

Public Accounts Committee

Oral evidence: Supporting primary care services: NHS England's contract with Capita, HC 698

Monday 18 June 2018

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Members present: Meg Hillier (Chair); Bim Afolami; Sir Geoffrey Clifton-Brown; Caroline Flint; Gillian Keegan; Anne Marie Morris; Lee Rowley.

Questions 1–147

Witnesses

I: Simon Stevens, Chief Executive, NHS England, Emily Lawson, National Director, Transformation and Corporate Operations, NHS England, Jonathan Lewis, Chief Executive, Capita plc, and Stephen Sharp, Executive Officer, Capita Government Services.

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



Report by the Comptroller and Auditor General

NHS England's management of the primary care support services contract with Capita (HC 632)

Examination of witnesses

Witnesses: Simon Stevens, Emily Lawson, Jonathan Lewis and Stephen Sharp.

Q1 Chair: Good afternoon. We are here today for a double purpose. First, we will look at what the National Audit Office has found out about NHS England's management of primary care support services that it contracted to Capita. The NAO has done a report that we will be looking through. The primary care support outsourced to Capita included back-office functions for around 39,000 GPs, dentists, opticians and pharmacists, and it did not go very well at all. In fact, it was rather a shambles. I know we have had some further information from today's panel about how things are improving, but there are still a lot of issues to be resolved. We will want to look at what happened and why it went wrong, and we will take it from there. In the second half of the session, which we will introduce properly later, we will talk with Capita directly about its role as a strategic supplier to the Government. It is one of the now 27 suppliers with contracts of £100 million or more across central Government.

I will introduce our witnesses, and then, Mr Stevens, as you might imagine, I am interested in your thoughts on some of the news today. From my left to right, we have Emily Lawson, the national director for transformation and corporate operations at NHS England; Simon Stevens, the chief executive of NHS England; Jonathan Lewis, the chief executive of Capita plc; and Stephen Sharp, the executive officer for Capita's Government services. Is that your correct title, Mr Sharp?

Stephen Sharp: Yes.

Q2 Chair: Mr Stevens, has Christmas come early for the NHS, then?

Simon Stevens: At this 70th anniversary of the national health service, it is right that the country has the opportunity to recommit to the service—

Q3 Chair: That's not what I asked. Are you happy with the settlement that the Government have given you?

Simon Stevens: It is very welcome that we have this certainty of NHS funding for the next five years, and what is more, it represents a clear gear change in the amount of funding that will be available for the next five years, compared with what we've had over the last five.

Q4 Chair: So it averages about 3.4% a year over five years, with some fluctuation in those figures. That's right, is it?



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Simon Stevens: Yes, but for next year and the year after the figure will be 3.6% and 3.6% in real terms, and as the Prime Minister set out this morning at the Royal Free Hospital, on top of that 3.6% is a further £1.25 billion that the Government are adding in to deal with some of the other costs that the NHS would be bearing for pensions. So, factoring that in, actually the real-terms growth for the NHS budget next year will be 4.6%.

Q5 **Chair:** Right. So the pensions thing is a one-off support for pensions?

Simon Stevens: Well, it is a one-off additional cost to the NHS, and that additional cost is being funded and then built into our baselines on an ongoing basis.

Q6 **Chair:** Right. So that is actually additional funding?

Simon Stevens: Yes it is.

Q7 **Chair:** Okay. So, you've got this extra money, but you are talking about it as though it is absolutely settled and sure.

Simon Stevens: Yes.

Chair: It depends on the Brexit dividend. So do you believe the Brexit dividend is going to deliver enough to make sure that you get this money?

Simon Stevens: Both the Prime Minister and the Chancellor are crystal clear that this money will be available to the national health service over the next five years. Obviously, where that is sourced from is a matter for the Chancellor of the Exchequer, but I can confirm that by 2023—the end of this five-year period—the NHS will indeed be getting more than £350 million a week in real terms.

Q8 **Chair:** So does it cover capital funding? Any capital money in there?

Simon Stevens: As the Prime Minister and the Chancellor have set out, there is a strong case for further improvements to infrastructure and to technology, and they will be considered as part of the overall spending review, which we think is a sensible approach.

Q9 **Chair:** Right. So are you expecting more out of the spending review than what has been announced today?

Simon Stevens: As the Prime Minister has just said at the Royal Free Hospital, the Government is asking the NHS to develop a long-term, 10-year plan, and as part of that we've got to look at workforce and capital, at prevention and at social care. Those will all come together in the long-term plan to supplement the specific commitments that have been given to the NHS by the Government today.

Q10 **Chair:** You are really sticking to the script that has been agreed today, Mr Stevens—unusually for you. But can we just be clear, then? You are going to be coming up with a 10-year plan. Part of the deal on this is transformation. We have looked at transformation with you over years now, and transformation is very difficult when you are cutting costs. So the transformation plans have not gone as far as I think you would



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acknowledge you would have liked at this point.

Is it really going to be possible to deliver the change in prevention work that you just touched on while receiving this money, or will it end up going where other money has gone—basically, stopping up the holes where you have got staff shortages, demands on pay and a need for staff training?

Simon Stevens: Well, we will use this period—now through November, as we develop this long-term plan—precisely to answer the question about what the phasing of improvement needs to be. But my view is that, looking out over the next five years, this does represent a faster rate of spending growth than over the prior five years, so we do have more opportunity than we have had hitherto.

- Q11 **Chair:** Okay, so it is another transformation plan to hit staff on the ground, and between now and November is quite an ambitious timetable. Can you give us a practical example of how you think that might make a difference, say in a typical acute hospital? What kind of change are you looking at?

Simon Stevens: We are obviously in the process of introducing the new Agenda for Change pay contract, so that will benefit frontline staff. In terms of the availability of staffing across the health service, the Prime Minister has confirmed this morning that doctors and nurses will no longer be subject to the tier 2 visa cap, so that will help hospitals in many parts of England.

However, much more fundamentally than that, we saw enormous pressure on accident and emergency departments over this past winter. It will take time to bring in the sorts of changes that are needed, but for A&E services, for mental health services and for cancer care, those are the key priorities, among others, that the long-term plan will address.

- Q12 **Chair:** So if you are a typical patient—a mental health patient, say—or you need to use your local A&E, when will you see the change? Clearly, it is not going to happen overnight. When do you predict the difference—

Simon Stevens: Well, in a sense, you are asking me to say today what the outcome and the content of the 10-year plan that we will develop with frontline staff between now and November will be.

- Q13 **Chair:** Come on, Mr Stevens, you've been in the job a while now. You have a plan. We know you have a plan—you come and talk to us about it often, and you often volunteer things even when we don't ask you about them, so you know what you want to achieve. You have a vision for the NHS, I think it would be fair to say. How long will it take to implement the change that you seek now you have what you say is a guarantee of further funding?

Simon Stevens: We are going to see further improvements over the next couple of years to deliver on the commitments that we have already made around the mental health taskforce service expansions and around improving cancer care and a number of other health conditions, but we



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now want to look beyond the period to 2020 and think about where we will get to in five years' time and 10 years' time. Crucially, we want to connect that with the workforce planning we need in the NHS in order to bring that about and, frankly, to respond to the Government's offer to the NHS today to work with it and with Parliament, including the Health and Social Care Committee, on whether there are consensus proposals for how any legislative impediments to getting done what needs to get done might be considered by Parliament itself.

- Q14 Chair:** Okay. You have previously talked to us about money being needed in social care to help you support the NHS. Do you envisage any of this money being passported by you to help social care providers, particularly with winter crisis situations?

Simon Stevens: As the Prime Minister said this morning, this is specifically a funding settlement for the national health service, but she also recognised, as I know the Chancellor does, that if social care were not addressed in the spending review, there would be additional pressures on the national health service. That is why we were pleased to see their joint commitment to ensuring that the funding settlement that will ultimately be developed by the Government for social care does not lead to further pressures on the NHS.

- Q15 Chair:** Right, so you're expecting another bung of money for social care, but you're not planning to fund it yourself.

My final question is about the NHS pay bill. There has obviously been pressure, because of the pay freeze, to put pay up. That is completely understandable, but will those pay increases come out of this settlement or is there an additional funding settlement from the Treasury for these pay increases?

Simon Stevens: For this year, which is the first chunk of the Agenda for Change increases that have been agreed across the national health service, we are receiving additional funding over and above our '18-'19 allocation to cover that off. That will be built into our baseline for next year, but the extra costs next year, in '19-'20, will form part of the 3.6% that we have been awarded.

- Q16 Chair:** Roughly how much of that 3.6% will go on pay?

Simon Stevens: Well, on a like-for-like basis, if you factored in the additional money we got for pay this year and compared that with our costs for next year, you could say that we were at about 3.1% real growth this year compared with 3.6% growth next year. Even with those additional Agenda for Change pay costs, it still represents a meaningful improvement in the revenue position in '19-'20.

- Q17 Chair:** So actually, a lot of this money will be going to pay staff more. I am not saying they don't deserve that—of course they do—but that is not necessarily going to lead to any particular practical change on the ground. If you have a nurse who is being paid more because they are due that pay rise, you will still have one nurse.



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Simon Stevens: This is a phased pay agreement over three years that will help with retention of staff across the national health service, will help reduce the temporary staffing bill, which we have been very successfully tackling over the last several years—and yes, in this 70th anniversary year of the national health service, it will give nurses a very well deserved pay rise.

- Q18 **Chair:** I think we would all agree they deserve it, but my point, as you know, is that we just need to make sure that we do not see this money going on things that are not going to lead to very definite improvements for patients. Can I just urge you and press you—

Simon Stevens: Yes, completely. That is why, in a way, it was good that we had the pay deal done before the funding settlement. We are not going to have inflation in that respect.

- Q19 **Chair:** Can I urge you as well, please, to evaluate—we will be pushing you on this—the impact of the pay increase on retention and recruitment?

Simon Stevens: Absolutely.

Chair: There would be no point—well, there would be a point to doing it otherwise, but it is important to measure that.

Simon Stevens: Yes, I completely agree.

- Q20 **Sir Geoffrey Clifton-Brown:** Two very short questions, Mr Stevens. First, can you give us an assurance that with this extra money we will not see a repeat of last winter, when a considerable number of elective procedures were cancelled due to emergency admissions because of the winter crisis? Are you preparing for that not to happen this winter?

Simon Stevens: Obviously the whole of the national health service will move heaven and earth to prepare for this winter. As you know, there were some particular pressures last winter—the highest flu rates we had seen since 2009-10, and various other pressures that A&Es were experiencing—but this new funding begins in April 2019, so it will be from April 2019 that we will begin to see the effect of the announcements made today.

- Q21 **Sir Geoffrey Clifton-Brown:** If the same conditions pertain this winter as did last winter, are you sure we will not see a repeat of those many thousands of cancelled elective procedures?

Simon Stevens: NHS Improvement is working with hospitals right now to try to ensure that the phasing of waiting list operations through the year means that there is not an expectation of a disconnect such as happened between emergency patients and waiting-list patients in January and February. But last week we set out very clearly the importance of trying to tackle the 18,000 or 19,000 hospital beds occupied by people who have been there for more than three weeks. The goal is that over time we will try to reduce that number by a quarter. That would free up significant hospital beds either to handle spikes in demand over winter or to create capacity for waiting list operations.



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We know there is not a magic wand there. We are building on some success with reductions in delayed transfers of care over the last 12 months, as you know, but we need to go further.

- Q22 **Sir Geoffrey Clifton-Brown:** While the money the Prime Minister has announced today for the NHS is extremely welcome, it will make the funding of social care—extra money for social care—even more difficult. What do you estimate the shortfall is in social care that needs to be plugged?

Simon Stevens: I would avoid giving you an off-the-cuff answer today. We know there are significant pressures—various third parties have estimated that, as has the Association of Directors of Adult Social Services. Of course, the point is that the absolute amount being spent on public social care is lower than the absolute amount being spent on the national health service. So even if the percentage increases are the same, the call for funding on taxpayers' resources is not as significant as in the NHS.

- Q23 **Sir Geoffrey Clifton-Brown:** We are told we will get a White Paper by the summer—whenever that is. If we do not know how much money we need to plug the gap, how do we know what mechanisms we are looking at?

Simon Stevens: As I say, I think there are various authoritative estimates of that, but what I do not want to be doing today is suggesting that somehow a particular number should form part of that discussion. There will be discussions—

- Q24 **Chair:** Sir Geoffrey is hitting a big, important nail on the head here. You can do what you can with the money when it comes to you, but, without social care being resolved, you are still going to have some of the same problems.

Simon Stevens: We need no persuading of that here. We have said that, as you know, many times in this Committee. I have previously made the point that—

- Q25 **Sir Geoffrey Clifton-Brown:** I cannot believe, Mr Stevens, that when you were making your pitch to the Government for this extra money—you were clear in that—you did not also have in your mind what pitch you needed to make for social care. One impacts on the other, and if you don't get enough money for social care it will put extra demand back on the NHS and the extra funds will then be insufficient.

Simon Stevens: Absolutely. That is why it was so important to get the explicit commitment from the Chancellor and the Prime Minister that the adult social care budget will be set in such a way as not to put further pressure on the NHS. We will use the process between now and the spending review to refine the estimates as to what that will be, but I think it is legitimate to say that the adult social care funding settlement is tied up with the local government funding settlement in the round and it is hard to answer on one without the other. So we are clear that there does



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need to be a watertight answer to both, but we also recognise that, for legitimate reasons, the timing differences have arisen as they have.

Q26 **Chair:** When will the first cash from the Chancellor be in your coffers?

Simon Stevens: 1 April 2019.

Q27 **Chair:** So you have still got some way to go with the current situation, basically we should not hold our breath on major transformation any time soon.

Simon Stevens: The 2018-19 position is as we previously described.

Q28 **Chair:** On the lifting of the cap, how quickly will that mean these overseas doctors can start working in our NHS? Are any in the pipeline now?

Simon Stevens: Yes, subject to confirmation of the mechanics with the Home Office—

Q29 **Chair:** Ah—you are glossing over that one quickly. That in itself is a problem.

Simon Stevens: No, I'm just being very practical about it. The Prime Minister said this morning that with immediate effect the tier 2 visa cap no longer applies to doctors and nurses, so I take "immediate effect" to mean today, but obviously there is a process to work through the applications that hospitals around the country have been considering and have had difficulty processing. I hope that within a matter of weeks and months, certainly not six or 12 months—much shorter than that—we will begin to see this unblocked.

Chair: We will leave it there for now, but we will come back to this and keep a close eye on it. I know that sister Committees are doing the same.

We will now move on to the shambles that has been the contract that Capita and NHS England entered into to run primary care support services. Anne Marie Morris will kick off.

Q30 **Anne Marie Morris:** I am going to focus on Mr Lewis and Mr Sharp and Capita's perspective. My colleague, Mr Afolami, will then look at the NHS perspective. It is easier to keep them separate.

Mr Lewis, when you tendered for this project, did you feel that you had got all the data that you needed from the NHS to make the decision you did about how you would pitch?

Jonathan Lewis: No. This tender reflects many of the learnings that the Committee has been gaining from my peers over the last week. This was an extremely complex outsourcing of services that I think both parties would recognise were not fully understood when the work was outsourced: the volumes, the scope, the fact that the service was being delivered in different ways across the different regions that became NHS England. At the same time I recognise the pressure NHS England was under to reduce costs, and hence the pressure on it to outsource. If we were to approach a contract of this nature today we would approach it very differently. Speaking for Capita, as the relatively newly appointed



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CEO, unless we were comfortable that we could deliver against the spec and we understood the risks, we would not bid on it.

- Q31 **Anne Marie Morris:** Mr Sharp, did Capita do its own due diligence? I hear what Mr Lewis says in terms of Capita not having all the data that was needed. Was there any specific due diligence that Capita did?

Stephen Sharp: I think it is fair to say there was not enough due diligence. There were visits facilitated by NHS England to allow Capita to visit various sites. There was information made available to Capita during the bid. So it is fair to say that Capita maybe did not do investigations and glean all the data that it could have or should have.

- Q32 **Anne Marie Morris:** How did Capita make the decision with regard to getting the cost savings up front to close so many of the offices, and only leaving three? Even though the data was incomplete, you had some, so how did you reach that decision?

Stephen Sharp: I think mistakes were made. During the bid stage, NHS England did say there were some inconsistencies and differences within the various operations. But it is fair to say that once Capita got into all the offices and looked at it, the inconsistencies and differences were not inconsequential. It was more or less 45 different services being run from 45 different offices, so the closure programme, which we adhered to and carried on with, we maybe should have stopped. We just made the problem worse as we went along.

- Q33 **Anne Marie Morris:** Why did you not stop? Even the NHS said, "We think you need to stop."

Stephen Sharp: We made a mistake. As the NAO Report indicated, we should have stopped.

- Q34 **Anne Marie Morris:** Why didn't you?

Stephen Sharp: Specifically, I think the reason why we didn't stop is that there was not a lot of data available. We were actually working blind for a period of time. It was only once the service had been running under our control for a few months that complaints started to come in and we started to see visibility that there were bigger issues than we thought there were. That was one of the prime reasons. But, to be clear, even when it was evident that there were problems within the offices and some arrears were building up and we could see some visibility, we still didn't stop, so that was clearly a mistake on our part.

- Q35 **Anne Marie Morris:** Right. What would you do differently, going forward?

Stephen Sharp: Going forward, I would not have closed any offices until we had got the procedures operating on a national basis, and then we could have folded those services instead of three centres on a like for like basis. In effect, we were folding 45 different services into three national centres, which just didn't work.

- Q36 **Chair:** Do you know what it would have cost you, on the contract, if you hadn't closed the offices that you did?

Stephen Sharp: I can't say exactly what the cost would have been.

Q37 **Chair:** But a ballpark scale of cost?

Stephen Sharp: It would have meant that the first two years of savings probably would not have been achieved in line with clients' expectations. It probably would have taken 18 months to two years to come up with national procedures, train all the staff, do all the procedures and all the guidance and then fold these in, so it probably would have delayed the benefits for about two years.

Q38 **Anne Marie Morris:** Presumably, therefore, it would have been a very different price for the project.

Stephen Sharp: It would have been a different price, yes.

Q39 **Anne Marie Morris:** Okay. What about the way you measured progress? As you said, even you began to realise early on that things weren't quite going right, so what procedures, what measures, what KPIs were in place? The sense I get is that although some were discussed, there wasn't something in place for all the different streams of work, and exactly how they would be interpreted was not agreed.

Stephen Sharp: As we took over the service, there was no national data available, so in effect, as we closed the offices and moved the work on to the national sites, we constructed the data, and then started to report on the KPIs going forward. Some of the KPIs were agreed at the time we took over the contract. They are not all quite agreed yet; we have made quite a bit of progress, but there are still one or two we need to finish off.

Q40 **Anne Marie Morris:** Why were they not agreed before you started? Would you not have done that on any other contract?

Stephen Sharp: On most contracts, you agree KPIs up front, but on most contracts there is a bit more richness of data available and it is a bit clearer what the KPIs should be. On this contract, because there was no national performance data available at the time we took it over, the aim was that in three months, we would have three months' experience and we could define the KPIs and agree them, but it actually took us a lot longer than three months to gain national data to allow us to articulate the key performance indicators.

Q41 **Anne Marie Morris:** So where are you now? You say that some are agreed and some are not. What does "agreed" mean—that it really is agreed at every level of detail?

Stephen Sharp: As the NAO Report pointed out, there were 11 KPIs that we hadn't agreed. We have now formally agreed seven of them, we have agreed two more in principle, and two more have yet to be finalised.

Q42 **Anne Marie Morris:** But how big are they; how significant are they? Which ones have you not agreed, and how significant are they to the contract?

Stephen Sharp: They are all significant, because they all play an important part in ensuring that we are doing the right things by NHS England, GPs and ophthalmic services; they are all important. Let me give



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you an example of why we have not quite been able to agree them. There is one for the national performers list; we had a target to turn the list round in, I think, 42 days as an end-to-end service, but actually trainee opticians were allowed to apply three months before they did the test, so it was actually impossible for us to hit a 42-day deadline, because they could apply three months before they were even allowed to go on the list. It is issues like that that we have been working through to try to get the KPIs correct.

Jonathan Lewis: I don't want the Committee thinking that our inability to hit KPIs is driven by a lack of funding. We have already invested—well, you can regard it as a loss or an investment—£125 million in this contract. If you add the loss of margin on the contract, it is closer to £140 million. And I have made it very clear to our partners at NHS England that we are committed to continuing to invest to ensure that we deliver the KPIs associated with this contract. As the NAO Report itself points out, we are delivering against 41 of the 45 today and making good progress against the remaining four. That does not in any way change the fact that our initial execution on this contract was not good, and for that we apologise unreservedly.

Q43 **Anne Marie Morris:** What are the four that are unagreed?

Jonathan Lewis: They are—help me out here, Steve.

Stephen Sharp: Let me just clarify. Jon has just referred to the fact that we are meeting 41 of the 45 KPIs that we are reporting against at the moment. An update: as of Friday, we are meeting 43 of the 45. The two we are not meeting at the moment apply to the ophthalmic services. We are not paying ophthalmic people correctly within the timescales and we are not returning to them incomplete forms within the agreed timescale. They are the two KPIs we are still not meeting.

Chair: Unfortunately for you, we all get this in the neck every time we visit our dentist, optician or GP, so it underlines, in very graphic detail, the problems that they are having.

Q44 **Anne Marie Morris:** How come those have been the last ones to be looked at to sort out?

Stephen Sharp: Let me go to ophthalmic payments, which I think is the most important one. From November 2017, we were achieving them, but then we hit some difficulties in March and April. We did not have enough resilience built into the service, so I have authorised another 60 staff to join that service. They joined in late April and early May and have just gone live. I am hopeful that will ensure we meet our obligations going forward.

Q45 **Chair:** Can you be clear? You were doing okay, then you did not have enough resilience built in. Is it just that you did not understand the flow of business and did not understand what you would need to put in at different points of the year? What changed?



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Stephen Sharp: What changed—this is our responsibility—is that we had bad weather in March, which meant we lost several days towards the payment runs, which meant we could not get them all out on time.

Chair: That was just because staff could not get to work.

Stephen Sharp: It was staff who could not get to work. Then, in April, there was an IT-related issue that meant we had some downtime on the IT systems, which meant we could not process the payments as we came to the deadline to do the payments. What happens if you lose your KPI for a couple of months is that obviously you get complaints and more queries into the service. That means it takes a little time to gain it back.

Q46 **Chair:** So they were pretty basic things—the IT and your staff being out.

Stephen Sharp: Pretty basic things, yes. For five months we had nothing go wrong, so we were fine. As soon as we hit some problems, we started to have some issues. As I say, we did not have enough resilience in the service. We have recruited an extra 60 staff, and I am hoping that gives us the resilience we require going forward.

Chair: You were running thin.

Anne Marie Morris: “Hoping” is not necessarily a happy word.

Stephen Sharp: The mathematics and the analysis we have done tells us that with the 60 extra staff, we will be able to meet our obligations.

Q47 **Chair:** Sixty staff is quite a lot. You were lucky for five months then, were you?

Stephen Sharp: We did not have any operational issues, therefore it went smoothly.

Chair: Because there were no external environmental changes.

Stephen Sharp: I accept that we did not have enough resilience in the service, but I am confident that I have just built that in.

Q48 **Anne Marie Morris:** Listening to everything that you said, it sounds like the KPIs are very numerical, and that in terms of the measures, given the complaints that we have had from the individual providers affected in primary care, the quality piece perhaps was not looked at in as much detail as the quantity piece. You could measure processes and days, but it does not sound like the impact on the working lives of those individual providers was factored in at all.

Stephen Sharp: The NAO Report confirms that most the KPIs were based on speed of process, not on quality, so I agree.

Q49 **Anne Marie Morris:** Do you think that was a mistake?

Stephen Sharp: Normally, when we do KPIs with clients there is a balance between quality and speed of process. It is fair to say, and it is

evidenced by the NAO Report, that this was more towards speed of process.

- Q50 **Anne Marie Morris:** Why did you make the assumption that that would be enough, given how many different people and professions you were dealing with?

Stephen Sharp: It is not normally us who decides what the key performance indicators are; they are normally led by the client.

- Q51 **Anne Marie Morris:** Presumably, then, if you think they are not appropriate, you challenge them.

Stephen Sharp: We do, but normally the decisions on what the key performance indicators are client-led.

Anne Marie Morris: You are making it sound like the contract was pretty much foisted upon you and you did not have much scope to negotiate.

Stephen Sharp: My experience of Government contracts in the recent past is that quite a lot of the time we are told what the KPIs are, and that is the basis of the contract. It is not normally a negotiation.

- Q52 **Chair:** Did you not look at it and think, "Some of these are just not going to work"? You gave the example of opticians applying while they are still studying, so you would never hit the 42-day target.

Stephen Sharp: I was not part of the bid team and I have had responsibility for this contract from January 2017, but the actual detail at the time of the contract was less about the negotiations on KPIs.

- Q53 **Chair:** We will talk to you later about some of this, but we have had other evidence from witnesses who looked at contracts and said, "We are just not going to be able to deliver that. It's not good for our reputation," and walked away. One of them even sunk £1 million into a bid and then walked away, because they felt the performance indicators, or whatever the terms of the contract were, were not deliverable. Did you not consider that?

Jonathan Lewis: On that particular contract at that point in time, we did not. I can assure you we will do that going forward.

- Q54 **Anne Marie Morris:** What sort of partnership did you want to develop with NHS England?

Jonathan Lewis: I spent 30-plus years in the private sector, primarily in the United States. All those 30 years were spent working for companies to whom services were outsourced. By far the most successful contracts were those where there was a strong alignment of objectives and KPIs between the contracting entity and the provider of the outsourced services, and an environment in which either party could challenge the other on assumptions about the contract, the KPIs, how it should be executed and so forth. We see that in our private sector business for Capita here in the UK, which accounts for 55% of our revenues. We see less of that in the public sector.



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Q55 **Anne Marie Morris:** You just described what you look for and what best practice looks like. Was this contract relationship like that, as you have described it should be?

Jonathan Lewis: It is today.

Q56 **Anne Marie Morris:** What made it change?

Jonathan Lewis: Simon, Emily and myself made a commitment to reset the working relationship. I have made a commitment, as has Emily, to work on a monthly basis going forward to ensure we bring the requisite resources and attention to any of the outstanding elements of contract execution.

Q57 **Chair:** But would you have done that if it hadn't been such a public disaster?

Jonathan Lewis: I have always done that throughout my career on any contract, whether in the public or private sector, to address a contract that might not be performing correctly. It is what you do.

Q58 **Chair:** You may speak for yourself, Mr Lewis, but Capita has a bit of a reputation, as we have seen a lot on this Committee, of contracts that have not gone well, and the publicity around them is what seems to have triggered change. You are saying that you would have implemented this change even if you hadn't had an army of GPs, opticians and pharmacists making noise about it, frankly.

Jonathan Lewis: We do not get any noise in the public domain around contracts that may not be executing against KPIs in the private sector, but I assure you that they get my attention.

Q59 **Anne Marie Morris:** You say that that relationship is now working and that you will meet monthly. When did these monthly meetings start happening?

Jonathan Lewis: In March of this year.

Q60 **Anne Marie Morris:** In March of this year? So you have had three meetings?

Jonathan Lewis: Emily and I have had at least three meetings.

Q61 **Anne Marie Morris:** And what have you agreed to differently?

Jonathan Lewis: Well, we are meeting on a regular basis, which of itself is important. Emily and I both bring the requisite leadership skills to bear on the contracts, so that the right resources are being brought to bear. I have made it very clear that we will resource this as necessary to deliver against the KPIs. We have brought in independent advisers for two areas that are still outstanding—ophthalmic payments and GPs' pensions—so that we can address those.

We have working teams in our respective organisations that work on the outstanding metrics and on the outstanding commercial terms. As Mr Sharp just pointed out, even since the NAO Report was published, we have



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made encouraging progress on an additional three of the outstanding KPIs. We have a very effective working relationship today and we are making progress on the remaining outstanding issues. Again, I emphasise that 44 of the 45 KPIs have now been met.

- Q62 **Anne Marie Morris:** That all sounds wonderful and dandy and how it should be, but there is a lot of, "This is what we're going to do." Are you setting yourselves timelines by which some of these things actually have to be delivered? It is no good talking if we do not get the action soon enough to actually get the contract completed.

Jonathan Lewis: Speaking personally, and I am sure for Emily as well, I am a great believer in defining what needs to be done, who is accountable for it and the timeframe within which it is going to be done. In terms of that which we collectively control, that is being put in place.

However, there are other stakeholders that have historically not been brought into this process to the extent that they should have been, such as the BMA in how we might implement the digitisation of pension payments and the management of its pensions, or the Confederation of Dental Employers with regard to ophthalmic payments. We want to bring them into the process in ways that they have not been historically because we think that that will ultimately lead to a more successful roll out of the technology.

- Q63 **Anne Marie Morris:** Is this something you have only just thought about, as opposed to something that you thought about when you first tendered for the project?

Jonathan Lewis: I can't speak to when we tendered it several years ago. Since I have been involved in this contract and in one other in the public sector, I have devoted the requisite time to them to ensure that we have a remediation or recovery plan for those specific contracts.

- Q64 **Anne Marie Morris:** Could either of those other bodies you referred to stop this contract reaching a successful conclusion soon?

Jonathan Lewis: They rightly have influence over the process. If we are going to roll out a process for digitising the 20,000 paper documents that cover the process by which you get refunded for an ophthalmic prescription today, surely those people need to be involved in the final roll-out and configuration of that solution.¹

Anne Marie Morris: Indeed, they should have been involved not just at this point, but when we first started.

Jonathan Lewis: We would agree with that.

- Q65 **Anne Marie Morris:** Is the fact that they have come on board rather late in the day going to put a spanner in the works?

¹ Note from witness: the figure is 20 million documents



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Jonathan Lewis: I would hope not. I am sure NHS England will have a view on this, but we are trying to make—we are going to make—their life easier with the digitisation of the process. They will be able to track where their prescriptions are through the system at any point in time awaiting payment. There will be fewer errors, because if you don't get it right in the initial submission on the digital system, as we go through the digital transformation, it will tell them that they have done it incorrectly.

Q66 **Anne Marie Morris:** Are you going to make any money out of this contract?

Jonathan Lewis: No, as I pointed out earlier, so far, we have lost £140 million.

Anne Marie Morris: That is not the same thing as over the period of the contract.

Jonathan Lewis: We will not make money over the life of this contract.

Q67 **Anne Marie Morris:** Any?

Jonathan Lewis: No.

Q68 **Anne Marie Morris:** Have you thought about asking the NHS, because it sounds to me—although that is a separate debate for later—that they have contributed to your losses, so will you be expecting a bit more from them?

Jonathan Lewis: No.

Simon Stevens: Is the right answer.

Jonathan Lewis: I think it is important to recognise that we rightly put a lot of scrutiny on contracts in the public sector. I have done thousands of large contracts in my career. They do not always go right. In any business's portfolio of contracts, there are always one or two that are going wrong. We have those. We commit the resource to putting them right.

Q69 **Anne Marie Morris:** Why, then, are you not walking away from this? If you are not going to make any money out of it, why are you still here?

Jonathan Lewis: Because we made a commitment to deliver this service and reputations depend on that commitment. We see the public sector—I guess this is going into the second session—as a segment of our market that helps us achieve a diversified revenue base. It is a segment where we have services and solutions, where we can create value for the taxpayer and that is why it is an attractive segment.

Q70 **Chair:** In this case, you were brought in to bring value for the taxpayer, to solve the problem that we will ask Mr Stevens about shortly. Figure 4 shows the money that you expected to make. You must have been aware pretty early on that you had made—as you were saying, Mr Sharp—some wrong assumptions. Yet you still went steaming in, closing offices. You say that you made a commitment, but you made a commitment and you



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just weren't delivering on it from the beginning. You could have made an earlier judgment to change the way you did this. It would have cost you money then, but it would have been better for the users.

Jonathan Lewis: We have already been clear and unambiguous: that was the wrong decision. It was a regrettable decision, which we apologised for. It would not happen under my watch.

Chair: Well, there is a strong commitment, Mr Lewis. I hope you are not back here in front of the Committee in future answering for the next contract.

Q71 **Anne Marie Morris:** Indeed. One final question from me. Between now and the end-date of the contract, what will you be doing to ensure that you will better manage it, that there will be better reporting, that you will deliver on the agreed budget—while not making any profit—on time? What is the continual review mechanism, which hopefully you have now put in place, to ensure that we will get this and how will you report it back to the various bodies, so that we know if it is working?

Jonathan Lewis: I have made it clear within our organisation that access to resource should not in any way impede our ability to execute against our contractual obligations. Steve has that directive specifically from me. That is one of the reasons why we are putting the additional 60 resources into the payment process for ophthalmic prescriptions. Secondly, we have a governance that we have put in place with NHS England, where Emily and I are meeting on a monthly basis to assess performance against the remedial plan. We will take proactive action as necessary.

Anne Marie Morris: Okay. I must admit, I would be concerned to be one of your shareholders, your having made some promises like that, but that is really a separate issue.

Jonathan Lewis: I have to address that, now that you have made that point. Some 55% of our revenue is in the private sector, which is very profitable—that is the vast majority. We have two large central Government contracts, which are not profitable, but the remainder are. It is no different from any other portfolio of contracts in any other business that I have operated—you have a range.

Chair: We will come back to that part later.

Q72 **Sir Geoffrey Clifton-Brown:** One quick question for you, Mr Lewis. It was reported immediately prior to your arrival at the company that Capita was not at fault and it was not willing to invest more money.

Jonathan Lewis: In this contract?

Sir Geoffrey Clifton-Brown: In this contract. To go back to the Chair's question, was that the right call in November 2017?

Jonathan Lewis: I am not sure where you have got that quote from.

Chair: It is not a quote. You arrived in December 2017, and there was a



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material change in direction. You just said that you have given Mr Sharp the licence to spend the money he needs to get this on track. What happened immediately before? You came in in December 2017 for a reason—presumably, because you had a different approach to your predecessors.

Jonathan Lewis: I started formally on 1 December. I was at Capita from 1 October. I have no recollection of any statement along the lines that you have just—

Q73 **Chair:** It was not a statement made by Capita necessarily; Sir Geoffrey is reading into the situation. You have only recently put money into the contract.

Jonathan Lewis: No.

Chair: So when did you start putting more money in? Just to be really clear.

Jonathan Lewis: It predates my arrival.

Chair: Okay. So you talk about extra money coming in, when did that start?

Stephen Sharp: If I could take that question, as I said, I have had responsibility for this contract since January 2017. I have been well funded ever since. We have had staff on the contract right the way through, over and in excess of what we budgeted for. I have not been placed under any pressure at all by Capita to take staff in or not to do the right thing by the contract at any time.

Q74 **Chair:** And at every point, the Government were aware of what you were doing—that you were investing more? The Government were aware of that plan?

Stephen Sharp: All the way through, yes. If you look at the staffing profile for the contract, we have been above the staffing levels all the way through.

Q75 **Sir Geoffrey Clifton-Brown:** Was that the understanding of your Crown Representative?

Stephen Sharp: I did not have any conversations with them.

Q76 **Chair:** You did not deal with the Crown Representative. Mr Lewis, was that you and your predecessor? Who would deal with them?

Jonathan Lewis: Prior to my arrival, it would have been my predecessor. I cannot speak specifically about the staffing levels, but is that the sort of thing that the Crown Representative would be very aware of? Yes, it is.

Q77 **Sir Geoffrey Clifton-Brown:** Mr Lewis, please would you examine the record of what your predecessor discussed with the Crown Representative, and if anything you have said in the Committee is inaccurate, will you let us have a letter?

Jonathan Lewis: Yes, I will happily do that.

- Q78 **Bim Afolami:** Now on to the NHS portion of this. Mr Stevens, in your view, what should be in place from the NHS England perspective before complex outsourcing contracts are awarded?

Simon Stevens: First, let me say that this has clearly been a rocky road, and the NAO accurately described the bumps along the way, which are regrettable. That should not obscure the fact that, notwithstanding the economic pain that Capita has experienced, the contract has saved taxpayers £60 million in lower administrative costs in the national health service over the first two years of its life, as is also reflected in the NAO Report. That £60 million of savings is not to be sniffed at; it is the equivalent of 30,000 operations. So to have that context in there—

Chair: We are aware of that.

Simon Stevens: Good. Understanding the prior conditions here is important to be able to answer your question sensibly.

Chair: You needed to do something—that is what you are saying.

Simon Stevens: We had to do something. We did not really have a choice; the status quo was going to fall over.

- Q79 **Bim Afolami:** From your perspective, when you are contracting out, what should be in place—I will help you a bit—in terms of data, measures of performance and so on, before you do that sort of contract?

Simon Stevens: The process that was followed here—in no way detracting from all the observations in the NAO Report—went through all the right milestones: it followed the Crown commercial service contract; it had an MPA review and got the thumbs-up from that process; and it was signed off by other parts of Government. There was a pragmatic recognition that, given the inheritance of 40-odd different offices and 80 different instances of very old IT systems going back 20 years, urgency was a factor here. We did not have the luxury of time—of sitting around for a year or so—in which case we would have forgone another £30 million of administrative savings.

- Q80 **Bim Afolami:** Let me see if I can answer my own question. Is it that in your speed, you pulled in the supposed experts from central Government and said, “We need to do this quickly. Give us your best way of doing it”? Is that what happened here?

Simon Stevens: It was a combination. Certainly, we did benefit from that expertise, but we also took the time between 2013 and 2014 to scope out services, and then the new contract kicked in in September 2015.

- Q81 **Bim Afolami:** The difficulty here is that every page of the NAO Report seems to show—and, in fact, colleagues from Capita have already said this today—that the data was not ready, the performance indicators were not ready, agreed or accurate. This has been such an iterative process over such a period of time. So I ask again, and I do want to ask about



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other things: surely you should make sure that whenever you contract out this sort of complex, big contract you have all these things nailed down?

Simon Stevens: In principle, of course that is right—

Q82 **Chair:** But you said there was urgency.

Simon Stevens: In practice there was not just urgency; the very transition period itself unearthed problems with the status quo ante. If you remember the discussion we had with you on the clinical correspondence issue—the SBS matter involving Sopra Steria, the joint venture—that came to light only because of this transition so I do not want to overstate the coherence of the legacy arrangements that we inherited.

Q83 **Bim Afolami:** Therefore, when you were running the bidding process, was this made clear to bidders, not just to Capita but to all bidders—“Look, this is our view but it’s not entirely clear. This is our best estimate”—so that they could base their bids on that that?

Simon Stevens: It was. Bidders were given the opportunity to kick the tyres to the greatest extent we could make available, and they were given the opportunity to flag to us any particular information items where they thought there was such uncertainty that they needed a—

Q84 **Chair:** Can you give us some examples? You say, “Kick the tyres”. Were they allowed to visit offices, talk to staff and see what was going on?

Simon Stevens: I believe that is right, and I am sure that Emily will come in on it as well, but I just want to be clear about this point. Bidders were given the opportunity to say, “Based on the information that has been available to us, here are the things that at this point we are unclear or uncertain about and we would like the opportunity to have a post-contract discussion with you about”. I think I am right in saying that the only item that was put forward on that basis was the number of staff who were going to TUPE transfer.

Q85 **Chair:** From any bidder?

Simon Stevens: From the successful bidder.

Q86 **Chair:** Perhaps we could just pick up on the point about what they actually visited, not just Capita but other bidders. Did they go into offices? Did they talk to staff?

Emily Lawson: I do not know whether they went. I know they were given the opportunity—

Q87 **Chair:** I know you joined only in November last year.

Emily Lawson: I joined in November, yes.

Q88 **Chair:** Was that option open to bidders, to go in?

Emily Lawson: Yes. There was a three-part process, with 40-something initial organisations invited to be part of the process. Those was reduced to three preferred—



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Q89 **Chair:** I bet it went down from 40 to three. That is not surprising.

Emily Lawson: Yes it did, and at the point at which there were three there were additional data dumps into the data room, which contained a huge amount of information, some of which is behind me. That included information on the existing IT systems, the number of people and where they were based, the existing offices and the leases that were available on those buildings. There was a huge amount of information. The original specification was 51 pages in itself.

Bim Afolami: I struggle with this a bit. I am going to stick up for Capita in this regard.

Chair: Enjoy it while you can, gentlemen.

Q90 **Bim Afolami:** Surely the onus should be on NHS England to absolutely do its best, not just to dump all the existing data but to really assess that properly? What you both seem to be saying is, "Look, we didn't really know what we were dealing with here and neither did the bidders".

Emily Lawson: I am not saying the extreme version of the question in the way you just asked it. Both Capita and NHS England engaged in an extensive process of coming to understand services, including—from the point at which NHS England decided that going to outsourcing was a good idea—setting up a team to manage it day to day and to start to make the kind of service improvements that were possible with NHS England's existing capabilities and capacity. So there was an ongoing effort from later in 2013 to get the services into a position where we could make a decision about whether we should be outsourcing or not. I do not think it is a case of either party needing to say, "It was your fault. You didn't give us enough staff" or the other way around. There was a process via which both parties needed to understand it. We tried to design a process, in my understanding, that allowed the preferred bidder to then get additional information as they started running the service and amend accordingly.

Q91 **Chair:** Okay, but I actually asked whether anyone—perhaps Capita can answer this—other than or including Capita visited actual offices. One of the things we do as MPs is we visit things and get out on the ground. With boots on the ground, you learn a lot. Was that part of the process of evaluating how the contract would run? Was that available to bidders?

Emily Lawson: It was available to them, yes.

Q92 **Chair:** Did any bidders do it?

Emily Lawson: I have to say, I have a feeling that they did, but—

Q93 **Chair:** You don't know. Okay. Capita, did you? Mr Sharp.

Stephen Sharp: There were visits that took place. Throughout quite a period of the bids, I think numerous visits were made.

Q94 **Chair:** That seems very sensible. If visits took place, how come you so woefully underestimated the level of work that needed to be done and the differences across the offices? Were they chaperoned visits where you



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only met the very happy members of staff?

Stephen Sharp: The biggest issue on these contracts—this is from years of experience—is always whether you have got good data. If you have good data, you have a reasonable chance of a reasonable outcome, but if you have not got good data, it becomes quite a bit more difficult. I have to say that the onus is on us as well to ensure we have got good data. It is on both parties, but clearly we were remiss in not ensuring we had access to all the data we should have had.

- Q95 **Sir Geoffrey Clifton-Brown:** Mr Sharp, you only asked for one variation in the contract, and that was on how many staff were to be TUPE-ed in. When you had done your due diligence, which might have included going around the 47 offices all operating different local methods of doing things, why did you not ask for other variations, particularly relating to the veracity of data?

Stephen Sharp: I will speak in general terms because, as I said, I was not on the bid. I only took this on in 2017. Sometimes there is a difference between what you ask for and what you are allowed as part of the process. It may be that we asked for other allowances, variance or assumptions to be written into the contract. Maybe that was refused. I was not there at the time, so I could not—

- Q96 **Sir Geoffrey Clifton-Brown:** Mr Stevens, you were there at the time. Did they ask for any other variations?

Simon Stevens: I do not believe so, but we can double-check that.

Jonathan Lewis: It would be wrong of any of us to assume that you could comprehend the complexity of service and process and, speaking to your point, the variation in how the service was being executed across the 47 offices through a due diligence process prior to tender. Candidly, that is not how this outsourcing should have been approached. It should have been piloted, and there should have been an assessment of what the issues were prior to the entire service being outsourced.

- Q97 **Bim Afolami:** Mr Stevens, do you agree with that?

Simon Stevens: Well, in some respects we already had a mixed system prior to the transition to Capita in that we had some in-house delivery and we had Serco, Anglian Community Enterprise and Sopra Steria. In that sense, that prior experience of working with different private partners as well as the in-house service was available.

- Q98 **Bim Afolami:** But do you agree with the more precise point that structurally this should have not been approached in this way?

Simon Stevens: No, because I think the consequence of not doing so would have been that we would have been exposed to a different set of risks. The prior service would have potentially fallen over. As we now know, it was itself subject to a number of important failures, as evidenced, for example, through the SBS.

- Q99 **Bim Afolami:** Forgive me, but that is not quite right. It is not an either/or



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between the big bang, very complex, multi-office approach that we took and it staying the way it was. Presumably there is a third way, which is that you could break up the contract into different bits, for example. What I am trying to say is that surely there were other ways of doing this. If I look at this, the NHS and the taxpayer have saved £60 million and Capita has lost a lot more than that. I can see why you wanted to do things this way, but do you think that is the right way to build proper strategic relationships with partners going forward on this sort of contract?

Simon Stevens: We certainly looked at whether the contract should be chunked geographically and go with more than one partner. I think I am right in saying that economically that was a less advantageous position, partly because how the savings were going to come out of this was through substituting a lot of manual systems and distributed bureaucracy with more concentrated service; and I think what the potential providers were telling us was that you would get those scale benefits over the life of the seven years of the contract if you did that at the England level rather than divvy it up four ways, or whatever it might be. So I think that was part of the consideration; but I do think the fair point you make, though—perhaps implicit, as well, in Jon Lewis’s comments—is that more of a transition during the early years of the contract, by whoever was the provider, as against the sort of big bang transition that we actually saw, would clearly, as Jon says, have been preferable in operational terms. I agree with his comments on that completely.

Q100 **Chair:** But the big bang approach was set by NHS England.

Simon Stevens: No, it wasn’t, but we understood that that was what was being proposed; so I don’t dissociate ourselves from that, but the actual decision on the timing of the office closures and so on was an operational decision, and I understand what Jon has just said—that with hindsight they would choose to do things differently. Clearly the economics of the contract drove them, I suspect, perhaps in that direction. That is reflected in the fact that taxpayers have saved £60 million during this period of time.

Q101 **Bim Afolami:** Just on the offices in particular, do you feel that it is important on a contract of this type for NHS England to have the power contractually to stop something happening that may have a significant impact on service levels and performance to patients? If so, why didn’t you have that and build that into the contract from the get-go?

Simon Stevens: If you are looking to get the most economically advantageous result from a procurement, obviously bidders have to price in the possibility that their ability to drive efficiencies in the service model might be stopped by the client. So it is not as straightforward as it might seem simply to say that there should be that veto, is my supposition.

Q102 **Bim Afolami:** I can recognise it is not straightforward. It is really a question of priority, and I am noting the fact that you have used the phrase “economically advantageous” quite a lot—



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Chair: And you have talked about £60 million a lot.

Bim Afolami: Which I think is driving a lot of this, which I don't inherently disagree with; but just on this point isn't the priority question between either you are saving more money more quickly or you are minimising potential downside for patients, in this particular instance, in relation to offices?

Simon Stevens: I think that is the implicit trade-off that was made, and I think with hindsight it would be beneficial, which is the situation we are now in as part of this sort of re-established working modus operandi, where we are doing that—making those kind of calls jointly.

Q103 **Chair:** We have had some quite compelling evidence from, among other people, the British Dental Association, which I won't repeat—it is on the record—highlighting some very challenging situations for both patients and keen dentists who want to serve the NHS, who were left waiting months for treatment or months to work, indeed, in some cases. What would you say to them now, in hindsight?

Emily Lawson: I think you are referring to a letter, particularly focusing on the east of England.

Q104 **Chair:** No, it is just written evidence that came into the Committee from the British Dental Association. I do not have a date when it was submitted, but it has come in ahead of the hearing. I have given the highlights: people waiting months for treatment, and dentists waiting months to be registered to treat patients.

Emily Lawson: There were delays as outlined in the NAO Report on getting people on to the performers list appropriately. Those backlogs have now largely been cleared and the turnaround is now two weeks on that list.

Q105 **Chair:** But it was months and it had a huge impact on service.

Emily Lawson: It was months, and there are still places where it is still months, which isn't good enough—some of which affect dentists. It doesn't just affect them. There are particular places where it will always take a long time, because people coming from overseas need a different kind of check by HEE to make sure that their qualification is actually applicable and allows them to work in the UK.

Q106 **Chair:** We are not talking about the exceptions; this is the general rule.

Emily Lawson: No. What Mr Lewis and I have agreed is that the performers list process needs a review end to end, because it is not one that is entirely within the control of the PCSE contract, because it involves HEE, it involves Public Health England occasionally, it obviously involves NHS England. Looking at the current cases that are backlogged, just under half of them involve not having enough information from the person who is applying to be on the list in the first place. We need to look to simplify and make sure it is clear what information—



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Q107 Chair: That is fine going forward. You are going to change the system again, and hopefully that will eventually improve things. What do you have to say to the dentists who could not work and to the patients who could not get their dental treatment while they were waiting months for the paperwork to go through? In hindsight, would you put a different balance on the £30 million a year that the NHS is saving from this contract, compared with the direct human impact on people who were living with toothache or worse while they waited for a dentist to be registered or for their paperwork to go through?

Emily Lawson: To the people who experienced delays completely outside their control, particularly during 2017 when a big backlog built up, I would say that it was unacceptable and it should not have happened.

Q108 Chair: Mr Afolami and Mr Stevens have both talked about the trade-off here. In hindsight, because obviously you only came into post in November 2017, do you think the trade-off was the right balance? Would you look at doing this differently if you were in charge of this contract? It is easy to say with hindsight, but it is that £30 million a year versus the proper service that patients should expect.

Emily Lawson: It is very difficult to sit here and say that you know what you would have done in a situation where highly qualified people did something different. In retrospect, along the lines that Simon, Mr Lewis and Mr Sharp outlined, there are places where, if I was going to do it again now, I would approach it in a different way. What we do not know is the relationship between the £30 million saved and the actual experience of people on the performers list, because it is not a one-to-one relationship. That absolutely should not have happened and the service should not have fallen into that level of backlog, and we are now endeavouring to make sure that does not happen again.

Q109 Bim Afolami: Mr Stevens, let us fast forward a few months or years to a similar—not identical, but similar—sort of contract that NHS England wants to procure. First, how would you get anyone to bid for it, bearing in mind the amount that Capita have lost on this? Secondly, what do you think are the big three changes you would make?

Simon Stevens: The recommendations the NAO set out in this Report are the right ones, so we will accept all those recommendations in full.

Q110 Bim Afolami: In relation to the cost, have you entered into a side letter or any other agreement to allow Capita to continue and to recover their losses in relation to this?

Simon Stevens: The £125 million that has been talked about? No.

Q111 Bim Afolami: Even if they do not make a profit, as they have already hinted that they might not?

Simon Stevens: No.

Chair: Do you mean extending the contract, Mr Afolami?

Q112 Bim Afolami: Extending the contract, yes.



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Simon Stevens: No is the answer to your question. There is a process that was described here in the Report for reviewing aspects of the service and being clear about what that will take going forward, but we have not agreed to underwrite losses.

Q113 **Chair:** The contract was a 10-year contract, just to be clear?

Simon Stevens: Seven, with a three-year extension.

Q114 **Chair:** Will you take all this into account when you look at renewing or retendering the contract?

Simon Stevens: I am certain we will be in a different position in three years' time when we get to year seven. Already we are in a much better position than we were 18 months ago. I am sure both parties will make smart choices at that point together, but I do not want to anticipate, other than to say that I am sure we will continue to build on the improvements we have seen.

Q115 **Bim Afolami:** Do you feel, Mr Stevens, that criticism of this contract is in any way unfair on Capita? The more I hear, the more I feel that Capita has taken the sharp end of this and NHS England, despite slight reputational difficulty, has saved £60 million. To what extent do you feel that you should take more of the blame here and Capita should take less of it?

Simon Stevens: The NAO has laid out the issues, and you have heard a set of very responsible comments from the new CEO of Capita. I think that will mark a different position going forwards, so there is not much point in attempting to relitigate the past. We are looking forward.

Q116 **Gillian Keegan:** I am struggling a little bit with the maths. You have saved £60 million, but by the end of the seven years I think you anticipate it will cost you £140 million. Therefore, it has not saved anything; it is just that you have been leveraged to bear the loss. Has this contract led to any efficiency savings in the round? Will you ever be able to make this work efficiently?

Jonathan Lewis: That is a really good question. There is a lot of complexity around the £60 million in saving that was sought and around why we will have invested £125 million and lost our margin. Should the outsourcing of this scope of work fundamentally deliver better value for money for the taxpayer? Absolutely. By the way, I define better value for money as a sustainable, resilient service that gives a better end result at a fair price. You look at what was inherited—47 different operations and so on—fundamentally it can be run more efficiently.

Q117 **Gillian Keegan:** Except it cannot this time over seven years.

Jonathan Lewis: Because of the learning curve—

Q118 **Gillian Keegan:** That is quite a big learning curve. If all your contracts were like that, you would be bust.

Jonathan Lewis: But they are not, thankfully.

Q119 **Gillian Keegan:** I know, but you did not know that this one would be like this, either, did you?

Jonathan Lewis: No, we didn't.

Q120 **Gillian Keegan:** You found out when you opened the lid.

Jonathan Lewis: Yes. But we made a commitment to execute against this contract. That is what we have done and that is what we will continue to do. It is a learning.

Q121 **Gillian Keegan:** Because you will not make any money over the seven years, I am concerned about whether, as you get to the end, this is a saving if you take this ongoing operation. You have already put 60 more people on it for your resilience, and you may need more—who knows?

Stephen Sharp: Can I explain? By the end of the seven years we should be in a transformed state. For example, we—

Q122 **Gillian Keegan:** You mean that year would be—

Stephen Sharp: No. Over the next 12 months we have plans to transform the service. For example, we have 20 million pieces of paper coming to the operation every year to do ophthalmic payments. That is a 1980s process in the year 2017. We can put that online.

The performer list is paper-based—bits of paper come in, and it is not always filled in correctly. If we put that online and we allow the information to come in only once all the mandatory fields have been completed, it will speed everything up. Within the next 12 to 18 months we should be able to take a lot of the economic benefits that were planned from the outset of the contract. We should have a digitalised service, and at the end of the seven years, whether the contract goes back to the NHS or potentially goes to someone else, the savings envisaged at the outset should be delivered and ongoing benefits should be available to the taxpayer.

Jonathan Lewis: To answer your question explicitly, it cost us more to get there, but when we get there there is a sustainable value.

Gillian Keegan: By year four.

Jonathan Lewis: What are we in now?

Stephen Sharp: We have got various programmes and projects in final test and final UAT. The thing we have got to do now, as the NAO Report clearly sets out, is to ensure we bring the stakeholders with us. We do that gradually. We test them properly and do them incrementally—there are no big bangs. We have got plenty of time left to do all of that, and I am fairly confident that the things we have planned will bring big benefits to the service going forwards, reducing cost and improving the service to the recipient GPs, ophthalmists and—

Q123 **Gillian Keegan:** By year four? By what year?

Stephen Sharp: Within the next 12 months we should make substantial progress.

Q124 **Chair:** Can I check? Who owns the IP on the IT?

Stephen Sharp: NHS England.

Q125 **Chair:** The NHS—that is right. Will you bid for the contract again, Mr Lewis, when it comes to the end?

Jonathan Lewis: As we do with all contracts, we will look at it on its merit. Depending on scope, fit and risk profile, we will make a decision on whether to bid or not. It would be completely wrong for me to communicate today, for reasons of competitive tension, whether we would or would not bid.

Q126 **Sir Geoffrey Clifton-Brown:** Mr Stevens, can I take you to page 11 of the NAO report? It says, “Contract penalties have yet to be applied from May 2017 because NHS England does not accept Capita’s reported performance data due to disagreements about the scope of some of the measures.” Is that still ongoing, or has it been agreed?

Emily Lawson: Mr Sharp referred to that earlier. That has been largely, but not completely, agreed. For example, we encouraged Capita, which had held up its invoicing because of that disagreement, to start invoicing again from February on the basis that we will sort it out retrospectively if we need to. We didn’t think it was appropriate for them to continue not to invoice.

Of the 11 metrics mentioned in the Report as not having been agreed, we have agreed seven, we have largely agreed two and two are remaining—one relates to medical records for people in military service and one to timing on payments.

Q127 **Sir Geoffrey Clifton-Brown:** Can I then take you to page 45? This is to do with the office closures. The paragraph in the bottom box—titled “Our conclusion”—says: “NHS England was unable to stop Capita’s aggressive office closure programme, without cancelling the contract, even though it was having a harmful impact on service delivery.” Mr Stevens, why was the contract written so that your contractor could take actions that were effectively putting patients’ lives in jeopardy?

Simon Stevens: I think the last part of that may not be quite right. The first part is, in a sense, the discussion we were having a bit earlier, which is that there is a trade-off between the client being able to second-guess the operational delivery model of a partner in a situation like this on the one hand, versus the control that you would want on key decisions. If you set a contract that enables the operational delivery to be constantly second-guessed by the client, you have to build in a cost premium for that as part of the bidding. In other words, costs to taxpayers could well have been higher if we had attempted to insert all those kinds of controls. As we said earlier, we are now, in a sense, in a different position and we are working together with Capita on these questions.



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Q128 Sir Geoffrey Clifton-Brown: I find that that implies something slightly strange. Costs to taxpayers are an excuse for allowing your contractor to carry out actions that might have put patients' lives at risk?

Simon Stevens: We don't accept that patients' lives were put at risk.

Chair: They received a pretty damn poor service.

Simon Stevens: In general, the point of bringing external capability to bear to redesign the service process is so that the entity that is selected then has the operating freedom to do so.

Q129 Sir Geoffrey Clifton-Brown: Is that the reason why, in your latest submission to the Committee—your response to the NAO Report—dated 14 June, you say that, even though the plan is approved, NHS England will still need to approve the go live recommendation from each project board? In other words, you are reserving to yourself far greater controls over the contract than you had before, because you would not have approved this aggressive office closure and the number of staff that were lost because of it.

Simon Stevens: Yes.

Emily Lawson: I hope the letter and the discussion reflect that we have obviously learned a lot during the life of the contract, as has Capita. Those learnings did not just start with this letter; there were changes to the governance of how we assured the contract during the process. For example, the monthly service line board meetings were set up in the first year because we recognised that we weren't having the right conversations with Capita and we didn't have the right ability to intervene in performance, so we used contractual mechanisms to try to get that to the right place.

We see the paragraph you refer to in the letter as being a positive thing, and Capita has been open to that. It is not just us in that situation; although they don't have a veto power, this involves the relevant stakeholders in every service line. For example, on ophthalmic payments, you have heard some of the problems that exist, and the Optical Confederation and the Local Optical Committee Support Unit are both involved in the steering committee for the transformation on ophthalmic payments, to make sure that we do this in a way that works for their members. There are other examples, but this is an example of how we are trying to learn as we go and to make sure that we improve as we go and embed as much of this learning as we can.

Q130 Chair: You were receiving £5.3 million in contract penalties from January 2016 to April last year. Surely some of these changes should have been brought in sooner?

Emily Lawson: Some of them were. The service line boards change, for example, occurred in 2016. As you have heard, we have had conversations about the KPIs consistently. We changed the way that management information flows to the monthly service line boards, to



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make sure that we had as much information as possible. I am not saying it is perfect—

Q131 **Chair:** But that is just more money into NHS coffers, which we would normally welcome, but not when patients and practitioners are suffering. That money is coming in because of a poor service; it is a dividend with a sting in the tail.

Emily Lawson: I am not sure what the question is.

Q132 **Chair:** You have £30 million of savings a year, and you had £5.3 million in penalties over 18 months or so. That money was coming into the NHS but it wasn't being put back into sorting out the system. That money had no impact on the patients who were seeing very directly the problems that this poor service was delivering.

Emily Lawson: We have spent money during the course of the contract to try and rectify problems if they come up, including the IEMT, which is referenced in the NAO Report, which was there for 18 months. There has not been a reluctance to invest in our assurance of the contract. Like I said, I am sure, if we went back, we might do something different, but we have tried to learn as we have gone along.

Q133 **Sir Geoffrey Clifton-Brown:** Final question. Do you think you have now negotiated back into this contract process sufficient controls to make sure that the contract does deliver the transformation that you originally expected it would?

Emily Lawson: It is not just a question of negotiating the contract. It is the partnership working that Mr Lewis referred to earlier. There is no way to ever write a contract that covers every eventuality and gives you perfect rights in every situation. As you have identified, we cannot identify every—

Q134 **Sir Geoffrey Clifton-Brown:** On the generality, the trend, of the different components of the contract, are you now satisfied that it is going to go in the direction that you originally intended it would?

Emily Lawson: I am satisfied that it is going in the direction, and there are places where we still have concerns, which we have outlined in the letter. If this trend continues, I would continue to be optimistic that we can get where we need to go, but we will obviously make sure we are assuring the contract in the right way and intervening where we need to.

Q135 **Sir Geoffrey Clifton-Brown:** Mr Lewis, you have got to take this contract on for another three years, when the seven years are up. Are you satisfied that you will be in a sufficient place to make sufficient money out of that last three years and that it is actually worth doing?

Jonathan Lewis: As we stated earlier, whether or not we make money on this contract is not the primary motivating factor right now.

Chair: Not right now.

Jonathan Lewis: It is to execute against the contract. Again, as I stated earlier, I am not sure we will make money on this contract.



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Q136 **Sir Geoffrey Clifton-Brown:** No, but making money is not the only thing. If you do it efficiently, as it was intended to be, you are likely to make money. The two go hand in hand. By the seven-year break clause, will it have got to the state where it was intended to be and therefore you will be making money?

Jonathan Lewis: As the NAO Report points out, I don't think the head count levels that we will be operating at year 7 will be what we originally bid. They will be greater. Secondly, we have sunk so much into this contract, we will not recoup that in the final three years. That is what it is. The point I would much prefer to make is that, working in partnership with Emily and Simon, we are committed to delivering against the contract.

Q137 **Chair:** Mr Lewis, can I come back to a point you made earlier? You talked about the decision to go big bang. I think you said that if you had been here—maybe it was Mr Sharp—you would have wanted to see a pilot. Simon Stevens has said that it was not NHS England that said go big bang. It was a decision by Capita. Do you recognise that description? Why did you decide to not go for a pilot?

Jonathan Lewis: I made a comment earlier that I think on first generation, highly complex outsourcing contracts where there are many unknowns, where you don't know what you don't know—

Q138 **Chair:** So why didn't Capita do a pilot?

Jonathan Lewis: I have no idea.

Q139 **Chair:** Even though you read up on why decisions were made before you came to the Committee.

Jonathan Lewis: As you might expect, some of the individuals who were involved in that contract in that timeframe are no longer in the employment of Capita.

Q140 **Chair:** You do not have any records that show why that decision was made. Was it financially advantageous just to go big bang?

Jonathan Lewis: So in the spirit of utter transparency, of course it was financially advantageous. They wanted to get the cost out of the contract.

Q141 **Chair:** But in the end it has cost you more. You talk about engaging, the NAO talked about it, and we would say of course you need to engage with stakeholders. Have you done an assessment of the costs to pharmacists, ophthalmologists, GPs, dentists and so on, who will have to install presumably new IT systems and train staff in how to input data? Do you have an idea of what it is going to cost them and in what timeframe?

Jonathan Lewis: I have no awareness of that.

Stephen Sharp: We are hoping that the implementation will take costs out of the whole chain. For example, ophthalmists are currently filling in 20 million pieces of paper. They have got postage costs. Often the forms come in incomplete. We send them back, which causes delays. They fill them in again and they come back. So we are hoping that the things we have got planned will take costs out for everybody.



Q142 **Chair:** But will they have to buy the software?

Stephen Sharp: Most of them will already have IT systems. Quite a lot of the ophthalmists have got quite big firms. We accept that some small ophthalmists might never adopt the new process. There might be quite a long tail before we get everybody converted. Maybe we will never get everybody converted. For example, if I was an ophthalmist without IT and I was looking to retire in the next 12 months, maybe I would not wish to invest in the system. I would carry on with the paperwork.

Q143 **Chair:** So you are getting that granular that you will know about a pharmacist in a small rural town who may be retiring and who won't ever do this, and you will allow for that?

Stephen Sharp: There are no plans at the moment for these to become mandatory adoption. We're hoping that—

Q144 **Chair:** Not at the moment, but maybe in time?

Stephen Sharp: I would hope that at some point in the future the whole world will catch up and maybe there is no need for paper forms, but we're not going to force it upon people.

Jonathan Lewis: It is not our decision.

Q145 **Chair:** I was going to ask NHS England: are you going to mandate—? I'm not saying that there is anything necessarily wrong with mandating people to use a new system, if it works. How do you see it rolling out, Ms Lawson, to the actual end-user—the computer system?

Emily Lawson: We are trying to support Capita in engaging with end-users early on. In fact, on ophthalmic, which Mr Sharp has just been talking about, that has resulted in some changes to the planned transformation, including exactly that amendment that he has just mentioned. So, what we need is to get that kind of granular understanding from stakeholders and their representatives, to say what is actually doable.

Q146 **Chair:** Do you think you might have had better granular understanding if there had been more engagement with those people before the contract was shaped?

Emily Lawson: There was engagement; I didn't intervene earlier when we were talking about it. There probably could have been more, but there has been engagement throughout. In getting feedback from stakeholders since I came on board, I think that some of that engagement has been perhaps a bit lip service. So, what we are trying to do is to make sure Capita makes it happen early and that it happens in a way that we really listen and respond appropriately.

Q147 **Chair:** I am glad that you recognise that, because on this Committee we often hear about consultations engaging users, and lip service is a phrase that springs to mind too often, I'm afraid.

Mr Stevens, I have a final question for you. This has been a shambles,



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frankly—well, you got £30 million a year in your budget, so probably you are not too unhappy on one level. Have you learned lessons from this that you are already applying elsewhere in NHS England contracting? If so, can you give us some practical examples of where you have learned from this, which has helped you to avoid mistakes in current or ongoing contracts?

Simon Stevens: We are not running any further procurements of this scale; we have not done since the letting of this contract. But, as I said earlier, I think we take very seriously the recommendations of the NAO and would be implementing them in any future such exercises.

Chair: I will leave it there for now with NHS England. So thank you to Ms Lawson and Mr Stevens. Mr Lewis and Mr Sharp are going to stay for the second half of our session.