Royal Devon and Exeter NHS Foundation Trust

The Royal Devon and Exeter NHS Foundation Trust ("RD&E")

Case Reference CCD -1/15: Monitor Investigation into NHS NEW Devon CCG commissioning of certain community services for the Eastern Locality

Response to Statement of Issues (SI)

Executive Summary

1. The Northern Devon Healthcare Trust (NDHT) challenge to NEW Devon CCG's decision to designate the RD&E as its preferred provider for adult complex care for its Eastern locality goes to the heart of the basic healthcare challenge in England today. In a period of unprecedented demand for care, with an aging population and a severely constrained economic climate how can the NHS improve wellbeing and prevention and deliver best care whilst using its limited resources more efficiently?

2. The challenge must be considered against a background of Government policy and laws which promote integrated care as well as patient choice and competition. The solution must deliver the best outcome for patients in a manner that is responsive and reflective of their needs and aspirations and most importantly in the best interests of society. Our proposals for delivering integrated care are consistent with national guidance and supported by a growing national and international evidence base that describes the most effective way to organise services for the benefit of local people.

3. The service model and changes that are required to deliver the aspirations set out in the Community Services 'A Strategy for the 21st Century' produced by the CCG following extensive public and patient engagement, require a radical and transformational approach. The RD&E submission as part of its assessment as a capable provider demonstrated how this could be achieved.

4. Under the Transforming Community Services (TCS) arrangement introduced in 2010 NEW Devon CCG and its Eastern Locality have not reaped the benefits other health systems that have integrated acute and community services achieved. Our population does not have access to the level of integrated care already available to people in the Northern Locality and are disadvantaged by the perpetuation of a silo approach to care delivery.

5. The NDHT decision to challenge the CCG award of prefer provider status to the RD&E has the potential to delay the much needed transfer to a new way of working in the Eastern Locality with consequential negative impact on the delivery of high quality safe and effective care to that population. Integration of community and acute services is one part of a wider service integration work programme that could be undermined if there is a delay in the process.

6. It is our view that NEW Devon CCG designed and followed a robust process to establish the model of care they wished to commission and fair, transparent and challenging process to test the capabilities of organisations to meet their service requirements. The RD&E believes the decision made is demonstrably in the interests of patients and the public in the Eastern Locality and looks forward to Monitor's confirmation that the service transfer may proceed.

Introduction

7. The RD&E is content to support and respond to the Statement of Issues in order to assist in the rapid resolution of this complaint. We urge the parties to this process to do the same and enable Monitor to conclude its investigation, confirm the lawfulness of the award and allow the process of transfer and integration to take place for the benefit of local people in the Eastern Locality of Devon. It is their interests, not the interests of individual organisations that are paramount; they will not be best served by extended and uncertain legal processes and timescales.

8. This investigation goes to the heart of the healthcare challenge in England today: how the NHS can care for patients better while using its limited resources more efficiently? The challenge must be considered against a background of Government policy and regulation which promote integrated care as well as patient choice and competition.

9. Amongst the parties involved in this challenge, there are different views of how to approach the commissioning of integrated care in the Eastern Locality of NEW Devon CCG. Essentially one party seeks a process-driven approach and the other an outcome-driven approach.

10. On the one hand, the complainant appears to argue that NEW Devon CCG adopted a flawed process to select the RD&E to provide community services for adults with complex care needs in the Eastern Locality. Amongst other things because it was neither truly competitive nor transparent. The complaint (as far as disclosed in the Statement of Issues) therefore focuses on what it sees as deficiencies in the process, which – in its view – must lead to an inferior outcome. Consequently, they argue there must be a competitive process to establish a choice between possible outcomes as well as providers. Their premise appears to be that there is no place for an outcome determined through consulting the community and patients. CCGs are required by statute to engage with and consult the public on the design and planning of services and respond to those views when commissioning of care. The complainant appears to contend that the views of the public should be discarded and a process that is anything other than fully competitively tendered is not acceptable.

11. On the other hand, the CCG's process was designed to effect a step change in patient care in the Eastern Locality. At the heart of this argument is the

CCG's development, through extensively consulting the public, patients and clinicians, of its own vision for the community services it wished to commission. The emergent strategy, in response to the strongly held views of the public and clinicians, was very different from the service the complainant is currently providing. In consequence, the CCG designed a process to achieve a specific outcome for community services and the RD&E was invited to discuss its capability to meet the CCG's aspirations. The question posed was could the RD&E demonstrate it had the capability to meet the specific step change requirements of the CCG's vision? If it could not be demonstrated how the RD&E would achieve the step change improvement required, the CCG would explore alternative options.

12. In short the question the investigation is asked to address is this: must the process determine the preferred solution; or can the preferred solution determine the process? Our case is that the preferred solution may determine the process, and that there is nothing in law or in practice that invalidates the approach adopted by NEW Devon CCG. In this paper the RD&E discusses its vision for integrating community services by reference to three of the issues under investigation:

    a. Does the RD&E plan to integrate derive a high quality, efficient and value for money solution?

    b. Was the CCG process adequate in order to make an assessment of the quality, efficiency and value for money solution, including the extent to which the public were engaged? and

    c. The question of transparency.

Deriving a high quality, efficient and value for money solution

13. An essential challenge for the NHS is how to improve the quality of patient care (better outcomes, a more personal service leading to greater patient satisfaction, and greater safety) while deploying scarce health care resources to best effect.

14. The debate is about how, not whether, to integrate. Our perception is that the procurement process was comprehensively designed to elicit proposals to transform community services for the benefit of the people of the Eastern Locality. The debate is therefore about how best to provide integrated care for adults with complex needs in the Eastern Locality of the NEW Devon CCG and whether the approach and solution adopted by the CCG is lawful and in the best interests of patients.

15. Monitor defines "integrated care and support" as "person-centred and coordinated", and defines a "person-centred narrative" as:

    "I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me."[1]

16. The relevant factors (which must be taken as a whole and weighed together) include:

    a. The local health economy;
    b. Applicability of models derived from national and international practices; and
    c. Consultation with the public and with patients.

17. Our view – from our weighing up of these factors – is that the appropriate form of integration was to realign local community services with the local acute hospital through a service transfer– a fully integrated pathway approach driven by a single organisation.

18. National and international evidence has found that a silo approach to service provision confounds the desired process and outcomes for patients. Research suggests that for some patient groups, e.g. adults with complex needs, population segmentation and an integrated pathway approach offer significant benefits to the patients and the funder of care.[2]

19. The silo problem is compounded by multiple organisational boundaries – between primary, community, tertiary, specialist and acute services plus social care, which contribute to sub-optimal outcomes for patients and an inefficient allocation and use of resources.

20. The answer is to design a holistic care delivery system for the person, focused on wellbeing with services wrapped around their needs. This is sometimes described as 'population health' and complements a capitation approach to funding. Capitation is a key future commissioning intention of the NEW Devon CCG and further demonstrates the alignment of its approach to adult complex care service procurement and its strategic direction.[3] The evidence suggests that this approach leads to the greatest gains in outcomes, quality and efficiency. The RD&E considered this body of evidence was relevant and

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[1] *Ibid*., extracted from section 1.1.

[2] For example: Geisinger (US); ChenMed (US); Alzira (Spain); Kinzigtal (Germany);

[3] See http://www.newdevonccg.nhs.uk//planning-and-programme-office/strategic-planning/101069 Local NHS Futures – Transforming Care in Devon and Plymouth. The Devon and Plymouth challenged health economy strategy. See page 7.

applicable to the situation in the Eastern Locality and incorporated it and the feedback from the public in its proposals for how it could provide integrated care within the Eastern Locality.

21. To develop services that can be wrapped around people, you have to ask them what they want. The public and our patients, including the c. 12,000 public members of the Foundation Trust, experience at first hand the current disjointed organisationally defined arrangements. They have made it clear that they want fully integrated care. NEW Devon CCG's engagement and consultation activity over the last 18 months also clearly demonstrated this need and a response is embodied in the Community Services Strategy:

    "*Ensuring that the services are co-ordinated and integrated. The importance of organisational boundaries being 'invisible' and services being wrapped around individuals and their families has been stressed time and again. As a result, we are linking our TCS work closely to the work on integration with the local authority.*"[4]

22. The RD&E proposals were developed with and in response to this feedback and strategy and are designed to achieve an effective, integrated and personalised service. They also sought to maximise gain from the best use of scarce financial and workforce resource. Services across the community/acute continuum will be realigned to create a holistic service offer with a responsible lead provider accountable for the delivery of care.

23. Whilst there are different ways of achieving integration, the circumstances of each case will determine which solution is right. For example, collaboration between independent organisations may succeed where organisations have ample resources and are not undergoing significant change. But collaborations or JVs in any sector are most likely to founder where one or more parties, or the background conditions in which they operate, are changing rapidly. This is particularly true where the parties are competing for a market or for scarce resources and eventually collaboration will fail and one party will acquire the other.

24. We believe that ultimately the leadership responsible for developing and implementing integrated care should sit under a single organisation – an accountable care organisation funded via a capitation approach. The service solutions under "integrated care" need to take a full pathway approach to holistic patient care i.e. ensuring that each stage of the patient journey is cognisant of, and complements the care delivery that precedes and follows it. This usually requires a complete redesign of patient pathways. A critical

[4] Pathways for the future: Transforming community health and integrated social care services in the Eastern locality of NEW Devon CCG - Public Engagement Report. See page 8.

http://www.newdevonccg.nhs.uk/your-ccg/eastern-devon/what-we-are-working-on/transforming-community-services-tcs/100547

aspect of successfully delivering this redesign of services is maintaining flexibility around workforce deployment and this is better achieved through a single leadership.

25. The improvement in service quality and gain in efficiency of healthcare resources is achieved by reducing duplication of patient assessments and minimising hand-offs between organisations. The differentiation of care between the specialist and community elements of the service people received will be removed, maximising the potential for home based care. Integration in this way facilitates greater personalisation of care and - via a single electronic patient record - enables predictive and pre-emptive care models to be developed particularly for people with multiple comorbidities and long-term conditions.

26. Importantly the model will enable an integrated population based approach to health and well-being to be developed offering the opportunity to transform health and care services in the future. Our proposals took account of the increasing demands for care, particularly apparent given the age demographic in eastern Devon. Addressing the limitations of a fragmented approach in responding across the whole system of care and the need to target resources to best effect for local people is a key feature. Examples of this style of integrated care have shown how a significant reduction in hospital bed days can have a material effect on reducing system expenditure.[5]

27. The current provider of community services in the Eastern locality, Northern Devon Healthcare Trust (NDCT), was awarded the contract for the Eastern Locality under the first phase of Transforming Community Services five years ago. Whilst progress has been made in integrating community nursing service with some social care provision in cluster teams, there is little alignment with acute care and no holistic and fully integrated pathways of care in place.

28. The present situation in the Eastern Locality is in marked contrast to other areas, for example Northumbria, where acute and community services are fully integrated. Over the same period there have been major programmes of transformational work to reshape care, create efficiencies and ensure clinically and financially sustainable services.

29. More locally in South Devon, two organisations that have endeavoured to collaborate, in a CCG that has a national and international reputation and track record of integrated community care, have concluded that full integration of acute and community services within a single integrated care organisation is the correct and necessary next step. In order to take their pioneering integration agenda to a new level of benefit for local people and to ensure the

[5] See ChenMed article September 20th 2015 (http://www.economist.com/news/united-states/21618901-hints-how-provide-better-health-care-less-money-problem-solvers)

best value for public money, South Devon Healthcare NHS Foundation Trust plan to merge with Torbay and Southern Devon NHS Health and Care Trust.[6]

30. In our view, the NEW Devon CCG's approach is consistent with the analysis of national policy and confirmed by NHS England's Five Year Forward View[7] and the Dalton Review.[8]

31. The NHS Five Year Forward view was released before the NEW Devon CCG governing body meeting (on the 5th November 2014) which awarded preferred bidder status to the RD&E. Whilst the Forward View does not prescribe a 'one size fits all' approach to developing new models of care and organisational form, it focusses on the need to radically change the model of care to enable a population health approach and fully integrated care.

32. The Dalton review provides further support to these arguments. See figure 1 below.

Figure 1 – Efficiency gain mapped against organisational form (Dalton Review)

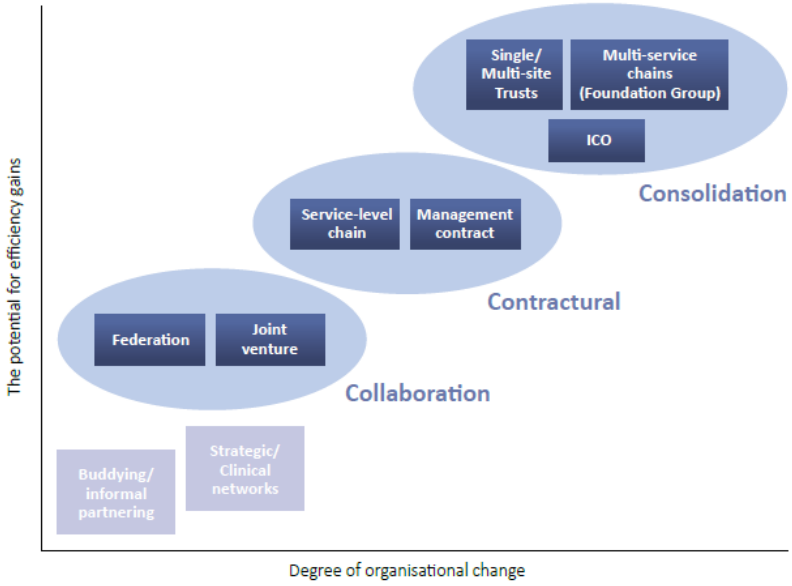

Figure 1: Different organisational forms and their potential ability to release efficiency gains[31]

[6] See: http://www.sdhct.nhs.uk/hospitalandcommunitycare/

[7] See NHS England, Five Year Forward View, October 2014; endorsed by Monitor, the Trust Development Authority and the Care Quality Commission.

8 See Dalton Review: Examining new options and opportunities for providers of NHS care- page 20

33. Dalton[9] explains that:-

> "*Where [the organisational form] is secondary care led it allows hospitals to operate in new areas of out of hospital care and to balance an investment in community-based services with a divestment in hospital-based care, without undue financial risk to the organisation. This is considered to provide an attractive model for secondary care providers, who might otherwise resist a transfer of resources from their organisation*."

34. It follows from the discussion above that the NEW Devon CCG's approach – and RD&E's response – is very much consistent with international and national approaches, with national policy, with patients and the general public expressed requirements.

An effective procurement process

35. The approach adopted by NEW Devon CCG in developing its service and procurement strategy has been robust and involved considerable public engagement. This extensive public and patient engagement enabled the CCG to co-create a Community Service Strategy and associated design principle. The emergent strategy and design principles have been tested against the national and international evidence base available and are fully consistent with national policy on the benefits that can be derived from comprehensive integrated care.

36. The RD&E, and its 12,000 plus public members, support and endorse the strategy and has participated in the procurement process to identify the preferred provider. The process has been open, robust, challenging and transparent. The people and clinicians in the communities within the Eastern Locality have been clear about their requirement and it is of significant concern the decision to challenge the CCG's decision may delay implementation of this needed and supported change.

37. The legal framework does not require competitive tendering, and Monitor's guidance confirms this.[10] Under Regulation 5, a CCG may award a new contract for the provision of healthcare services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.

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[9] The Dalton review page 26 on Integrated Care delivered through consolidation.

[10] The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, SI 2013/500 (the "Regulations"), and the Health and Social Care Act 2012/the National Health Service Act 2006. See also "Substantive guidance on the Procurement, Patient Choice and Competition Regulations" at www.monitor.gov.uk.

38. This provision complements the scheme of Regulation 3, which requires the CCG to act in a transparent and proportionate way, and to treat providers equally and in a non-discriminatory way, but does not go so far as requiring competitive tendering. Indeed, under Regulation 3(4), enabling providers to compete to provide the services is *one* permitted way which the CCG must consider in seeking to improve the quality and efficiency of the services, but crucially, the CCG is not required to conclude that it must carry out its procurement through the formal, contract notice route.

39. The law therefore permits a CCG to select a provider without a call for competition in appropriate cases. Monitor states that there is no default process that commissioners should use to secure services, and that:

> *"In particular, the Procurement, Patient Choice and Competition Regulations do not establish a competitive tender process as the default mechanism that commissioners should use to buy services. Commissioners need to consider on a case-by-case basis what the most appropriate way of procuring services is, having regard to the general principles…"*[11]

40. It follows that the only relevant process question in this investigation is whether this was an appropriate case for procurement without call for competition. In other words: does the process determine the solution, or vice-versa?

41. In turn, this core question raises various issues:

    a. whether the CCG may define what it wants to buy first, or whether it must follow its suppliers' lead;

    b. whether the CCG was right to spend 15 months in consultation with the community to define those services;

    c. whether the decision on what was to be procured should have been less influenced than it was by what the local community said they wanted, and more by what the available providers were offering;

    d. whether the CCG properly concluded that it could proceed on a most capable provider basis without a contract notice;

    e. whether the disruption from moving provider should have weighed more in the assessment of whether to proceed without a contract notice; and

    f. whether the CCG took enough account of what NDHT could achieve if re-awarded the contract.

[11] Section 3.2 of Monitor substantive guidance on the Procurement, Patient Choice and Competition Regulations.

42. The RD&E's case – supported by Monitor's guidance[12] - is that it is for the CCG, as the commissioner of services working with and on behalf of the population served, to work out how to improve the quality and efficiency of the services, including whether to seeking to provide services in a more integrated way. Having done so through extensive consultation – designed to find out what the public and patients actually want – it was then entitled to design a process for assessing the most capable provider, which in turn it did. We now turn to the detail of this process.

43. The clear commissioning intentions of the NEW Devon CCG were published in its document: Community Services for the 21st Century - A Strategic Framework.[13] Its aim is to commission services that are integrated, personal and sustainable.

44. It is clear that the CCG and its communities expect high quality services (reference to quality occurs 16 times in this document). It is also clear in the NEW Devon CCG commissioner publications that a sustainable solution must represent good value for money. Indeed on page 7 of the Strategic framework document the CCG states that:-

    "*Creating services that are strong and ready to stand the test of time is of utmost importance…we need to prepare now for quality and affordable services in the future*." [emphasis added]

45. In July 2014 the RD&E submitted its proposal to the CCG, setting out how it would deliver integrated high quality care for adults with complex needs.

46. The CCG asked the RD&E to:

    "Detail how you would approach delivery of integrated, personal and sustainable community services as described in NEW Devon CCGs proposed strategic framework. Please present this with specific regard to the commissioning principles for community services and their implications for experience as described on page 17 of the short strategic framework document…"

47. The commissioning principles are:

    1) Integrated and seamless delivery
    2) Clear pathways and access
    3) Consistent outcomes

[12] See for example Monitor substantive guidance on the Procurement, Patient Choice and Competition Regulations, Foreward at page 4 (fourth paragraph); Section 1: Introduction at page 6; Section 2 at page 18 and 19.

[13] Community Services for the 21st Century - A Strategic Framework. See https://www.newdevonccg.nhs.uk/involve/community-services/101039

4) Evidence based foundations
5) Individuals and carers at the centre
6) Personalised and localised models
7) Honest and open relationships
8) Care which reflects health needs
9) Sustainable, agile and flexible responses
10) Shifts of resources and innovation

48. "Value" here means "maximising outcomes per pound spent." Our presentation sought to address both quality and value for money and we draw your attention to slides 6, 20, 18, and 42. In these slides we refer to how we would seek to make a step-change through the provision of high-quality, seamless services provided safely, and delivered with courtesy and respect. The presentation process was both robust and challenging.

49. The invitation to present followed publication of the community services strategy which stated that the CCG was minded to follow a non-competitive approach based on the hypothesis that the local acute hospital afforded the greatest opportunity to deliver transformed fully integrated community services. The invitation to attend the assessment process confirmed that the CCG was testing this hypothesis by asking us to:

    1) Show how we would break down the barriers to integration;
    2) Demonstrate our track record of service innovations;
    3) Explain how we would create a truly Integrated Care Organisation ("ICO"); and
    4) Demonstrate that we had the resources to do it, and in particular:
        a. The investment required to deliver a truly transformational electronic patient record system; and
        b. How the RD&E would build a multi-discipline team with the appropriate set of capabilities for using these resources and delivering the transformational change effectively.

50. In September 2014, the CCG asked us to give further information, based on a set of questions, detailing how the proposed solution would deliver against a specified set of criteria. The RD&E in its response explained the approach it would adopt:

    a. We had defined an ambition and had the commitment to become an ICO delivering population health for specific groups of patients across the Eastern Locality and that it was the only provider that could deliver this solution for this region;

    b. In so doing, we had the unique opportunity to leverage local partnerships between secondary care, primary care, mental health and

social care. This created a natural system leadership role for the RD&E across the Eastern Locality where we could use a single accountable provider model to put patient needs at the centre of care.

c. The single accountable provider approach aligns and manages care within a single organisation. The governance system of the ICO would identify problems and direct the resources required to achieve rapid resolution, avoiding the often protracted transactional contract route.

d. We recognised the importance of expertise from other providers in the health and social care system, with whom we will need to work in partnership. A good example is the strong relationship with Devon Partnership NHS Trust, where we have agreed a joint approach to expanding this into our work to further integrate care.

e. The RD&E is fully committed to the transfer of health and care information between the person and all agencies involved in their care. We are in the process of procuring an integrated patient health record which will include a patient portal giving people controlled access to the same medical records their doctors use via internet browser or mobile application. Self-serve online functions can help motivate people to improve their own health, reduce the cost of service and provide a vital communication link to support accountable self-care. We strongly believe that the RD&E is the only possible provider of such a system to support the integrated health needs of the Eastern Locality population.

f. To design services around people's needs and to amplify the CCG engagement feedback it is critical that we ask people in surveys, "Members' Say" events and via their Governor representatives. We have a deep relationship with our local people through the engagement with c. 12,000 public members.

51. We believe that an integral part of the preferred provider assessment was to understand how focusing on outcomes and quality can lead to a more productive use of healthcare resources. Focusing on population health for this cohort of patients means placing more emphasis on better managing people's long-term conditions, particularly out of hospital. This is central to understanding value for money because there is an emerging body of national analytical research that demonstrates how the cost of care rises out of proportion with the rise in number of co-morbidities. For example a study, conducted in South Somerset,[14] confirmed that the annual cost per patient for

[14] See Symphony Project, South Somerset Integration Plan, Health Services Journal, August 2013.

an individual with seven or more comorbidities (£10,741), is 13 times that of a patient with just one comorbidity.

52. A small number of health economies, for example Northwest London, Southwark and Lambeth Integrated care[15] have been able to advance this analysis to understand the health care cost of various segments of their population. For people with multiple comorbidities i.e. complex needs, this suggests that a population health approach with deep integration of services from community to acute and back to community represents an opportunity to align incentives across the health and social care system and deliver improved use of health resources. Indeed international research[16] has shown that these care models have worked successfully. In each of these examples the acute-community relationship is one of single organisation driven pathways of care not multi-organisation, collaborative arrangements for pathways of care.

53. Importantly, this international experience warns that without close cooperation between single integrated acute-community organisations and primary care physicians, efficient and high performing population health approaches are at risk. It is very hard to see how leaving the Community Services provision with a provider based out of Northern Devon, with no involvement with the acute or specialist services people receive in the Eastern Locality, would allow for the fertile debates that could be achieved between a single integrated community-acute and local GPs.

54. During this rigorous process, there was never any suggestion that RD&E was receiving any information or insight that was not being shared equally with competing providers.

55. It follows that the process – as the RD&E understands - gave plenty of scope for CCG to assess different solutions and capabilities of different providers. NDHT, as the incumbent provider of adult complex care, had significant opportunities to influence and shape CCG thinking on the future design of complex care for adults. This privileged position and regular dialogue on performance and development as part of the delivery of its contractual obligations for these services in the Eastern Locality, created much greater opportunity to shape thinking than was available to other potential providers. We understand that the CCG did seek proposals also from NDHT, thus creating further opportunities for NDHT to suggest a better solution. The complaint – as expressed in the Statement of Issues – is therefore not correct when it states that the process was "tantamount to the direct award of a

[15] See http://www.hsj.co.uk/Journals/2014/11/25/m/d/p/McKinsey.pdf

[16] See Geisinger (US); ChenMed (US); Alzira (Spain); Kinzigtal (Germany).

contract without competition."[17] The process was competed and the RD&E was successful because – in our view - it provided a solution that better met the requirements of the commissioner, the public and patients.

56. In the coming years we expect to see the three localities across NEW Devon concentrating on delivering step change improvements in the way integrated care is delivered for their communities. Some specific services are likely to be subtly different between localities, each providing a fertile ground where the best ideas are tested, shared and implemented, and overall standards raised. We will see three providers developing three Devon markets for integrated care. This type of market development represents true competition for the market – and in the market – precisely the policy intent of introducing competition.

57. The complainant has alleged that the process used to select the provider was not proportionate to the value, complexity and clinical risk associated with the provision of the services in question. The complainant has apparently suggested that the contract was worth £100 million (and this is the figure that has been reported in the media). At £49 million per annum, the contract is actually worth less than half that which has been reported. In our view, the CCG's process was more than adequate to assure a proper assessment of the most capable provider for its needs, for a contract of that value, complexity and clinical risk.

58. It also follows from the earlier discussion that NEW Devon CCG did consider appropriate ways of improving the quality and efficiency of the services including the services being provided in a more integrated way. In fact, this was the very basis of their approach in long public consultation.

Transparency

59. The Statement of Issues questions whether NEW Devon CCG failed to act transparently towards NDHT.[18]

60. Plainly the RD&E can comment on its own experience of the process rather than what NDHT experienced. However, it is important to make certain facts clear:

    a) All communication between NEW Devon CCG and RD&E was formal and written; there were no other verbal or email discussions outside these formal interactions.

[17] Statement of Issues, paragraph 16, second bullet point.

[18] See paragraphs 25-26 of the Statement of Issues.

b) We note that Monitor's description of the complaint does not allege that there was no competition; only that the process – as NDHT perceives it – was "tantamount" to a direct award without competition. The process gave NDHT an opportunity to present proposals, and for these to be evaluated.

c) The real reason NDHT's proposal was not selected is likely to be related to its ability to provide genuinely integrated care – of the sort the RD&E can provide – in the Eastern Locality. The integrated care NDHT provides in the Eastern Locality is narrowly defined and does not include any elements of the acute pathway. This differs from the service offered in the Northern Locality where acute and community services are integrated. It is time for people in the Eastern Locality to enjoy the same or better levels of integrated care that their compatriots in the Northern Locality enjoy.

Conclusions

61. For the above reasons, we urge Monitor to move rapidly to conclude its investigation and permit NEW Devon CCG and the RD&E to proceed with the job of providing innovative and integrated care in the eastern locality of the NEW Devon CCG.

11 February 2015.