Submission to Monitor by Northern Devon Healthcare NHS Trust

CCD 01/15: Investigation into NHS Northern, Eastern and Western Devon Clinical Commissioning Group's commissioning of certain community services for the eastern part of the area

1 Purpose

1.1 This submission sets out the basis of the Northern Devon Healthcare NHS Trust (NDHT) complaint it has raised with the sector regulator, Monitor, in relation to the Northern, Eastern and Western Devon CCG's commissioning of adult complex care community services in its Eastern locality.

1.2 NDHT wishes to make it absolutely clear that in deciding to make this complaint, it is acting, and will continue to act, for one reason and one reason only: to ensure the delivery of safe and effective care to patients. We do not believe that the transfer of services at this time will do anything other than compromise patient care.

2 Background

2.1 Northern Devon Healthcare NHS Trust has successfully run adult complex care community services for Eastern Devon for nearly 4 years, following a long, successful record of delivering similar services in Northern Devon for the previous five years. These services are judged by the CQC as Good, and in places verging on Outstanding. Eastern Devon forms part of a wider team that is led by an outstanding Community Leadership Team that deliver award winning community services that were viewed as the best so far inspected. Not only are these services Good, they provide improved outcomes for patients, ensure good patient flow from the acute hospital and importantly are delivered within budget year on year offering extremely good value for money for the wider healthcare economy. Finally, they are delivered by staff who enjoy working for their employer and feel fulfilled in their roles: the composite staff survey score for NDHT places it second in the South West, and in the top quintile in the country.

2.2 In July 2014 the Board of NDHT received a report on the first three years operation of the services. This report highlighted the significant successes in the first three years as well as identifying areas for further work and improvement. This report is attached at **Appendix A**.

2.3 In the Chief Inspector of Hospitals' inspection, undertaken in July 2014, Community Adult Services and Community Inpatient Services were both rated as 'Good' (the reports are attached as **Appendices B and C**). At the subsequent Quality Summit the Lead Inspector was quoted as saying: "These are the best community services we have so far inspected," and, "Some aspects are verging on 'Outstanding'", and, "On reading our report, our Deputy Chief Inspector stated that she wished she and her family lived in Devon."

2.4 This does not mean that NDHT is resting on its laurels – it recognises that there is still much to be done to integrate services further and to respond to the challenges of an ageing population, recruitment issues and the financial environment.

2.5 The NHS as a whole is facing its toughest financial outlook in decades. In April 2014, Devon was identified as one of 11 financially-challenged health economies in England, and, in October 2014 the CCG announced that the Devon health economy faced a £430 million deficit by 2018/19 if significant changes were not made, and is itself now projecting a £41 million accumulated deficit this year. It is important and relevant to note that NDHT has delivered its financial control target for each of the last seven years and is forecast to do so in 2014/15.

2.6 The NHS Futures programme, which has evolved out of the special support offered following being identified as financially-challenged, is still at the planning stage, with no concrete outcomes yet identified. There remains no underpinning financial strategy for the local health economy as a whole, let alone for the services that are the subject of this commissioning process.

2.7 We are also seriously concerned that the CCG has not properly considered the risks and issues associated with any proposed transfer. Whilst some of these risks are associated with any procurement process and should not normally prevent an organisation going down its chosen route, they should be properly considered. There are also additional risks and issues pertaining to this specific procurement. These include, but are not restricted to:

- The costs of TUPE;
- Staff recruitment and retention difficulties because of the uncertainty about future plans;
- Management effort required by all parties to effect a safe transfer which will divert effort away from completing transformation and dealing with the financial crisis,;
- The likelihood that local control and ownership of the NHS community estate will be lost, as properties transfer to NHS Property Services;
- The loss of benefit and significant exit costs from a multi-million pound contract for the provision of an integrated ground-breaking community patient information system as part of a wider Electronic Health Care record system spanning primary and secondary care;
- The time and cost of the training required by staff joining a new organisation;
- Downturn in morale of staff who have clearly stated they do not want a change of employer, running the risk of deflecting staff effort away from patients and increase the risks to delivery of safe care.

2.8 The fundamental argument of NDHT is that we are clearly a high quality provider of services, with a proven track record of delivering transformation safely within a budget. This should be reason enough not to change provider. But to do so now, to impose organisational change and significant non-recurrent costs at a time of financial crisis, with currently no financial strategy to escape from it, is too high risk. Put simply, now is the time to continue to transform, not transfer.

3 The procurement process

3.1 Whilst the above may not be directly linked to a complaint about the process followed during a procurement, it sets a necessary context for the concerns NDHT has about the procurement process itself.

3.2 At **Appendix D** is the timeline of events covering the period from when NDHT took over responsibility for the delivery of adult complex care services in the Eastern locality. This formed the evidence pack for the complaint when we originally submitted this to Monitor on 18 December 2014. It has been updated to include details of the meeting held on 8 January 2015 with the CCG in a final, failed attempt at local resolution.

3.3 (Appendix D refers to a number of documents as further evidence. These have not been included in this submission as they are simply there to provide documentary evidence supporting the statements made in the paper. All such documents are available on request, with the exception of those labelled "Commercial-in-Confidence", and have been lodged with Monitor)

3.4 Appendix D demonstrates that, despite the strong performance and high quality of the existing services, along with a previous commitment that NDHT would be allowed to bid for the services at the end of the contract, the decision to transfer services to RD&E without competition was made some time before March 2014. Despite what has happened since, the decision was clearly pre-ordained to the extent that many CCG senior managers and commissioning GPs openly talked about 'when' services would transfer, irrespective of any process going on at the time.

3.5 NDHT contends that the rapidly-arranged quasi-procurement process launched in September amounted to little more than window-dressing for a decision that had already been made. The process amounted to no more than an essay-writing contest, with 9,000 words to determine the future of a £200 million contract – or over £20,000 per word, with no financial assessment whatsoever.

3.6 It is notable that, across the various service lines and localities, the 'preferred options' and consequent 'preferred providers' identified following procurement option appraisal and quasi-competition processes are precisely the same as those communicated to NDHT in March and April 2014, and included in the draft Strategic Framework, published in May 2014.

3.7 And throughout this process it has been clear, both from their actions and their words, that officers and GPs of the CCG have intended only one outcome, thus making the process followed meaningless.

3.8 Notwithstanding our concerns that the stripped-down competitive process was non-compliant with the regulations, NDHT has sought to be assured that the process itself conducted during September/October was undertaken in a non-discriminatory way.

3.9 NDHT submitted a Freedom of Information (FOI) request to the Commissioning Support Unit (CSU) co-ordinating the process. NDHT remains concerned that individuals who were involved in the development of the original TCS Draft Strategic Framework (published in May 2014), were also involved in the process that resulted in the identification of Preferred Provider: this would have represented a conflict of interest. The CSU:

- has refused to identify individuals involved in the evaluation process (NDHT believes this is in contravention of Nolan Principles 4 (Accountability) & 5 (Openness);
- states that none involved in evaluation were involved in the 'creation of the original provision proposals'. NDHT is concerned that the CSU might have taken an overly-narrow definition of the term 'creation';
- states that, whilst locality clinical leads were not involved in the initial evaluation, they were involved in the moderation meetings held to achieve a unanimous consensus score. The locality clinical leads were certainly involved in the drafting of the original provision proposals, so NDHT believes their involvement in moderation seriously risked perverting the final scores.

3.10 As a result of this NDHT does not have assurance that the process conducted during September and October was objective.

3.11 The rest of this paper details how, by individual regulation, NDHT contends that the CCG has conducted a procurement process in breach of the Section 75 Regulations. Some of the detailed complaints relate to the overall process the CCG has followed since March 2014, others specifically to the stripped-down process conducted during September and October.

4 Detailed complaints

Regulation 2

When procuring health care services for the purposes of the NHS (including taking a decision referred to in regulation 7(2)), a relevant body must act with a view to—

(a) securing the needs of the people who use the services,

(b) improving the quality of the services, and

(c) improving efficiency in the provision of the services.

4.1 NDHT contends that, on the basis of six answers totalling 9,000 words for services worth in excess of £60 million per annum, it was impossible for the CCG to assure itself that, by changing provider, the **quality of services** would be improved, particularly as the precise scope of services had not been determined.

4.2 NDHT also contends that, with no financial assessment whatsoever, the CCG cannot assure itself that, by changing provider, it will improve **efficiency** in service provision.

Regulation 3(2)

When procuring health care services for the purposes of the NHS (including taking a decision referred to in regulation 7(2)), a relevant body must —

(a) act in a transparent and proportionate way, and

(b) treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership.

4.3 NDHT contends that the CCG behaviour has been characterised by a marked lack of **transparency**. Much of the evidence for this is contained within the Timeline, but can be summarised as:

- The over-arching process to be followed has never been made clear to providers, or at least to NDHT. Changes and delays have occurred with no explanation.
- Reasonable requests for information made on 8 July 2014 were not responded to until the stripped-down competitive process had commenced, enabling the CCG to refuse to answer some of these questions. These included:
  - Asking for the risk assessment of undertaking a change of provider at a moment of significant financial challenge;
  - Asking for the 'National evidence' that demonstrates that vertical integration *per se* is likely to add value;
  - Asking for details of meetings etc that developed the provision proposals.
- Refusing to identify which CCG senior officers were involved in the evaluation process.

4.4 NDHT contends that the CCG has not acted in a **proportionate** way. To determine a Preferred Provider on the basis of six questions with a total word count of 9,000 with no financial assessment is not commensurate with services which, across the CCG area (i.e. including Northern and Western localities) have a contract value of approximately £400 million over three years. Our assessment is that, given the size of the services, proportionate action could only have meant one of the following:

- Continuing with the incumbent provider, if the assessment was that the costs and disruption of the procurement process were likely to outweigh the benefits of competition;
- Undertaking a full competitive process, with a much more clearly defined and detailed process, including a full financial assessment and based on a proper set of service specifications. This could have included or excluded non-local providers.

4.5 NDHT contends that the CCG has not treated all providers **equally** and in a **non-discriminatory way**. There is much evidence of this:

- During the period from March 2014 until at least July 2014, NDHT was told it would not have the opportunity to bid for the services, it would simply be stripped of them;
- As demonstrated in the Timeline, frequent occasions when it was clear that the decision was pre-determined, with officers and commissioning GPs referring to the assumption that services would transfer to the RD&E;
- The Case for Change makes comments which are discriminatory, and on which NDHT has not had the opportunity to put forward its view:
  - [In the] "Eastern locality the community provision is governed by an organisation primarily focused in a different urgent care system."
  - "It is more straightforward to deliver seamless care within an organisation than across organisations."
  - [The CCG] "proposes to commission community services for people with complex needs from organisations that are fully embedded in the locality urgent care system."
  - Each of the above puts a bias in the process in favour of the local acute A&E provider and against a provider whose HQ happens to be outside the locality.
- The process by which the weightings were arrived at. As the email from the Commissioning Support Unit states: "It was clear that the greatest importance was on designing a system with fewer operational boundaries throughout the care pathway." As the local acute A&E provider is an essential element of the system, the weightings would be automatically skewed in favour of that provider proposing also to provide community services and thus appearing to remove a boundary.
- This bias in favour of the local acute A&E provider represents a breach of this regulation also in that it favours a provider on the **basis of ownership**.

Regulation 3(3)

The relevant body must procure the services from one or more providers that—

(a) are most capable of delivering the objective referred to in regulation 2 in relation to the services, and

(b) provide best value for money in doing so.

4.6 NDHT contends that the CCG is unable to demonstrate that the Preferred Provider is that **most capable** of delivering the objective in relation to the services. It certainly wasn't able to demonstrate this when it informed NDHT of its decision in March 2014. And, because of the weak process undertaken in September and October, NDHT believes it is unlikely to be able to do so now.

4.7 However, the more fundamental complaint is that the CCG will be incapable of demonstrating that it will provide best value for money in selecting the RD&E as Preferred Provider. This regulation requires **both** the capability and value for money tests to be satisfied before making a decision. It is impossible to demonstrate value for money as there was no financial assessment undertaken.

4.8 Even if it had been made clear (which it was not) it would be unreasonable to assume that all providers used the same financial assumptions when developing their proposals:

- The scope of services has not been finalised;
- The RD&E does not know the existing cost base;
- On this basis, any provider could 'promise the world';
- The Transforming Community Services Strategic Framework has no underpinning financial strategy;
- It would be unreasonable to assume 'flat cash' going forward. Devon is one of 11 financially-challenged health economies, facing a potential £430 million deficit in 2018/19: it would be a hostage to fortune to assume anything for any service line.

4.9 The CCG proposes to look at the precise scope of services and resources available during the due diligence phase. This is entirely inappropriate as this should have been clearly set out in the specification and assessed during the procurement process. In addition any element of competition there might have been has now been lost.

Regulation 5 (1) & (2)

(1) A relevant body may award a new contract for the provision of health care 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.

(2) The services are to be determined as capable of being provided by a single provider only when—

(a) for technical reasons, or for reasons connected with the protection of exclusive rights, the contract may be awarded only to that provider; or

(b) (only if it is strictly necessary) for reasons of extreme urgency brought about by events unforeseeable by, and not attributable to, the relevant body, it is not possible to award the contract to another provider within the time available to the relevant body for securing the provision of the services.

4.10 NDHT contends that the process followed since March 2014 has effectively been that of awarding to a single provider. The process used during September and October was so weak, and pre-determined, as to render any true competition meaningless, as supported by the fact that all provision proposals confirmed in November 2014 by the CCG were exactly the same as those announced in their draft Strategic Framework in May 2014.

4.11 Assuming that Monitor agrees that there was not a proper competition, and that therefore this is an award to a single provider NDHT contends that neither of the two possible options for so awarding are satisfied: there are no **technical** reasons (if there were, how could NDHT have delivered the services since April 2011?) and there is insufficient **urgency** (the existing contract lasts until at least October 2015).

Regulation 6(1)

A relevant body must not award a contract for the provision of health care services for the purposes of the NHS where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.

4.12 NDHT contends that anyone involved in the thinking, development and production of the original proposal to transfer the service without competition to RD&E should have made clear the conflict of interest before the process undertaken in September and October leading to the Governing Body decision in November and not taken any further part in the process. This includes taking part in, and voting at, the Governing Body meeting.

4.13 Whilst this type of conflict is not explicitly referred to in the Substantive Guidance on the Procurement, Patient Choice and Competition Regulations (Monitor, December 2013), NDHT contends that best procurement practice would state that any individual who has explicitly stated their preference of provider prior to procurement should either not be involved in any way in the procurement process or decision or their conflict of interest should be noted.

4.14 NDHT also contends that, as some key commissioning GPs in the Eastern locality are also employees of the service being procured, they should not have been involved in either the thinking, development and production of the original proposal, nor in the process undertaken in September and October leading to the Governing Body decision in November.

Regulation 10(1)

When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour.

4.15 NDHT contends that much of the evidence demonstrating **discriminatory** behaviour is also evidence of **anti-competitive** behaviour, particularly:

- Discriminating in favour of the local acute A&E provider;
- CCG officers and commissioning GPs clearly working on the assumption that the service would transfer to RD&E, even when a competitive process was apparently underway.

Monitor Statement of Issues

4.16 Since the submission of the detailed complaints listed above, Monitor has accepted the complaint and published a Statement of Issues. This covers most of the areas in which NDHT has raised concerns.

4.17 It is clearly for Monitor to determine which issues it considers are worthy of investigation. NDHT wishes to make clear that it is content with the Statement of Issues.

5 Requested Enforcement Actions

5.1 NDHT requests that Monitor considers the following enforcement actions, should it uphold the complaint.

- To declare the existing procurement process being undertaken by NEW Devon CCG ineffective;
- To seek an undertaking from NEW Devon CCG that the CCG will:
  - *Either* extend the contract with NDHT for complex adult care community services until a point when it is reasonable to assume that there is sufficient momentum across the health economy to be confident that the financial crisis will be resolved (we would suggest that this is at least March 2018);
  - *Or* undertake a proper competitive process in line with best practice, either restricted to local NHS providers or not, and that in doing so, the CCG would first deliver:
    - comprehensive service specifications to inform the service scope;
    - either activity assumptions, or the outcomes the procured service would be expected to deliver;
    - an over-arching financial strategy, making clear its expectations for investment (or disinvestment) in this service;
    - a process that describes, clearly and transparently, both the process and the timetable from initial engagement and specification development through to service commencement.
  - *Or* both – to extend the contract with NDHT whilst also developing a robust timetable for re-procurement, and then conducting that procurement, either restricted to local NHS providers or not, in line with best practice.

5.2 To direct NEW Devon CCG to put in place measures that will prevent similar or other breaches of the Procurement, Patient Choice and Competition Regulations. This is of particular concern given that other elements of community services (community urgent care, and specialist services) are already being considered for procurement exercises.

Timeline of events leading to the Northern, Eastern and Western Devon CCG TCS decision

1 Purpose

1.1 The purpose of this paper is to brief Monitor on the events relating to the approach of Northern, Eastern and Western Devon CCG (CCG) to reaching a decision on the future procurement of adult complex care community services.

1.2 The paper refers to various piece of evidence. These have not been included with this submission as they are simply documentary evidence to support this paper. With the exception of those marked "Commercial-in-Confidence" (which have been provided to Monitor under separate cover) all other pieces of evidence are available on request.

2 Background

2.1 Transforming Community Services (TCS) – the national process to transform community services and to establish new governance arrangements for those services directly provided by Primary Care Trusts (PCTs), commenced in January 2009[1]. A key part of this was to investigate alternative methods of provision, potentially through integration with existing NHS Trusts, the establishment of Social Enterprises or Community Foundation Trusts. However, many PCTs (including Devon) did not make much progress during 2009/10.

2.2 In May 2010 the Coalition Government was formed, and in one of their first actions relating to the NHS they issued a directive insisting that all PCTs divest their directly-provided services by April 2011[2]. PCTs had four options:

- Open competition;
- Application as a Community Foundation Trust;
- Creation of a Social Enterprise;
- Integration with an existing NHS Trust (Foundation or otherwise).

2.3 Open competition was chosen in very few cases across the country.

2.4 The Department of Health advised that to apply as a Community Foundation Trust (CFT) the services needed to have a turnover of at least £80 million. Whilst the services in Devon under consideration were around this figure, the management at that time was not considered to have the capability necessary to run a CFT.

2.5 Social enterprises were relatively uncommon (although this was the chosen solution in half the PCT areas in the South West, including Plymouth and Cornwall). This was not considered appropriate in Devon, partly for the same reason as for not choosing the CFT option, but also there was strong staff opposition to the possibility.

2.6 In some 75% of cases across the country integration with an existing NHS organisation was selected. In some areas a shortened procurement process was undertaken to select the host organisation (e.g. Dorset), whereas in others there was none (e.g. Devon).

2.7 To satisfy DH competition regulations at that time (i.e. pre-Health & Social Care Act 2012) all organisations that were proposed to acquire services without any element of competition (social enterprises, CFTs and existing NHS organisations) had to prepare an Integrated Business Plan demonstrating both sustainability and value for money. In addition, an analysis of the impact on competition was undertaken by the Strategic Health Authority. Finally, in the South West, it was insisted that contracts be awarded on an interim basis (initially two, but later extended to three years). The exit strategy, agreed between relevant parties[3], stated that there would be one of three options considered for the exit:

- **Competitive Tender:** which was expected to be the default position when procuring health services, but used only is the requirements of single tender action are not met;
- **Single Tender Action:** which may be appropriate if the service to be procured has such strong service alliances with an existing provider that there is in effect only one fully capable provider, or through investigation only one capable provider is found to be present in the marketplace;
- **Any Willing Provider.** (This last option would never have been appropriate for the complex adult community services).

2.8 As a result of these measures, the Co-operation and Competition Panel generally only undertook full merger assessments in those cases where there was a proposed integration of GMS or APMS (primary care) services with the local acute provider[4].

2.9 As a result of the TCS process, both Boards approved the transfer[5] and Eastern community services and county-wide specialist services were transferred to Northern Devon Healthcare NHS Trust (NDHT) on 1 April 2011.

2.10 The services were acquired on the basis that NDHT would (a) transform the services and (b) earn the right to bid for the services once the contract period ended.

3 April 2011 to March 2014

3.1 NDHT delivered on its commitment. It proceeded to transform community services, it strengthened governance, improved quality and proceeded to deliver its vision of more care closer to home. For the first time in years, community services were delivered within budget and Cost Improvement Programme savings were delivered, when these programmes were within the control of the Trust[6].

3.2 The dissolution of the PCT and imminent creation of the clinical commissioning group, combined with a growing realisation by the commissioners of the enormity of undertaking a full competitive procurement (not least being the preparation of a meaningful service specification for the existing services which has never been in place) led the then Chief Executive of the PCT to write to NDHT in July 2012to extend the contract for community services until 30 September 2015, an 18-month extension, to allow time for a full 'open and transparent' procurement[7].

3.3 In April 2013 the Northern, Eastern and Western NHS Clinical Commissioning Group (NEW Devon CCG, or 'the CCG') was formed and assumed responsibility for the commissioning of services in those areas of Devon covered by Devon County Council and Plymouth City Council (i.e. excluding Torbay Council).

3.4 The negotiation process for the 2013/14 contract was particularly difficult, and resulted in the parties requiring arbitration. The arbitration result primarily favoured NDHT, but did require the delivery of a £2.2 million CIP within the community contract, based on the closure and consolidation of community hospital beds as more services were delivered in the community.

3.5 This was always going to be a difficult CIP to achieve given the likely public opposition to any proposals and the CCG and NDHT agreed to approach it jointly. At times throughout discussions, the CCG frustrated the delivery of the CIP programme, preventing or delaying the transformation of services. Eventually NDHT raised a formal dispute because it felt that the CCG was unreasonably frustrating NDHT from delivering its CIP programme. Just before the dispute was to be formally heard by the Trust Development Authority and NHS England, the CCG agreed to meet half the costs of the undelivered CIP.

3.6 In the autumn of 2013 the CCG commenced an engagement process to assist in the development of a strategic framework for community services. The CCG engaged with approximately 2,000 people. Although some NDHT officers were invited to some multi-stakeholder events which included the public, there were no formal provider engagement events, at least not with NDHT.

4 March – July 2014

4.1 On 5 March 2014, the Chief Officer of the CCG met with the Deputy Chief Executive of NDHT in order to give him early warning of what was about to be published in the CCG Draft Strategic Framework for Community Services – that the document would propose the transfer of Eastern adult complex care services to the Royal Devon & Exeter NHS Foundation Trust (RD&E). The Chief Officer was asked if this was a final decision and she replied that, whilst there was a formal consultation process to be followed on the overall framework, the provision proposals would be delivered.

4.2 As this was an unminuted meeting, the Deputy Chief Executive felt it important to follow it up with a confidential letter on 7 March 2014 to the Chief Officer[8].

4.3 On 18 March 2014 the Chief Officer of the CCG wrote to NDHT confirming the proposal to transfer responsibility for the provision of adult complex care services in the Eastern locality.[9]

4.4 This proposal was made explicit in a letter from the CCG to NDHT on 28 April 2014[10].

4.5 In telephone conversations between the two organisations, NDHT expressed the strong opinion that the proposed transfer of services without competition was unlawful. NDHT contends that the proposal is evidence of **anti-competitive behaviour** and, despite processes that have happened since, the intention of the CCG has always been to deliver the provision proposals outlined at that time, regardless of any feedback received during engagement.

4.6 On 14 May 2014, the draft Strategic Framework for Transforming Community Services was published[11], with a consultation period finishing on 8 July 2014. The argument for transfer to RD&E was on the basis that vertical integration would improve services ("We are therefore proposing to commission patterns of provision centred on locality geographies.") This argument was also used as the basis for northern community services to remain with NDHT. However, the same was not proposed for the Western locality, where all services looking to Derriford Hospital as the acute provider would be transferred (or retained as appropriate) to Plymouth Community Healthcare, a Social Enterprise.

4.7 The CCG also proposed that this would be achieved without formal procurement, "This [integration of services] underpins a no-competition proposal for these services, and re-procurement in each locality geography."

4.8 This approach was certainly assumed to be the anticipated way forward as in both formal meetings between NDHT and the CCG (particularly the Eastern locality), and as Eastern GPs met community staff during normal working arrangements, the CCG officers and GPs would frequently use phrases such as: "when the service transfers to RD&E", "we are talking with RD&E about how best to deliver services". There is little documentary evidence of this; however, the number of NDHT staff who witnessed this gives the overwhelming impression that the CCG had already decided the outcome. In an email exchange on 24 June 2014 between various people involved in the community hospital bed reconfiguration, Dr Simon Kerr (Vice Chair, Eastern Locality) states: "That is our plan" in response to an Axminster GP's suggestion that Wonford (RD&E) should run the community hospital services (first line of second page of attachment)[12].

4.9 During the period April to June 2014, NDHT undertook its annual roadshow of the various locations across the Trust: sharing the successes of the previous year and its plans for the future[13]. Given the timing of the TCS consultation it agreed with the CCG to use the events to promote the TCS consultation and use the specially-prepared slides by the CCG to describe the framework. Given the provision proposals, it also took the opportunity to assess the views of the staff affected. The roadshows were attended by a quarter of the Trust's workforce, and the overwhelming view was that the staff did not see any benefits in transferring services to RD&E.

4.10 [✂]

4.11 On 18 and 19 June 2014, the Department of Health carried out a Department of Health Gateway Review of the TCS process for the CCG. Unfortunately, a breakdown in communication meant that NDHT were not interviewed as part of this Review. NDHT made a request for a copy of the Gateway report but this has been refused, with the ongoing procurement process cited as rationale for rejecting the request.

4.12 Although the evidence is circumstantial, it is the belief of NDHT that the Gateway Review made the CCG reconsider its process of procurement.

4.13 This assertion is supported by the fact that in June 2014 the Chief Officer of the CCG informed the Trust that a final decision on the provision proposals would not be made until September 2014.

4.14 On 8 July 2014 NDHT responded to the consultation with a response supporting the overall direction of travel, whilst raising a number of clarification questions[14]. This response was written in the expectation that, as is common with consultations, it would be made public. It also sent a confidential letter and accompanying paper which challenged the provision proposals and asked a number of detailed questions seeking to understand the rationale of the CCG[15],[16]. It stressed the desire of NDHT to achieve local resolution. It asked for responses to the questions by 22 July 2014, the date of the NDHT Board meeting.

4.15 Unfortunately the responses were not received until 2 October 2014[17], by which time the selection process had commenced, and so the CCG cited this as a reason to refuse to answer many of the questions. We would contend that both the response and its delay are evidence of a **lack of transparency**.

4.16 On 16 July 2014 the CCG Governing Body met and received the engagement report. It agreed to evaluate feedback responses against the provision proposals and produce a 'Case for Change' document that would appraise the different options for procurement[18]. On the same day it also published its final Strategic Framework for Transforming Community Services[19]. This final version made no reference to potential provision proposals. NDHT sees this as more evidence that the Gateway Review had caused the CCG to reconsider its approach to procurement.

4.17 On 28 July 2014 there was a meeting of the Community Services Delivery Board – a group of Executive officers from the CCG and NDHT whose purpose was to oversee the delivery of the agreed community CIP programme. The opportunity was taken during this meeting to discuss the TCS provision proposals. The Chief Officer of the CCG undertook to provide the published evidence that vertical integration *per se* was beneficial to service transformation and also advised NDHT to talk with the RD&E to see if there was a compromise solution. This was a repeat of the one of the questions asked in NDHT's provision concerns paper sent on 8 July 2014. This evidence has never been received.

4.18 The opportunity was taken by NDHT at this meeting to press the CCG for responses to the questions it had submitted on 8 July 2014.

4.19 Despite many requests, the minutes of this meeting that were taken by the CCG have never been produced. The CCG has since announced that the Board will not meet again, stating that its purpose can be delivered via a lower-level joint team.

4.20 Immediately following the meeting, the Chief Officer re-iterated to the Commercial Director of NDHT that it should discuss with the RD&E to see if there was a compromise solution that could be agreed that would satisfy the CCG.

5 August 2014

5.1 During August 2014 there was relatively little formal communication from the CCG. When this was queried by the NDHT Chief Executive, the CCG Chief Officer stated that she felt the CCG could not negotiate with NDHT because we had said in our letter of 8 July that we had been speaking with Monitor, [✂].

5.2 On 29 August 2014, the Chief Executive of NDHT emailed the Chief Executive of the RD&E to see if there was a compromise solution, one in which both providers could work together in the delivery of community services in the Eastern locality. The RD&E Chief Executive turned down the opportunity, stating that it was better to wait until the CCG decision had been made.

6 September – October 2014

6.1 'The Case for Change'[20], [21] document, which sought to justify the rationale for vertical integration, was published on 4 September 2014. This contains statements made to support vertical integration which NDHT had no opportunity to counter (for example, "Eastern locality the community provision is governed by an organisation primarily focused in a different urgent care system" and, "Due to the current provider configuration it has not been possible to view Cost Improvement Plans across the whole urgent care system. This means providers have to focus on services they provide rather than looking to address whole system inefficiencies", both page 14). We would certainly have offered a tangible alternative perspective to this, based on delivered S256 projects, had we had the opportunity.

6.2 In addition, on pages 30 & 31 there are various statements made in an attempt to demonstrate how the proposals do not break the Section 75 regulations. NDHT fundamentally disagrees with a number of the statements made, and would have wished to debate this before the production of the document, had it had the opportunity to do so. The fact that there was not is further evidence of a lack of **transparency**.

6.3 On page 29 of the Case for Change, the CCG states:

> *"It is our view, based on national evidence and local experience that it is more straightforward to deliver seamless care within an organisation than across organisations".*

6.4 As referred to earlier, NDHT has asked for this national evidence, but the CCG has failed to provide it.

6.5 Also on page 29, the CCG determines that its preferred procurement option is to:

> ***"Collaborate locally:** We are supportive of a collaborative approach or prime provider model that will enable the delivery of our ambitions of community services for people with complex needs focused on the locality urgent care system. In the absence of a collaborative proposal from our provision system to assess we would now wish to explore the prime provider option further".*

6.6 As stated above, NDHT attempted a collaborative approach with the RD&E but was rebuffed. There is a degree of irony here that, by implication, it is NDHT which is assessed as not having the ability to deliver CCG ambitions for community services. Also, it is hardly surprising that the RD&E rebuffed the offer – all the evidence it had until that point (and since) would lead it to assume that it was bound to be acquiring the services: it would not have thought there was any point in collaboration.

6.7 Also on page 29, the CCG states that it:

> *"…proposes to commission community services for people with complex needs from organisations that are fully embedded in the locality urgent care system".*

6.8 Combined with the comment above stating that NDHT's primary focus was in a different urgent care system, this implies that the only acceptable provider is that which runs the acute hospital in that locality. NDHT contends that this represents **discrimination** on the basis of **ownership**.

6.9 The Case for Change was approved by the CCG Governing Body and therefore it was determined to adopt a process of identifying the most 'capable provider'. Given that the Governing Body had already approved the concept of procuring from organisations fully embedded within the locality urgent care system, and care was best delivered seamlessly from **within** an organisation, NDHT contends that, as has been the case since March 2014, any decision was pre-ordained, and the capable provider process simply a cover and applied retrospectively. Again, **discriminatory** behaviour.

6.10 On 15 September, the CCG wrote to NDHT[22] informing us of the process to be followed to identify the most capable provider. The process was:

- An option appraisal would be undertaken by the CCG to determine the preferred procurement route. The Case for Change would help inform that appraisal. The procurement options were:

- Maintain the status quo;
- Select the 'most capable provider' from local NHS providers; or
- Open competition using competitive tender;

- Local providers would have to
  - Within 4 working days, express interest in which localities they would like to deliver services;
  - Then provide responses to a number of questions detailing how they would propose to deliver and develop services.

6.11 NDHT responded by the deadline stating that it wished to be considered to deliver services in both the Northern and Eastern localities.

6.12 The six questions were published on 22 September[23],[24],[25] with a deadline of 17:00 on 13 October 2014 for the submission of responses. Each question response had a word-limit of 1,500 words. No financial assessment was included. Just three weeks and 9,000 words with no financial assessment whatsoever – so no value for money assessment could be undertaken. This provides further evidence that not only the decision was pre-ordained, but also that the decision was **disproportionate**.

6.13 The process was administered by the South West Commissioning Support Unit (the CSU).

6.14 [✂]

6.15 On 2 October 2014, following a further chasing request, NDHT finally received responses to the questions it had raised in its letter of 8 July[26]. A number of the responses were unsatisfactory (not least the request for evidence that Vertical Integration works). In addition, because of the now ongoing quasi-procurement process, the CCG refused to respond to many others, stating that there were commercial-in-confidence issues. The timing of the response, so long after the initial letter and during the capable provider process suggests strongly that the CCG deliberately delayed responding as it did not wish to provide **transparent** responses.

6.16 On 13 October 2014, NDHT submitted its responses to the questions; a different set for each locality[27],[28].

6.17 Coinciding with the 'procurement' process was the CCG's consultation on its TCS commissioning intentions, and NDHT's own engagement process on the consolidation of community hospital beds on to fewer sites. Given that these were each proposing either the temporary or permanent loss of beds from some community hospitals the public meetings to discuss the proposals were very well-attended, particularly those undertaken by the CCG. After some initial confusion it was agreed that both organisations should be present at each organisation's events. Four senior staff, including Directors of the Board attended one such event in Axminster at which they were alarmed to hear various statements made by CCG officers which implied that the decision to award services to the RD&E had already been made, despite the evaluation process of the TCS submissions not yet being complete. The statements made by the lead CCG GPs statements included:

"Whilst we transition between providers."

"Discussions with the RD&E are underway."(in relation to how services would change with a new provider)

6.18 NDHT was so concerned about the bias and **anti-competitive** stance being taken by senior CCG officers that the Chief Executive wrote to the Chief Officer on 31 October 2014[29]. The Chief Officer of the CCG responded on 17 November. She neither denied nor accepted that the statements were made, simply stating that the minutes do not quote these statements[30].

6.19 During October 2014 a further OGC Gateway Review was undertaken by the Department of Health of the TCS process. Again, a Freedom of Information request for the resulting report made since the identification of Preferred Provider has been refused by the CCG.

7 November - December 2014

7.1 The Governing Body of the CCG met on 5 November 2014 to decide the future providers of community adult complex care services in Devon.

7.2 At lunchtime on 6 November 2014, the Deputy Chief Executive of NDHT was contacted by the Chief Executive of the CCG to be informed that:

- NDHT was the Preferred Provider for the Northern Locality;
- However, whilst its proposal was acceptable, the RD&E had scored more highly against the evaluation criteria, and RD&E was therefore the Preferred Provider for the Eastern Locality; and
- No contracts had yet been awarded, as due diligence was now necessary.

7.3 During the afternoon of 6 November, an embargoed Staff Express[31] was issued to NDHT staff informing them of the decision. The Express also stated that the NDHT Board would consider the situation and inform them of any developments.

7.4 Later that afternoon the evaluation reports of the NDHT submissions were received from the CCG[32], [33], [34], [35].

7.5 At 09:00 on 7 November 2014, the decision was announced to the media by the CCG.

7.6 On 10 November 2014, the Chief Executive of NDHT asked the CCG Chief Officer what the due diligence process would entail. She replied stating that she wasn't sure as it had not been designed yet, but that further information would be issued during the week commencing 24 November 2014. Again, this is evidence of a **lack of transparency**. NDHT has always been in the position of either not knowing what the next stage in the process is, or having to respond very quickly to deliver the next stage: there has never been a route map produced that would describe a procurement process from start to end. It hasn't been produced, because it the process has been developed 'on the hoof'. One member of staff has described it like the "dance of the seven veils – trouble is, the dancer goes off-stage after each veil for a costume change!".

7.7 For the Chief Officer not to know what would be included in the next stage of a process that is aimed to deliver service contracts worth nearly £400 million across Devon is of concern.

7.8 The NDHT Board met for an urgent Board Briefing on 10 November 2014 and agreed to:

- Seek further advice from the NHS Trust Development Authority and Monitor;
- Submit Freedom of Information requests around the process used to evaluate the submitted options from the different providers;
- Seek legal advice around a challenge based on competition;
- Undertake a SWOT analysis for the rationale of any legal challenge based on either the process and/or the outcome of the Clinical Commissioning Group's decision.

7.9 It also undertook to issue a Staff Express to ensure that staff were kept informed of progress.[36]

7.10 The Risk Benefit Analysis[37] was considered at a subsequent Board Briefing held the following week, on 17 November. The analysis looked at the risks and benefits of three scenarios:

- Retain services;
- Transfer services;

- The challenge process.

7.11 The Board was keen that, prior to determining its course of action, it should properly assess the risk and benefits of each scenario in order that it could make an informed decision. As always, its decision-making was informed from four perspectives, in decreasing order of priority:

- The patient;
- The staff;
- The health and care system;
- The organisation.

7.12 The Board agreed to:

- Produce a draft timeline on the process and events to date;
- Circulate the Risk Benefits Analysis with the agreed amendments for comment;
- Issue communications to Trust staff to keep them informed of the Board's position;
- Undertake a staff survey seeking the staff's views of the Clinical Commissioning Group's decision;
- Make further requests for information and clarification for the Clinical Commissioning Group;
- Contact key representatives from the Clinical Commissioning Group to talk through the possibility of a challenge informally;
- Seek advice from the NHS Trust Development Authority;
- Seek legal advice;
- Ensure that representatives of the Local Area Team NHS England are kept informed.

7.13 The indicative view of the Board was to challenge the Clinical Commissioning Group Governing Body's decision-making process on the grounds of the negative impact on patient experience and safety and lawfulness. It was agreed that further discussion would take place at the next formal Trust Board meeting as the collation of information was not yet completed.

7.14 Informal telephone conversations took place between NDHT and senior officers of the CCG, TDA and NHS England in which stakeholders were informed that, as things stood, NDHT was minded to challenge the CCG decision-making process on the grounds of the negative impact on patient experience and safety, as well as its lawfulness.

7.15 Legal advice was sought on both on the process to be followed and on the likelihood of a successful challenge.

7.16 On 25 November there was a Board meeting and, after long and careful consideration[38], it was agreed that one last attempt should be made to seek local resolution. The Board was satisfied that there was a strong case for challenging the CCG decision-making process and therefore, an immediate complaint to Monitor should be made, if urgent local resolution was unsuccessful.

7.17 On 27 November 2014 the Chair and Chief Executive of NDHT wrote to their counterparts at the CCG seeking an urgent face-to-face meeting (by the week commencing 15 December 2014) and asking there to be immediate pause to the procurement process[39]. They also stated that they would want the NHS England Area Team to be present at the meeting.

7.18 On 28 November the CCG replied[40], stating that the request would be considered at the forthcoming Governing Body meeting, and that the process would continue in the meantime.

7.19 Accordingly the CSU emailed NDHT on 28 November with details of the next stage of the process, titled "The Transition Framework"[41]. It was only in this stage – **after** the decision to identify Preferred Provider – that the scope of and resources (i.e. financial framework) for the complex adults community services would be finally identified (3rd page). This should have been identified before the procurement process started. It also assumed the transfer of commercial-in-confidence information **prior** to contract award. It also asked for identification of a named point of contact from the Trust.

7.20 On 8 December, in a conversation with the CSU, the Commercial Director of NDHT confirmed that he would be the named contact. He confirmed with the CSU that they were aware of the request by NDHT to suspend the process until the urgent meeting had taken place between the CCG and NDHT.

7.21 Also, on 8 December 2014, the CCG finally responded to the request for an urgent meeting by offering just one slot six weeks after NDHT's original request. Their response[42] ignored the request for a suspension of the procurement process and also appears to suggest a misunderstanding of the rationale for the meeting, in that the CCG refers to it as a 'debrief' meeting.

7.22 As a result of this delay and further evidence of an **unwillingness to engage**, NDHT decided to file a formal complaint with Monitor as soon as possible. [✂].

7.23 On 15 December 2014, the Chairman and Chief Executive of NDHT wrote to their counterparts at the CCG stating that NDHT now had no option but to file a formal complaint with Monitor[43], but making clear that it would withdraw that complaint if the resolution meeting was successful. It also stated that it was suspending any further engagement with the process being followed by the CCG, at least until the resolution meeting had taken place.

7.24 It is clear from the above that the Board has considered carefully whether or not to issue a formal complaint to Monitor.

7.25 On 18 December 2014, NDHT filed a complaint to Monitor, asking it to investigate formally the decision by NEW Devon CCG to identify the RD&E as Preferred Provider of adult complex care services in the Eastern Locality.

8 January 2015

8.1 On 8 January 2015 the local resolution meeting was held between senior officers of NDHT and the CCG. The meeting failed to reach agreement.

8.2 Notes of the meeting were produced and several attempts were made to agree them. The final draft were shared with the CCG on 26 January 2015[44].

8.3 An update was written and shared with all members of the NDHT Board on 12 January 2015[45].

8.4 A letter was sent by NDHT to Monitor on 16 January confirming that the local resolution meeting had failed in its purpose, and that therefore the previously submitted complaint still stood[46].

[1]-[46] [✂]