these services. However, this assumption was later proved to have significantly underestimated the cost of the community service; and
- there was some uncertainty about the precise scope of services to be included in the contract. Bidders received minor scope clarifications as late as September 2014, and the CCG continued to discuss some detailed aspects of the scope with UnitingCare Partnership even after the contract was signed.

10 The UnitingCare Partnership bid was £726 million, some 3.5% below the CCG's maximum contract price, despite increasing demand for services.

The CCG assessed that its maximum contract price of £752 million would be tight but achievable. The other shortlisted bidders bid at the CCG's maximum value of £752 million but UnitingCare Partnership made a tactical decision to submit a lower bid of £726 million to win the tender. This lower bid helped UnitingCare Partnership to win the contract, but neither organisation could fully assess whether the contract price was viable due to limitations in the data.

11 There was a large number of outstanding cost and clarification issues when the CCG chose UnitingCare Partnership as its preferred bidder in October 2014.

UnitingCare Partnership believes there were 71 outstanding issues at this time, although the CCG believes the number to be lower. Although both parties continued to work on these issues, a number of significant items were still outstanding when the contract was signed in November. Many items were critical to pricing, such as the detailed scope of services included in the contract, and a reconciliation of community services costs against recent years' funding. However, UnitingCare Partnership did not take opportunities to revise its bid price to reflect the uncertainty, stating to the CCG that it could deliver services at this price without relying on additional income.

12 Reflecting the cost issues, UnitingCare Partnership expected to negotiate more than 20% additional funding from the CCG than its original bid price as outstanding clarifications were settled. In January 2015, the CCG agreed to a small increase in the contract value to reflect 2014-15 activity and expenditure once known. In the same month, Cambridgeshire and Peterborough NHS Foundation Trust's business case contained an assumption that it would be able to negotiate a total increase of more than 20% to the contract price, reflecting other costs. The business case assumed that UnitingCare Partnership would agree contract variations on scope or price if it was unable to deliver the services within the agreed budget.

13 UnitingCare Partnership agreed to begin the contract from April 2015 while continuing to negotiate on cost clarifications. There was significant pressure from the CCG to begin the contract on 1 April 2015 even though it was aware that the contract price would change, because existing contracts expired on that date and more than 1,000 community care staff were due to transfer their employment to Cambridgeshire and Peterborough NHS Foundation Trust. Other bidders told us that they would not have proceeded with so many issues outstanding.

14 One month into the contract, UnitingCare Partnership requested £34 million of extra funding for the first year, some 21% more than the contract price for that year. This additional funding was requested for a number of reasons, including the expected increase to reflect 2014-15 expenditure, and additional factors such as reduced savings due to delays in starting the contract. Although both parties negotiated to reduce the funding gap, they were not able to resolve this. In the meantime, the CCG began to advance some funds to UnitingCare Partnership, which was spending more than the agreed amount.

15 In early December 2015, UnitingCare Partnership was forced to terminate the contract when the CCG informed it that no further advance funding was available. NHS England and Monitor mediated to allocate the £16 million of incurred unfunded costs between the CCG and the partner trusts.² The CCG agreed to pay approximately 50% of the costs, and the two trusts each paid approximately 25%. The contract signatories were not legally obliged to meet these costs but felt a moral obligation to ensure that charities and community providers were not left financially disadvantaged.

16 Upon termination of the contract, the CCG immediately took on direct commissioning of the services but told us that the cost it incurred in doing so was significantly higher than the contract value. UnitingCare Partnership had only just started to reconfigure its services, so the anticipated efficiencies had not yet materialised. The current cost of the services, and the impact of the additional costs it incurred to protect community providers when the contract failed, means that the CCG is unable to implement all of the service changes it had planned to make in 2016-17, although it has kept some elements of the new service model.

17 The termination of the older people's and adult community services contract indicates that the health sector may not have learned lessons about assessing and managing risk when working with a private provider, despite the earlier failure of the Hinchingsbrooke contract and experience in wider government. The Committee of Public Accounts previously commented on the health sector's need to develop its commercial skills when it looked at the failure of the Hinchingsbrooke contract in March 2015.³ We have found similar contractual mistakes in other parts of government: for example, our report on the Ministry of Justice's language services contract commented on a lack of knowledge about activity and costs.⁴ The contract design and the negotiation process both indicate a lack of commercial expertise on the part of both the CCG and the trusts.

² Since April 2016, Monitor has been part of NHS improvement.

³ HC Committee of Public Accounts, *An update on Hinchingsbrooke Health Care NHS Trust*, Forty-sixth Report of Session 2014-15, HC 971, March 2015.

⁴ Comptroller and Auditor General, *The Ministry of Justice's language services contract: progress update*, Session 2013-14, HC 995, National Audit Office, January 2014.

Oversight and regulation

18 Under the Health and Social Care Act 2012, Monitor is the regulator for foundation trusts but its remit only covered part of the transaction. Although UnitingCare Partnership was a limited liability partnership formed by two foundation trusts, it was a separate legal entity and subject to company law. It was not subject to regulation by Monitor or any other health sector body. In addition, Monitor's approach to risk-assessing new transactions led it to consider the implications of the contract for only one of the two trusts, Cambridgeshire and Peterborough NHS Foundation Trust. Cambridge University Hospitals NHS Foundation Trust submitted a self-certification to Monitor for its involvement in the partnership because the additional contract value did not qualify as substantial according to the thresholds set by the regulator.

19 UnitingCare Partnership's actions to limit the trusts' financial liability were an important factor in Monitor's decision to issue an amber risk rating for Cambridgeshire and Peterborough NHS Foundation Trust's role in the transaction. Monitor's transaction assessment took assurance from the financial protections that UnitingCare Partnership had negotiated with the CCG to allow it to negotiate a higher contract price if new information about existing costs surfaced, and to terminate the contract if in financial distress. Without these clauses, it is likely that Monitor would have issued an unfavourable risk assessment if Cambridgeshire and Peterborough NHS Foundation Trust had proposed to go ahead with the transaction.

20 NHS England had very limited involvement in the procurement until the contract failure. The contract fell within the CCG's commissioning responsibility. This meant that NHS England had no formal assurance role in the procurement. Although NHS England held regular update meetings with the CCG, these covered the CCG's responsibilities as a whole and did not specifically focus on this contract. The CCG did not inform NHS England of the difficulties in resolving the financial gap in the contract until October 2015. NHS England and Monitor then convened a meeting of key stakeholders, but the commissioner and the provider could not reach agreement. NHS England did not consider it appropriate to provide additional funding itself. In December 2015 NHS England recommended that the contract be terminated. Since the termination, NHS England paused similar contracts while undertaking its own review of what went wrong. It now plans to develop an assurance framework for similar procurements in future.

21 Neither the Department of Health, nor NHS England, nor Monitor was responsible for holding a holistic view of the contract, or assessing whether the anticipated benefits would merit continued support of this innovative approach.

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 but, ultimately, regulatory checks on individual bodies' risks did not ensure that the contract was viable. Monitor took assurance from UnitingCare Partnership's actions to limit its financial contractual liability and assessed that the risk taken by Cambridgeshire and Peterborough NHS Foundation Trust was reasonable. The effect of the additional clauses was that the CCG bore more of the financial risk of the contract, without comparable scrutiny from NHS England. Each body acted within its defined role but no organisation held a holistic view of remaining risk in the system. The cost to the CCG and trusts of the set-up, bid and termination costs of the contract was £8.9 million.

22 The Five Year Forward View encourages the health sector to use new and more joined-up ways of providing care, which may not always align with existing regulatory and oversight arrangements. Examples of more integrated services such as in the UnitingCare Partnership contract are likely to increase. The Department of Health, NHS England and Monitor are currently developing their approach to overseeing similar models. Without closer joint working or a more holistic view, there are significant risks for the sector that individual oversight decisions will not lead to the best outcomes for patients or for the system as a whole.

Part One

The CCG's service model

1.1 This part sets out why Cambridgeshire and Peterborough clinical commissioning group (the CCG) wanted to improve older people's and adult community services and how it designed the tender. It describes why UnitingCare Partnership wanted the contract, its approach to providing its services, some early indications of success and what happened afterwards.

The case for change

1.2 In early 2013, the newly formed CCG consulted stakeholders to identify the area's top health concerns. They reported that their top concern was to improve older people's health services, so the CCG decided to make this its first priority. In particular, the CCG wanted to improve out-of-hospital care for frail older people, and improve urgent care pathways.

1.3 The CCG operates within a financially constrained local health system, which received 3.1% less than its target level of health funding per person in 2015-16 (**Figure 1** overleaf). The CCG identified that, in the five years to 2018-19, it might face a funding shortfall of up to £250 million. It also has a fast-growing elderly population, which contributes to this shortfall. The CCG expects the number of people over 65 in Cambridgeshire and Peterborough to increase by 31% between 2011 and 2021. Hospital care for patients aged 65 to 74 costs an average of £250 per person per year. This increases to more than £1,500 for patients aged over 80 years.

1.4 To address the expected funding shortfall, the CCG decided to adopt an entirely new approach. It wanted to promote a more integrated health service for all those over 65 years old and for adults requiring community services. To do this, it wanted to contract with one service provider for a wide range of services, including:

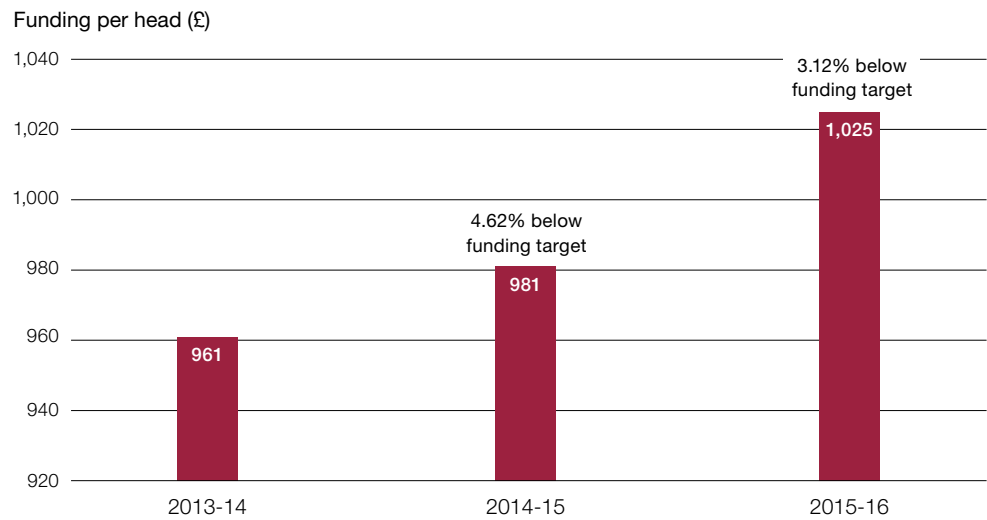
- unplanned hospital care, including accident and emergency attendances and urgent admissions;
- community health services (previously provided by Cambridgeshire Community Services NHS Trust);
- care in and around other community hospitals;
- mental health services (previously provided by Cambridgeshire and Peterborough NHS Foundation Trust); and
- end of life care.

The CCG's proposal included community and acute healthcare services, but not social care services commissioned by local authorities.

Figure 1

Funding for Cambridgeshire and Peterborough CCG, and percentage distance from funding target from 2013-14 to 2015-16

Since 2013, the CCG's funding per head has increased each year, although it remained an estimated £29.9 million (3.1%) below its target in 2015-16



Note

1 The CCG's distance from the funding target is not available for 2013-14.

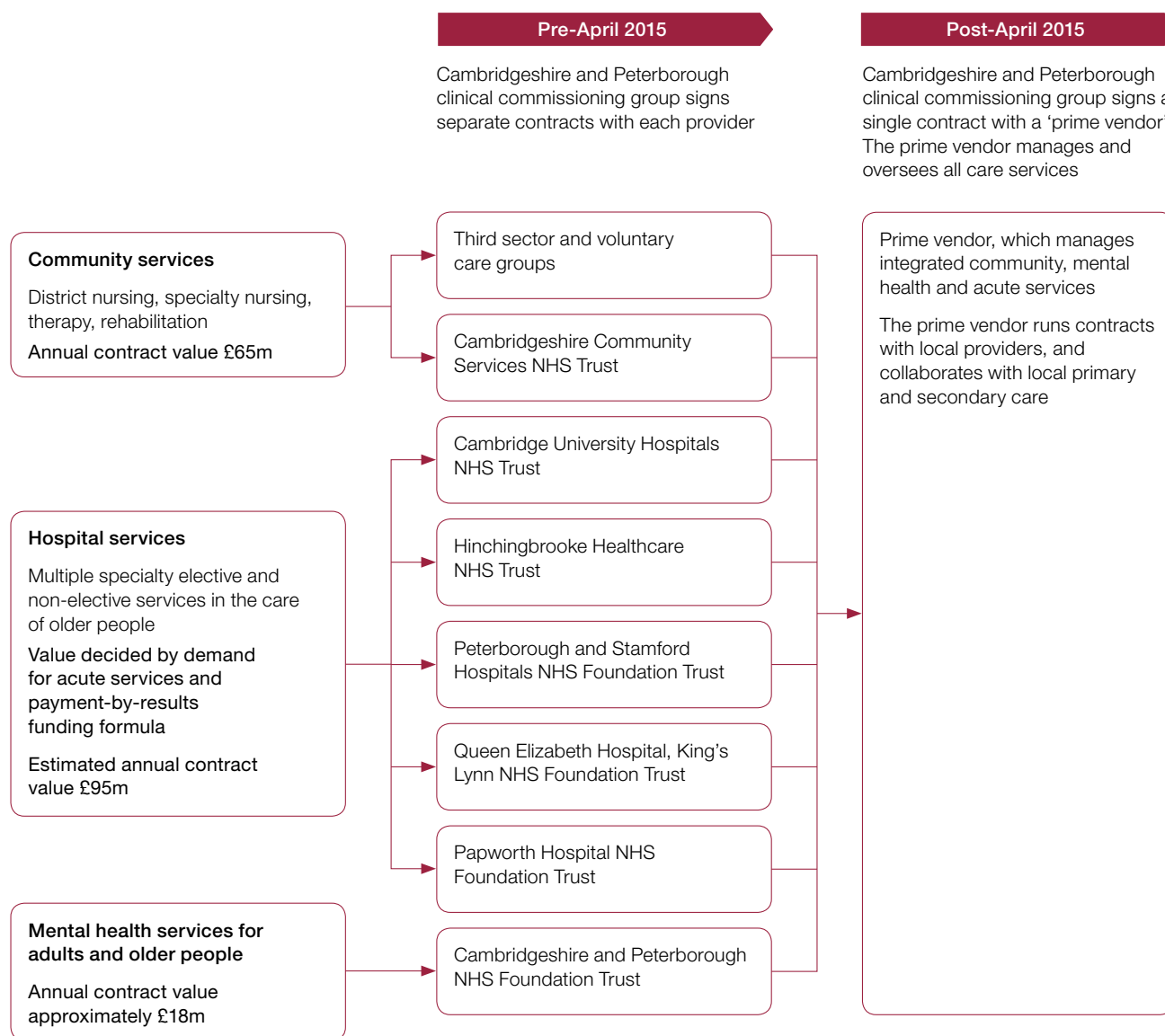
Source: NHS England funding tables

The service model

1.5 The CCG aimed to contract with a 'prime vendor' (single lead) organisation to deliver this new model of care, promoting greater integration. The lead provider would deliver a range of health services, letting its own sub-contracts with local providers where necessary (**Figure 2**). This contract design intended the lead provider to bear the financial risks of delivering services. The CCG's invitation to tender was for a five-year contract with an optional two-year extension. This approach would allow time to implement the model and make savings.

Figure 2

How the CCG commissioned older people’s and adult community services pre- and post-April 2015

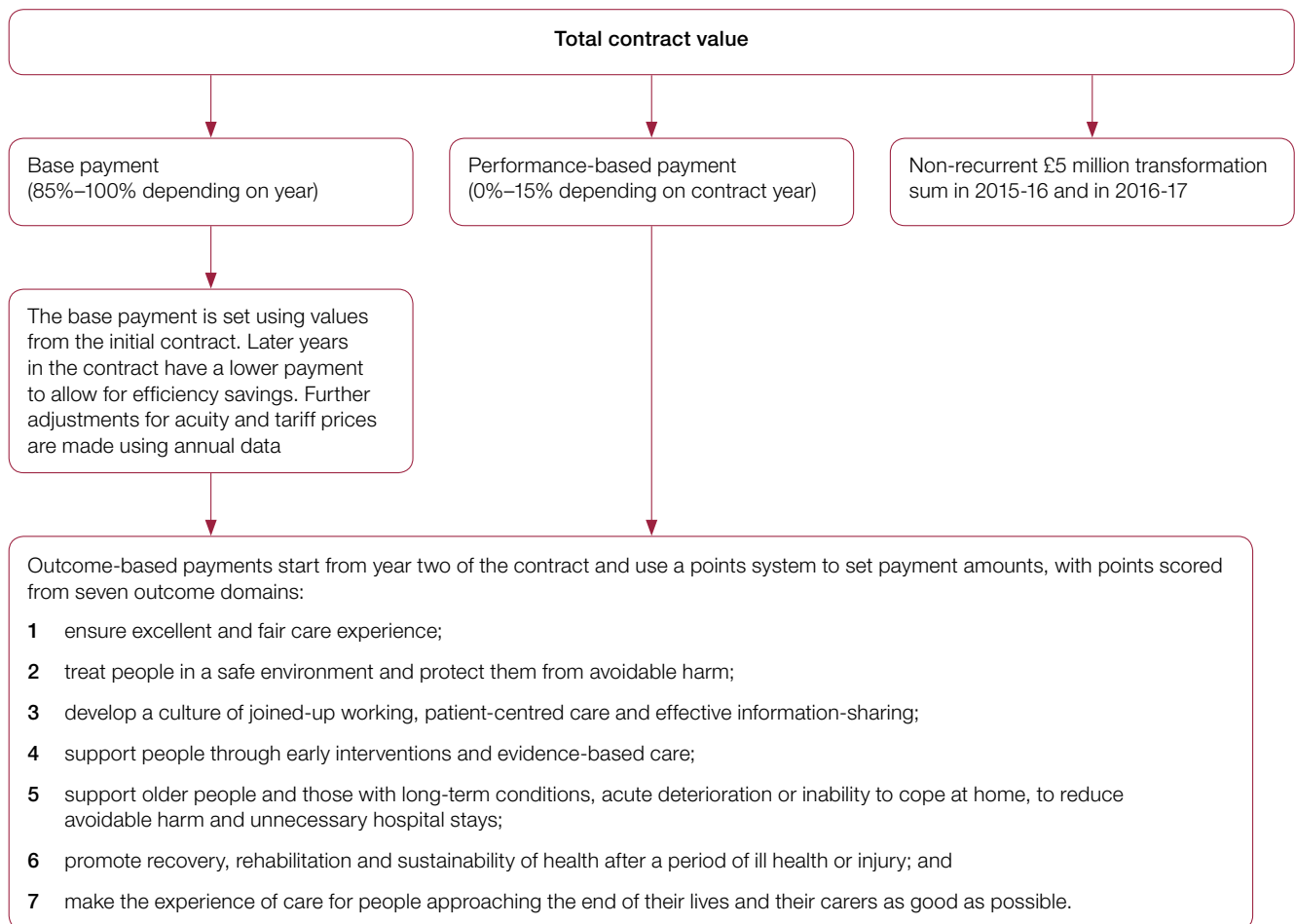


Source: National Audit Office document review

1.6 The CCG’s invitation to tender set out the broad scope of services it required under the contract. It also set a five-year maximum budget of £752 million to deliver these services. The CCG described this budget as ‘tight but achievable’. Over the contract term the annual budget reduced by approximately 10% to reflect the savings that the CCG expected from reconfiguring services. Some providers told us they had concerns about the financial viability of the contract and about the cost reduction profile. The contract broke down the £752 million into a base payment and a smaller outcome-based payment, which would start from the second year of the contract (**Figure 3**).

1.7 The contract included £10 million in non-recurrent transformation funding to help redesign the service. But other bidders were concerned that this would not be enough, given the scale of change required. The CCG told us that it expected the provider to invest some of its own funds up front to assist with service transformation, although this was not a requirement in the contract and UnitingCare Partnership disagreed with this expectation.

Figure 3
How the older people’s and adult community services contract worked



The trusts' interest in the contract

1.8 UnitingCare Partnership was made up of Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust. The latter is a small trust, with a turnover of £127 million in 2014-15. Of this amount, approximately £18 million related to services tendered by the CCG under the older people's and adult community services contract. The trust was therefore concerned that if it did not win the contract, the reduction in its income might reduce its viability as a foundation trust in future.

1.9 Cambridge University Hospitals NHS Foundation Trust is a large teaching trust that provides specialist, elective and urgent acute care. The trust has experienced increasing demand for urgent care, particularly for elderly patients. Between 2013-14 and 2014-15, the number of emergency attendances and acute non-elective stays both increased by approximately 10%. Given these increases, the trust wanted to win the contract so that it could better manage its capacity, improve patient experience and offer more elective surgery.

1.10 Together, the trusts chose to enter into a limited liability partnership (LLP) agreement to form UnitingCare Partnership LLP for this contract. The company had minimal assets but sub-contracted with others to provide the health services. The financial risks of the partnership were shared equally across each trust in their agreement, although Cambridgeshire and Peterborough NHS Foundation Trust is a much smaller trust. **Figure 4** overleaf shows how UnitingCare Partnership was organised and its relationship with contractors.

UnitingCare Partnership's proposal

1.11 Stakeholders told us that the UnitingCare Partnership bid was an innovative early attempt to provide more joined-up, community-based healthcare. It planned to use integrated teams such as joint emergency teams and neighbourhood teams to create a new model of care around the patient. **Figure 5** on page 17 sets out the range of services covered by the contract, and how UnitingCare Partnership planned to provide them.

1.12 UnitingCare Partnership's business case set out the service improvements it expected from its approach. It believed that demand would continue to rise if nothing was done but that its services would relieve pressure on acute care through reducing emergency attendances and shortening stays in hospital (**Figure 6** on page 18).

1.13 UnitingCare Partnership also estimated that its service model would generate £178 million in net efficiency savings over the life of the contract. Of these savings, it expected £116 million of gross savings by reducing emergency admissions in acute care. Other savings would be made through reducing staff, estate and clinical costs (**Figure 7** on page 18).

Figure 4

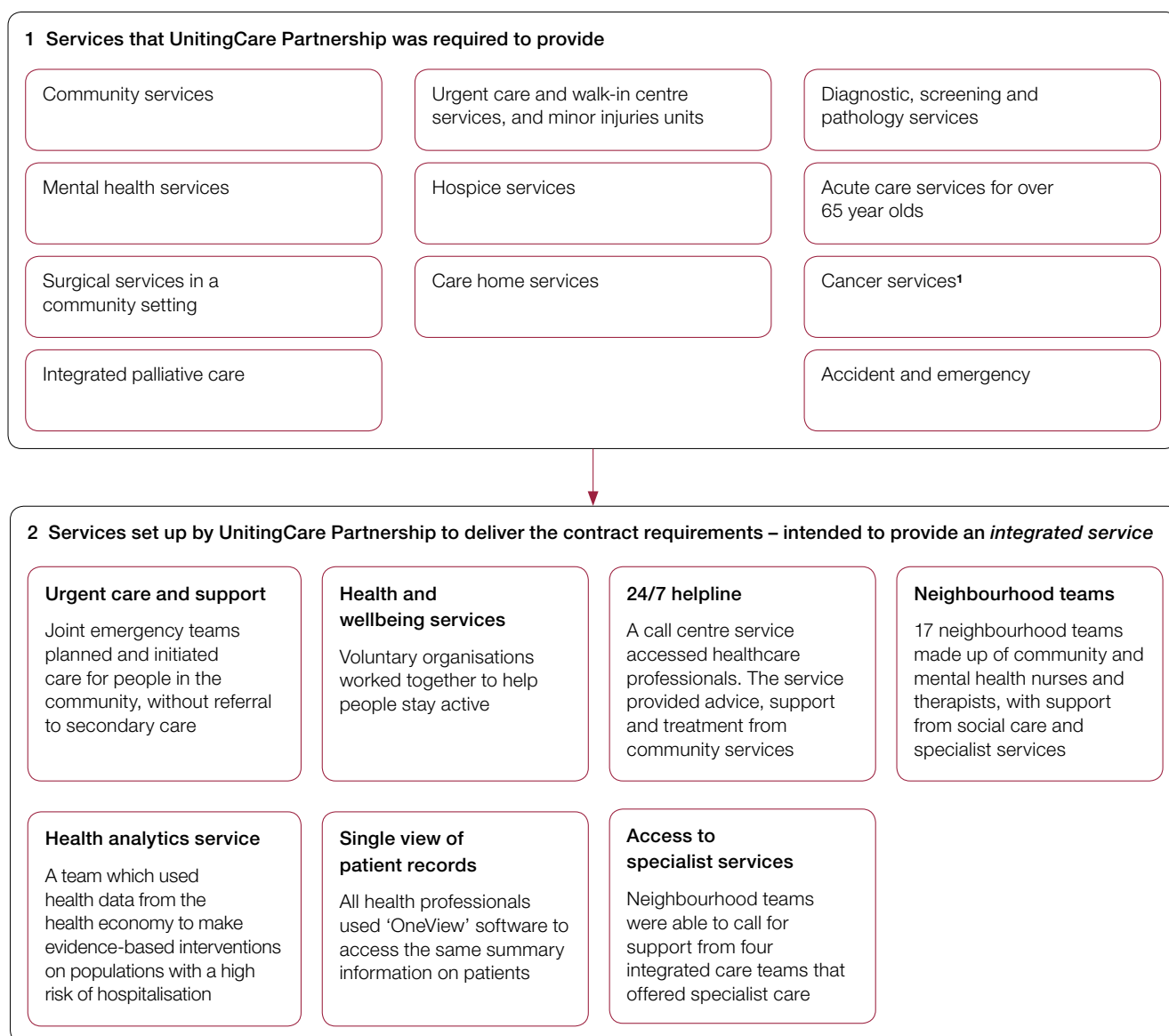
How UnitingCare Partnership was organised and its relationship with contractors



Source: National Audit Office analysis of trusts' accounts and UnitingCare Partnership contract documents

Figure 5

Services provided by UnitingCare Partnership under its contract with Cambridgeshire and Peterborough clinical commissioning group

**Note**

¹ Cancer services in the contract to exclude those already funded by NHS England.

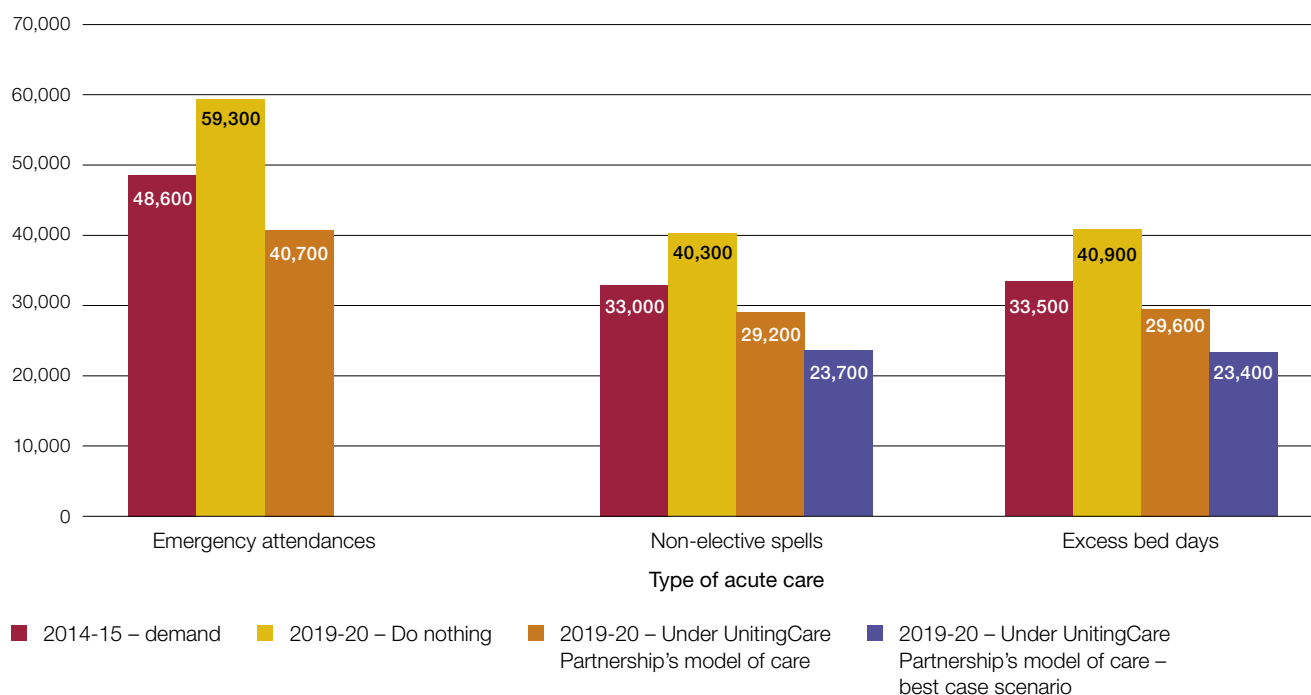
Source: National Audit Office document review

Figure 6

Activity for acute services in Cambridgeshire and Peterborough in 2014-15, compared with 2019-20 forecasts made by UnitingCare Partnership

UnitingCare Partnership expected demand for acute care to fall by 2019-20 under its model of care

Number of attendances, spells, days



Source: Cambridgeshire and Peterborough NHS Foundation Trust's estimate of the model's impact on hospital activity

Figure 7

UnitingCare Partnership's expected efficiency savings to 2020 from its model of care

Area of savings	Savings expected by UnitingCare Partnership						Total (£m)
	Year 1 (£m)	Year 2 (£m)	Year 3 (£m)	Year 4 (£m)	Year 5 (£m)	Year 6 (£m)	
Shifting demand from acute hospitals to the community	3.6	16.0	22.6	28.9	35.2	9.9	116.1
Reducing the full costs of clinical services	0.7	2.2	2.3	2.3	2.4	0.6	10.6
Workforce	3.8	11.3	14.7	18.2	21.7	6.4	76.0
Estate	0.0	0.2	0.7	0.7	0.7	0.2	2.4
Gross savings	8.1	29.6	40.2	50.1	60.0	17.0	205.0
Savings net of investments made by UnitingCare Partnership	3.9	23.6	34.8	44.9	54.6	15.7	177.5

Note

1 Totals may not sum due to rounding.

Source: UnitingCare Partnership bid financial submission

How the service was received

1.14 There was significant support from stakeholders for the contract's design. We heard a consistent view that the new model was innovative and ambitious, requiring a significant amount of workforce and funding restructuring to reconfigure existing services, but offering considerable prospective benefits. The approach had strong potential to join together all bodies in the local health economy and to deliver better care for patients. The new approach was popular with patients, staff and providers alike.

1.15 The contract was awarded in November 2014 and started in April 2015. The bid indicated a budget of £152 million in the first year, plus transformation funds. Although the contract started, UnitingCare Partnership continued its mobilisation phase until October 2015, due to delays during procurement. By November 2015, some services were still being, or had only recently been, reconfigured, but stakeholders noted promising early signs that new services such as joint emergency teams were well received. It was too early to know whether the new approach would reduce emergency admissions and attendances as the business case predicted.

The CCG's service model following the contract's collapse

1.16 In December 2015 the contract collapsed for financial reasons, despite the positive reception of the new services and early signs that it might deliver benefits. The CCG continued to believe that an integrated, outcomes-based model was the right one. It thought that the UnitingCare Partnership model was starting to deliver benefits such as:

- a system-wide focus on improving services for older people;
- a framework for improving health outcomes;
- improvements in integrating services; and
- better partnership working.

1.17 However, the CCG found that given its worsened financial position after the contract collapsed and the gap between its funding and the planned cost of services, it was not able to implement all of the service changes that UnitingCare Partnership had planned. **Figure 8** overleaf shows where the CCG has identified that it was not able to continue with UnitingCare Partnership's planned services.

Figure 8

How the CCG reduced UnitingCare Partnership's planned services after December 2015 to make them affordable

Service	Impact
Creation of four specialist locality teams mainly relating to expertise in long-term conditions.	Existing services to continue but capacity will not increase in 2016-17. A proactive care and prevention service will progress.
Integrated care workers, including joint emergency teams.	Some funding provided but increase in staffing lower than envisaged by UnitingCare Partnership.
Case management.	Neighbourhood team pilots to test different approaches but the CCG is unable to deliver the significant increase in capacity originally envisaged.
OneView – IT system to give a single view of the patient record.	The planned system has not been commissioned.
Analytics capacity – system-wide analytics service to provide disaggregated timely information on admissions.	This system is not currently in place.
NHS continuing healthcare.	This will be provided as before but will not be increased.

Source: Cambridgeshire and Peterborough clinical commissioning group presentation, *Older People's and Adult Community Services Learning Event*, May 2016

Part Two

Managing risk: the contractual terms

2.1 This part looks at the commercial capability of contract signatories, the terms of the contract, the risks and financial impact, and the expert input to the procurement.

The implications of a limited liability partnership

2.2 The Cambridgeshire and Peterborough clinical commissioning group (the CCG) designed a tender to contract with a lead provider which could commission services from other organisations. The UnitingCare Partnership consortium comprising Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust noted in its outline bid that it intended to use a limited liability partnership to contract with the CCG. This arrangement reduced the risk to the two partner trusts; as neither was in a financial position to become the lead provider and therefore be exposed to high potential losses. However, operating as a private company also introduced some legal constraints, such as the requirement for the partnership to remain solvent. This would not have been the case if the contract had been between NHS bodies where temporary borrowing facilities are in place. In August 2014, the trusts sought legal and financial advice on the best model, and made a final decision to register as a limited liability partnership in October 2014.

2.3 The VAT rules allow organisations within the NHS divisional VAT registration to reclaim from HM Revenue & Customs some of their VAT incurred in relation to services provided to other bodies within the NHS VAT arrangements. However, as a private company, UnitingCare Partnership would be outside the NHS VAT arrangements. Therefore its own VAT costs were not recoverable, and NHS bodies including the two partner trusts lost their ability to recover any VAT on the services they provided to UnitingCare Partnership. In August 2014, the trusts commissioned a report to confirm the VAT implications of becoming a limited liability partnership. The trusts considered this the best model overall and went ahead, but also contacted HM Revenue & Customs to ask for an exemption since the partnership was wholly owned by NHS bodies. The CCG assumed that any additional VAT cost was included in the bid price as it would have been for any other private sector bidders. But UnitingCare Partnership considered the potential VAT liability to be an additional cost incurred due to the CCG's requirement for a lead provider and expected the CCG to provide for it.

Managing risk: contract provisions

2.4 In its invitation to tender, the CCG specified that it wanted a lead provider for the contract but did not specify the legal form this must take. One objective of this approach was that the lead provider would subcontract services and, therefore, bear the financial risk of managing the costs. However, the CCG did not manage to pass these risks to UnitingCare Partnership as it intended because it failed to ensure that UnitingCare Partnership had parent guarantees from the two partner trusts. The absence of these guarantees meant that if the UnitingCare Partnership contract were to fail, the cost of commissioning would transfer back to the CCG.

2.5 We were told that if such parent guarantees had been in place, the contract may not have gone ahead as the trusts may have found the financial risk unacceptable. If they had proposed to go ahead, Monitor, which regulates foundation trusts, may have given a red risk rating in its transaction assessment for Cambridgeshire and Peterborough NHS Foundation Trust's involvement, and considered using its enforcement powers to stop the transaction from going ahead because of the financial risk to the trust.

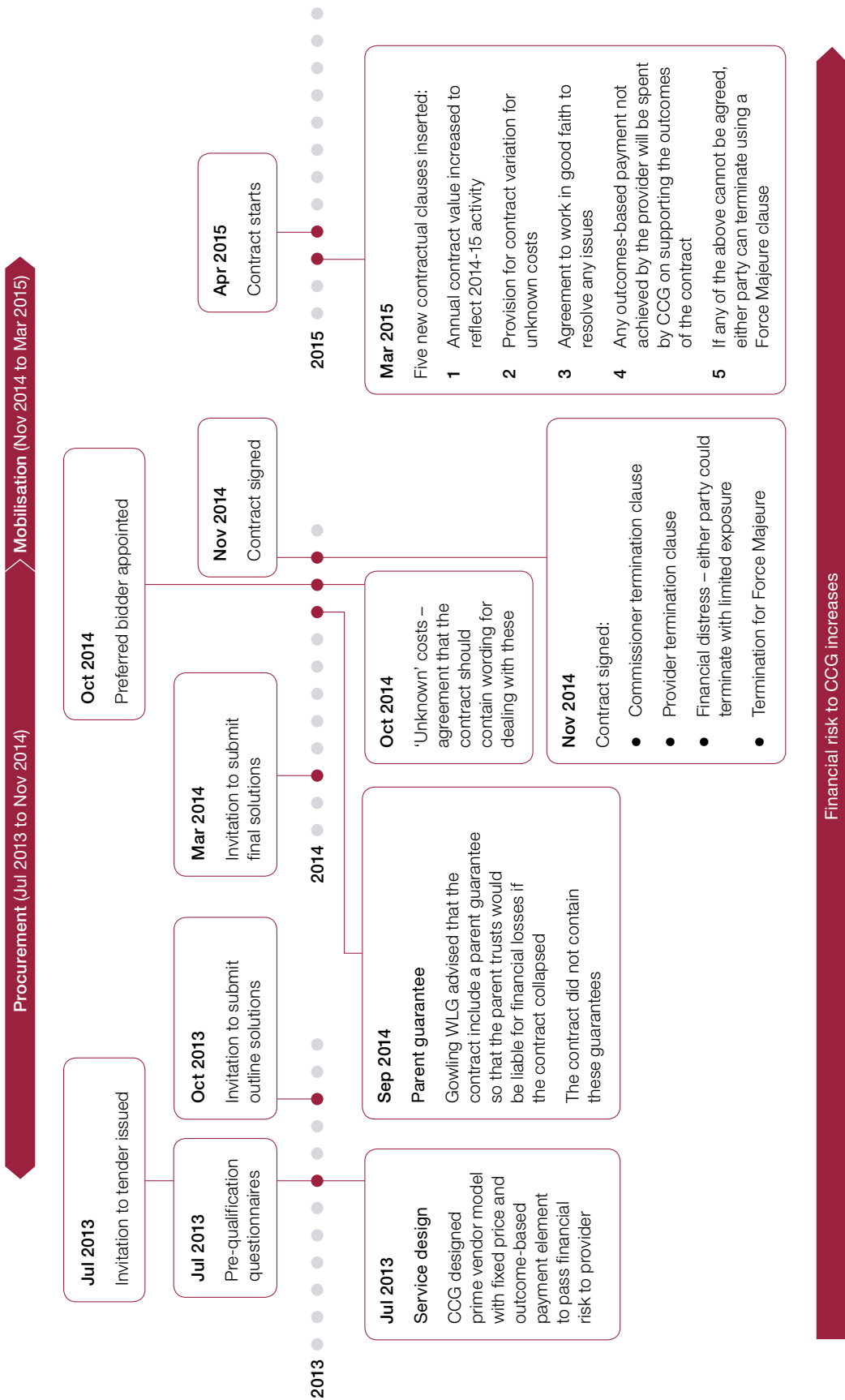
2.6 Before the contract began, UnitingCare Partnership secured several new clauses in the contract. These clauses provided for UnitingCare Partnership to negotiate additional contract income if new information about existing costs became available, or to terminate the contract. **Figure 9** outlines the additional clauses. The effect of each contract addition was to help insulate UnitingCare Partnership (and therefore the trusts) from the risks of insufficient funding in the contract, while the CCG would bear much of the commissioning risk.

The termination costs

2.7 There were several termination clauses in the contract:

- A 'no fault' or 'Force Majeure' clause allowed either party to terminate the contract without penalty, subject to an agreed notice period.
- A 'financial distress' clause, allowed the provider to terminate the contract if it encountered financial challenges that could not be resolved. This clause was subject to a minimum forecast loss for the provider. This clause applied from the second year of the contract only. It required the partnership to pay £0.5 million to the commissioner plus its own operating losses.
- A 'provider termination event' or a 'commissioner termination event' clause allowed either party to terminate the contract in line with the conditions of the NHS standard contract. In both cases, the liability would be capped at £7.5 million.

Figure 9
The contract's financial risk



2.8 Terminating the contract led to unfunded costs for both the CCG and for the trusts that made up UnitingCare Partnership. However, the NHS bodies took a practical approach to managing these costs. NHS England and Monitor mediated to allocate the costs between the CCG and the partner trusts. The CCG agreed to pay approximately 50% of the costs that had been incurred, and the two trusts each paid approximately 25%. The NHS bodies felt a moral obligation to protect their subcontractors, particularly non-NHS creditors, from losses when negotiating the settlement. **Figure 10** sets out each trust's exposure from the relevant termination clause, and the amounts actually paid upon termination.

Expert input to the procurement

2.9 The CCG first issued its tender under European Union regulations in July 2013. It received 60 expressions of interest. The tender then went through the pre-qualification, outline bid, public consultation and final bid stages. The process remained competitive, with three bids received at final bid stage. **Figure 11** on page 26 sets out the key events in the procurement.

2.10 During the procurement the CCG engaged the strategic projects team (a business unit of the ArdenGEM commissioning support unit) as specialist procurement and commercial advisers; Deloitte LLP as financial advisers; and Gowling WLG as legal advisers.⁵ The CCG also separately engaged Deloitte LLP to conduct limited financial due diligence work on part of the costs of the service. **Figure 12** on page 27 sets out the roles of each organisation. The CCG asked the Department of Health's gateway review team to carry out reviews at different stages. **Figure 11** on page 26 sets out when and how the organisations supported the CCG during the procurement.

⁵ Gowling WLG was at that time called Wragge, Lawrence and Graham.

Figure 10

The allocation of UnitingCare Partnership's costs upon termination compared with the termination clause

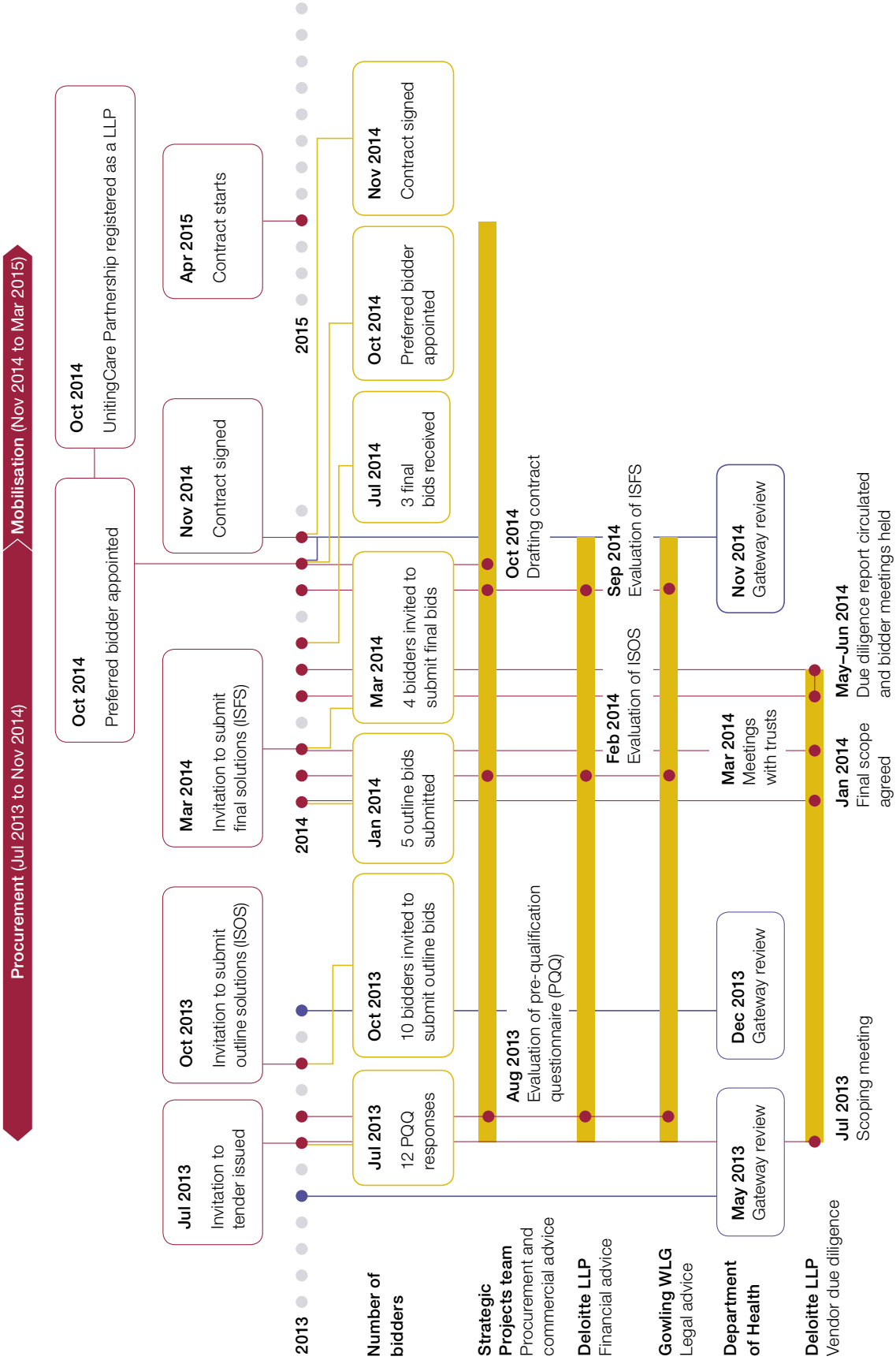
	Total UnitingCare Partnership liabilities (£m)	Of which Cambridge University Hospitals NHS Foundation Trust pays (£m)	Of which Cambridgeshire and Peterborough NHS Foundation Trust pays (£m)	Of which Cambridgeshire and Peterborough CCG pays (£m)
Known liabilities				
UnitingCare Partnership known liabilities to NHS and non-NHS bodies (excluding the two partner trusts)	8.89	4.45	4.45	
UnitingCare Partnership liabilities to the two trusts (foregone by the trusts to enable payment of other creditors)	9.50	0.65	0.65	8.20
Less UnitingCare Partnership cash available to offset	-1.96	-0.98	-0.98	
Sub-total	16.43	4.12	4.12	8.20
Potential liabilities				
Underwrite termination of single view patient record contract	0.35	0.09	0.09	0.18
Underwrite the VAT risk	2.20	0.55	0.55	1.10
Underwrite redundancy fees for seconded staff	0.64	0.32	0.32	
Sub-total	3.19	0.96	0.96	1.28
Grand total	19.62	5.07	5.07	9.48
Trust's liability if provider contract termination used		3.75	3.75	

Note

1 Totals may not sum due to rounding.

Source: National Audit Office analysis of clinical commissioning group and UnitingCare Partnership agreed settlement documents

Figure 11
Procurement timeline and CCG's advisers' input



Source: National Audit Office document review

Figure 12
Roles of CCG's expert advisers during procurement

Organisation	Cost of service (£)	Date	Overview of role
Strategic Projects team (non-profit NHS business unit)	292,700	April 2013 – March 2015	<p>Procurement and commercial advisers</p> <p>Market sounding and consultation, including:</p> <ul style="list-style-type: none"> to act as advisers for the procurement, bid evaluation and deal negotiation; to lead on developing and issuing tender and evaluation documents; to manage bidder clarifications and bidder meetings; to lead on evaluation of tender responses; and to advise on mobilisation.
Deloitte LLP (financial advisory arm)	95,800	June 2013 – September 2014	<p>Financial advisers</p> <p>To provide financial advice on:</p> <ul style="list-style-type: none"> drafting and evaluating the pre-qualification questionnaire; drafting both the outline bid and final bid documentation; evaluating bids received; and support in drafting the finance-related contract terms and other liaison.
Gowling WLG (previously Wragge, Lawrence & Graham)	95,000	April 2013 – September 2014	<p>Legal advisers</p> <p>To provide legal advice on:</p> <ul style="list-style-type: none"> drafting and evaluating the pre-qualification questionnaire; drafting the outline bid and final bid documentation; evaluating bids received; and support in drafting the contract terms and other liaison.
Deloitte LLP (transaction services team)	95,500	July 2013 – May 2014	<p>Conduct due diligence (limited scope) for the CCG on:</p> <ul style="list-style-type: none"> analysis of Cambridgeshire Community Services NHS trust and Cambridgeshire and Peterborough NHS Foundation Trust trading performance; analysis of current year trading for older people's and adult community services, compared to budget and prior year; review of key reports such as internal and external audit; and analysis and commentary on employees and assets to provide these services, and consistency with the reported cost of providing the service.

Note

1 All contract values exclude VAT where chargeable.

Source: Clinical Commissioning Group and Strategic Projects team documentation

2.11 However, the expert advice did not protect the CCG from every risk:

- Deloitte LLP carried out financial analysis for the pre-qualification questionnaire responses. This exercise involved looking at the financial position of each individual body within each proposed consortium. As such, the assessment was redone when new bodies joined consortia. It was not required to conduct a new assessment to reflect UnitingCare Partnership's intention to become a limited liability partnership, as the two partner trusts remained the same so the underlying financial assessment of the two trusts would not have changed.
- The financial evaluation criteria for the bids gave higher scores for lower-priced bids that would deliver more savings for the CCG. UnitingCare Partnership's bid was 3.5% lower than the CCG's budget.⁶ Although the CCG had considered its budget to be tight, we saw limited consideration of whether UnitingCare Partnership's bid price was viable. The assumptions in UnitingCare Partnership's bid and queries resulting from those do not appear to have been fully followed up by the CCG's procurement and commercial advisers. However, subsequently, these advisers asked UnitingCare Partnership to confirm that it could deliver the services within the bid price without relying on receiving additional income and UnitingCare Partnership confirmed that it could.
- The Strategic Projects team was responsible for marshalling the different advice and writing a summary evaluation for the CCG. The CCG's legal advisers' evaluation report had highlighted a need to secure performance guarantees in the contract (which include parent guarantees). This advice was attached to the Strategic Projects team's summary report evaluating the bids. However, it was not mentioned in the text, nor were the implications drawn out in the summary report or advice. The CCG did not seek such a guarantee in its contract.

⁶ The figures for both the bid and the budget exclude non-recurrent transformational funding of £5 million in each of the first two years.

Part Three

Agreeing the contract price

3.1 This part sets out the negotiations over the contract price during procurement (**Figure 13** overleaf). It also covers the funding gap as it emerged after the contract started. It was this financial gap that ultimately led to the termination of the contract.

Price negotiations during procurement

The CCG's budget

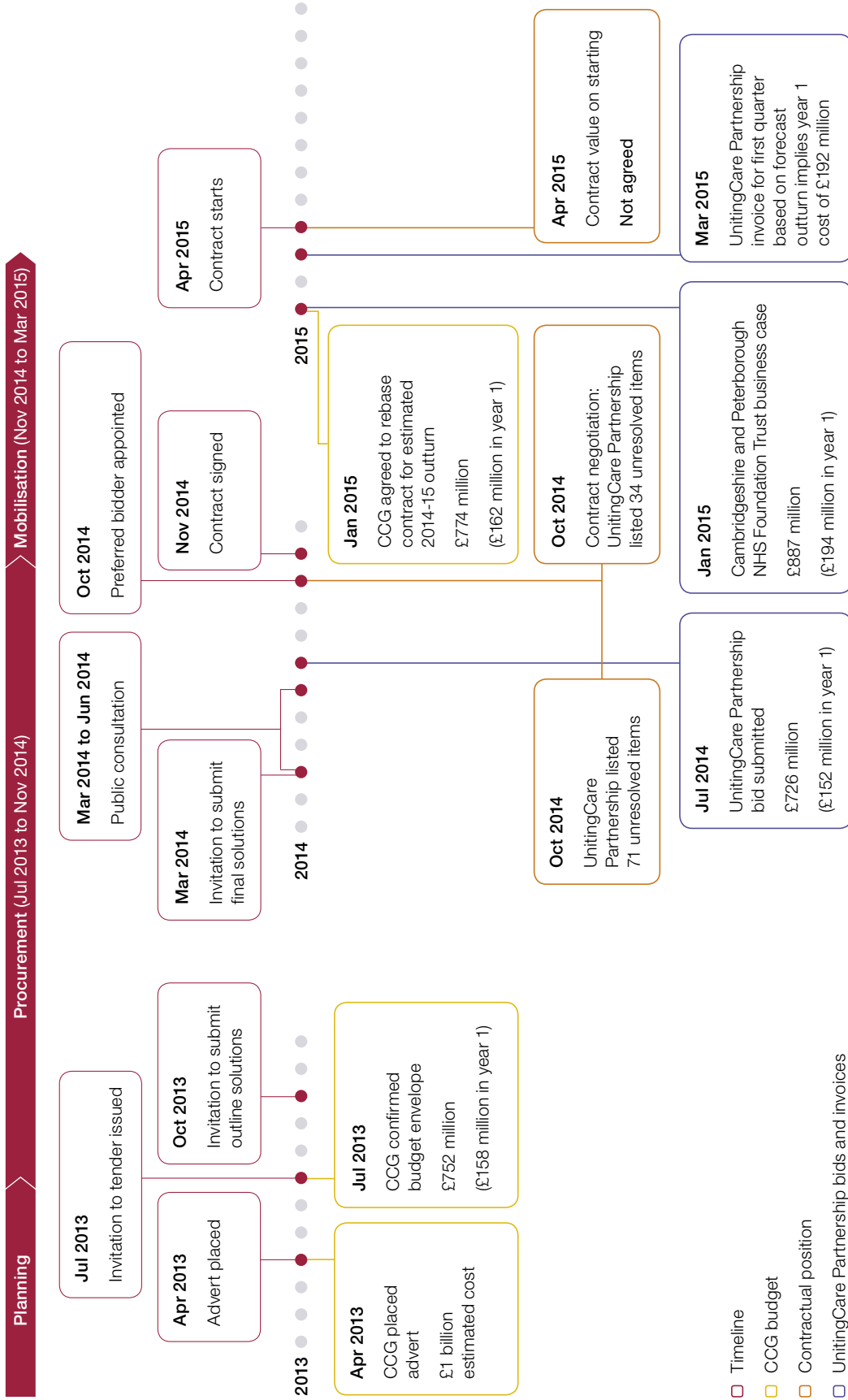
3.2 During procurement the Cambridgeshire and Peterborough clinical commissioning group (the CCG) asked bidders to submit contract prices within a maximum budget of £752 million excluding transformation funds. This budget was in part based on the CCG's assessment of the current costs of delivering services. The budget already contained some efficiency savings on the existing cost, which it expected could be achieved by reconfiguring services.

3.3 When it was first tendered, the contract was due to start in summer 2014, so the original budget envelope was based on 2013-14 activity. Following delays to the contract's start date, the CCG agreed in January 2015 to increase the contract's value to reflect 2014-15 activity and expenditure. This resulted in a revised total contract value of £774 million over the five-year contract, plus £10 million transformation funding.

Uncertainties in cost data available for bidders

3.4 It was not straightforward to discover the existing activity levels or costs of services for older people's and adult community services. Bidders could estimate some elements of the service quite easily, such as hospital activity costs, and contract sums for smaller sub-contracts. However, it was harder to disaggregate block or fixed-sum contracts, particularly the community services costs. The CCG worked with Cambridgeshire Community Services NHS Trust to establish 2013-14 costs. Cambridgeshire Community Services NHS Trust was reluctant to disclose the indirect costs of the contract during bidding as these were commercially sensitive and it had also bid for the contract as part of another consortium. The CCG also retained Deloitte LLP to carry out a due diligence report, which it delivered in May 2014. However, despite these attempts, the CCG could not demonstrate to bidders that the total contract sum, particularly the community services component, properly reflected the underlying cost of providing the service. The due diligence report highlighted the need to supplement this initial limited scope work with additional due diligence across a range of financial and non-financial areas once the CCG had chosen a preferred bidder.

Figure 13
Procurement timeline – contract price



Note

1 All budgets exclude an additional £5 million transformation funding in each of years 1 and 2 of the contract, except the Cambridgeshire and Peterborough NHS Foundation Trust business case of £887 million, which included £10 million transformation funding in year 1.

Source: National Audit Office document review

3.5 There was also a lack of clarity about the precise scope of services to be included in the contract. The initial service specification was deliberately broad so that the CCG could see how bidders proposed to transform existing services. However, the scope of the contract was sometimes clarified or altered late in the procurement process. For example, as late as September 2014, the CCG wrote to the bidders to tell them that the contract would include services such as phlebotomy for housebound patients and complex dressing/wound care for housebound patients and all those over 65 years old. The trusts told us that these services had not previously been mentioned. The CCG continued to clarify detailed aspects of the scope with UnitingCare Partnership even after the contract was signed.

UnitingCare Partnership's bid price

3.6 At the final bid stage, the other shortlisted bidders submitted bids at the CCG's maximum value of £752 million but UnitingCare Partnership made a tactical decision to submit a lower bid of £726 million to achieve a more favourable financial evaluation score. This decision reflected how important it was to the trusts to win the bid. However, even at this stage there remained a great deal of uncertainty about costs, so UnitingCare Partnership made a number of explicit cost assumptions in its bid price. It did not take opportunities offered by the CCG to revise its bid in the light of remaining uncertainties.

3.7 The CCG evaluated each bid based on the quality of the solution and on financial considerations. Of the 25% of the score that evaluated financial considerations, half of this was scored on contract price, with a financial scoring mechanism that favoured lower bids. The other half of the financial element covered a range of other factors such as the plan to deliver cost savings, how the bid will fund working capital, and acceptance of the scheme's payment mechanisms.

3.8 UnitingCare Partnership told us that there were 71 clarifications and cost issues outstanding when it was awarded preferred bidder status in October 2014, although the CCG believes the number to be lower than this. Both parties continued to work on these issues, but in UnitingCare Partnership's view, a significant minority of important cost clarifications were still outstanding when the contracts were signed in November 2014.

Figure 14 sets out some examples.

Figure 14

Examples from UnitingCare Partnership's list of unresolved cost information it needed to validate its budget as at early November 2014

- Detail of indirect costs and overheads in 2013-14 for Cambridgeshire Community Services NHS Trust
- Reconciliation at direct service line level of Cambridgeshire Community Services NHS Trust staffing, direct costs, indirect costs and overheads against contract values for 2013-14 and 2014-15
- Split between adults and older people for service costs in 2013-14 outturn
- Updated estimates of estates costs for 2013-14 and 2014-15, and estimates of NHS Property Services' management costs
- Confirmation of in-scope and out-of-scope services
- List of Cambridgeshire Community Services NHS Trust assets currently being used to deliver the service, together with acquisition costs and dates.

Note

¹ The CCG's and Cambridgeshire Community Services NHS Trust's view was that answers to some of these requests had been previously provided.

Source: UnitingCare Partnership documentation

3.9 There was significant pressure from the CCG to begin the contract on 1 April 2015 even though a final contract price had not yet been agreed. This was to avoid destabilising the services, as existing contracts expired on this date and more than 1,000 community care staff were due to transfer their employment to Cambridgeshire and Peterborough NHS Foundation Trust. This concern led to the CCG and UnitingCare Partnership signing the contract in November 2014 without a final agreed contract amount, on the basis that this would be confirmed later. Such action left the CCG exposed to continued negotiation on price and left UnitingCare Partnership exposed to providing a service without complete information on costs. Other bidders told us that they would not have proceeded with so many issues outstanding.

Differences in cost assumptions

3.10 There were some significant differences between the cost assumptions made by the CCG and by the trusts. In its financial plan, UnitingCare Partnership assumed it would receive additional income for example to reflect: transformation funding; savings from inappropriate readmissions; and savings in ambulance journeys. The CCG stated that UnitingCare Partnership would not receive these funds, but the latter did not revise its bid price to reflect this. UnitingCare Partnership subsequently confirmed to the CCG in September 2014 that it could deliver its services from its bid price and did not need to rely on any additional funding sources.

3.11 UnitingCare Partnership assumed it would be able to negotiate additional income once it was awarded the contract. Cambridgeshire and Peterborough NHS Foundation Trust's January 2015 business case contained an assumption that it would be able to negotiate total funding of £887 million – more than 20% above the original contract price (**Figure 15**). This was based on the premise that the contract value reflected the number of people using the services, so additional activity would be reflected by the CCG. This business case was not shared with the CCG.

3.12 More fundamentally, the two parties had a different understanding of the finality of the contract price. UnitingCare Partnership believed that it could continue to negotiate on cost after signing the contract; the CCG regarded the price as final except for the agreed increase for rising activity in 2014-15, which could not be calculated until summer 2015. Furthermore, UnitingCare Partnership's mitigations for the risks it identified to achieving savings and delivering services within the contract price relied on an assumption that it could negotiate with the CCG to revise the scope or cost of the contract.

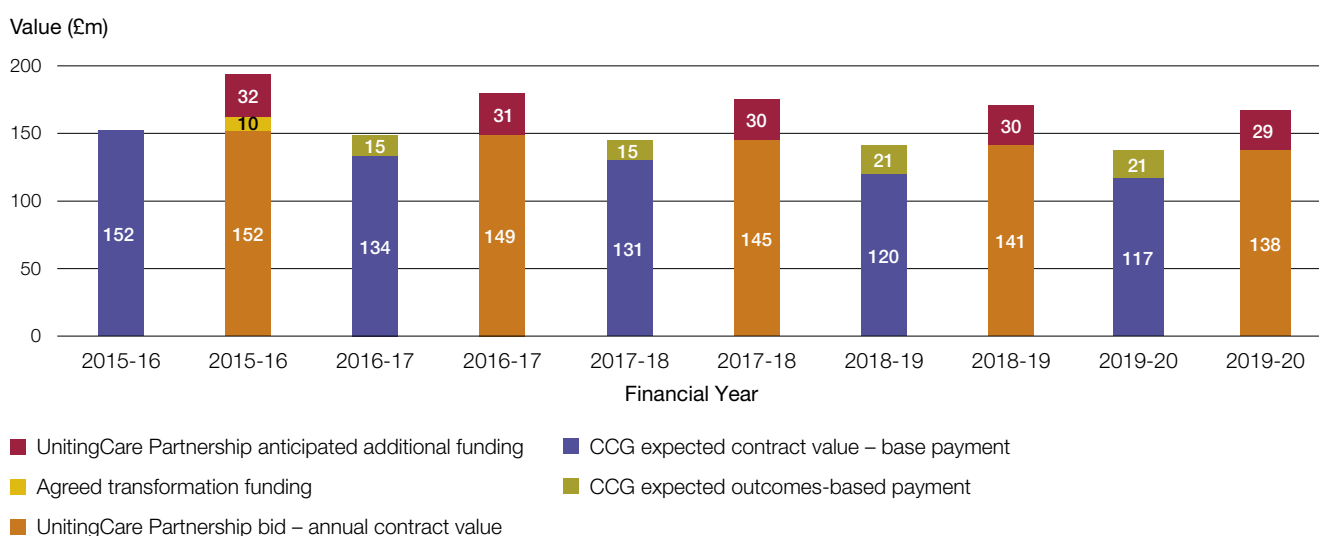
The emerging funding gap during the contract

3.13 In May 2015, UnitingCare Partnership requested £34 million of extra funding for the first year (**Figure 16**). This was 21% more than the contract price for that year. This request was made for a number of reasons, including an increase to reflect 2014-15 actual expenditure, and additional factors such as reduced savings due to delayed mobilisation. UnitingCare Partnership estimated at that time that it would need an extra £197 million above the contract bid price over the five-year contract.

Figure 15

Annual value of contract expected by CCG and by UnitingCare Partnership, 2015-16 to 2019-20

UnitingCare Partnership's business case model assumed more income than its bid for the contract

**Note**

1 Figures for 2017-18 do not sum due to rounding.

Source: Cambridgeshire and Peterborough NHS Foundation Trust business case, January 2015

Figure 16

Additional required funding calculated by UnitingCare Partnership, May 2015

Description	2015-16 value (£m)	Contract total (£m)	Reason for shortfall
Complexity of patient need	6.0	91.9	The CCG had assumed that complexity would increase by 1.5% a year, and all bidders were required to use this assumption. But UnitingCare Partnership analysis made it believe that an increase in complexity of 5.2% a year was more accurate.
VAT	4.9	17.6	The VAT costs arising from UnitingCare Partnership's limited liability partnership status had not been built into the bid. UnitingCare Partnership viewed this cost as a direct result of the CCG wanting to contract using a lead provider model.
Delays	9.4	9.4	Due to various delays, UnitingCare Partnership had incurred additional mobilisation costs of £1 million, and had lost the opportunity to make an estimated £8.4 million savings.
Technical adjustments	2.1	78.5	This relates to changes made to national tariffs and similar adjustments made by the central NHS.
Activity adjustments reflecting 2014-15 outturn	11.9		
Total	34.3	197.4	
Of which:			
Recurring	23.2	186.3	
Non-recurring	11.1	11.1	

Source: National Audit Office document review

3.14 The CCG's estimate of cost differences did not align with that of UnitingCare Partnership. During the next few months, the two organisations worked to resolve these cost issues and reduce the 2015-16 funding gap (**Figure 17**). By September 2015 they had managed to reduce the gap by £10.9 million by agreeing to omit potential differences that had not yet materialised

- **Complexity of need**

Neither party could accurately assess what the level of need would be. UnitingCare Partnership agreed to accept the CCG's estimated increase of 1.5% each year on the understanding that if the level of need turned out to be greater, it would be able to invoke the relevant financial destabilisation clause in the contract. Therefore it agreed to remove £6 million from the gap.

- **VAT**

UnitingCare Partnership and the CCG thought the VAT liability may not arise if HM Revenue & Customs approved UnitingCare Partnership's request, so they removed the £4.9 million from the funding gap.

3.15 However, this still left a gap of £23.4 million. Part of the remaining difference was that UnitingCare Partnership thought that all funding from 2014-15 for services that were within the scope of the contract should be included within the contract baseline value. It thought that the 2014-15 figures were understated because they did not include non-recurrent funding such as:

- £3.9 million assigned to marginal rate emergency tariff (MRET) funding;⁷
- £2.9 million assigned to emergency readmissions; and
- £0.6 million assigned due to winter pressures in 2014-15.

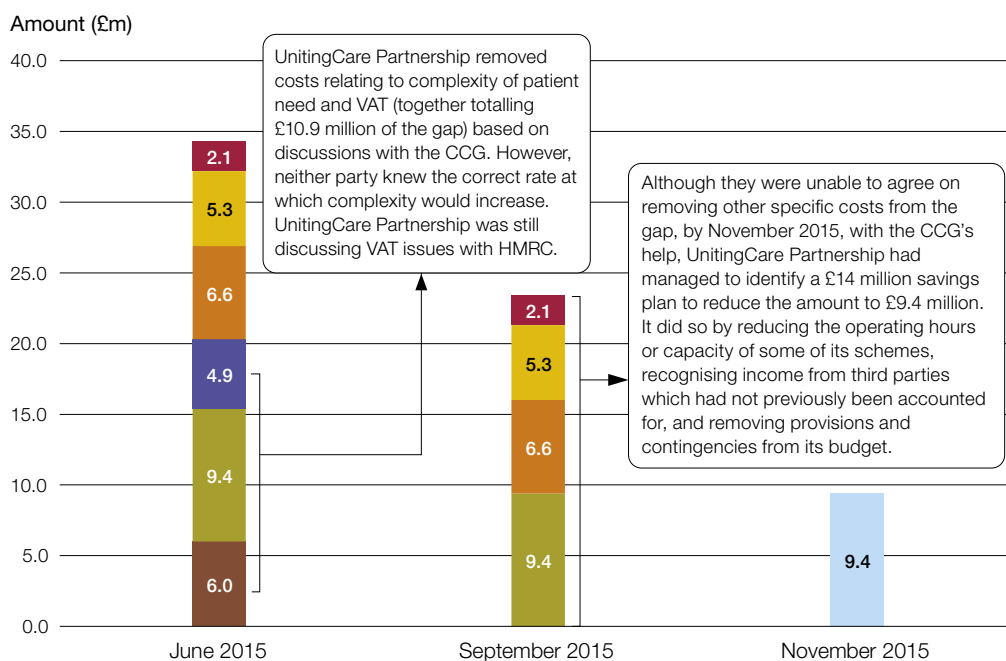
However, the CCG maintained that the £10 million of transformation funding that it was making available in the first two years of the contract replaced non-recurrent funding from 2014-15. The two parties were unable to come to an agreement on this issue.

3.16 To help UnitingCare Partnership reduce the funding gap, the CCG performed an 'open book' exercise on the partnership's costs to identify areas where it could make savings. UnitingCare Partnership agreed to this exercise to help keep the contract running, and to support its negotiation around the community care costs it had inherited from Cambridgeshire Community Services NHS Trust. By November, the CCG and UnitingCare Partnership between them had agreed on items that would reduce the funding gap by a further £14 million. This left a £9.4 million gap remaining in 2015-16.

⁷ Marginal rate emergency tariff refers to extra money made available in 2014-15, in line with Monitor guidance, to invest in community services to try to reduce demand for emergency admissions.

Figure 17
Progress in reducing the funding gap

Some progress was made in reducing the gap, but a £9.4 million gap remained by November 2015



UnitingCare Partnership removed costs relating to complexity of patient need and VAT (together totalling £10.9 million of the gap) based on discussions with the CCG. However, neither party knew the correct rate at which complexity would increase. UnitingCare Partnership was still discussing VAT issues with HMRC.

Although they were unable to agree on removing other specific costs from the gap, by November 2015, with the CCG's help, UnitingCare Partnership had managed to identify a £14 million savings plan to reduce the amount to £9.4 million. It did so by reducing the operating hours or capacity of some of its schemes, recognising income from third parties which had not previously been accounted for, and removing provisions and contingencies from its budget.

- Technical adjustments
- Other activity adjustments
- Marginal rate emergency tariff (MRET) adjustments¹
- VAT costs
- Lost savings in acute and community care due to contract being started late
- Complexity of patient need
- Remaining gap based on recovery plan as at November 2015

Note

¹ Marginal rate emergency tariff (MRET) refers to additional money made available in 2014-15 to invest in community services to try to reduce demand for emergency admissions.

Source: National Audit Office document review

3.17 Of the £14 million reduction, £8.4 million related to areas where recurrent savings could be made across the course of the contract by, among other things, reducing the hours that services were available when demand was low and removing provision in the budget to increase capacity at times of peak demand. The CCG also identified £3.2 million of income from third parties not previously accounted for. The remaining savings came from items that would not recur in future years but helped to mitigate the immediate funding issues. These included removing provisions for redundancies and vacant posts, as well as the general contingency built into the budget.

3.18 UnitingCare Partnership's operational due diligence was completed by the end of August 2015, five months into the contract. This exercise identified that the true staff cost of providing in-scope services was significantly higher than the CCG had originally assumed in its budget. UnitingCare Partnership's bid had assumed that community services costs were equal to the contract value of £53 million paid by the CCG. However, it found the costs transferred across to UnitingCare Partnership on 1 April 2015 were £59.6 million, due to reasons such as additional staff not previously identified. UnitingCare Partnership's reconciliation of staff costs and services transferred from Cambridgeshire Community Services NHS Trust indicated that the latter had employed some staff on permanent contracts for schemes funded on a one-off basis by the CCG. These staff had moved across to UnitingCare Partnership but the CCG did not include the funding for them in its budget allocation. UnitingCare Partnership sought to obtain additional funding to cover these costs using the contractual clause that any costs identified late due to information shortfalls would be addressed through an agreed process before September 2015.

3.19 After the initial bid, the CCG made three offers to increase the contract value (**Figure 18**). In January 2015 it agreed an extra £48 million to reflect the estimated 2014-15 costs. In May 2015, following a validation of the budget meeting with UnitingCare Partnership, the CCG offered to increase the total contract value across the five years of the contract by a further £8 million to £782 million, before transformation money was included. The CCG offered a further small increase in August to bring the total to £783 million plus £11 million for transformation funds and other adjustments. However, UnitingCare Partnership rejected these offers because of the remaining funding gap.

The contract's termination

3.20 In November 2015, it became clear that the differences between the CCG and UnitingCare Partnership over funding were becoming irreconcilable. In spite of efforts to reduce the funding shortfall, there remained a gap of £9.4 million. In the meantime, the CCG had advanced some funds to UnitingCare Partnership which was spending more than the contract value to provide its services. In late November UnitingCare Partnership asked for further advance funds but the CCG suggested that it should approach its partners in the first instance. Neither trust was in a financial position to provide the funding required.

Figure 18

CCG's offers to increase the contract price

Revenue	2015-16	2016-17	2017-18	2018-19	2019-20	Contract value over five years
	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)
Recurrent						
CCG tender: Expected maximum annual contract value	157.8	154.3	150.5	146.6	142.6	751.8
UnitingCare Partnership original bid – annual contract value	152.3	148.9	145.3	141.4	137.6	725.5
CCG offer: New contract value as at 27 January 2015 (including increase to annual contract value to reflect 2014-15 estimated expenditure)	161.8	158.5	155.0	151.2	147.4	773.9
CCG offer: New contract value as at 21 May 2015 (reflecting changes in scope and adjustments to 2014-15 actual expenditure)	161.5	159.8	156.9	153.7	150.5	782.4
CCG offer: New contract value as at 5 August 2015 (changes to reflect further adjustments to 2014-15 actual expenditure)	161.6	159.8	156.9	153.7	150.5	782.6
Non-recurrent						
Transformation funding agreed at final bid stage	5.0	5.0				10.0
Transition and transformation (additional) agreed 5 August 2015	1.0					1.0
To reflect changes to funding at Hinchingsbrooke agreed 5 August 2015	0.2					0.2
Non-recurrent total	6.2	5.0				11.2
Final total revenue offered by CCG	167.8	164.8	156.9	153.7	150.5	793.8

Source: National Audit Office document review

3.21 At the end of November 2015, the CCG informed UnitingCare Partnership that no further advance funding would be available. UnitingCare Partnership was then forced to terminate the contract in December 2015 to avoid trading insolvently. Upon termination, the CCG immediately took on direct commissioning of the services. It told us that the cost it incurred in doing so was significantly higher than the contract value. UnitingCare Partnership had only just started to reconfigure its services, so the anticipated efficiencies had not yet materialised.

The costs to the NHS of the contract

3.22 Conducting a large-scale procurement is costly for both commissioners and bidders. Although there were some enduring features of the service design, the failure of the contract after only eight months has resulted in costs to the NHS, both in cash terms and in staff time. **Figure 19** sets out an estimate of the main costs to the contract signatories. A more accurate estimate of the cost to the health sector would include the costs of Cambridgeshire Community Services NHS Trust, resources spent on Monitor's transaction review and the time of key NHS England officials. We have not tried to quantify these additional costs in this investigation.

Figure 19

The estimated cost to contract signatories of the failed contract

Cost	Amount (£000)
Total cost	8,923
comprising	
CCG procurement and termination costs	1,430
UnitingCare Partnership set up, management and termination costs	4,807
comprising	
UnitingCare Partnership bid and set-up costs	3,155
UnitingCare Partnership management costs	1,614
Termination costs	38
Trusts' bid costs pre-contract award	2,686

Source: National Audit Office document review

Part Four

Oversight and regulation

4.1 Under the Health and Social Care Act 2012, several oversight and regulatory organisations have an interest in this contract including NHS England, which oversees clinical commissioning groups, and Monitor, regulator for NHS foundation trusts and licensed providers of healthcare services (**Figure 20** overleaf). This part looks at the role of these oversight bodies regarding this contract.

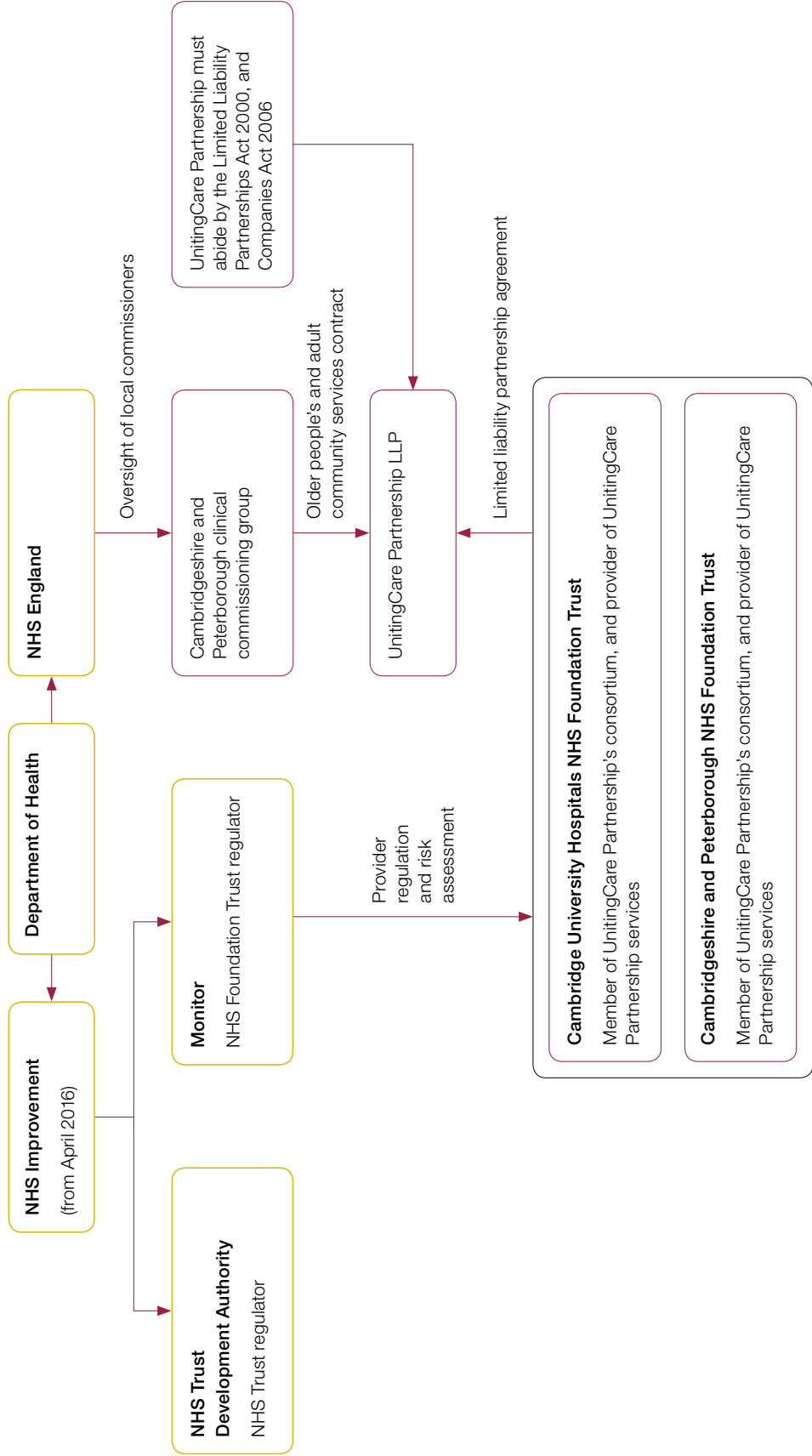
Oversight during the procurement

4.2 Monitor's responsibilities include overseeing foundation trusts and independent providers that provide NHS-funded care. UnitingCare Partnership was a limited liability partnership formed by two foundation trusts, but it was a separate legal entity and subject to company law. As it was not itself a provider of health services, no health sector regulator or oversight body had responsibility for assessing the implications of the contract for UnitingCare Partnership.

4.3 Monitor was informed of the potential transaction in September 2014, and the two trusts first discussed this with Monitor in early November 2014. Monitor uses criteria and thresholds as a guide to decide whether or not to conduct a detailed review of a trust's transaction, depending how significant it is to the trust's finances (**Figure 21** on page 41). Using these criteria Monitor decided to carry out a transaction review on Cambridgeshire and Peterborough NHS Foundation Trust's involvement in this contract, as the new services would increase the trust's income by more than 50%.

4.4 Monitor's transaction assessment review for Cambridgeshire and Peterborough NHS Foundation Trust began in January 2015. Such reviews normally take three to four months. However, the Cambridgeshire and Peterborough clinical commissioning group's (the CCG's) concern for the contract to start on 1 April 2015, due to the adverse impact of any delay on patients and staff, led Monitor to agree to conduct a limited review within a shorter timetable in the knowledge that contractual provisions were in place to terminate the contract if required. It did so on the understanding that it would complete its review as part of an investigation after April 2015. **Figure 22** on page 42 sets out Monitor's actions during the procurement. The review focused on the trust's exposure to risk, and how the trust might exit the contract if needed. In the time available, it was not able to look in detail at the trust's underlying financial position, or conduct detailed calculations of the financial risks associated with the contract. It conducted this work after April 2015.

Figure 20
Oversight and regulatory landscape



□ Regulatory/oversight role

Note

1 Since 1 April 2016, Monitor has been part of NHS Improvement.

Source: National Audit Office

Figure 21

Monitor's thresholds for carrying out transaction reviews

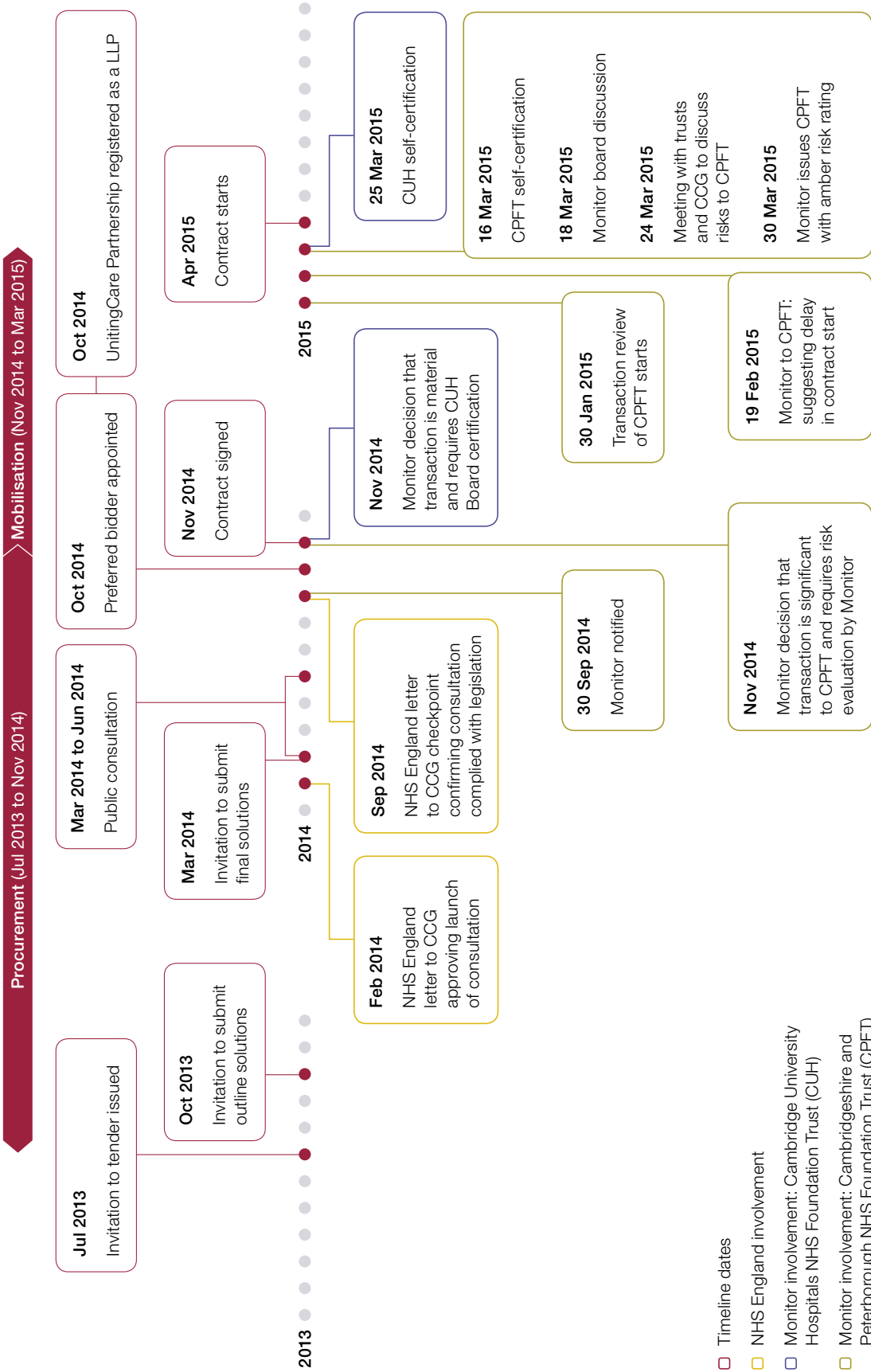
Ratio	Description	Reporting threshold (%)
Assets	The transaction's assets, divided by the foundation trust's assets	>10
Income	The income from the contract, divided by the income of the foundation trust	>10
Total foundation trust capital	The capital of the transaction divided by the foundation trust's total capital, or the effects on the capital of the foundation trust resulting from a transaction	>10

Source: Monitor's risk assessment framework 2015

4.5 The central issue during the procurement was whether the contract price was sufficient, particularly given the lack of information about costs. For its transaction review, Monitor requested both the UnitingCare Partnership bid documentation and Cambridgeshire and Peterborough NHS Foundation Trust's business case. In the former document the contract value was £726 million, whereas its value in the latter document was £887 million. Monitor told us that the focus of its transaction review work was on Cambridgeshire and Peterborough NHS Foundation Trust's subcontract rather than the contract between UnitingCare Partnership and the CCG. Monitor was content for the transaction to go ahead with significant unresolved cost issues in the contract on the basis that Cambridgeshire and Peterborough NHS Foundation Trust would be able to exit the contract if financial risks materialised. Monitor was concerned that the joint agreement between the trusts and UnitingCare Partnership was still in draft. Monitor spoke to the trusts and the CCG on 24 March 2015 to gain assurance on these issues before it was willing to give a risk rating. On 30 March 2015, following assurances about Cambridgeshire and Peterborough NHS Foundation Trust's maximum risk exposure and greater clarity about contractual terms, Monitor issued an amber risk rating for the transaction.

4.6 Monitor's risk assessment criteria did not trigger a review of the contract for Cambridge University Hospitals NHS Foundation Trust because the additional contract value did not exceed the thresholds set by the regulator. Instead the trust's Board was required to self certify the transaction, and it did so. At 31 March 2014, the trust had a deficit of £8 million. This had increased to almost £17 million by 31 March 2015. The trust was also introducing a new IT system and other clinical service changes, such as pathology services at this time.

Figure 22
Timeline: Monitor and NHS England assurance



- Timeline dates
- NHS England involvement
- Monitor involvement: Cambridge University Hospitals NHS Foundation Trust (CUH)
- Monitor involvement: Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

Source: Analysis of documentation and meeting notes

4.7 NHS England had very limited involvement during the procurement of this contract. The services fell within the CCG's commissioning responsibility, which meant that NHS England had no formal assurance role in the procurement. Although NHS England held regular update meetings with the CCG, these covered the CCG's responsibilities as a whole and did not specifically focus on the risks to the CCG from this contract. Their involvement with the procurement was primarily to ensure that the CCG had complied with procurement rules such as its public consultation about its plans.

Oversight during operation and termination

4.8 During the contract's operation, the CCG and the two partner trusts had some contact with oversight bodies about this contract.

- The gateway review team had disbanded in March 2015 and the Department of Health had no further direct contact.
- Monitor completed its full review of the transaction for Cambridgeshire and Peterborough NHS Foundation Trust in the first six months of the contract's operation as part of an investigation into the trust's finances, although it kept its investigation open due to the continuing funding difficulties.
- Monitor placed Cambridge University Hospitals NHS Foundation Trust into special measures in September 2015 on the advice of the Chief Inspector of Hospitals following an inadequate rating from the Care Quality Commission.
- NHS England continued to meet with the CCG for its routine oversight meetings but these meetings did not focus specifically on the UnitingCare Partnership contract.

4.9 The CCG did not inform NHS England of the difficulties in resolving the gap in the contract value until October 2015. NHS England and Monitor then convened a meeting of major stakeholders, but the contract signatories were unable to reach an agreement. NHS England did not consider it appropriate to provide additional funding itself to fill the gap. NHS England's regional office agreed to explore whether there was another way to bridge the funding gap but felt that this was unlikely. In December it recommended that the contract should be terminated. It instructed the contract signatories to plan for a withdrawal from the contract while preserving as many of the scheme's benefits as possible.

4.10 Immediately before the termination, Monitor recommended that UnitingCare Partnership took professional advice about the risk of insolvency. The Department of Health felt that the parties involved should adhere to the contract terms. It confirmed to Monitor that it would not fund any losses at the provider trusts over the contractual amounts. The Department of Health had no other involvement.

4.11 Following the contract's failure, NHS England commissioned two reviews of what went wrong. In the meantime it paused similar contracts elsewhere, so that it could consider how to prevent the same situation from happening again. It now plans to develop an assurance framework to assess similar procurements in future. Monitor is also reviewing the issues raised by the collapse of this contract.

Taking a health sector perspective

4.12 The regulators and oversight bodies met their statutory roles, but ultimately, individual regulatory bodies' actions only looked at individual contract signatories' risks. For its review of Cambridgeshire and Peterborough NHS Foundation Trust, Monitor took assurance from UnitingCare Partnership's actions to limit its financial contractual liability, but it was not Monitor's role to assess the resulting impact on the CCG.

4.13 Individual bodies' actions moved risk around the system but did not reduce overall risk or ensure that the contract arrangements and price were viable. Because each regulatory body acted only within its defined role, none acted to mitigate the more fundamental risk of the contract failing due to insufficient funding. No organisation was responsible for taking a holistic view of the risks and benefits of this approach, or considering whether the anticipated longer-term benefits were sufficient to justify additional short-term support.

4.14 In the end the legal liabilities of the two trusts were less important than other considerations. The trusts agreed to pay for part of the unfunded costs and therefore worsen their financial positions because they felt a moral obligation to protect charity and community subcontractors by ensuring they were paid for their services.

4.15 The Five Year Forward View encourages the health sector to use new and more joined-up ways of providing care, which may not always align with existing regulatory and oversight arrangements. Without closer joint working or a more holistic view, there are significant risks that individual oversight decisions will not lead to the best outcomes for patients or the most efficient use of funding. For the New Care Models programme, Monitor and NHS England are currently working with the Department of Health to devise an oversight regime including pre-contract assurance, contract provisions and regulatory oversight.

Appendix One

Our investigative approach

Scope

1 In response to correspondence we received, we conducted an investigation into the collapse of the contract to provide older people's and adult community services in Cambridgeshire and Peterborough. There are several other reviews looking at the failure of this contract from different perspectives. This investigation provides an independent view of what happened and sets out the main reasons for the contract's collapse.

We set out the following:

- the design, procurement and operation of the UnitingCare Partnership contract;
- the events that led to the contract's termination, including accountability and risk management factors; and
- an estimate of the cost of the contract's failure.

2 We carried out the investigation between late April and early June 2016. Our work was not designed to evaluate the decision to use this particular design for the model of care, or the value for money of the services provided by the contract.

Methods

3 In examining these issues, we drew on a variety of evidence sources.

4 We interviewed more than 30 officials from organisations that were involved in the contract, to establish the facts. The organisations we interviewed included: the Department of Health, NHS England (including the Strategic Projects team and its sponsor team, ArdenGEM commissioning support unit), NHS Improvement, Cambridgeshire and Peterborough clinical commissioning group, Cambridge University Hospitals NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire Community Services NHS Trust, Cambridgeshire County Council, Deloitte LLP, Gowling WLG, Healthwatch Cambridgeshire, West Midlands Internal Audit team (providing internal audit services for the CCG), Virgin Care Ltd, Interserve plc, and NHS Providers network.

5 We reviewed documents held by each of the bodies relating to the contract. These documents included procurement documentation and evaluations, business cases, financial analysis, board meeting minutes and correspondence between different organisations. We used the documentation to confirm our understanding of events and to present detailed data such as on costs.

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