

**Cambridge Judge Business School
Centre for Health Leadership and Enterprise**

Review of the UCP Contract Termination, August 2016

Review of CPFT's Role in UnitingCare and the Impact of Terminating the UnitingCare Contract

Commissioned by Cambridgeshire and
Peterborough NHS Foundation Trust

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LIST OF ACRONYMS

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| C&P CCG: | Cambridgeshire and Peterborough Clinical Commissioning Group |
| CCG: | Clinical Commissioning Group |
| CCS: | Cambridgeshire Community Services NHS Trust |
| CHLE: | Centre for Health Leadership and Enterprise, University of Cambridge Judge Business School |
| CJBS: | University of Cambridge Judge Business School |
| CPFT: | Cambridgeshire and Peterborough NHS Foundation Trust |
| CQC: | Care Quality Commission |
| CUH: | Cambridge University Hospitals NHS Foundation Trust |
| GP: | General Practitioner |
| ISFS: | Invitation to Submit Final Solutions |
| ISOS: | Invitation to Submit Outline Solutions |
| IT: | Information Technology |
| JET: | Joint Emergency Teams |
| LLP: | Limited Liability Partnership |
| MAR: | Medication Administration Record |
| OPACS: | Older People's and Adult Community Services |
| PQQ: | Pre-Qualification Questionnaire |
| SPT: | NHS Strategic Projects Team |
| UCP: | UnitingCare Partnership |

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SUMMARY REPORT



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SUMMARY REPORT

Commissioned by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), this report provides an account and an analysis of the creation and collapse of the UnitingCare Partnership (UCP). The main purpose of this review is to provide independent insight into the events surrounding the UCP contract for the Governors and Board of CPFT.

The report is based on:

- a detailed study of the documentation relating to the tender process, operation and closure of the UCP, including Board reports, financial analyses, confidential material and minutes as well as material publicly available from the Trusts' and the Cambridgeshire and Peterborough Clinical Commissioning Group's (C&P CCG) website;
- interviews with senior leaders and board members from across the system;
- a group meeting with the Council of Governors;
- expertise and knowledge from across the health economy (e.g. national policy guidance, reports produced by other bodies on the UCP and national examples of good practice in contracting, integrating services and reducing demand on acute hospitals);
- expertise and knowledge from within University of Cambridge Judge Business School (CJBS).

Following guidance from CPFT, we investigated a series of questions that fell naturally into three main themes that emerged during the course of the study (see Table 1).

Table A: Three key themes that emerged

(1) Competitive tendering and risk sharing

- T1. Could the partners have done anything differently during contract negotiations to prevent its failure?
 - T1(a) Should or could the Trusts have put money into the UCP up front to enable its survival?
 - T1(b) Should parent boards have owned the UCP debt?
 - T1(c) Why was a parent company guarantee for the limited liability partnership (LLP) not put in place?
- T2. Did the commissioners raise specific concerns about how the negotiations and contract process were carried out?
 - T2(a) Were the overheads for the UCP higher than expected?
 - T2(b) Was C&P CCG concerned about performance issues in relation to service delivery?
 - T2(c) Was there a conflict of interest in the cross-membership of the Trusts' and the UCP's boards, and if so, were the arrangements for managing this conflict adequate?

(2) Partnering and collaboration during contract execution

- P1. What were the roles of CPFT and Cambridge University Hospitals NHS Foundation Trust (CUH)? Could the Trusts have been more proactive in developing, implementing and supporting the contract, especially given that it was one of the NHS pioneer programmes?
- P2. Once the funding gap had been identified, what more could have been done to ensure the continuation of the contract or was termination inevitable?
- P3. Was there any guidance or commercial advice not identified by the UCP or its partners that could have enhanced the ability of the new organisation to deliver a complex health contract?

(3) Cost and salvaging created value

- C1. Were the losses to the health economy greater than the cost of keeping the contract going? If so, why, and could the Trusts have prevented this?
 - C2. What were the wasted costs for CPFT?
 - C3. What could be done to build on the apparent initial successes of the UCP and keep the integration benefits in terms of better care provision at a lower cost?
-

It is limiting to study the creation and collapse of UCP without understanding the wider system and organisational context. Therefore, we extend the scope of the analysis when it is relevant to our brief and provide a whole system account of the UCP story. Within this context, we draw out what we consider to be the key learning points for the whole system and what might have been done differently in the context of the health economy in Cambridgeshire and Peterborough.

During the fieldwork for this report three other reviews of UCP were commissioned/undertaken by C&P CCG, NHS England, and the National Audit Office. Each had a particular focus and each was commissioned to meet the organisational and governance needs of the sponsoring organisation. As such no report was concerned with the system and inter-organisational context for the UCP tender and its eventual closure, which we emphasise in this review. The reports and their terms of reference were:

1. Review of Procurement, Operation and Termination of the Older People's and Adult Community Services (OPACS) Contract; Internal Audit Final Report: CP CCG15/23, March 2016

Carried out by the West Midlands Ambulance Service acting as the Internal Audit agency, this was an independent internal review to document and evaluate the C&P CCG's systems, processes and controls deployed in the procurement and management of the OPACS contract to identify any systemic weaknesses that may have contributed to the termination of the contract and learning points for future procurements. The review of evidence was restricted to that held by the C&P CCG or available in the public domain. It did not encompass a review of any further evidence held by any of the contract bidders or other parties such as NHS England or Monitor.

2. NHS England Review of UnitingCare Contract: The Key Facts and Root Causes Behind the Termination of the UnitingCare Partnership Contract; NHS England Publications Gateway Ref 05072, April 2016

The review, from a commissioner perspective, sought to establish the key facts and root causes behind the collapse of the C&P CCG contract with UCP in December 2015, and to advise on next steps. It covered the events leading up to the collapse of the UCP contract in order to draw out the lessons to be learnt for other novel contracting forms in the context of implementation of the New Models of Care strategy. It did not cover governance arrangements, costing and tendering processes from a provider perspective, as this is seen as a matter for the individual Foundation Trusts and Monitor.

3. The Collapse of the UnitingCare Partnership Contract to Provide Older People's and Adult Community Services in Cambridgeshire and Peterborough; National Audit Office Report, Summer 2016

This investigation was an independent review of events and set out the main reasons for the contract's collapse. It covered the design, procurement and operation of the UCP 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. It was not designed to evaluate inter-organizational aspects during contract negotiation, implementation and ultimate failure.

Competitive tendering and risk sharing

Even with the benefit of hindsight, it is difficult to identify anything substantial that could have been done differently once the tender process had begun. The tight and overly structured rules set out for competitive procurement and bidding against the private sector led CPFT and CUH to focus on the risks and benefits for their *own* organisations rather than to find common goals with C&P CCG and share, system-wide, the risks and benefits. Given this context, as well as the tight financial positions of CPFT and CUH, it would be unrealistic to expect the Trusts to invest substantial funds in the UCP up front to ensure its survival, to own the UCP debt or to engage a parent company guarantee for the LLP. Such commitments would have adversely affected core services and programmes provided by the Trusts; in CPFT's case in particular, this could have negatively affected the development of mental health services and had a significant impact on users and carers.

However, it is possible that a concerted push by the provider organisations *prior to* the competitive tendering decision being made might have persuaded C&P CCG to develop a more organic and developmental approach to Older People's and Adult Community Services (OPACS). CPFT and CUH could have argued more strongly for a phased implementation of the changes as well as for the establishment of the necessary infrastructure at an early stage; the integration of complex services cannot be successful without the appropriate information- and data-sharing infrastructure to support collaboration and help clarify shared objectives and develop shared analyses and progress measures. The Trusts could have insisted on more time being taken to build a workable information- and data-sharing platform as well as to establish conditions for successful integration before full service delivery commenced. Such an approach might have been particularly effective if combined with a pilot programme for a suitable sub-population in the initial phase.

During contract negotiations, there was a sense of urgency to develop the new service and maintain impetus that outweighed the need for a comprehensive understanding of the operational and financial details of the service transformation and the relationships necessary for its successful delivery. The feeling was that taking time to understand the details was a distraction from the task in hand. The negotiations moved forward rapidly, often without the necessary degree of clarity – something that is not viable in competitive contracting and complex procurement. More time and effort should have been invested to obtain the relevant information and build clarity ahead of contracting.

The scale of the savings that were realistically achievable with the OPACS programme and the costs of integrating and delivering the care model were highly uncertain at the time of negotiation. C&P CCG effectively insured itself against these risks by setting a tender price that incorporated savings targets from the start – without conducting a proper analysis of whether these targets were realistic – based on optimistic estimates of the transformation and delivery costs. Therefore, the providers and UCP were left with the considerable downside risks of below-target savings and higher-than-estimated costs. These risks were not balanced by any financial upsides beyond the contract value – the benefits of which dependent on cost savings and service improvements in later years. From a risk-sharing perspective, this was a one-sided contract framework. Given that C&P CCG had insured itself against the risks, the parent companies of the UCP had no choice but to also insure themselves and they did this by creating an LLP. This returned the risk of contract failure largely to C&P CCG and, importantly, made contract failure more likely because the parties who could trigger it had already limited their losses. A procurement deal with an embedded degree of shared responsibility and risk from the outset could have provided the basis for a more sustainable contract and improvement programme – and the partners should have pushed harder for such an agreement. Given the uncertainties and lack of effective risk sharing that became apparent

during contract negotiation, CPFT and CUH could have seriously considered withdrawing from the tender as it became clear that the costs, timescale, detail and clarity of the contract process were problematic.

While the partnership collapsed before there was any certainty about performance issues in service delivery, documentation and interviews reveal that there were concerns that the contract negotiations and subsequent mobilisation discussions were a source of conflict between the UCP and the commissioners and that there was a lack of trust between the contracting parties. For example, frustration was generated by a difference in views on the nature of the contract, specifically, to what extent further negotiation after the contract was let was normal and to be expected, or whether it went beyond what was reasonable. In addition, the UCP took on some of the system improvement and service monitoring and management work that was also the province of C&P CCG. This created a measure of doubling up – and hence a burden on the health system through duplicated costs – and led to role ambiguity that was a further source of conflict between C&P CCG and the UCP. If trust cannot be built between the parties in complex procurement, an adversarial relationship is inevitable. Focussing on rapid, large-scale, ‘radical’ change is dangerous in contexts where trust and collaboration are underdeveloped. In this case, rather than chasing complex procurement and mobilisation, a smaller-scale pilot programme could have been set up to test the ideas and operational realities and, importantly, to enable the contracting parties to build a culture of partnership with well-defined roles and responsibilities.

The UCP’s position as neither solely a commissioner nor a provider but a hybrid organisation focused on system improvement, challenged the rigid purchaser–provider divide that is the dominant policy and mode of operation in NHS commissioning. This hybrid organisational model wasn’t fully understood or supported nationally or in much of the local economy. Wider and more sustained negotiation and consultation on the UCP’s hybrid role would have been necessary for a shared understanding to emerge. The UCP partners’ extensive expertise in service development and organisational change could have been used more forcibly during the start-up period to build a more grounded understanding with commissioners about the UCP’s role and what was realistically achievable in the early years of the contract.

While it is not apparent that any conflicts of interest in terms of governance arose during the operation of the UCP, it is likely that such conflicts would have emerged in time, particularly as the UCP assumed greater responsibility for performance and service development and took up its role in the health economy more fully. Specifically, the UCP’s narrowly scoped board membership may have come to compromise the role of the UCP as an integrator. The UCP should have developed a wider consultation and engagement governance structure to allow it to draw on the expertise and opinions of a greater breadth of stakeholders in relation to OPACS, particularly in primary care and social services. Developing links at board level with the wider health economy and with citizens and patients would have strengthened the UCP’s governance and could potentially have broadened its capacity to develop strategies and support to address the problems it faced. In time, the relationship between the governance of the UCP and that of CPFT and CUH would have needed to be resolved more clearly.

Partnering and collaboration during contract execution

The UCP – and its potential as an innovator – lacked powerful and truly committed advocates. When difficulties emerged with the contract and operational deficit, it was easier to let the contract fold than to push ahead into year two and beyond. Transformation projects at the scale of the UCP target multiple objectives that are often conflicting. Resolving these tensions for the greater good requires a cadre of strong leaders across all parties to develop shared

values, a clear vision, a sense of mission and long-term measurable goals that create a willingness to compromise when risks materialise. External support and constructive challenges further enhance the collaborative nature of such transformations. The local health economy as a whole should have invested more in developing both these leaders and a leadership system, creating a united, broadly based collective to champion the initiative and sustain improvements over time.

At the time of contract closure, the partners had no alternative besides termination. The contract negotiations and pressure to deliver improvements in admission figures had taken the organisations involved as far as they could go. There was a strong sense that managers and leaders – commissioners and providers alike – had been fenced in by the negotiation process they had created themselves and that there were no options left to them other than closure. We believe that, started earlier, a more engaged and collaborative approach to service improvement and risk management could have provided a wider range of possible futures for the UCP. Evidence suggests that the contract was insufficiently funded and that the OPACS programme was loaded onto a local system facing serious financial pressure. This lack of funding made *reactive* risk management extremely difficult. It is also the case that ground breaking programmes such as the UCP face a great number of systemic and cultural challenges and are more likely to uncover serious financial and cost issues. In the wider commercial environment, organisations often manage short interruptions to cash flow by drawing on emergency funds. A transformation with the scale and complexity of OPACS would have benefitted from access to specific transitional emergency funds set aside by NHS England, over and above the local dissemination of general transformation funds, which are often over-subscribed and subject to multiple demands. A well-governed national contingency fund could also have ensured greater engagement from NHS England and helped overcome the impediments and governance requirements that lone organisations naturally face.

The key lesson that can be drawn from commercial enterprises and public and private experiences of integration nationally and internationally is that such major projects should be viewed as long-term collaborative endeavours. Evidence suggests that the cultural changes, organisational development and personal relationships that underpin successful integration can take 10 years or more to develop before sustainable, high-quality outcomes are delivered. Building clear and effective partnerships, based on trust and robust understanding of each other's positions, takes time. Competition, urgency and severe resource constraints tend to undermine these facilitative factors in the development of successful integration. In addition, without integrating information systems and developing accurate and focused data on integration – which are long-term and significant projects on their own – it is impossible for organisations to identify the levers for delivering higher quality at lower cost and establish a culture of evidence-based interrogation, innovation and improvement.

Major procurement and change programmes – such as the OPACS contract and UCP creation – create a momentum and internal logic of their own that often drives project planning and decision-making along linear pathways. Perhaps the greatest challenge for leaders and public representatives is to find opportunities and mechanisms to take a step back from the inexorable process of bidding, mobilisation, implementation and contract monitoring and ask the big questions about whether the programme is working and whether there is a better way of delivering improvement. This becomes harder as the scale and public profile of the transformation project increases. An alternative is a less 'radical' and more incremental, organic approach to service transformation that enables learning and adaptation, with scale being achieved over time.

Cost and salvaging created value

The total cost of the UCP – as calculated by CPFT and CUH – was an estimated £18.6 million. This includes £12.4 million in costs for CPFT and CUH, split evenly between the two partners; the lion's share of this – £7 million – was in inherited payments to contractors and providers above the contract price for OPACS and was used to support existing OPACS services. The cost of the UCP to the local health system, over and above what would have been spent in the normal provision of services had the tender exercise not been undertaken, was estimated at £10.3 million.

It is impossible to assess the opportunity costs with any degree of accuracy. However, given the considerable problems facing the local health services, it is reasonable to assume that substantial positive outcomes could have been achieved for the health economy had the considerable talents and efforts of the NHS staff and Trusts been focused in different ways.

The positive legacy of the UCP for the health system is that there is now a genuine movement towards integration, a clearer understanding of how payments and rewards can be brought together through improved patient pathways and a better infrastructure for older people's and adult services that is already being built upon. The contracting process has also brought into sharper focus the details of the complex services that provide community care and support. We have also observed a fresh desire to drive integration and service improvement in OPACS as well as greater commitment to collaboration and shared working in the interest of the system as a whole. To maintain this momentum, local health economy leaders must take care not to fall back into their secure positions within individual organisations but to see the UCP experience as an opportunity to learn and develop more robust models, a greater degree of mutual understanding and solid shared objectives for the delivery of integrated care in the future.

Furthermore, as a result of the OPACS tender, CPFT's service and cost base has expanded, and it has been able to introduce a degree of integration for mental health and adult services, resulting in greater efficiencies in its management and operational overheads. Consequently, CPFT has been able to manage its cost savings targets more easily, it has become a more sustainable organisation overall, and its impact within the region has become more significant.

The UCP marked the starting point for the development of integrated information infrastructure, which has now been put on hold. This is perhaps the greatest foregone salvage opportunity. International experience has shown that sustainably successful integration is impossible without reliable integrated information systems that can identify and prioritise change opportunities and, importantly, evaluate service changes at both the level of patient journeys through all of the service touchpoints in a local health and social care system and the level of a population's long-term health and service costs. Successful examples are emerging from elsewhere in the world, and the Cambridgeshire and Peterborough local health economy should learn from these as it continues to develop its integrated care services.

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MAIN REPORT



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MAIN REPORT

1. INTRODUCTION

The Centre for Health Leadership and Enterprise (CHLE) at the University of Cambridge Judge Business School (CJBS) was commissioned by the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) to undertake a review of the tendering, procurement and eventual collapse of the Older People's and Adult Community Services (OPACS) contract between the Cambridgeshire and Peterborough Clinical Commissioning Group (C&P CCG) and the UnitingCare Partnership (UCP), a limited liability partnership (LLP) between CPFT and Cambridge University Hospitals NHS Foundation Trust (CUH). The main purpose of this review is to provide independent insight into the events surrounding the UCP contract for the benefit of CPFT's governors and board members. The goal is not to identify individual or organisational failures but to draw out the lessons that can be learnt for the benefit of the local and national health economy. As part of this review we examined:

1. the *tendering process*, its operationalisation through a *competitive tender* and how *operational and financial risks* were handled throughout;
2. the effectiveness of *partnerships* and *collaboration* during contract execution;
3. the *costs of the failed partnership* for CPFT and the local health economy as well as *effective salvaging of the value created* by the partnership.

We investigated a series of questions within these three main themes (Table 1).

This report has been published in the context of a number of other enquires and investigations commissioned by the NHS and other national bodies, including enquires by internal audit for C&P CCG and Monitor, NHS England and the National Audit Office.¹ While these reports help improve public understanding of the UCP case, none looks across the system at the lessons that can be learnt; instead, they focus on the particular concerns of their commissioning agency. Indeed, the system today is characterised by the lack of a general regulatory or development body with a remit to examine the healthcare system as a whole or how integrated services could be developed and operated across organisations or localities. This fragmented structure was quick to emerge in our study as an important factor in the UCP story.

In answering the questions in Table 1, we looked particularly at the processes and decisions surrounding the creation and operation of the UCP and the relationships between the people, organisations and systems involved; we examined how the UCP story developed and what could have been done differently in the context of the health economy in Cambridgeshire and Peterborough.

Overall, this report seeks to provide a *whole-system account of the UCP for the benefit of the local and national health economies*.

¹ Review of Procurement, Operation and Termination of the Older People's and Adult Community Services (OPACS) Contract; Internal Audit Final Report: CPCCG15/23, March 2016; NHS England Review of UnitingCare Contract: The Key Facts and Root Causes Behind the Termination of the UnitingCare Partnership Contract; NHS England Publications Gateway Ref 05072, April 2016; The Collapse of the UnitingCare Partnership Contract to Provide Older People's and Adult Community Services in Cambridgeshire and Peterborough; National Audit Office Report, Summer 2016.

Table 1: Three key themes that emerged

(1) Competitive tendering and risk sharing

- T1. Could the partners have done anything differently during contract negotiations to prevent its failure?
 - T1(d) Should or could the Trusts have put money into the UCP up front to enable its survival?
 - T1(e) Should parent boards have owned the UCP debt?
 - T1(f) Why was a parent company guarantee for the limited liability partnership (LLP) not put in place?
- T2. Did the commissioners raise specific concerns about how the negotiations and contract process were carried out?
 - T2(d) Were the overheads for the UCP higher than expected?
 - T2(e) Was C&P CCG concerned about performance issues in relation to service delivery?
 - T2(f) Was there a conflict of interest in the cross-membership of the Trusts' and the UCP's boards, and if so, were the arrangements for managing this conflict adequate?

(2) Partnering and collaboration during contract execution

- P1. What were the roles of CPFT and Cambridge University Hospitals NHS Foundation Trust (CUH)? Could the Trusts have been more proactive in developing, implementing and supporting the contract, especially given that it was one of the NHS pioneers programmes?
- P2. Once the funding gap had been identified, what more could have been done to ensure the continuation of the contract or was termination inevitable?
- P3. Was there any guidance or commercial advice not identified by the UCP or its partners that could have enhanced the ability of the new organisation to deliver a complex health contract?

(3) Cost and salvaging created value

- C1. Were the losses to the health economy greater than the cost of keeping the contract going? If so, why, and could the Trusts have prevented this?
 - C2. What were the wasted costs for CPFT?
 - C3. What could be done to build on the apparent initial successes of the UCP and keep the integration benefits in terms of better care provision at a lower cost?
-

2. METHODOLOGY AND DATA SOURCES

This analysis was produced from an in-depth study of the documentation relating to the tender process and the operation and closure of the UCP. We were afforded unique access to the rich documentation generated by the process, including board reports, financial analyses, confidential material and minutes. We also made use of material that is publicly available from the Trusts' and C&P CCG's websites. We interviewed 20 senior leaders and board members from across the system. This included directors, non-executive directors and board positions (six people from the CCG, six from UCP itself many of whom held senior positions in CUH or CPFT before the creation of UCP or subsequently, and seven officers and members from CPFT). We also attended a CPFT Council of Governors meeting to present our initial findings and harvest thoughts and comments. We also examined national policy guidance, the reports produced by other bodies on the UCP and national and international examples of good practice in contracting, integrating services and reducing demand on acute hospitals. Finally, in producing this report we made use of the expertise and knowledge within CJBS, drawing in particular on evidence from sectors and economies beyond healthcare.

We are acutely aware that when reviewing processes and decisions with the benefit of hindsight, reviewers can be guilty of applying judgements and evidence that fit the timeline of events but convey a predictable sequence of decision-making by key people. The complexity and nuances faced by decision-makers can easily be lost or given insufficient weight in retrospective studies. In reality, and particularly in the often-confusing and urgent context of major change, decisions are seldom straightforward or linear; participants in the drama lack perfect knowledge and make the best judgements they can given the situation they are in and the incomplete and often conflicting information that they must draw upon. We recognise that leadership and decision-making are often gritty, messy and taxing tasks and have made

strenuous efforts to understand the context, possibilities and systemic influences that shaped the UCP case.

We have attempted to account for the realities of decision-making by conducting interviews with key participants in which we encouraged them to think back to the decision-making context and recall their experiences and motivations in that moment (see Appendix A for interview questions). We have also taken into account the national policy context and directives operating within the NHS at the time. Our interviews were structured to interpret the decisions made before, during and after tendering in order to address themes (1) and (2) in Table 1. To respond to the third theme, we relied on financial analyses.

3. BACKGROUND AND CHRONOLOGY

We begin by providing a timeline of the events leading to the collapse of the UCP, starting from the pre-tender stage (Table 2).

Following the Health and Social Care Act of 2012, clinical commissioning groups (CCGs) were established to provide clinical leadership of the planning, procurement and monitoring of local NHS services. CCGs replaced the broader commissioning and locality focus of primary care Trusts. Their mandate was to address the rising cost of and demand for healthcare, the increasing number of older people with chronic and multiple conditions and the need for improved quality and response speed and greater accountability of general practice. CCGs were established in the context of a nationally protected NHS budget that was, given continuing demand growth, among the tightest funding settlements that the NHS had ever faced.

Government policy statements at the time made it clear that CCGs could not simply continue in the same vein as previous commissioning organisations: radical change was encouraged to meet the challenges faced. The legislation stated that competition and integration should be central to this change:

'In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through— (a) the services being provided in a more integrated way (including with other health care services, health-related services, or social care services), (b) enabling providers to compete to provide the services, and (c) allowing patients a choice of provider of the service.' The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, p 2

C&P CCG was formed within this policy context in April 2013. The largest CCG in England, it serves a registered population of over 900,000, with over 100 primary care practices. Following consultation with member general practitioners (GPs) and the general public, C&P CCG determined three key priorities: reducing inequalities in coronary heart disease, end of life care and services for older people. Given these priorities and in the face of growing demand and costs for older people's services, C&P CCG commenced the procurement of OPACS for the area.

Table 2. Timeline of event

| | Date | Event |
|--|--------------------------|--|
| Pre-tender events | April 2013 | C&P CCG formed. Three key priorities determined: inequalities in coronary heart disease, end of life care and services for older people. |
| | 3 July 2013 | C&P CCG begins competitive procurement process for OPACS. <ul style="list-style-type: none"> • 12 completed pre-qualification questionnaires (PQQ) received and evaluated |
| | 9 September 2013 | Invitation to submit outline solutions (ISOS stage). <ul style="list-style-type: none"> • 10 bidders invited to submit outline solutions |
| | 8 October 2013 | ISOS documentation due. <ul style="list-style-type: none"> • original due date 26 August 2013 • further delay occurs (until 9 November 2013) in bidders receiving more detailed information Invitation to submit final solutions (ISFS stage). <ul style="list-style-type: none"> • four suppliers asked to prepare and submit final bids |
| | 28 July 2014 | Closing date for competitive procurement process. <ul style="list-style-type: none"> • three final bids submitted |
| | July–November | Government holds Gateway review on safety, robustness and legal and policy compliance of contract and submitted bids. |
| Tender events | 11 November 2014 | Contract signed between C&P CCG and UCP with a start date of 1 April 2015. Contract value £725.5 million plus £10 million in non-recurrent government transformation funds. |
| | November 2014–April 2015 | Intensive contract amendments and negotiations up until start date. <ul style="list-style-type: none"> • joint discussions in January 2015 based on estimated outturn for 2014/2015 lead to increase in total contract value from £735.5 million to £784 million • contract commences April 2015, at which time more than 30 significant issues are still open |
| Events leading to collapse of UCP | 21 May 2015 | UCP and C&P CCG exchange respective assessments of financial implications. <ul style="list-style-type: none"> • UCP identifies £34.3 million gap in budget (of which £23.2 million is recurring expenditure) • funding gap disputed by C&P CCG |
| | 5 August 2015 | Negotiations on £34.3 million gap continue over summer and culminate in C&P CCG offering UCP £782.5 million plus £11.2 million in non-recurrent transformation funding for 2015/16, bringing total contract value over £793.7 million. |
| | 21 August 2015 | UCP rejects offer on basis that it is insufficient to meet revenue gap. |
| | Late summer | Care Quality Commission (CQC) inspection of CUH leads to change of chief executive in Autumn 2015 and creates instability and change in CUH priorities (see Sections 4.3-4.4). |
| | September 2015 | Actual cost of transferring staff and services from Cambridgeshire Community Services NHS Trust (CCS) calculated by UCP. Negotiations continue throughout September without resolution. C&P CCG informs NHS England of UCP's request for additional funding of £23.4 million for 2015/2016 and £15 million for 2016/2017. |
| Collapse of UCP | 23 November 2015 | Meeting held with NHS England and Monitor. |
| | 27 November 2015 | C&P CCG asks Trusts to provide financial support for remainder of 2015/2016. Trusts reject request on grounds of financial position and legal basis of LLP. |
| | 1–2 December 2015 | Conference calls between UCP, CPFT, CUH, C&P CCG, NHS England and Monitor fail to resolve funding issues or identify any other source of financial support. Termination letter sent from UCP to C&P CCG on grounds of risk of insolvency. |

C&P CCG summarised its intentions for the tendering process thus:

'The CCG has identified that the current model of commissioning services for older people has serious shortcomings including: fragmentation; non-aligned incentives; is a reactive illness service; focusing on the measurement of specific processes rather than outcomes; and, is subject to local issues such as delayed transfers of care, high hospital occupancy and challenges around sharing information.

Accordingly the commissioning of older people's services through integrated service transformation is an opportunity to make significant improvements and to introduce innovative solutions.' C&P CCG PQQ, July 2013

Following extensive consultation with the public and key stakeholders, C&P CCG resolved that a competitive tendering process for OPACS was appropriate. This was partly because it envisaged that engaging a range of providers, including the private sector, could introduce fresh thinking and challenges as well as new expertise and capabilities. Following legal advice, C&P CCG submitted its proposed procurement for approval through the Department of Health's Gateway process. It was assisted by NHS England's Strategic Projects Team (SPT) and legal advisors.

C&P CCG set the contract period as a minimum of five years with the option to extend for a further two. The services covered included all community care for people over the age of 18, acute emergency care for people over the age of 65 and older people's mental health services in the Cambridgeshire and Peterborough area. The costs for these services and the savings potentials were highly uncertain, with some estimates suggesting costs of up to £800 million over five years. C&P CCG set a maximum contract value of £752 million.

It is clear that C&P CCG recognised that the improvements and integration needed for these services were complex and would require an extended period to implement. The longer contract period also allowed for the planned costs savings – linked to better aligned incentives around prevention and community support for older people – to be realised in time. It was the efficiency gain through prevention and community intervention that C&P CCG felt would be attractive for potential bidders.

The competitive procurement process commenced on 3 July 2013 with the publication of a contract notice in the Official Journal of the European Union and Supply2Health. The notice invited expressions of interest from parties wishing to submit a PQQ to deliver integrated care pathways for older people and a range of community services for adults. The targets were parties with an interest in testing their capacities, capabilities, financial standing and eligibility to take part in the procurement process. C&P CCG received and evaluated 12 completed PQQs.

On 9 September 2013, C&P CCG issued a press release announcing that 10 bidders had progressed to the ISOS stage: (1) Albion Care Alliance Community Interest Company, (2) Capita with CCS, Circle and Oxford Health NHS Foundation Trust, (3) Care UK with Lincolnshire Community Health Services NHS Trusts and Norfolk Community Health and Care NHS Trust, (4) CUH and CPFT, (5) Interserve with Central Essex Community Services, (6) North Essex Partnership University NHS Foundation Trust, (7) Northamptonshire Healthcare NHS Foundation Trust, (8) Serco, (9) United Health UK and (10) Virgin Care.

The ISOS documentation was due to be issued to bidders on 26 August 2013 but was delayed until 8 October 2013. There was a further delay in bidders receiving more detailed information as the SPT did not make the 'data room' available to bidders until 9 November 2013. The documentation made it clear that:

'There should be a clear Lead Provider(s) which is accountable for delivery of the defined service scope for older people and adult community services. The Lead Provider(s) may comprise a consortium or other collective arrangement. The Lead Provider(s) must directly provide services for older people and adults requiring community services and they must be capable of coordinating care both at individual patient level and through contracts with provider organisations.'

After evaluating the ISOS submissions, C&P CCG asked four suppliers to prepare and submit final solutions (ISFS stage), with a closing date of 28 July 2014. After one bidder withdrew, the three submitted bids (Care UK with Lincolnshire Community Health Services NHS Trusts and Norfolk Community Health and Care NHS Trust, CPFT and CUH, and Virgin Care) were subjected to evaluation. This evaluation was thorough and included extensive GP engagement in evaluating the proposed service models, clinical quality and care outcomes.

The Government held a Gateway review of whether the contract was safe to proceed and ruled that the procurement was robust and complied with legal and policy requirements.

The contract was signed with the winning bidder – CUH and CPFT – on 11 November 2014. The business case was reviewed by Monitor before approval was given to CPFT to proceed with the contract. The value of the contract was £725.5 million plus £10 million in non-recurrent government transformation funding over five years, with a value in Year 1 of £152.3 million (2015/2016). This value was significantly below C&P CCG's maximum value of £752 million. The contract was heavily caveated with provisions for further adjustment due to information shortfalls, contract values and payments from national tariffs. At this time, there was considerable ongoing negotiation and intense pressure to meet the April 2015 start date. This was driven in large part by the need to give assurance to staff transferring to the new service from CCS and ensure that the anticipated savings could begin to be made.

In particular, there was recognition on both sides that the contract value would need to be amended to take into account the activity outturn for 2014/2015 once the value of this rebasing had been quantified. In January 2015, C&P CCG rebased the UCP's 2015/2016 maximum contract value in light of the estimated outturn for 2014/2015. This led the total contract value to increase from £735.5 million to £784 million, including an increase from £152.3 million to £161 million for 2015/2016.

Many issues were unresolved at the time of contract signing; resolution of these issues was earmarked for the subsequent Mobilisation and Transition Planning arrangements between C&P CCG and the UCP. By April 2015, there were over 30 outstanding items for agreement and clarification, some of which had considerable cost implications – not least the actual cost of transferring staff and services to CPFT from CCS. There was still uncertainty at this time about the exact specification of services to be included in the contract.

On 21 May 2015, the UCP and C&P CCG exchanged assessments of the financial implications of the data received by C&P CCG up to that point. The UCP had uncovered higher costs of the services it was inheriting from CCS as well as costs resulting from the delayed start of the programme. These costs were in excess of the price quoted in the tender. The UCP estimated that for 2015/2016, these costs would be £34.3 million higher than the amount offered by C&P CCG in January 2015 (£161 million). This comprised an additional £23.2 million in recurring expenditure and from non-recoverable VAT as well as costs resulting from higher-than-predicted rates of frailty and illness (acuity), delays in commencing the improvement programme and the final outturn figures for OPACS for 2014/2015. The claim by UCP was based on the calculations displayed in Table 3.

Table 3. Immediate cash shortfall estimation

| £M (nominal) | 2015/2016 | Comment |
|----------------------------|------------------|--|
| Acuity | 6.0 | 5.2% pa (previously 1.5% pa) |
| VAT | 4.9 | Irrecoverable VAT |
| Delays | 9.4 | Lost savings (£8.4M), mobilisation costs (£1M) |
| Technical Adjustments | 2.1 | National Tariff changes etc. |
| Outturn Spend in 2014/2015 | 11.9 | Based on information available |
| | 34.3 | |
| Recurring | 23.2 | |
| Nonrecurring | 11.1 | |

Negotiations on this funding gap continued over the summer and culminated in an offer from C&P CCG on 5 August 2015 of £793.7 million, including £782.5 million in recurrent funding and £11.2 million in non-recurrent transformation funding. This equated to an additional £9.2 million in funding for 2015/2016. The UCP rejected this offer on 21 August 2015 on the basis that it was insufficient to meet the £34.3 million funding gap it had identified. It was acknowledged that £10.9 million of this amount might not in fact arise, leaving a confirmed gap of £23.4 million for 2015/2016 – £8.4 million related to savings delays and £15.2 million in recurrent funding.

In September, the UCP calculated that the actual cost of transferring staff and services including subcontracts with other providers from CCS was £8.2 million higher than C&P CCG's estimate of £61.6 million. Negotiations continued through September without resolution although some issues were clarified including the actual VAT costs following negotiations with HMRC. In an escalation meeting, the chief executives finally agreed that as the financial gap could not be closed, C&P CCG would inform NHS England that the UCP had requested additional funding of £23.4 million for 2015/2016 and £15 million recurrent annually from 2016/2017.

A meeting was held between the UCP, C&P CCG, NHS England and Monitor on 23 November 2015. On 27 November 2015, C&P CCG wrote to the UCP partners requiring them to provide working capital facilities to support the UCP's revenue position and cash flow requirements for the rest of 2015/2016. The Trusts rejected this on the grounds that their financial position could not support a transfer of funds and that this was outside the legal basis of the LLP.

Conference calls between the UCP, CPFT, CUH, C&P CCG, NHS England and Monitor on 1 and 2 December failed to resolve the funding issue or identify other sources of financial support. Following an emergency LLP board meeting, the UCP sent C&P CCG a termination letter on the grounds of risk of insolvency.

4. NARRATIVE

4.1 RATIONALE FOR OPACS

At the time in question, the entire health and care system was facing increased and higher-intensity demand that was not expected to subside and was extremely constrained in terms of resources. For C&P CCG, the issue of increased demand, rapid population growth and resource scarcity was – and still is – particularly acute. C&P CCG predicted that if it did not make changes, it would face a £250 million deficit by 2018/2019. Previous initiatives to improve quality and reduce costs had been inadequate for the scale of the problem, driving the view that dramatic change was needed. As such, C&P CCG embarked on a tendering process for OPACS as a way of significantly altering how innovation, demand and resources were reconciled.

This change would involve recasting service structures and relationships entirely. At its heart was the need to divert care, and particularly care for the elderly, away from expensive hospital treatments towards lower-cost and more integrated care in the community. C&P CCG identified that it could alleviate some of the problems facing the health economy by identifying patients in the community, and particularly those at high risk of hospitalisation, and bringing services closer to them, thus avoiding the need for escalation and crisis response. Integral to this was the belief that quality and patient experience would naturally improve as people were being treated in their community or family setting, maintaining social structures and delivering less disruptive and more integrated care around the person. The view that greater integration could be achieved and more people diverted from acute care by aligning the rewards and costs of services for older people was backed up by evidence from the field and shared by other parties to the tender, including CPFT and CUH.

The tendering process for OPACS was therefore designed with the view of creating one overarching agency that would be able to balance costs in one part of the system with the potential savings of better treatment in another: having one agency to both support older people in the community and bear the cost of their in-hospital care would better align incentives to prevent hospital admissions and avoid lengthy hospital stays.

The agency providing this integrated care model would be required to operate within the C&P CCG budget for these services, including assumptions about future cost improvements. There was, however, considerable uncertainty about the actual operational costs of these services as well as a lack of detailed knowledge about some of the community services involved, which were being packaged together for the first time.

In response to this challenge and to support the commissioning process, C&P CCG compiled evidence on what appeared to be working in other health systems.² In particular, C&P CCG set out to develop a detailed outcomes framework with 33 domains and over 100 outcome measures to measure and shape the new service interventions. It was recognised that this focus on outcomes and the shift in payment systems would deliver more than just ‘tweaking and tinkering at the edges’, as one respondent described it, and would align long-term goals with shorter-term tariffs and payments. It was suggested to us that C&P CCG’s approach reflected the expertise and focus of GP-led commissioning at the time.

² NHS C&P CCG website. Older People’s Programme.

<http://www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm>

4.2 THE TENDER DECISION

Our interviews suggest that prior to the tender decision, local providers, including CPFT and CUH, had discussions with C&P CCG leaders about achieving the desired service integration without the need for competitive tendering. However, C&P CCG rejected such an organic transformation option in favour of a competitive tender, with the inclusion of private sector bidders. This decision had a profound effect on the bid made by CPFT and CUH. The Trusts felt that their need to win was greater as they knew that their operational and financial models would be substantially affected and potentially put at risk, if an external party were to win the OPACS contract.

For CPFT, losing the contract would result in it losing the provision of older people's mental health services – a substantial source of activity and income – and would threaten the Trust's viability in the medium term. CPFT estimated at the time that the reduced cost base would require an extra £6 million in savings. By contrast, winning the bid would *expand* the Trust's budget and cost base – relieving pressure on costs and overheads – and achieve the much-desired expanded community service model. Faced with the possibility of outsourcing to a new provider, CPFT staff and unions were also strongly in favour of a CPFT bid. Given that many hundreds of staff would have been directly affected by this scenario, CPFT felt an additional compulsion to bring forward a bid.

From CUH's perspective, there was recognition that highly fragmented community services were leading to high admission rates for older people as well as a high level of delayed discharges; transfer delays and patient referrals, which were outside CUH's control, were placing particularly severe pressure on beds. As such, CUH was anxious to be involved in shaping community provision such that patients could be cared for in the most appropriate setting, releasing capacity for its elective patients.

As such, there is clear evidence that the competitive tendering process forced the local NHS organisations to consider their own survival first and foremost; winning became an imperative when the alternative would be a weaker organisational position and a narrower service base. In this way, the competitive tender introduced a measure of gaming that was unhelpful in terms of achieving the ultimate objective of better care at a lower cost.

In addition, CPFT and CUH's view was that the local experience of private sector provision had been one of failure, with the NHS being 'left to pick up the pieces'. Being part of the change was therefore seen as the only way of keeping the health economy viable and retaining control over what was evidently seen as the Trusts' service space – 'it was our business', as one respondent described it. There was also a sense from some of the people we spoke to that NHS leaders, who had long careers in the service, were acting on their professional and ethical duty by leading bids on behalf of NHS organisations. These leaders broadly shared the view held by NHS England and C&P CCG that radical change was necessary and saw it as their responsibility to be part of the change process in order to safeguard the local NHS system.

Taken together, these factors led CPFT and CUH not only to feel unable to seriously consider withdrawing from the bidding process but also to offer a price (£726 million) that was significantly below the CCG's maximum – and the amount bid by competing bidders – of £752 million. This low bid value, combined with the significant risk inherent in any major contract to provide a radical, new solution, led CPFT and CUH to emulate private providers in protecting their interests and to enter an LLP arrangement. While this arrangement protected the providers' financial risk – something the providers were legally obliged to do – it left a substantial part of the default risk with C&P CCG, as any contract with a private provider would likely have done.

4.3 URGENCY

A distinctive feature of the UCP contract is the speed at which it was developed and implemented as well as at which the UCP was required to achieve service improvements and cost savings. C&P CCG clearly initiated the contract and its implementation rapidly to reflect the urgency of the financial situation and pressing need to shift demand away from acute hospitals. There may well have been the view that speed would generate the momentum for change that the system required – that a sense of urgency would be productive. This attitude was encouraged by a broader national emphasis on rapid change and had a number of key consequences.

Firstly, it made Year 1 very challenging for the UCP, requiring complex organisational and operational changes within a short time frame: the UCP had to develop its role and authority within the system and develop an understanding of the services it had inherited, staff transfers to the new service had to be completed and services within the scope of the tender, including back office functions such as information technology (IT) and personnel, had to be developed. Delays were inevitable as subcontractors had to be sourced and contracted, operational procedures agreed upon and partnership work developed. As such, the essential complexities of setting up a new organisation significantly affected the UCP's ability to focus on its contractual goal – to make rapid savings through diverting patients to community services.

Secondly, new ways of commissioning and managing services demand a new culture and understanding of new conditions as well as capacity and capability changes, which take time to develop. There is evidence that the culture within the local health economy has shifted since the procurement of OPACS, possibly as a result of the broad involvement and consultation exercises undertaken by C&P CCG and the UCP. For instance, we found widespread understanding of the objectives of the OPACS tender and UCP model as well as recognition that this kind of integration was desirable. Similarly, some of the roles and relationships created by the new care model appear to have begun to work well, despite there being no clear productivity improvements so far. Nonetheless, during its short period of operation, the UCP experienced a great deal of turbulence in the local system that might have been mitigated by having a longer development period.

Thirdly, a number of new services and configurations had to be developed and implemented including joint emergency teams (JETs) and locality teams. The training, operational and inter-agency aspects of these developments were complex and new for the area. Protocols, procedures and resources had to be aligned to make these services effective. While the plan was that staff would be co-located within 18 months, this has still not been achieved. Similarly, agile IT is still being implemented, and configuration, training and care management were still in a state of development 14 months after the UCP contract commenced.

Finally, the UCP was required to begin the process of establishing how it would work with its partner Trusts, its stakeholders and C&P CCG in a system that had not experienced anything remotely similar before. This task seems huge given the state of the health economy and broader national context, where so much was in flux and the risks of instability were great. For example, a CQC inspection of CUH in late summer 2015 created huge instability and a change in priorities for one of the UCP partners. Similarly, at the time of moving together with the UCP, CCS was already in partnership with other organisations and putting together its own bid for the OPACS tender. This competitive situation precluded the possibility of a partnership across existing providers and made it more difficult to assess the costs of integration. External stakeholders found the timescales equally challenging as they were facing challenges of their own. For instance, social care had declined to join the partnership partly because of past experiences with pooled budget arrangements that began in 2004 but collapsed in 2012/2013; this made elected members cautious about entering into new agreements, particularly given the service cuts they were already having to make.

The negative effects of the perceived urgency of the contract negotiations were further amplified by delays in decision-making. It was suggested to us that C&P CCG found it difficult to commit to activity and decision-making at the pace required by the UCP: being accountable to its members (GPs), C&P CCG often needed the endorsement of its membership before confirming key decisions and actions.

Consideration could have been given to a slower timetable and softer launch of the contract, allowing the UCP to deal more effectively with individual elements of its start-up and giving CPFT and CUH more time to deal with pressing operational and financial difficulties. Alternatively – or perhaps simultaneously – a gentler introduction of the UCP's performance and savings targets could have been considered, with results being back-loaded more towards the end of the five-year contract.

4.4 REALISTIC OBJECTIVES AND EXPECTATIONS

The details of the UCP's proposal are included in Appendix B, but the key objectives were thus:

- to deliver a savings programme of £178 million over the life of the contract;
- to reduce spending on acute hospital care by £116 million over the life of the contract;
- to use IT to link hospitals and the community, making care plans and key clinical data available to clinicians to support clinical decision-making;
- to reduce prescribing costs;
- to reduce outpatient attendances in the acute setting;
- to reduce demand for residential and long-term care.

These projections and targets were drawn from the examination of case studies from across the UK, including models from Kingston, North West London, East London and the City and Torbay.

Many of these saving objectives appear extremely difficult to achieve; some were unlikely to have resulted in savings, while others were likely to have involved *higher* costs as the scale and intensity of specialised community services increased. For example, the bid proposed increasing contact with vulnerable older people from 1,200 to 2,400 individuals, effectively doubling the number of people under care management. This move aimed to identify older people whose risk of requiring more intensive services could be reduced through earlier intervention and prevention measures at home. In terms of quality and good practice, this was a sensible and enlightened proposal that would lead to better quality care for the elderly. However, earlier contact with more coordinated services could also result in the discovery of hitherto unmet need or alert patients to new, additional services, resulting in additional demand and higher costs.

The improvements that were envisaged in the flow and allocation of resources to patient care were too focused on NHS interventions alone. Although the model developed by UCP included non-NHS interventions such as the social care element in the JET staffing and about £1 million to be spent for voluntary sector support in neighbourhoods, overall the commission from C&P CCG and the UCP model was predicated on the assumption that costly hospitalisation can be reduced by strengthening community-based health services to provide better rehabilitation after hospitalisation and early intervention at home. This is a good ambition and one that is in line with the choices that older people themselves make about their care. However, while adjusting the NHS treatment pathway may have some impact on the need for hospitalisation, this effect may be marginal compared to the much greater forces that are creating the demand for care in the first place. There is evidence to suggest that wider community support beyond NHS services – developing stronger societal bonds, greater levels of voluntary and self-help

activity and the provision of quality material assets such as good housing, transport and leisure activities – has a long-term impact on health and well-being. While these are long-term policy issues that require the engagement of partners beyond the NHS, none of these levers for cost savings were included in or facilitated by the OPACS procurement. Importantly, the expertise and integration potential of social care services – which have a major impact on healthcare for the elderly – were outside the remit of this contract.

There were also severe financial constraints on the health economy in Cambridgeshire and Peterborough at the time, as evidenced by underfunding compared to acuity and population growth, a financial crisis in acute services and growing deficits across the local health economy. These conditions became worse over the period of the UCP tender. The scale of the financial challenges was something that all respondents commented upon during our review. For CUH, the financial pressures were huge: the winter of 2014/2015 was particularly critical, with demands for elderly care creating contingency beds and delayed discharges. The Trust was declared in financial distress and lost its chief executive in autumn 2015 following a CQC inspection. In addition to reducing its deficit, C&P CCG was required by national legislation to generate 1% savings and was facing a £250-million funding gap for the coming five years.

This crippling financial pressure heavily influenced the thinking of key leaders and managers, firstly by encouraging them to drive the contract forward with almost no regard for the financial risks involved in the hope that drastic improvements could be made and secondly by driving them to terminate the programme so rapidly as there was no financial buffer for funding gaps.

Overall, the cost and service improvements put forward by the UCP were highly ambitious and, given that this was a new service, necessarily speculative. However, as early as January 2014, CUH and CPFT had produced a clear and, as it transpires, highly accurate summary of the risks involved. These included risks associated with insufficient cash flow, the transfer of staff, the inadequate budget for inherited liabilities, the lack of agreement with C&P CCG on financial assumptions, delays in achieving cost savings and the capital costs of the IT system. In terms of financial risk, the tender documentation and evaluation made it clear that the provider 'should not assume any additional funding from the CCG over and above the budget' and C&P CCG appeared to expect the UCP to manage the costs and transfers of services in line with its role as a prime contractor. In light of this, it is unsurprising that the UCP was established as an LLP, insuring the Trusts against a highly likely downside.

4.5 UNCERTAINTIES AND RENEGOTIATION

When the contract was signed, it was heavily caveated with complex and unresolved financial conditions. In this case, there was an expectation that the full costs and execution of these services would be derived over time. This may be explained in part by the shift in contracting and commissioning processes when the CCGs were created. Prior to this, NHS contracts had been based largely on historical calculations of costs for entire services, with payments made to providers for large blocks of care. Under the CCG regime, the new procurement process for OPACS, which was based on outcomes and payments for performance, required an entirely different level of specificity and detail that had not been experienced before.

After the contract was signed, a number of changes were made to the scope of the services included in the package and further details of existing services emerged that required new subcontracts. For instance, changes made after the fact made the UCP responsible for a contract with Cambridge Nursing Centre amounting to £1.1 million a year as well as for £330,000 in annual payments to GP practices to support community care. These changes make it apparent that the contract specification was incomplete at the time of signing. Moreover, given the complexity of community services, and particularly the details of

subcontracts with the third sector and specialist providers, it is questionable whether a reasonably complete specification could have been achieved at that time.

A number of risks are inherent in such uncertainty, and a fundamental problem in this case was that the parties did not know enough at the contract stage to specify the costs of providing the services. Nonetheless, there was a general expectation that the full costs and execution of these services would be derived over time. Having accepted the tender on the basis of the caveats, it is unsurprising that the UCP expected to negotiate with C&P CCG further about the contract content and price; it appeared that the UCP wanted to achieve a fully accurate costing in Year 1 and expected to engage in continued negotiations on these issues. On the other hand, while C&P CCG recognised the contract uncertainty, it failed to cost in any headroom for these factors.

When contracts are incomplete, renegotiation is inevitable and such renegotiation tends to hold up speedy execution; the contract then falls behind schedule and a vicious cycle ensues. In this case, there is little evidence to suggest that the renegotiations that took place during 2015 were close to resolving the underlying financial risks in the contract: the prevalent approach focused on short-term mitigation rather than a fundamental resolution of the problems. For instance, the £34.3 million funding gap for 2015/2016 identified by the UCP on 21 May had been reduced to £23.4 million; however, it remained the case that even if the UCP had been supported through its cash flow crisis over October–December 2015, it is clear that this would have had no effect on the financial gaps that would likely have emerged in 2016/2017 and beyond.

There are examples of successful partnering in the context of incomplete contracts in other industries from which the NHS could and should learn. One notable example is the £4.3 billion construction of Heathrow's Terminal 5.³ The fundamental factor that drives the successful execution of incomplete contracts is a culture of trust that allows difficulties to be resolved collaboratively and fairly if and when they arise. The development of a genuine, trust-based working relationship between C&P CCG and the UCP partners could have fundamentally altered the contract's chances of success. Without it, the uncertainty around the contract made it impossible to succeed.

4.6 THE ROLE OF THE UCP

At the national level, there are examples of one organisation taking on an overarching role in arranging and planning services, and a range of different models for this have emerged, including prime contractor arrangements, lead providers and accountable provider roles as well as commissioning and arranging through prime integrator models.

The creation of the UCP resulted in one organisation charged with overseeing and delivering integrated services for adults and older people. However, it was not clear what the exact purpose of the UCP was, and there is evidence that different partners saw its role differently. Our interviews with key leaders and a review of the documentation show there was an apparent lack of clarity about the place of the UCP in the local system. For some, and particularly for the staff employed directly within the UCP, there was the view that the UCP should have played a lead role in service integration and system reconfiguration, driving other organisations and services into alignment and leading and challenging reform.

At the same time, C&P CCG, CPFT and CUH appear to have had different and more limited expectations. For C&P CCG, there was the apparent expectation that the UCP would primarily

³ Procurement of Heathrow T5. http://www.designingbuildings.co.uk/wiki/Procurement_of_Heathrow_T5

be a lead provider, responsible for the operational delivery of the clinical outcomes set out in the tendering process within the block budget agreed. C&P CCG did not seem to regard the UCP as a commissioner and retained its existing staff and budget for commissioning adults and older people's services, estimated to account for 20% of its overheads. This created a situation where there was some doubling up and caused frustration for UCP staff, who wanted discussions with providers to take place primarily through the UCP. For CPFT and CUH, the UCP was primarily a vehicle for transacting with C&P CCG and for transferring funds for service delivery. In this context, establishing the UCP as an LLP was a pragmatic way of containing the risks associated with the contract.

One respondent described what they saw as a flat refusal to change the old architecture of the system after the UCP had been established: monitoring meetings and relationships between providers and C&P CCG remained in place, by-passing the role the UCP saw for itself. This is not surprising as C&P CCG remained responsible for its commissions and their performance and the Trusts were still accountable to their boards and regulators. For the UCP to function – and in the absence of a large degree of trust between parties – some rationalisation of these management and governance arrangements would have been necessary.

We are left with the view that the UCP was something of a paper tiger: owned by the Trusts as an LLP, it was principally a mechanism for reducing and isolating risk. For C&P CCG, the UCP was a convenient vehicle for reducing transactional complexity. Overall, the UCP had little leverage: it was not empowered to make a difference by either the Trusts – for whom the LLP was principally a risk-reducing vehicle for handling the contract – or C&P CCG, who failed to transfer the resources or authority needed to enable it to take up system leadership and a transformational role. While this may have suited local organisations tactically, it was a major flaw in the specification, procurement and contract negotiations.

4.7 COMMUNICATION, CONSULTATION AND GOVERNANCE

There is plenty of evidence that C&P CCG and the delivery partners made strenuous efforts in terms of consultation. Similarly, the UCP, CUH and CPFT involved their members and the Council of Governors in proposals as they developed. Board members appear to have been well briefed and engaged in both the bid process and shaping the services. In particular, the consequences for CPFT in terms of risk appear to have been well understood by the board and governors; this was significantly aided by confidential briefings and a high degree of engagement with Monitor as the contract constituted a significant transaction for the Trust. The general public and trade unions were engaged at a number of points in the process, and while the nature and scale of the contract clearly worried some participants, the consultations did not generally reveal any concerted opposition to the procurement and development of the UCP. In addition to holding briefing meetings for staff and stakeholders, the UCP itself published 15 bulletins between December 2014 and November 2015, and the engagement and involvement activities undertaken by C&P CCG and the UCP were given high priority and appear to have been effective.

Overall, we are impressed with the efforts made by C&P CCG and the Trusts to engage the public and ensure proper governance and accountability. However, two issues stand out.

Firstly, the degree of public engagement in tendering for and establishing the UCP was not matched by the same engagement at its closure. The risk of insolvency of the UCP in December 2015 required rapid action by the partners, and a sequence of decisions and communications had to be delivered urgently. However, we are struck that there was not an attempt to gauge public support for the continuation of the UCP as part of a rescue strategy. As a public service provider, the UCP was accountable to the public, and consultation on the

future of the organisation would have simply been good governance. There is also the risk that the public will become jaded by NHS calls for engagement when it is used to support major change or legitimate a new service but overlooked when major decisions have to be made at the system level to rescue failing transformation attempts.

Secondly, in our discussions we became aware that while board members reported high levels of engagement and information and being engaged fully at key moments in the process, there was a sense of dissatisfaction and unease; some governors reported finding the whole business deeply uncomfortable. This appears to stem from the sheer complexity of the contract and the feeling that the process itself had put the governors in a difficult position.

As a consequence, we have to question whether traditional governance and board processes were adequate for such a complex, large-scale development or the rapid pace of its execution. The nature of board reporting, with officers presenting material for approval, limited time for debate and chairs needing to achieve a resolution, made it difficult for concerns to be formulated and aired and forward plans to be revised. Added to this were the numerous unknowns and need to access external advice and support – something that the governors may have benefitted from at the time.

It may be helpful in cases such as these to introduce key break points in the governance process, akin to the Gateway process, at which governors can pause, undertake a fundamental appraisal (or reappraisal), seek alternative input from outside the routine governance model and generally form a more detached view of the risks and whether or not to proceed. Acknowledgement of these shortcomings and a more customised governance process may not have altered the UCP outcome but would have provided a higher level of governance quality and confidence.

4.8 COMPETITION AND TRUST

It has been interesting for us to note the impact that competitive tendering has had on relationships and behaviours across the healthcare system. It has generated more rigid and demarcated organisational silos and attitudes towards risk. The protracted and legalised context of competitive tendering has also had a paralysing effect, creating prolonged uncertainty for staff and making it more difficult to invest or innovate in joint working. Overall, organisations have become more conscious and careful when it comes to resource management, the risk of legal challenges from other competitors and commercial confidentiality.

Under competitive tendering, organisational protectiveness and self-interest – not factors normally associated with the healthcare sector in the UK – have become paramount. For C&P CCG, organisational protectiveness manifested as anxiety to ensure that the resources absorbed by the tendering process and letting of the tender did not add to the financial challenges it already faced. For CCS, it meant attempting to safeguard the viability of the organisation through the transition process. For CPFT and CUH, it meant ensuring that they, as public providers, were not asked to provide more resources than those stated in the contract, which was to their overall detriment.

Competitive tendering has brought about a shift in local health systems from partnerships to clearly delineated commissioner–provider relationships, with resultant restrictions on the flow of key information. For example, we were told that C&P CCG had never seen the UCP business plan developed for Monitor, despite having made a number of requests to do so. Similar issues were highlighted with a joint bid for the OPACS contract by Capita and CCS, many of whose staff and resources would be transferred to CPFT under the new model. In the UCP case, competition created additional delays in implementation since the details of staffing

costs, timescales and so on could not be provided until after the contract was signed, but at the same time, signing could not take place until the costs were understood.

There is evidence to suggest that the tendering process reduced trust, transparency and the sharing of intelligence. Some of this was the result of legal and regulatory restrictions. More specifically, the legal advice and NHS England rules around competitive tendering seriously reduced the scope for flexibility – particularly for C&P CCG. However, at the same time, we would suggest that this lack of flexibility also stemmed from the style of the tendering process itself, the prevailing culture and players' conceptions about how tendering and competition works. As was said to us on more than one occasion, would a successful private sector bidder have been willing to subsidise the contract by putting its own resources into the operating costs? What is significant about such comparisons is that the 'private sector approach' may have entered into the thinking of NHS providers as a result of engaging in a competitive process.

As questions of trust and transparency became more apparent within the local system, players tended to second-guess others' intentions rather than maintain an open dialogue. For instance, there was a view among the UCP partners that C&P CCG hoped to hold back resources from the contract in order to fund services elsewhere; in reality, C&P CCG was facing a growing deficit. Similarly, the UCP thought that CCS was holding back resources from the transfer arrangement, while others thought that the UCP could have been funded by CUH and CPFT, even though the Trusts' financial positions were deteriorating. This misreading of partners' intentions and capabilities proved disastrous for the contract and subsequent renegotiation process.

We do not mean to suggest here that decision-makers were being unreasonable – quite the reverse is apparent. It is the responsibility of directors, boards and governors to safeguard the assets and resources of their organisations and to provide fair employment and protection for their staff and quality care and treatment for their patients – and this is what they did. Instead, what we noted was that the organisations had become more acutely aware of their boundaries and more concerned with delivering narrower governance priorities to meet their own responsibilities.

This meant that at crucial times – such as when trying to discover the true cost of Transfer of Undertakings (Protection of Employment) Regulations (TUPE) services from CCS or to find ways of covering the operating deficit – there was a tendency to mask activities and decision-making to protect organisational interests. It could be argued that the competitive process and clearer (or rigid) boundaries that emerged from the contracting process made decision-makers more acutely aware of the inherent risks. However, this came at the cost of reduced sharing and balancing of risks across the system. There was a clear sense that the notion of all being part of one NHS service had diminished and been replaced by a greater focus on separate organisational responsibilities.

4.9 REGULATION

The fragmented nature of the healthcare system means that chief executives and board members are primarily responsible for their respective organisations' financial health and quality of provision. Chief executives need to ensure that they deliver the financial and performance goals set out by their respective regulators. It was said to us on a number of occasions and by different players in the system that these factors heavily hamper integration and joint working. While chief executives may want to commit to collective system change in local partnership or commissioning meetings, this is hard to implement back in the operational and regulatory environments of their Trusts.

The role of regulatory bodies in the commissioning, procurement and operation of the UCP was prominent and significant but not generally positive. We have mentioned that in the system operating at the time there was no regulatory oversight or developmental support for service integration of the kind being pursued by C&P CCG and the UCP. Instead, each element of the local system was regulated separately and had distinct performance and quality criteria to meet. To make matters worse, the regulatory regime focused on the viability and financial health of foundation Trusts, NHS Trusts and CCGs individually. There was no possibility of managing and allocating the considerable risks associated with fundamental system change within such a fragmented regulatory infrastructure.

This fragmented regime further entrenched the narrow organisational focus introduced by the competitive tendering process. Ensuring that their regulators were satisfied and that the procurement process or delivery contract met with their approval were the organisations' primary concerns. For boards and chief executives, this was because an unfavourable or unsupportive response from a regulator could provoke an existential crisis for their organisation. This was overlaid with heightened concerns among provider Trusts about commercial confidentiality and, for C&P CCG, the possibility of a legal challenge on the basis of unfair procurement and contracting practices. A good example is that C&P CCG maintains that it never saw the business case for UCP developed by the partnership and submitted as part of due diligence by CPFT to Monitor. It seems incredible to us that the commissioner would not have access to the detailed evidence and plans for cash flow, risk handling and income generation for the prime contractor to whom it was paying considerable sums for the delivery of a contract. This, however, is the inescapable logic of a competitive process and fragmented regulatory environment. In short, we have a system where each component organisation can pass its individual regulatory and governance tests but an integration project of considerable significance is very likely to fail.

There is also evidence to suggest that even the regulators' internal processes were not up to the task of evaluating programmes such as the UCP. For instance, Monitor's regulatory oversight of CPFT and the UCP used its existing mergers and acquisitions framework, which was the closest evaluation framework that was available. Monitor's primary concerns were the risks and costs of CPFT absorbing new services and the risks associated with the LLP. There is no evidence to suggest that a commensurate effort was made to understand the risks inherent in the integration effort itself. As a change and integration vehicle within the wider health economy, the UCP had a role that was beyond the capacity and competency of the mergers and acquisitions framework.

Finally, it is clear that the involvement of regulators slowed the entire process down and added to delays and costs: approval for CPFT to enter into the UCP process was finally given by Monitor on 31 March 2015 for a contract that was due to start on 1 April 2015.

5. ANALYSIS

In this section, we return to the three key themes and eight questions posed at the start of the inquiry.

5.1 COMPETITIVE TENDERING AND RISK SHARING

T1. Could the partners have done anything differently during contract negotiations to prevent its failure?

Even with the benefit of hindsight, it is difficult to identify anything of substance that could have been done differently once the tender process had begun. The competitive procurement was bound by the rules set out by NHS England, the Department of Health and the Government, and this procurement adopted a particularly tight approach to agreeing contracts and services. One of the consequences of private sector involvement is that public sector providers adopt a similar approach to private providers to make themselves more competitive. In this case, this approach led to a focus on the risks and benefits to each organisation rather than on emphasising common goals and the efficient and fair sharing of system-wide risks and benefits. Given the substantial nature of the transaction, CPFT was under particular pressure to ensure that the partnership and contract arrangements kept its own financial survival separate from the fate of the UCP. The C&P CCG procurement demanded the creation of one umbrella body where there had been more than one organisation in partnership. This, combined with the internal pressure on CPFT and CUH to limit the financial risks to their organisations, led to the formation of the LLP.

It is possible that a concerted push by the provider organisations *prior* to the competitive tendering decision being made might have persuaded C&P CCG to develop a more organic, local solution and developmental approach to OPACS. Although the chief executives and chairs of the Trusts approached senior figures in C&P CCG to halt the tendering process before it began, we believe that even more could have been done to this effect. A focused attempt to develop a different strategy might have removed the need for the competitive tendering process altogether or adapted it into a more incremental model. The complexity of the changes proposed by the UCP for OPACS, including transferring staff, establishing new services and building new IT systems, was such that a slower pace of implementation and incremental approach would have been realistic and advantageous. Using their provider expertise and strong positions in the local health economy, CPFT and CUH should have argued more strongly for a phased implementation of the changes.

We acknowledge that the pressure on C&P CCG and national policy emphasis on competitive procurement and radical system change at the time would have made this a difficult argument to win. In addition, a vigorous response by providers always risks alienating commissioners and undermining trust, particularly in a competitive environment. Given the commissioning atmosphere, the providers were clearly conscious of these risks. The financial pressure on the local health system and their own organisations also meant that CUH and CPFT had a shared interest in making rapid progress: a slower, less risky strategy was unlikely to find much support among the partners. Nevertheless, this would have been a more sustainable alternative.

The partners should have acknowledged that although the programme they put together contained innovative, promising and tested modules, there was no credible evidence that these elements would work effectively when put together in the local system, especially on the scale proposed. It was evident that configuring the range of measures proposed for the local context would be challenging, even in the best of conditions. It also became clear early on that the financial details of the contract were insufficiently clear. Therefore, an alternative strategy

would have been to withdraw from the tender when it became clear that the timescale, detail and clarity of the procurement process were problematic. The prevailing view, however, was that NHS providers had an obligation to bid. In fact, CPFT (and to a lesser extent CUH) saw its business model being threatened if an external party, and specifically a private provider, were to win this contract; thus, winning became a matter of survival. We have not found any evidence that the underlying assumption that CPFT and CUH had to win this contract was seriously challenged at any point. Competing against other bidders for whom the contract was only 'nice to have' led to underpricing from the start – something that the contract parties never recovered from.

In terms of the way risk was handled throughout the tender process, the scale of the realistically achievable savings and costs of delivering the care model were highly uncertain at the time of negotiation. C&P CCG effectively insured itself against this risk by incorporating savings targets in the contract value, without properly analysing whether these targets were realistic. The winning bidder was therefore left with the considerable downside risks of lower-than-expected savings and higher-than-expected costs, which were not balanced by the potential of upside benefits beyond the agreed contract value. From a risk-sharing perspective, this was a one-sided contract framework.

In managing the substantial operational and financial risks, the UCP did not have access to two basic tools. First, the size of the contract and significant interdependencies between the various operational projects meant that the UCP and its partners were not able to diversify the risk across independent activities. Second, while incorporating flexible response mechanisms that allowed the UCP to respond if and when downside risks materialised would be the natural risk management approach for such a large-scale, undiversified project, this strategy was not pursued; in fact, it is difficult to see how it could have been pursued within the tight procurement regime and under competitive pressure from other bidders, with an emphasis on maximising the notional savings incorporated in the contract value. This left the UCP partners with the least desirable risk management option: to respond to C&P CCG's insurance mindset in kind by limiting their own liability through an LLP and returning the risk of failure to C&P CCG. This made the collapse of the contract more likely as it limited the UCP's headroom for continuation. It is not clear whether it would have been possible to negotiate a more mature risk management strategy as the transfer of risk was at the heart of the rationale for procurement. However, a procurement process with a greater level of shared responsibility and risk embedded and a contract that included explicit flexible response mechanisms might have provided the basis for a more sustainable programme of improvement. The partners should have pushed harder for such an agreement.

T1(a) Should or could the Trusts have put money into the UCP up front to enable its survival?

Given the complexity of procurement and development, major projects such as the OPACS programme normally include the provision of substantial contingency funds to enable effective risk response; however, C&P CCG did not require this provision contractually. In addition, none of the organisations in the local system had the resources to underwrite such a fund. If the contract had been constructed differently, with a greater risk-sharing element, it might have been possible for the commissioners and providers to create a joint contingency fund. However, given the tight financial position of all partners, this would have been very difficult to achieve and the involvement of NHS England would have been necessary.

T1(b) Should parent boards have owned the UCP debt?

The debt faced by the UCP was principally the gap between the amended price offered in the tender and the costs of the services inherited as part of the OPACS programme. C&P CCG's position was that the partners should have borne and managed this debt. The discussions about closing the funding gap, which foundered without reaching agreement, were concerned with the shortfall in operational funding in Year 1. However, there was also the question of an ongoing deficit of £15.2 million for the following years of the contract. The UCP's parent boards sought assurance that the gap for 2015/2016 and any subsequent years could have been bridged through further efficiencies, system rationalisation and performance rewards.

The funding gap had two fundamental sources: (i) the competitive environment had led the UCP's bid price to be too low; and (ii) the cost of services was highly uncertain at the time of contracting. It could be argued that the UCP partners should own the debt arising from bidding too low. However, we could also argue that C&P CCG should own the debt that arose from a lack of information about the cost of service provision prior to contracting. The problem is that the relative magnitudes of the two factors are difficult to identify.

The partners opted for the LLP model precisely to protect their core services from the well-acknowledged risks associated with the UCP. Shouldering the UCP debt would have had an adverse effect on CPFT's and CUH's core services; for CPFT in particular, this could have depressed the development of mental health services and had a significant impact on users and carers.

At the same time, the Trusts' regulators needed assurance that the strategy of owning the UCP shortfall from the outset was sound and would have been repayable later. It is unlikely that Monitor would have supported this position given the longer-term shortfall and overall financial position of the Trusts; the financial climate for CUH worsened significantly during 2015, and CPFT was facing pressure to identify efficiency savings in the longer term. Realistically, it was highly unlikely that the parent boards would have been able to subsidise the UCP in Year 1, and this would have done little to resolve the longer-term structural debt inherited with OPACS.

T1(c) Why was a parent company guarantee for the LLP not put in place?

There has been much comment in our enquiry and in reports by other bodies about the nature of the LLP created by CUH and CPFT and, in particular, whether the parent organisations should have provided additional financial guarantees for the UCP. This was a particular focus of the internal audit report, which suggested that C&P CCG should have conducted a further assessment of the UCP tender when the LLP proposal first became known.

While it has been suggested that the LLP arrangement was made relatively late in the contracting process, the evidence we have seen suggests that CPFT and CUH made their intention to create an LLP clear in the competitive dialogue process in October 2013. Furthermore, the Trusts were never required to provide a parent company guarantee during the contracting process nor were they required to commit to put additional funds into the operation of the service. Indeed, had that have been so, it is unlikely that Monitor would support CPFT proceeding with the contract because of the risk that this would have caused for the Trust.

The Trusts took extensive legal advice about the impact of creating an LLP and its usefulness in limiting liabilities for the parent bodies. CPFT and CUH were clear that they would be happy to provide short-term capital to ensure the UCP had the cash flow to operate but that the LLP existed specifically to limit their exposure to ongoing deficits in operational funding. When it became clear to the directors that the UCP was at the risk of insolvency, the legal advice was

that it was their duty to act primarily in the interests of the LLP's creditors. In this context, C&P CCG's suggestion on 27 November 2015 that CPFT and CUH provide working capital to support the UCP's cash flow for 2015/2016 merely brought this risk into sharper focus.

In our view, creating the LLP was a sensible move to isolate the problems associated with the UCP from the Trusts' wider service responsibilities. The competitive procurement process and involvement of private sector organisations changed the terms of engagement for all partners. In this new environment, it would have been highly unlikely that a private company would have committed its own resources to the contract over and above the contract value. This view became dominant among public sector bidders, who consequently felt that it was legitimate to limit their financial exposure to the headline values in the contract.

T2. Did the commissioners raise specific concerns about how the negotiations and contract process were carried out?

In some of our interviews it was intimated that the contract negotiations and subsequent mobilisation discussions were a source of conflict between the UCP and the commissioners. These negotiations were weighty and highly significant: a great deal of money, reputations and organisational viability were at stake. In addition, a measure of frustration was generated by a difference in views about the nature of the contract and whether further negotiation after the contract had been signed was normal and to be expected or went beyond what was reasonable. Such frustrations hindered stakeholders' ability to start building a culture of partnership with well-defined roles and responsibilities early on, and this later contributed to the collapse of the partnership. Finally, the ambiguity surrounding the UCP's purpose in the health economy and its role as integrator, commissioner and provider remained unresolved.

T2(a) Were the overheads for the UCP higher than expected?

As we have seen, the operating costs for the inherited OPACS were significantly higher than the tender price. The operating overheads for the UCP itself, however, were low, at around 1% of operating costs, and did not significantly impinge on the UCP's operational deficit: the UCP was designed to be a lean organisation.

There were, however, increased costs for the health system as the UCP took on some of the system improvement and service monitoring and management work that was also the province of C&P CCG. This created a measure of double up and was a further source of dispute between C&P CCG and the UCP. A difference in views about the role of the UCP, which could have been clarified during the mobilisation discussions, was once again at the heart of this dispute. To avoid this double cost to the system C&P CCG would have needed to devolve responsibility for contract monitoring and system improvement and transfer costs and resources to the UCP – a course of action that would have constrained its responsibility for system oversight and affected its capabilities, exposing it even more to the risk of UCP failure. Conversely, the UCP could have relinquished its system improvement role. This would have removed the impetus for improvement and placed the key cost and efficiency gains of pathway reform outside the UCP's control, increasing the risk for the UCP and its parent Trusts.

An alternative could have been a joint approach to system improvement that required a collaborative effort between C&P CCG and the UCP and an understanding by CPFT, CUH and other providers in the system. All in all, this would have required a level of trust and sharing that was not present at that time.

Resolving this duplication of expertise and resources would have been essential if the UCP contract had continued. The position of the UCP as neither solely a commissioner nor a provider but a hybrid organisation focused on system improvement proved to be a challenge for the NHS and the rigid purchaser–provider split that operated at the time. Wider and more

sustained negotiation and consultation about this role would have been necessary for a shared understanding to emerge.

T2(b) Was C&P CCG concerned about performance issues in relation to service delivery?

In our review we found no evidence that C&P CCG was concerned about service outputs and outcomes. Indeed, given the early development of the contract and relatively limited amount of outcome data available, any concrete observations about service performance would have been premature. Performance and reward estimations were largely based on the outcome measures developed by C&P CCG, but these were not sufficiently flexible or fine-tuned to support definitive in-year contract performance assessment in Year 1. There were some indications that the UCP services were starting to have an effect on patient pathways and prevention. For instance, by July 2015, the UCP was reporting a reduction in expected emergency bed days for people over the age of 65 of 9.7%. However, with the limited available data it is difficult to ascertain whether this reduction was due to UCP interventions, and other indicators showed increases in incidents and demand. In any case, it would have been too early to make robust inferences about significant performance trends.

Nonetheless, the documentation and interviews showed that there were contextual concerns. The continued disputes over costs and contract values appear to have been a distraction from service outcomes and outputs and weakened the signals in the system around admission avoidance and integration. During contract negotiation and mobilisation there were a succession of delays and barriers to implementation that slowed the development of the UCP and the delivery of service outputs against targets. Some of these barriers were imposed on the local system through the interventions and assurance processes of the Government and regulators. Others were a consequence of the complexity of the tender and mobilisation negotiations. However, delays in implementation and the necessarily slow start to new service provision and configurations of staff and processes built into C&P CCG's concerns. The expertise of the UCP partners in service development and organisational change could potentially have been used more forcibly during the start-up period to build a more grounded understanding with commissioners about what was realistically achievable in Year 1.

T2(c) Was there a conflict of interest in the cross-membership of the Trusts' and the UCP's boards, and if so, were the arrangements for managing this conflict adequate?

The board of the LLP was established in April 2015. It was comprised of two non-executive directors (chair, CUH, and deputy chair, CPFT), a chief executive officer (CPFT), a director of service integration (CPFT), a director of finance (CUH) and a chief operating officer (CUH). Board meetings were attended by the UCP chair, chief executive and finance director, and there were subcommittees for audit, business and performance as well as a clinical advisory committee. The terms of reference for the LLP board are listed in Table 4.

Table 4. Terms of reference for LLP board

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1. To ensure that the UCP has an effective executive management team in place with a clear mandate to deliver the UCP objectives, including an overseeing strategy, vision, mission and values.
 2. To ensure that there are robust and appropriate governance, financial strategy and risk management arrangements in place.
 3. To provide approval and sign off for service-level agreements.
 4. To provide high-level performance reviews in relation to the contract and the delivery of the services.
 5. To provide guidance, remove blockages, assist with significant issue resolution and to support the UCP executive team in delivering the UCP contract.
 6. To work collaboratively and to present a corporate approach across the health and social care system in Cambridgeshire and Peterborough, resolving disputes between members as appropriate.
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During the UCP's operation, it is not apparent that any conflicts of interest arose. The focus of the board at this time was on mobilising UCP services, developing contracts and the ongoing negotiations with C&P CCG on budget and funding. However, it is likely that conflicts of interest would have emerged between the UCP and CUH and CPFT, particularly as the UCP assumed greater responsibility for performance and service development and took up its role in the health economy more fully. In time, this conflict may have compromised the UCP's role as an integrator. However, this could have been balanced by bringing together the mutual interest of the UCP, CUH and CPFT in service improvement.

Board membership was confined to UCP, CUH and CPFT executives. This is a narrow base for an organization with a complex integration remit. Although a number of discussions took place about enlarging the board to include other provider partners and social care early on, financial and clinical governance issues of potential partners limited UCP's ability to do so. The intention was to revisit this issue once the contract was let and running. Indeed, we would expect some measure of independent and external representation to be built into such a board's membership. The opportunity to develop links at board level with the wider health economy and with citizens and patients would have strengthened the UCP's governance and potentially broadened its capacity to develop strategies to address the problems it faced. In time, the relationship between the governance of the UCP and that of CPFT and CUH would have needed clearer resolution.

5.2 PARTNERING AND COLLABORATION DURING CONTRACT EXECUTION

P1. What were the roles of CPFT and CUH? Could the Trusts have been more proactive in developing, implementing and supporting the contract, especially given that it was one of the NHS pioneers programmes?

We have highlighted the difficulties faced by CPFT and CUH in negotiating this contract and how it would have been unrealistic to expect the parties to act any differently to private bidders in the procurement process.

In our opinion, the question whether CUH, CPFT and the UCP could have done more to mobilise other stakeholders and users to support the OPACS transformation from an earlier stage remains open. It would have been difficult for them to step outside the tight constraints of the tender and contracting process; their capacity to do so was also limited as the intense and heavy workload associated with establishing the UCP was consuming so much of staff

members' time and energy. In addition, the lack of a formal relationship between the UCP partners and NHS England made direct communication between these parties impossible. Instead the partners had to rely on third party communication with NHS England (via Monitor and C&P CCG) making communication ineffective and slow. While it would have been desirable for the UCP partners to collaborate with C&P CCG in bringing NHS England and other stakeholders further into the integration programme, it is difficult to ascertain whether this would have been feasible or effective.

As we note in our narrative, some interviewees expressed the view that the UCP and its potential as an innovator lacked powerful and truly committed advocates. When difficulties emerged with the contract and operational deficit, it was easier to let the contract fold than to continue the battle into years two and beyond.

P2. Once the funding gap had been identified, what more could have been done to ensure the continuation of the contract or was termination inevitable?

Evidence suggests that the contract was insufficiently funded and that the OPACS programme was loaded onto a local system that was in serious financial distress. This lack of funding made reactive risk management extremely difficult. Groundbreaking programmes such as the UCP generally face a great number of systemic and cultural challenges and are likely to uncover serious financial and cost issues. In the wider commercial environment, organisations often handle short interruptions to income and expenditure by drawing on emergency funds. It is our opinion that transformations with the scale and complexity of OPACS – or indeed any NHS pioneers programme project – would benefit from access to transitional emergency funds set aside by NHS England, over and above the generic transformation funding that is available to the whole system. Such national contingency funding would also help overcome the impediments and governance requirements naturally faced by lone organisations.

At the time of termination, there were no alternatives left to the partners. The contract negotiations and pressure to deliver improvements in admission figures had taken the organisations involved as far as they could go. There was a strong sense that managers and leaders – commissioners and providers – were fenced in and that there were no options other than closure. We believe that, started earlier, a more engaged and collaborative approach to risk management could have provided a wider range of possible futures for the UCP. More focus on a representative set of scenarios for the development of OPACS could have provided a clearer picture of 'what if' alternatives. As we have noted, this would have required a level of partnership and collaboration as well as accurate data and information that was not available at the time.

As this contract was the biggest NHS procurement of its type to date and followed earlier procurement failures in the local health system, we feel that NHS England, as the ultimate parent organization, should have been more closely involved in this transformation programme. NHS England was made aware of the financial problems in September 2015, three months after the first signs of financial trouble had emerged. Had NHS England been more closely involved, alternative short- and long-term solutions, including necessary funds to keep the programme going, could have been generated. Importantly, NHS England could have played a key role in improving relationships and trust between the parties by reminding them of their social obligation to find workable solutions for the healthcare system as a whole.

P3. Was there any guidance or commercial advice not identified by the UCP or its partners that could have enhanced the ability of the new organisation to deliver a complex health contract?

We have highlighted a number of ways in which changes to the contracting and design of the UCP could have assisted with its survival and success. Similarly, the provision of emergency or contingency funding might have helped smooth out the cash flow problems during start-up and provided more support in the difficult first year of operation. We have also suggested that sharing risk, as well as data and information that could help with the assessment of specific risks, could have provided a fairer basis for development and created incentives for problem resolution and successful development across the purchaser-provider divide. As it stood, the contract largely insulated C&P CCG against financial risk up until the point when the contract failed, after which the LLP protected the partner Trusts from the risk of continuing with a loss-making operation.

A key lesson that can be drawn from commercial enterprises and public and private experiences of integration nationally and internationally is that major projects of this kind should be viewed as long-term joint endeavours. Evidence suggests that the cultural changes, organisational development and personal relationships that underpin successful integration often take 10 years or more to deliver high-quality outcomes.

Without robust and timely data, system integration efforts are 'shots in the dark' and it is impossible to identify what needs to change and to develop and evaluate new processes, leveraging innovation and enterprise. High-quality data is crucial for developing a shared view of systems and where they can and should be improved; it is what replaces anecdotes with evidence. The integration of complex services therefore requires the development of infrastructure that can support collaboration and help develop shared analysis and objectives, and the integration of information systems and development of accurate and focused data on integration are significant, long-term projects. Without reliable data for measuring costs and desired outcomes, integrated care cannot be managed.

This aspect should have been given much more emphasis at the start of the procurement process. While the UCP contract included some elements for the development of this scaffolding – and particularly the development of a shared IT platform and some organisational and leadership development work – the timeframes for these developments were unclear. Overall, more could have been done to build the conditions for integration before service provision began; for example, by establishing an initial workable, integrated IT infrastructure for a suitable subpopulation before the contract commenced.

Finally, we feel that more could have been done to develop formal governance by broadening the base of the UCP's board, potentially including a clearer distinction between the organisational and operational governance of the UCP and the legal and financial responsibilities of the LLP. At the same time, the UCP would have benefited from formally developing a wider consultation and engagement governance structure to allow it to draw on the expertise and opinions of wider stakeholders in relation to OPACS, particularly in terms of primary care and social services. The difficulty for UCP was that a large set of stakeholders were introduced during the initial implementation phase to monitor the contract, which hampered the engagement on the model; a slower timetable that gave CPFT and CUH more time to deal with pressing operational and financial difficulties rather than focussing on performance and savings targets could have improved the engagement.

5.3 COST AND SALVAGING CREATED VALUE

We were tasked with responding to the following three questions:

C1. Were the losses to the health economy greater than the cost of keeping the contract going? If so, why, and could the Trusts have prevented this?

C2. What were the wasted costs for CPFT?

C3. What could be done to build on the apparent initial successes of the UCP and keep the integration benefits in terms of better care at a lower cost?

We consider these three questions together since the identified costs need to be offset against any benefits.

We were asked to attempt to estimate the costs for the public purse of the tendering and collapse of the OPACS contract. This is a complex calculation, much of which is dependent on access to details that are internal to the organisations involved. Identifying the *extra* costs of the OPACS tender distinct from the costs of services that would have otherwise been provided by CCS, CPFT, CUH and C&P CCG is particularly difficult as C&P CCG did not have an accurate cost baseline for these services.

The final calculation produced by CPFT and CUH for the total costs of the UCP to the health economy is in excess of £18.6 million, as detailed in Table 5.⁴

Table 5. Total costs of the UCP

| | | (in £ 000s) |
|--|---------------------------------|---------------|
| A) Procurement and termination costs for C&P CCG* | | 1,430 |
| B) UCP costs (paid within the contract price) | | 4,807 |
| Comprising | post-contract set-up costs | 3,155 |
| | management costs | 1,614 |
| | termination costs | 38 |
| C) Trusts' pre-contract bid costs | | 2,686 |
| D) Trusts' termination costs | | 9,700 |
| Comprising | payments to providers | 7,000 |
| | C&P CCG–provider contract costs | 1,300 |
| | VAT and legal costs | 1,400 |
| TOTAL | | 18,623 |

* Figure taken from C&P CCG submission to National Audit Office.

There are two calculations from these figures that are relevant for this report: (1) the cost to CUH and CPFT of the failure of the UCP and (2) the additional cost to the health economy.

(1) Cost to the Trusts: The costs that fell to CUH and CPFT were C) £2,686,000 and D) £9,700,000, totalling £12,386,000. This money was split evenly between CUH and CPFT. The lion's share of this – £7 million – was in inherited payments to contractors and providers above the contract price for OPACS. This money was used to support existing OPACS services. As such, it is a clear indication of the gap between the actual cost of the commitments inherited with the contract and the contract price set at the project's commencement.

(2) Cost to the health economy: This is a more complex calculation that has to take into account costs that were over and above the 'normal' costs of system operation if the UCP had

⁴ Different reports estimate the cost of the tendering and collapse of the OPACS contract for the public purse from different trusts' perspectives. For example, NHS England's report only considered the costs for C&P CCG over and above its baseline cost for the contract, which was estimated at £6 million. Since our focus in this enquiry was not on C&P CCG's costs, we are not able to verify how this figure was arrived at.

not been created. Some of the UCP's expenditure went to supporting patient services; therefore, this cannot be considered an additional cost to the health economy.

The true additional costs include the procurement and termination costs for C&P CCG, A) £1,430,000, the UCP's costs, B) £4,807,000, the Trusts' pre-contract bid costs, C) £2,686,000, and the VAT and legal costs (£1,400,000). This totals £10,323,000.

There are additional costs of the effort and energy involved in the process of tendering, contract negotiations, awarding the contract, managing the mobilisation and transition, running the services and closing the contract, not only on the part of local organisations and citizens but also on the part of regulators, government agencies and other failed bidders. Calculating these inputs is impossible, but they are likely to be substantial.

The energy and focus that the OPACS contract adsorbed also had an opportunity cost for the health system as this effort and expertise could have been deployed elsewhere, potentially to better effect. It is impossible to say with any confidence what could have been achieved if the organisations involved had devoted the time, energy and, indeed, funds to something other than OPACS and the UCP. The problems facing the local health economy were considerable. As such, it is not unreasonable to assume that positive outcomes might have been achieved if the considerable talents and efforts of the NHS staff and Trusts had been focused in a different way.

The OPACS tender also had costs in terms of the reputational damage caused to both local and national organisations along the way. We also recognise that certain individuals carried a heavy burden throughout this process and that the stress and attrition on key personnel in the local health economy was significant. The impact of such high-profile, highly contested commissioning and contracting processes upon the people involved can be detrimental to both individuals' health and, through people leaving their posts, the talent base and capacity of the local health economy.

Importantly, however, as we have noted elsewhere in this report, the OPACS tender and creation of the UCP also had a positive impact on the local health economy. The legacy of the UCP is that there is now a genuine movement towards integration and a clearer understanding of how payments and rewards can be brought together through improved patient pathways. There is also a new infrastructure for OPACS that is being built upon. The contracting process has also brought the details of the complex services that provide community care and support into sharper focus.

We have observed a real willingness to learn from the UCP experience, a strengthened desire to drive integration and service improvement in OPACS and a greater commitment to collaboration and shared working in the interest of the system as a whole.

6. CONCLUSION

This report describes the unique and fascinating story of the UCP, an attempt to build a model of integrated services for adults and older people at a rapid pace. One of the overriding realities that proved insurmountable for the partnership was the severe squeeze on resources experienced by C&P CCG, CUH, CPFT and the local health economy year in, year out. Without adequate resourcing, competitive tendering was never likely to produce sustainable innovation, and without adequate funding, no organisation can survive, particularly in the difficult first year of start-up. Given the competitive nature of the procurement environment, we were unable to identify how the UCP contract and collaborative working relationship, or

rather lack thereof, could have been turned into a long-term success story and therefore believe it was best to cancel the contract early and start afresh.

Nonetheless, as this report has shown, there were things that CPFT and CUH as well as other stakeholders could have done differently during the contract negotiations and execution, and several lessons can be learnt from this experience for the good for the health economy. For us, three lessons stand out:

1. Urgency and risk: Although the ambition and scale of the programme was admirable, it was too much, too soon. In particular, there was very little evidence and data on which to base the contract. A slower, staged approach with a smaller initial contract for a subset of the services for a subpopulation may have allowed the parties to learn over time and better prepare for large scale system transformation.

2. Competitive tendering: The tendering, and specifically the inclusion of bidders from the private sector, amplified the risk by putting substantial pressure on the local NHS providers to win the bid, which was felt to be only possible by underbidding the competition in terms of contract value and emulating the risk protection strategies of the private sector bidders, leading to a LLP without parent guarantee. Given the scale of the integration and transformation programme, it is unlikely that the C&P CCG, which was still in its infancy, had a sufficient understanding of the financial, operational and legal implications of the complex contract, including how to interact with an LLP. While the NHS providers, and in particular CPFT, had developed strategies to limit their exposure in case of failure of the partnership, little thought had gone into processes to proactively mitigate and manage the risk of unforeseen operational and financial difficulties at the level of the C&P CCG-UCP relationship.

3. Partnership and collaboration: Projects of this size and complexity are always based on incomplete contracts; it is impossible to specify what each contract party is required to do in every future contingency. Inevitably, unforeseen circumstances will arise that can only be resolved through genuine trust-based partnering in the interest of the jointly agreed purpose of the contractual relationship, rather than the letter of the contract itself. This requires strong leaders on all sides of the contract, who are aware of this challenge and lead decisively to overcome the fall-back onto secure positions. Unfortunately, this was not the case. Local relationships between the C&P CCG and the Trusts, and between the Trusts themselves, were not strong to start with and there was no phase that would have allowed the parties to develop greater trust and understanding. When the first signs of trouble emerged, the parties fell back to legal arguments and created an adversarial relationship rather than a true partnership. Although NHS England bodies could have played a unifying role during the hardship, their involvement was too little, too late.

Complex integration projects should be viewed as long-term collaborative endeavours; cultural changes, organisational development and personal relationships that underpin successful integration can take a decade or more to develop before sustainable, high-quality outcomes are delivered. Integrating information systems and developing accurate and focused data are key to a successful integration. Without these, it is impossible for organisations to identify the levers for delivering higher quality at lower cost and establish a culture of evidence-based interrogation, innovation and improvement.

ACKNOWLEDGEMENTS

We are grateful for the help we received from across the health economy in completing this review. In particular, we would like to thank all of those who generously gave their time to be interviewed; everyone approached the conversations openly and frankly. We are grateful to those who completed the detailed timeline and documentation; access to this level of detail is unusual and extremely valuable. Particular thanks go to Helen Thomson at the Cambridgeshire and Peterborough NHS Foundation Trust for her patience and forbearance. Without her help in timetabling interviews and meetings, this review would have taken much longer. Finally, we would like to thank Christine Dentten for her help with copy-editing the manuscript.

The Centre for Health Leadership and Enterprise at the University of Cambridge Judge Business School was pleased to take up this commission on two counts. Firstly, the story of the UnitingCare Partnership is a particularly fascinating account of the reform process within the NHS, and there is much that can be learnt from this case study. Secondly, the Centre is part of the locality of Cambridgeshire and its wider region and we are committed to contributing to the development of sustainable quality healthcare in our own locale. If, through this analysis, we have contributed to learning and discussion in our health economy, we will have met one of our prime objectives.

APPENDICES

APPENDIX A. CHLE INTERVIEW OUTLINE

The CHLE has been commissioned by CPFT and CUH to undertake a rapid enquiry into the tendering, negotiations, contract agreement and termination of the contract for OPACS, which resulted in the creation of the UCP. In particular, we have been asked to consider what could have been done differently, how risk was handled and the role that the public voice played in the process. The intention is to learn from the process but also to maximise its successes for the benefit of the wider health economy. Our intention, and that of CPFT and CUH, is to publish in full.

Preamble

- We are undertaking a review into the circumstances and not making an enquiry or investigation. The goal is not to apportion blame to individuals or organisations but to capture learning points for the future. We intend to interview 20–25 people across the health system.
- This interview is confidential, but CPFT intends to publish the final report.
- We will not include interview quotes in the report unless this is agreed with the interviewee.
- The interview will be recorded for accuracy and verification.
- The interview will take no more than one hour.
- We will frame the discussion around key themes but want interviewees to feel free to raise issues that are important to them.
- We will examine:
 - the underlying intentions of the tender and contract negotiations;
 - how risk was handled and shared;
 - the nature of the partnership and collaboration during the negotiation and execution phases and how these were affected by the tendering process;
 - whether there could have been other, better ways of achieving the commission's objectives.

Interview framework

1. Can you explain your current role and what engagement/role you had with the tendering process/UCP? (Prompt on dates and times.)
2. **Commissioning process**
 - How did the concept of procuring OPACS arise – what do you know about the relevant history of C&P CCG and the local health economy?
 - What were the aims – how did these emerge? (How clear was the vision and how was it shared?)
 - How did you see a private provider contributing to the objectives and/or the local health economy?
 - What evidence was taken into account, specifically from successful services elsewhere? (Evidence of diversion and prevention is thin nationally – what examples did C&P CCG learn from?)
 - What was the rationale for the UCP model? Why were the services bundled in this way? (There is a complex set of services and patient groups here – some of the costs and demands in this sector are uncontrolled – was any attempt made to balance risk by creating a balanced service package?)
 - The timescale appears to have been tight – why was this the case? Who/what was driving the urgency?

3. **Tendering and contracting process**
 - How were the public/patients/governors/etc. involved in consultation?
 - It appears that contract negotiations were still taking place eight months after the commencement of the service – was this unusual in your view?

4. **Construction of the UCP**
 - The UCP signed up to an ambitious set of changes and savings – what is your view on this and how robust were the changes and savings?
 - How were the risks shared here – clearly investment needed to take place while also maintaining and making savings in services in from the start?
 - Social care chose not to participate in the partnership – why, and what efforts were made to include local government?
 - The LLP was proposed at an early stage – what were the reasons for this?
 - Was the absence of a parent company guarantee a deal-breaker in the end? What would have been the effect of raising this in the tender negotiations? Would it have brought about a crisis earlier?

5. **Budget, targets and risk**
 - Original risks identified at the ISOS stage do not seem to have been bottomed – what was the partners' understanding at the start of the contract about how these risks would be mitigated?
 - What were the financial drivers for your organisation? How did you see this tender working for your organisation? How did the business case set out the monetary flow?
 - There appears to have been a difference in views between commissioners and providers about the nature of the contract and the extent to which variation and negotiation were possible – what is your view?
 - How were the public and board members engaged in the management of the contract risks? Was there an opportunity to escalate or to review?
 - The contract costs never seem to have been bottomed – what was the real gap in your opinion?
 - What were the levels of trust and common purpose between stakeholders throughout the operation of the UCP? Where are they now?

6. **Operation – service effectiveness**
 - What happened to services during the tender negotiations and during the contract? Did you see improvements?
 - Some of the service changes implemented by the UCP are still being supported – do we have a picture of the costs and benefits of these services?

7. **Termination and aftermath**
 - What hangover is there from the tender, operation and demise of the UCP?
 - How would you have done things differently?
 - Is there a different approach across the health economy?

8. **What would have been the alternatives to tendering these services to gain the same objectives?**
 - Could it have been packaged differently or over a different timescale?

9. **Close and final thoughts**
 - What are your reflections on risk and its management?
 - What could have been done differently? Are there any key moments that could have been deciding factors for the failure in retrospect?
 - What are your reflections on accountability and public engagement?
 - What are your thoughts on the roles of Monitor, SPT, CQC and NHS England?

APPENDIX B. UCP SAVINGS AND IMPROVEMENT PROPOSALS

- To deliver a savings programme of £178 million over the life of the contract.
- To reduce spending on acute hospital care by £116 million over the life of the contract.
- To deliver a significant programme of investment in community services, including mental health and the third sector.
- To move away from acute PbR (payment by results) to contracts that incentivise outcomes and control cost and demand.
- To streamline the response to crisis through the UnitingCare Centre and JET.
- To use IT to link hospitals and the community and make care plans and key clinical data available to clinicians to support decision-making.
- To work with patients, carers and the appropriate services, supporting them to develop plans and strategies to help patients deal with their condition and crisis without needing admission.
- To enhance end-of-life services so that people can die where they want.
- To embed ambulatory care pathways to give prompt assessment, treatment and care without admission.
- To introduce a risk-based case management approach that provides:
 - intensive case management for the 10,000 (rising to 40,000) patients with the highest clinical need;
 - supported self-management and care planning for 250,000 patients with elevated risk of admission to prevent progression of their conditions and support them to stay healthy.
- To develop mental health services that better meet the needs of older people with dementia and other mental health problems.

It was also proposed that the UCP would grasp other opportunities as the contract proceeded:

- Primary care prescribing: Through regular and comprehensive medication reviews, to improve formulary compliance and reduce prescribing costs. A single patient record, including electronic medication administration record (MAR) charts, would enable prescribers to view patient compliance with medication in real-time. This would allow prescribers to make more informed decisions about which prescriptions should be altered or stopped based on which were actually being taken and when, allowing repeats that are not used to be amended or cancelled. MARs would be accessible on a mobile app, allowing patients to share this information with community pharmacists to support them with community medication usage reviews.
- IT portal and integration: IT solutions would make care plans and key information instantly accessible to patients, carers and professionals to facilitate the delivery of the UCP's clinical vision for adults and older people. These systems and the integrated portal would be flexed up to include systems beyond the current scope of the bid. This would extend access to clinicians, carers and other involved professionals and, with it, the potential to shape more effective, efficient and patient-focused services.
- Primary care and general practice: By working in an integrated way with general practice, the UCP would support practices to:
 - better manage many of their most complex and resource-intensive patients, reducing the frequency and duration of attendance at practices and the associated prescription costs;
 - develop more effective and efficient pathways for patients with complex needs and long-term conditions, ensuring the achievement of the maximum associated QOF (quality and outcomes framework) points;
 - provide easy access to clinical information and care plans for patients, allowing practices' clinical and administrative staff to be more productive, thus avoiding wasted time chasing up records, results and other information.
- NHS England commissioned services: By developing specialist neurology services in the community, the UCP would reduce outpatient attendances in the acute setting. It

would also integrate with general practice to support continued improvement in services.

- Social care:
 - reducing demand for residential and long-term care;
 - brokerage around personal care budgets;
 - developing the integrated care worker role.
- Other budgets outside of the core scope of services:

The UCP would remain keen to discuss NHS continuing care, community hospital outpatient attendances and specific planned community services with C&P CCG. The UCP feels that there are significant opportunities for synergy and additional savings in these areas.

BIOGRAPHIES



BRIAN COX

Brian is a consultant in health and social care specialising particularly in whole system development aimed at shaping demand and aligning objectives, strategy and delivery. He has a background in education, development and workforce strategy with a particular emphasis on system leadership, the leadership of networks and health and social care integration for users and patients. As a consultant he has worked as the workforce lead for the national Putting People First Programme, was the Director of Leadership at the National Skills Academy for Social Care and has led reviews of commissioning and operations in health and social care.

Brian has over 35 years of experience in leadership and management, research, local government, and health services. Originally studying as community worker in Birmingham, he has practiced as a social worker, mental health social worker, lecturer, researcher and senior manager. He led a national research project on inequality and ethnic minority take up of care services, managed a community development unit in Nottingham and delivered social regeneration and anti-poverty schemes in Birmingham. He was Assistant Director Commissioning in Nottingham City Social Services for 9 years and a Regional Director for the NHS University. He also served as an elected member in Derbyshire. Brian currently works as a part-time Senior Lecturer on NHS Leadership Academy programmes at the Health Services Management Centre and is an associate with CHLE. Brian is particularly interest in supporting the development of effective integration of services, supporting users, carers and patients to exert more control over the service they use and developing system leadership that is fit for purpose.



FERYAL ERHUN

Feryal Erhun received her Ph.D. in Business Administration, with a concentration in Production and Operations Management from the Graduate School of Industrial Administration, Carnegie Mellon University in 2002. She holds a B.S. and a M.S. in Industrial Engineering from Bilkent University, Turkey. She was a faculty member in the Management Science and Engineering Department of Stanford University from 2002 until 2013, and a Research Fellow at Clinical Excellence Research Center of Stanford University from 2013 until 2015.

Dr. Erhun's research interests are in the strategic interactions between stakeholders in supply chains. In this context, Dr. Erhun has studied topics related to supply chain contracting, capacity, and inventory decisions. More recently, she has turned her attention to socially responsible operations: today, both for-profit businesses and nonprofit organizations aim to create the highest value for their shareholders, employees, partners, and the environment. Her research on nonprofits, healthcare operations management, and sustainable supply chains has informed the development of theory addressing the unique challenges arising for these organizations and has extended traditional operations management theory to these new and important settings.

Dr. Erhun is a strong proponent of practice-based research. Through collaborations with Intel Corporation, Cisco, Stanford University Medical Center, etc., she has been able to combine her academic interests with firms' needs to deliver insights for both communities. Her work has been selected as one of the finalists in the 2012 Franz Edelman Award, which recognizes outstanding examples of innovative operations research that improves organizations, and Dr. Erhun has been inducted as an Edelman Laureate. Dr. Erhun is a recipient of 2006 NSF CAREER Award with her project titled "Moving from Risks to Opportunities: An Exploratory Study of Risk Management in Supply Chains." She is an associate editor on the Production and Operations Management journal.



STEFAN SCHOLTES

Following undergraduate studies in Industrial Engineering and doctoral and post-doctoral studies in Operations Research and Statistics in Germany (Karlsruhe Institute of Technology) and the USA (Cornell University), Dr. Scholtes took up a joint faculty appointment in Cambridge University's Engineering Department and Judge Business School in 1996. In 2003, he was appointed Professor of Management Science and in 2010 Dennis Gillings Professor of Health Management at Cambridge Judge Business School.

Dr. Scholtes is the founding Director of the Centre for Health Leadership and Enterprise at Cambridge Judge Business School. His research focuses on the operational challenges of service improvement and service transformation in hospitals and local health economies and is embedded in a long-term collaboration with Cambridge University Hospitals NHS FT. He teaches operations management, business analytics, leads the healthcare strategy concentration on the Cambridge MBA programme, and develops and directs leadership courses for clinicians.

Dr. Scholtes has been Director of the PhD Programme, Director of Research and Subject Area Head for Management Science at Cambridge Judge Business School, a board member of JBS Executive Education Ltd, the Management Board of the Institute for Public Health at Cambridge University and the Cambridge Collaboration for Leadership in Applied Health Research and Care (CLAHRC), and has served as a UK representative on the International Federation for Information Processing. He has held editorial appointments with the Journal of Operations Management, Operations Research, Mathematics of Operations Research, SIAM Journal on Optimization, and the IMA Journal of Numerical Analysis.

**Cambridge Judge Business School
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Review of the UCP Contract Termination, August 2016



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