Northern Devon Healthcare NHS Trust

Case CCD 01/15

Further submission to Monitor regarding the procurement of community services for adults with complex needs in East Devon

Summary

1 In this further submission Northern Devon Healthcare NHS Trust (NDHT) responds to Northern, Eastern and Western Devon CCG's (the CCG) *Response to Monitor Investigation* dated 11 February 2015 (the Response).

2 In summary NDHT submits that the CCG's Response confirms that it did not comply with the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (the PPCC) when it appointed Royal Devon and Exeter NHS Foundation Trust (RD&E) as its preferred provider of adult complex care services in its Eastern locality.

3 The CCG's process could not and did not assure it of the quality, efficiency and value for money of service provision:

- It did not carry out any assessment of best value for money
- It took no account of the likely costs involved in transferring the services
- Its process was not proportionate to the scale, value and complexity of the services.

4 The CCG did not act transparently:

- Its procurement approach kept changing: quite literally, the CCG made the process up as it went along
- It was and is self-contradictory as to whether the procurement was competitive or not
- It failed to specify the adult complex care services that it is commissioning
- The CCG did not disclose that it had set a flat cash assumption for evaluating proposals.

5 The CCG did not treat providers equally and in a non-discriminatory way. At the time it invited proposals for adult complex care services, the CCG had publicly stated its preferences in its draft Case for Change:

- That RD&E was its preferred option to deliver adult complex care services

- To reduce the number of organisations delivering services and therefore to appoint a single organisation (RD&E) to provide both urgent care services and adult complex care services.

6 There were conflicts of interest which affected the CCG's proposed contract award.

7 NDHT sets out the CCG's failures in further detail below. Key documents that NDHT refers to include:

- The CCG's draft Case for Change dated 28 August 2014. Minutes of the CCG's meeting on 4 September 2014 record that the CCG's Governing Body "received the draft Case for Change and supported the direction of travel".
- The CCG's *Invitation to Propose a Solution for Pathways for People with Complex Needs* (the Invitation to Propose) dated 22 September 2014 comprising a Guidance Document and Questions and Submission Booklet. The Guidance Document states that the draft Case for Change was one of three documents to be read in conjunction with it (the others being the CCG's Strategic Framework and Engagement Report).
- The CCG's final Case for Change dated 29 October 2014
- Draft minutes of a meeting between NDHT and the CCG on 8 January 2015. Please note that the CCG's changes have not been agreed as an accurate record of the meeting and are therefore shown as struck out.

8 In addition, NDHT refers to:

- NDHT's comments on the CCG's Response that it has previously submitted to Monitor
- Annex 1 to this submission which sets out inaccuracies in the CCG's Response regarding NDHT and its current provision of services.

Quality, efficiency and value for money of service

Value for money

9 At para 65 of the Response, the CCG states:

> *The CCG designed an options appraisal and due diligence approach to identify the most capable provider(s) to deliver community services.*

10 It is difficult to understand what process the CCG thinks it in fact followed to identify RD&E as the most capable provider to deliver community services.

11 As explained in detail below, the "options appraisal" was not in itself a process to identify the most capable provider, but instead was a CCG exercise to determine if the procurement process should be "do nothing, collaboration or tender".

12 As to due diligence, the CCG never intended that due diligence would be part of its process to select the most capable provider. Instead as set out at para 3.9 on page 10 of the Guidance Document to the Invitation to Propose:

> *Following evaluation of submissions and consideration of the outcomes of the options appraisal if NEW Devon CCG are able to identify a most capable preferred provider for each locality the CCG will enter into a period of Due Diligence prior to the award of any contract.*

13 Insofar as the CCG undertook any due diligence before selecting RD&E, it undertook limited due diligence enquiry of RD&E to assess if it was a capable provider. It undertook no due diligence of NDHT because it was already satisfied that as the incumbent provider, it was capable.

14 NDHT refers to the draft minutes (as amended by the CCG) of a meeting between it and the CCG on 8 January 2015 which record what the CCG said about the limited nature of its financial assessment of bidders:

> [✂] *(CCG): The CCG explained that the capable provider assessment conducted as part of the initial proposal did include financial assessment and information. we did do financial due diligence on RD&E - prior to September.*
>
> [✂] *(NDHT): were other providers checked?*
>
> [✂] *the CCG): yes, but existing providers of community services were not checked as we were already satisfied they were capable from the contracts with them. It was undertaken to provide a first high level assurance to the GB* [ie the CCG's Governing Body] *that they were capable of taking on these services. After the engagement the process changed to take the feedback into account*

15 Therefore the CCG undertook no detailed or comparative due diligence of NDHT or RD&E before it nominated RD&E as the most capable provider. Instead as page 20 of the CCG's final Case for Change states:

> ***Timeline for action:*** *Pending the outcome of the Governing Body decision in relation to the procurement process we propose proceeding to identify preferred providers, or further actions to achieve preferred providers, for each of Northern,*

Eastern and Western localities during November 2014. This will be followed by a period of detailed due diligence prior to decisions regarding contract award.

16 So the CCG's final Case for Change confirms that even before the CCG had decided what its procurement process would be, it proceeded with identifying its preferred provider.

17 The CCG purported to identify its preferred provider by way of the Invitation to Propose. Its Response at para 120 states:

The aim of the process [ie the Invitation to Propose] *was to appoint a preferred provider for future services to take through to the next stage of detailed due diligence prior to a formal recommendation of award.*

18 So the CCG admits in the Response that before nominating RD&E as the most capable provider, it did not undertake detailed or comparative due diligence to assess which of NDHT or RD&E would be most capable of providing the services and would provide best value for money in doing so.

19 In the Response the CCG confuses a best value for money assessment with a financial sustainability assessment (see para 115 where the CCG equates question 2 in the Invitation to Propose regarding financial sustainability and allocation of resources to a best value for money assessment). Even if that question were apt, it allowed a response limited to 1,500 words, which would by no means be adequate due diligence enquiry to assess best value for money.

20 NDHT again refers to the draft minutes of its meeting with the CCG on 8 January 2015 which record the following exchange:

[✂] *(NDHT): where is the VFM test in the decision?*

[✂] *(CCG): To do that we would have had to have undertaken a full procurement.*

21 The draft minutes have not been finalised, but when the CCG amended them, it did not amend the above text. In its own amendment to the draft minutes of that meeting, the CCG added:

[✂] *(CCG): The CCG explained that the due diligence will look at value for money ahead of contract award. The same due diligence is occurring for all three localities at the same time. Reiterated the most capable provider process looked at the stretch needed to deliver the 6 questions over and above core service delivery.*

22 At para 121 of the Response, the CCG sets out the type of financial information it will be seeking and assessing as part of the future transition process. This is the type of financial information which should accompany proposals to deliver services to ensure a robust assessment of best value for money.

23 The CCG should also have stipulated assumptions and/or parameters within which to provide value for money information to ensure parity of assessment. The appearance of a 'flat cash' assumption in Appendix 1 of the Response is new information to NDHT and does not reflect the reality of the health economy in Devon.

24 In addressing the best value for money issue, the Response is blank on the costs of transferring the services to a successor provider. This submission by NDHT is not the place to identify those costs in any detail but there would be multi million pound costs in disaggregating the services. For example, the CCG supported the procurement and acquisition of a total Electronic Health Care solution for the Northern Acute and Community hospital sites and Eastern Community hospital sites in July 2014. HM Treasury has provided about £7m assisted funding. If eastern locality services transfer to RD&E, then they will lose the benefit of the Electronic Health Care solution (including Treasury funding), but the CCG has not undertaken any financial or service impact assessment of the loss.

25 At para 64 of the Response, the CCG states:

> *It should be noted that in describing a non-competitive approach, the CCG was contemplating a comparative assessment of different potential providers in order to identify the Most Capable.*

26 But by its own admission the CCG did not undertake a comparative assessment of value for money before it purported to assess RD&E as the most capable provider, so that in fact it could not and (contrary to the PPCC) did not assess whether NDHT or RD&E would provide best value for money. All that the CCG had in fact done was assess that they were both capable providers.

Proportionality

27 The CCG's approach to assessing which provider was most capable of providing the services was disproportionate to the scale, value and complexity of the services. The service provision is for a potential three year period and amounts to over £50million each year. The process as set out in the Invitation to Propose to determine a provider was, relative to the services to be commissioned, inadequate.

28 The Response contains very little information regarding how it has tested which provider is most capable of and provides the best value for money in providing the services. In particular, NDHT highlights below the absence of service specifications; the 1,500 word limit; the absence of due diligence; and the absence of a comparative best value for money assessment.

29 The CCG's *Invitation to Propose* and documents to be read with it do not contain <u>any</u> service specifications.

30 Instead at para 126 of the Response, the CCG states:

> *The scope of the service being commissioned is services for people with complex health needs as described in the Case for Change'*

31 Page 26 of the draft Case for Change sets out "an overview of current service lines that are presently included and excluded" for pathways for people with complex needs, but there are no service specifications. On the contrary, page 26 goes on to say:

> *Within this larger grouping of services further work will be needed to identify components that align to the preventive and personalised bundle and those where bespoke arrangements may be appropriate. This will be explored further as the new service specifications are developed and implemented.*

32 And page 27 of the draft Case for Change states:

> ***Specification**: Core specifications will look for a consistent and co-ordinated service for patients with a community model that works seamlessly within the wider system , which pro-actively assesses risk of a crisis as part of care planning and builds in timely interventions to manage people at home supported by strong local services that support people 7 days a week.*

33 And page 20 of the final Case for Change states:

> ***Design and specification:** In commissioning services for people with complex needs it is important to recognise the dynamic nature of this service. Current*

locality proposals, the outcomes of involvement and consultation, and any subsequent redesign plans will need to be taken into account when preparing the detailed content of the overall complex adults services. Additionally further work on the personalised and preventive bundle will impact on the detailed design.

34 So at the time when the CCG invited and purported to evaluate proposals, it had no service specifications or bidder information by reference to which it could evaluate capability and value for money.

35 In fact the CCG now asserts at para 81 of the Response that one reason for not having a competitive process was so that it would not have to have a service specification:

Concerns were also raised that a formal competitive process would stop ongoing transformation and would also require a service specification which would inhibit transformation over the life of the contract.

36 Remarkably it seems that the CCG's team who assessed the Options Appraisal believed that the CCG could only draft specifications that would inhibit change. They seem to have been wholly unfamiliar with drafting outcomes-based commissioning specifications which encourage provider innovation.

37 As well as an absence of service specifications, the Invitation to Propose does not distinguish between service provision in the northern, eastern or western localities with a common form used for all three localities. This is despite asymmetries in the health and social care landscape in these regions as set out in the draft Case for Change.

38 In the absence of a detailed, tailored approach, the CCG could not have carried out an adequate assessment of the most capable provider of the services in the eastern locality, nor assessed whether a provider provided best value for money in doing so.

39 In the Invitation to Propose, the CCG allowed for a three week response with a 1,500 word count per assessment criterion i.e. 9,000 words in total, which would include diagrams, spreadsheets and similar data. At para 119 of the Response, the CCG states that:

This word limit was specifically set to enable succinct strategic responses.

40 'Succinct strategic responses' are not proportionate or sufficient to assess capability and value for money. Such an approach by the CCG was disproportionate to the scale, value and complexity of providing services for adults with complex needs in eastern Devon over a potential three year period with a value of £50m a year.

41 The CCG's assessment was based on its evaluation of six criteria set out in the Invitation to Propose. At para 103 of the Response, the CCG states:

> *These criteria and questions and the process to assess them were purposefully designed to look beyond core capabilities towards the solutions that would best achieve a step change in integrated community services to deliver the vision*.

42 It is untenable to maintain that such far-reaching solutions could be articulated in a total word count of 9,000 words. NDHT maintains such a limited approach does not allow for an adequate assessment relative to the scale, value and complexity of the services.

43 NDHT therefore submits that (contrary to the PPCC) the CCG did not act in a proportionate way when it purported to select RD&E as the most capable provider.

Transparency

44 The CCG's procurement process was not transparent. Its Response is obscure and either contradicts itself or other key documents issued as part of the procurement process.

45 At para 125 of the Response the CCG states:

> *Taking account of the product of its engagement from May-July 2014 the CCG recognised that some form of competitive assessment needed to be undertaken.*

46 But at page 34 of the draft Case for Change, the CCG had stated that it had not yet decided on a "do nothing, collaboration or tender" process:

- *We consider that the present community delivery system complexity does not set the best foundations for future delivery in the context of rising needs and system pressures.*
- *To progress we are looking to commission a service that satisfies our requirements for governance around patient flows in the urgent care system.*
- *It also needs to support maximum pace and transition to the end point of integrated care or accountable care organisation in eastern locality.*
- *We believe this could be achieved through a starting point of integration within the complex adults health pathway in readiness for local authority integration.*
- *Although this could be achieved in a range of ways, in the absence of a collaborative model then we would aim to progress to a prime provider approach. It is our view that the Royal Devon & Exeter Foundation Trust is*

best placed to deliver our requirements and therefore are currently our preferred option. Further work is, however, required to evaluate and assess the options that best secure the overall objectives of the regulations and the outcomes we are striving to achieve.

- *We consider the risks posed by tendering would work against the progress with local authority integration that is a key priority for the future.*
- *We propose to publish a formal options appraisal comparing do nothing, collaboration or tender in order to further test our conclusions in this regard. The result of this will be included in the final version of the Case for Change.*

47 Notwithstanding these statements in the draft Case for Change, at para 58 of the Response the CCG states:

When the draft Case for Change was sent to providers ahead of formal publication, this was the first clear indication that there was to be a competitive procurement process.

48 But the CCG's proposal in its draft Case for Change was only "to publish a formal options appraisal comparing do nothing, collaboration or tender" and was not at all "the first clear indication that there was to be a competitive procurement process".

49 In fact the CCG's [✂] wrote in a letter of 15 September 2014 to NDHT's [✂]:

For those organisations being assessed an Invitation to submit an outline solution to our proposals as detailed in the Case for Change will be issued on 22 September 2014 for return by 13 October 2014. This will be subject to review and moderation ahead of decisions of the Governing Body on 5 November 2014. We are working to this November timeline to enable progression to a competitive approach if our current proposed non-competitive route changes in the light of this process. [Our emphasis underlined.]

50 Para 59 of the Response confirms that the CCG's Governing Body had approved the draft Case for Change at its public meeting on 4 September 2014:

The draft Case for Change document was presented to the Governing Body at the September 2014 Public Meeting for review and for them to consider the risks within the proposed direction, notably surrounding the procurement process. The Governing Body endorsed the direction of travel including the proposed procurement process.

51 So contrary to what the CCG asserts at para 125 of the Response, as at September 2014 it had **not** "recognised that some form of competitive assessment needed to be undertaken". Instead it had decided that (1) RD&E was "best placed to deliver our requirements"; (2) it proposed to undertake a non-competitive process; and (3) it would undertake an Options Appraisal which would be included in its final Case for Change and confirm the procurement process that it would follow.

52 Para 59 of the Response goes onto confirm that:

> *The final Case for Change was presented to the public Governing Body meeting on 05 November 2014; the same date as the result of the procurement process was presented to the confidential section of the Governing Body*

53 In other words, by the time of the Invitation to Propose the CCG had decided that RD&E was its preferred provider, but it had not decided the process it would follow to appoint RD&E. It would decide the process only after it had issued the Invitation to Proceed.

54 The final Case for Change included the Options Appraisal at Appendix 2 which concludes:

> *Based on the Procurement Options Appraisal, the preferred procurement model for the Transforming Community Services programme is:*
>
> *Allocating contracts in a non-competitive way to those providers deemed most capable to deliver the contract.* [Our emphasis underlined.]
>
> *This is to be discussed and agreed at the Governing Body meeting on 01 October 2014.*

55 At para 79 of the Response, the CCG states that:

> *The Options Appraisal was assessed independently by 15 members of the CCG including representatives from Finance, Commissioning, GP Leads, and the CCG Executive Team. The overwhelming outcome of the appraisal was to follow a process to allocate services to the most capable provider. This was presented in private session to the Governing Body on 01 October 2014, where the Governing Body formally adopted the recommendation from the Provider Options Appraisal.*

56 So on 1 October 2014 the CCG's Governing Body had in fact privately adopted the Options Appraisal and decided to run a non-competitive process to allocate services to the most capable provider, having already publicly at its meeting on 4 September

2014 supported the direction of travel set out in the draft Case for Change which included its "view that the Royal Devon & Exeter Foundation Trust was best placed to deliver our requirements and therefore are currently our preferred option". (NDHT also points out that it is self-contradictory to say that members of the CCG assessed its Options Appraisal "independently". How could members of the CCG act independently of it?)

57 There is no suggestion in the minutes of its public meeting on 5 November 2014 or in para 59 of the Response that the CCG's Governing Body resiled from either its earlier decision of 1 October 2014 to adopt a non-competitive process to allocate services to the most capable provider or from the direction of travel endorsed on 4 September 2014.

58 Between receiving the Invitation to Propose and submitting its proposal, NDHT could not have known and did not know whether or not the procurement process was competitive. All it could have known was what the CCG stated at page 3 of the Guidance Document to the Invitation to Propose:

> *NHS Northern, Eastern and Western Devon Clinical Commissioning Group set out a draft Case for Change for community services in September 2014. This set out a proposed way forward for procuring services for people with complex health needs and identified further work to be completed before decisions are made. This includes a capable provider assessment should a non-competitive approach be adopted for these services.*

59 At para 84 of the Response the CCG refers to its meeting with Monitor on 15 October 2014 and at para 85 says:

> *At this meeting, we took note of Monitor's comments that the process should no longer be described as being non-competitive as it was, in essence, a process to test the market and establish the most capable provider according to the CCG's criteria. As such, following this meeting, the CCG's procurement process was renamed as being to "Allocate contracts to those providers deemed most capable to deliver the contract". This was reflected in the 05 November 2014 Governing Body procurement paper. Other aspects of Monitor's informal advice were taken carefully into account alongside the advice of external procurement experts from the South West Commissioning Support Unit and the CCG's legal advisors.*

60 But (as described above) in fact the CCG had already privately decided on 1 October 2014 that its preferred procurement model was, "*Allocating contracts in a non-*

competitive way to those providers deemed most capable to deliver the contract," and it did not amend this description when it publicly received the final Case for Change at its meeting on 5 November 2014.

61 And (as also described above) the CCG states at para 64 of the Response that:

> *It should be noted that in describing a non-competitive approach, the CCG was contemplating a comparative assessment of different potential providers in order to identify the Most Capable.*

62 It is clear that the CCG has confused itself between undertaking a competitive process and a comparative assessment. Selecting which one of two capable providers is the most capable (the CCG having already assessed that NDHT and RD&E were both capable) is of course a comparative assessment (by contrast, selecting an only capable provider is not). Although Monitor suggested that the CCG's process could no longer be described as "non-competitive" (ie it was in fact a competition), the CCG continued to undertake a comparative assessment without running a competition that complied with the requirements of the PPCC.

63 NDHT further maintains that there has been no proportionate level of transparency regarding who carried out the procurement process. This is also relevant regarding compliance with Regulation 6 (Conflicts between interests in purchasing healthcare services and supplying such services) and Regulation 8 (Assistance or support for purchasing activities).

64 The CCG should declare the identities of who carried out the Invitation to Propose assessment and the subsequent moderation. It does not do this in the Response but instead states at para. 216 that it has 'many processes in place to manage conflicts of interest and managed them assiduously'. If this is the case, the CCG should have no concerns in disclosing this information and the accompanying declarations of interest. To refuse to do so is not transparent. If the assessors themselves refuse to be publicly disclosed, that is also not transparent.

65 NDHT therefore submits that (contrary to the PPCC) did not act transparently when it purported to select RD&E as the most capable provider.

Equal treatment and non-discrimination

66 The CCG has failed to treat NDHT and RD&E equally and in a non-discriminatory way. Its decision to select RD&E as preferred provider was predetermined before the Invitation to Propose. It treated RD&E more favourably than NDHT on grounds of

location and the fact that NDHT does not provide acute services in the eastern locality.

Predetermination

67 At page 34 of the CCG's draft Case for Change, which was one of the key documents to be read with the Invitation to Propose, the CCG expressly stated a preference for RD&E to provide services for adults with complex needs in the eastern locality:

> *It is our view that the Royal Devon & Exeter Foundation Trust is best placed to deliver our requirements and therefore are currently our preferred option.*

68 Remarkably the CCG's Response does not address this issue at all. It remains unrefuted (and indeed irrefutable) that by the time of the Invitation to Propose, the CCG had predetermined that its preferred option was to transfer services for adults with complex needs in the eastern locality to RD&E. It took no action to remedy its predetermination.

69 In the draft Case for Change, the CCG explained its preference for RD&E to provide services in the eastern locality for adults with complex needs:

- Page 14

  In Eastern locality the community provision is governed by an organisation primarily focused in a different urgent care system …

  Where the provision of community services is governed by an organisation outside of the urgent care system they are delivered in, there are competing incentives that prevent the delivery of care in the most efficient manner.

- Page 19

  We have previously described the principle of natural geographies around the complex needs services, however the right geographical footprint is important for a whole range of services. Our default is for care to be provided as local as possible particularly for preventive and support services, scaling up into logical footprints for other services. We see patient flows within the urgent care system as a key factor in planning ahead particularly for community services for people with complex needs.

- Page 28

  We consider that it is important to commission services aligned to the urgent care systems. By commissioning in an area that that reflects the majority of

patient flows within urgent care system the Clinical Commissioning Group has the best possible opportunity to shift care more towards home and community provision.

- Page 29

  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 … We propose to commission community services for people with complex needs:

  •From organisations that are fully embedded in the locality urgent care system…

70 In its Response the CCG repeats the above views and states at para 51:

In the Eastern Locality, we highlighted that there are Northern Devon facing clinical and strategic governance arrangements for community services and that this delivery system arrangement does not align to the natural flow of patients. This can lead to increased clinical risk due to differing medicine and clinical practice, as well as different corporate and clinical priorities.

71 It is clear from the above extracts from the CCG's draft Case for Change and from the Response that before it issued the Invitation to Propose, the CCG had predetermined its preference (and therefore proposed in the draft Case for Change) that it would commission a single organisation, namely RD&E, to provide urgent care and community services for people with complex needs in the eastern locality.

Bias

72 But not only had the CCG predetermined its preference, its explanation for its preference is unsubstantiated and demonstrates bias. In particular, the CCG has produced no evidence (because there is none) to support its bogus assertions that:

- *Where the provision of community services is governed by an organisation outside of the urgent care system they are delivered in, there are competing incentives that prevent the delivery of care in the most efficient manner*
- *national evidence and local experience that it is more straightforward to deliver seamless care within an organisation than across organisations*
- *there are Northern Devon facing clinical and strategic governance arrangements for community services and that this delivery system arrangement does not align to the natural flow of patients. This can lead to*

increased clinical risk due to differing medicine and clinical practice, as well as different corporate and clinical priorities.

73 In *'Transforming Community Services: NDHT concerns with provision proposals'* (dated 8 July 2014 and as provided to Monitor previously), NDHT asked the CCG for evidence regarding the benefits of vertical integration within one organisation. The CCG's reply on 2 October 2014 referred NDHT back to the draft Case for Change, which contains no such evidence.

74 At para 96 of the Response, the CCG continues to refer to '*reduc[ing] the inter-organisational barriers, duplications and distractions that presently exist'*. It does not present any evidence to that effect despite these apparent issues being a '*key point on the rationale for a system approach*'.

75 And at para 112 the CCG further states that, in considering the vision in the Strategic Framework, '*it was clear that the greatest importance was on designing a system with fewer operational boundaries'* (and then contradicts itself by continuing that the single provider approach was '*not central to the actual decision on which provider was award[ed] Preferred Provider status*'.

76 This view is not supported by the Options Appraisal or the criteria in the Invitation to Propose. The Response shows the importance the CCG placed on the removal or reduction in organisational boundaries in both the Options Appraisal and the Invitation to Propose criteria (see Appendices 1 and 2 of the Response).

77 With regard to NDHT's view that the CCG has shown a preference for an acute provider which can provide both acute and community services, the CCG states at para 202 of the Response that NDHT '*has misunderstood the difference between urgent care system and providing A&E services*'.

78 There is no misunderstanding: the Response references on several occasions the requirement for 'good patient flow' in the urgent care system. The urgent care system comprises acute (including A&E) and community care services. Patient flow in the urgent care system means in real terms the flow of patients from the acute setting to the community setting. In the eastern locality, that means the flow from RD&E to community providers.

79 Whether NDHT describes RD&E as an acute provider or as a provider of A&E services is not relevant. In the current healthcare system, only an acute provider can be a provider of Emergency Department services.

80 In responding to NDHT's view that the CCG is in favour of a provider who can provide both urgent and community care, the CCG states at para 202 of the Response that the provider of the services in the western locality is not a provider of A&E (acute) services. This refers to the selection of Plymouth Community Health CIC as the preferred provider of community services in the western locality. The CCG does not say if there were any alternative capable providers. If there were none, then its response at para 202 is probative of nothing. But in any event the CCG repeatedly expresses its preference for a single organisation to provide urgent and community services in the eastern locality.

81 The western locality is further distinguished by the current radical transformation there towards full integration between community health and social care. There is joint working and a joint budget between Plymouth City Council and NEW CCG in the planning, commissioning and delivery of care.

82 This complexity surrounding the model of service provision in the western locality is recognised by the CCG at pages 32 and 35 of the draft Case for Change and it cannot be compared to the situation in the eastern locality. Plymouth Community Healthcare is already identified by the CCG in that document as best placed to deliver complex needs services. The CCG states 'the risks posed by tendering would work against the progress with local authority integration that is a key priority for the future'.

83 The draft Case for Change was issued several months after the May 2014 Capable Provider Assessment where the CCG assessed RD&E's capability to provide adult complex needs services. As explained above, this was an assessment from which NDHT was excluded on the basis that it already provided the services and NDHT does not therefore know what that assessment entailed.

84 RD&E had an opportunity at the earliest stages of the CCG's decision making process to present its capabilities as a provider of services – an opportunity which was not granted to NDHT. The strategic advantage for RD&E in being able to do so in the absence of a contemporaneous presentation from NDHT is significant and another example of the CCG's failure to treat providers equally.

Conflicts of interest

85 NDHT refers to its submissions about lack of transparency at paragraphs 63 and 64 above which are also relevant to conflicts of interest.

86 NDHT further refers to paragraphs 66 and 84 above with again are relevant to conflicts of interest.

Conclusion

87 For the reasons set out in this document and in its earlier submissions, NDHT submits that it is clear that the CCG has breached the PPCC in appointing RD&E as its preferred provider of services for complex adult needs in its eastern locality. The CCG's breaches are so serious that Monitor should declare that RD&E's appointment is ineffective.

Northern Devon Healthcare NHS Trust

Annex 1: Additional comments to address certain inaccuracies in NEW CCG's Response to Monitor dated 11 February 2015.

1 At para 51 of the Response, the CCG effectively states that that the way in which NDHT delivers services currently does not align with the 'natural flow of patients', leading to 'increased clinical risk'. NDHT refutes that there is or has been any increased clinical risk to service users due to NDHT's clinical and strategic governance arrangements (see para 82 for similar claims). NDHT notes that the CCG does not substantiate this in any meaningful way. NDHT can confirm that the CCG has previously raised clinical and strategic governance issues generally during its commissioning work. In 'Transforming Community Services: NDHT concerns with provision proposals' (dated 08 July 2014), we asked the CCG for confirmation that it had no concerns regarding NDHT's performance of the services, NDHT received a reply dated 02 October 2014 which chose to interpret 'concern' narrowly as something which would lead to a contract review notice (and which has not happened).

2 Notwithstanding Devon's challenged health economy, community health services provided by NDHT were rated by the CQC as 'good' (September 2014). NDHT agrees with the CCG's strategy as set out at para 51 that more care be provided in community settings and would argue that NDHT has demonstrably achieved this since it assumed service provision in 2011. The CQC found this to be the case and has stated that NDHT has a 'strongly developed multidisciplinary collaborative approach to care and treatment, with consistently strong examples of this throughout the community services'. NDHT's services were found by the CQC to 'promote[…] independence and deliver[…] services as close to home as possible.' The adult complex care teams were recognised by the CQC as providing care and treatment to patients in their own homes to prevent further admissions to acute or community hospitals. NDHT's good performance to date in providing these services has been apparently ignored in the CCG's decision-making process in favour of an organisation which has no track record in providing either urgent or community care in the eastern locality.

3 As recently as March 2015, the CCG has commented that, when faced with significant pressure on acute provision at RD&E, patient flow from RD&E into NDHT community care was recognised by the CCG as 'good' (see email from the CCG dated 10 March 2015 to NDHT and others attached). Over Easter the pressure

continued and NDHT was able to assist with effective flow from the RD&E into the community as recognised at the CCG Strategic Resilience Group on 9 April 2015 (see draft minutes attached).

4 Paras 92 et seq. imply that, in providing community services, NDHT is not working effectively within the urgent care system. NDHT currently provides urgent care in the locality and has been rated as providing effective urgent care by the CQC (plus the CQC does not raise any concerns in the interaction between NDHT's provision of complex adult care and urgent care). As regards integration with acute provision, even in the past few months NDHT has been praised for its efforts in continuing to respond quickly and effectively to immense pressure on RD&E. For example, in February 2015 NDHT responded to demands on the system by maximising its capacity and providing community beds to facilitate discharges from RD&E, and sought further agency staff to cover additional shifts. RD&E was appreciative of these efforts and expressed its appreciation at the CCG Executive Escalation Call of 20 February 2015 (see minutes attached).

5 Para 95 states that the CCG's commissioning decision will deliver certain patient and administrative benefits – the majority of which apparently stem from the use of a single provider – and the CCG implies that NDHT could not deliver these benefits. Whilst NDHT is of the view that improvements can and should be made to the already high levels of integration in the locality, NDHT is most capable in delivering these benefits (as set out to the CCG as part of the assessment process). In the CCG Debrief Report, NDHT was marked down in respect of its lack of clarity regarding changes to governance within the acute setting and describing further how to foster arrangements with secondary care providers. These comments have not been substantiated by the CCG.

6 With regard to the CCG's contention at para 185 that NDHT has failed to specify or provide evidence for its claim that the CCG has shown consistent bias in favour of the single provider approach and, in this case, RD&E, we would reference our response in the Submission and the Timeline which we have previously provided to Monitor where the transfer of services to the RD&E was presented as a *fait accompli*. The CCG's Response repeats unsubstantiated statements regarding 'feedback from the wider system' leading to 'clarity of the benefits of a single accountable provider' (para 148).

7 Paras 201-202 effectively state that NDHT failed to demonstrate to the CCG how it could embed community services within the local urgent care system. As explained

above, NDHT has been firmly embedded into the urgent care system in the eastern locality for some time as a provider of urgent and community healthcare services. NDHT's introduction of Urgent Care Co-ordinators into each locality has helped to create fully embedded solutions within the local Urgent Care Systems.

8 NDHT disagrees with the CCG's comments at para 207 regarding the Capable Provider assessment (we comment further on this failure to treat providers equally in the Submission).

9 With regard to the CCG's request that NDHT substantiates any breach of Regulation 6 (para 211), NDHT does not know the identity of those involved in the most capable provider assessment process; it is therefore impossible to ascertain whether or not any assessors were involved in the CCG's earlier commissioning strategy and whether they were in favour of a particular provider or type of provider.

In addition to members of the CCG itself, Regulation 8 requires that in using external support for its commissioning functions, the CCG must ensure that those persons comply with, in particular in this case, Regulation 3 (re discrimination) and 6 (re conflict of interest). If the CCG is certain that there were no conflicts of interests, NDHT does not understand why the identity of the assessors cannot be disclosed, even if this were to NDHT alone (cf. para 194).

10 The CCG refers on several occasions to the importance of independent assessment but, other than a reference to confirming independence from the providers (para 194), it is not at all apparent how this independence was tested or secured.