

Cooperation and Competition Panel

Commissioning and procurement of secure mental health services by North West Specialised Commissioning Group: investigation of a complaint by Hanover Healthcare

19 November 2010

EXECUTIVE SUMMARY

1. In 2008 and 2009, North West Specialised Commissioning Group (NWSCG) held two competitive tenders for four-year framework agreements relating to the provision of secure mental health services in the North West of England. In its complaint to the Cooperation and Competition Panel (CCP), Hanover Healthcare (Hanover) submitted that NWSCG had breached the Principles and Rules for Cooperation and Competition (Principles and Rules) because it had not acted transparently and had discriminated against Hanover in excluding it at the PQQ stage of the tender processes and had restricted choice and competition in entering into the framework agreements on an exclusive basis.
2. Having investigated this complaint, the CCP concluded that NWSCG's decision to exclude Hanover at the PQQ stage of the two tenders was within the range of reasonable decisions that NWSCG could have taken. We therefore did not find a breach of the Principles and Rules in this regard. We note, however, that it was unfortunate that NWSCG was not able to explain why Hanover had been excluded from the two tenders when queried on this first by Hanover and subsequently by the CCP, and had to carry out a retrospective assessment of Hanover's tender to identify clearly the reasons why Hanover had not been successful.
3. Hanover also submitted that NWSCG's failure to provide feedback on its exclusion at the PQQ stage of the two tenders was in breach of the Principles and Rules. While guidance from the Office of Government Commerce (OGC) indicates that giving feedback at the PQQ stage of the process is good practice, the CCP concluded that failure to provide feedback to unsuccessful potential bidders at the PQQ stage did not amount to a breach of the transparency requirement of Principle 3 of the Principles and Rules.
4. However, the CCP found that NWSCG's decision to enter into the two four-year framework agreements for secure mental health services on an exclusive basis restricts choice and competition and gives rise to material net costs for patients and taxpayers. As a result this decision is in breach of Principles 1 and 4 of the Principles and Rules.
5. In entering these four year framework agreements on an exclusive basis, NWSCG – a practice which is clearly not envisaged by OGC in its guidance on framework agreements - committed not to purchase from any other providers of secure mental health services for the four year duration of the agreements. This means that NWSCG is unable to take advantage of any improvements in the services that may become available from providers not admitted to the frameworks, including new entrants, even where these services would represent better value for patients and taxpayers. Further, NWSCG's decision to award business to framework providers based on the offer they submitted during the tender process rather than running mini competitions between framework providers during the life of the two framework agreements means that there is little incentive for framework providers to improve their services for the duration of the two agreements. The CCP concluded that the commitment not to purchase outside the framework agreements and the decision not to hold mini competitions between framework providers results in material costs to patients and taxpayers. The CCP also concluded that NWSCG's use of the framework agreements was likely to deter entry by a potential provider with a better service offer than existing providers, thereby resulting in material costs to patients and taxpayers.

6. NWSCG submitted that patients and taxpayers would benefit from the exclusive nature of these framework agreements as a result of NWSCG achieving better terms from providers, and ultimately, encouraging greater competition between providers. The CCP did not find these arguments persuasive, and in particular, the CCP found that, given NWSCG's powerful position as a buyer of the relevant services in the North West, long term exclusivity did not materially enhance NWSCG's bargaining position with service providers and therefore did not lead to material benefits to patients or taxpayers in terms of higher quality services or lower prices. NWSCG also submitted these agreements would reduce transaction costs. The CCP found that they would reduce transaction costs but that any savings would be modest compared to the costs arising from the conduct. Accordingly, the CCP has concluded that the costs to patients and taxpayers arising from NWSCG's conduct outweigh the benefits arising from it and therefore has found a breach of Principles 1 and 4 of the Principles and Rules.
7. Having concluded that NWSCG's conduct is in breach of the Principles and Rules, the CCP is now seeking views from interested parties on how the breach of the Principles and Rules may best be remedied. The CCP aims to recommend remedies that are effective in dealing with the harm identified and proportionate to the breach in terms of the costs of implementing the remedy. Following consideration of any submissions, the CCP will decide which remedy or remedies to recommend to the Secretary of State for Health. A statement of possible remedies is available on the CCP's website at www.ccp-panel.gsi.gov.uk. Interested third parties are invited to submit written observations on suitable remedies by close of business on Monday, 29 November to consultation@ccpanel.gsi.gov.uk. The CCP will finalise its recommendation to the Secretary of State for Health by 16 December 2010.

INTRODUCTION

8. On 2 June 2010, the CCP commenced an investigation into the commissioning and procurement of secure mental health services in the North West of England following a complaint by Hanover Healthcare.¹ This report sets out the CCP's findings on the issues raised by Hanover's complaint.
9. Hanover submitted that NWSCG had acted in breach of Principles 1, 3 and 4 of the Principles and Rules in the context of the commissioning and procurement of secure mental health services in the North West of England. These principles lay down a requirement for commissioners to commission services from providers who are best placed to deliver the needs of their patients and populations; a requirement to commission and procure services in a transparent and non-discriminatory manner; and a requirement to foster choice.²
10. In particular, Hanover submitted that NWSCG acted inconsistently with the Principles and Rules in not permitting it to participate in tenders for two framework agreements relating to services for: (i) low secure females and (ii) medium secure males and females/low secure males (the Framework Agreements or Frameworks) which were let by NWSCG in 2009 and are intended to have a duration of four years. In addition, Hanover submitted that NWSCG's decision not to allow

¹ Notice of Acceptance, www.ccp-panel.org.uk.

² For the purpose of this case, we refer to the Principles and Rules published on 13 December 2007.

Hanover to contest the market by refusing to commission services outside the Framework Agreements during their four year duration is contrary to the Principles and Rules.

11. We have structured our report as follows:
- Parties to the complaint – the parties to this complaint are described in paragraphs 12-13.
 - Jurisdiction – the CCP’s remit to deal with the issues raised by the complaint is set out in paragraphs 14-23.
 - Investigation process – this section describes the CCP’s process (paragraphs 24-27).
 - Framework for assessing the complaint – this section explains at a high level which of the Principles and Rules are relevant to the types of issues raised by the complaint and describes how we have analysed the different elements of the complaint (paragraphs 28-34).
 - Background to the commissioning of secure services
 - i. National policy (paragraphs 36-45)
 - ii. Commissioning of secure mental health services in the North West (paragraphs 46-58).
 - Decision not to admit Hanover to the Framework Agreements – this section deals with NWSCG’s decision that Hanover’s response to the pre-qualification questionnaires was inadequate (paragraphs 59-93).
 - Decision to use exclusive four year Framework Agreements - this section sets out the cost/benefit analysis associated with NWSCG’s decision to operate the four year Framework Agreements on an exclusive basis (paragraphs 94-143).
 - Wider issues relating to NWSCG’s commissioning practices:
 - i. Renewal and expansion of block contracts in the absence of competitive tendering (paragraphs 146-153);
 - ii. Adopting different procedures for designating Framework and non-Framework providers (paragraphs 154-166); and
 - iii. Supporting the development of NHS facilities, but not providing the same degree of support to independent sector developments (paragraphs 167-174).

PARTIES TO THE COMPLAINT

12. Revona LLP, trading under the name Hanover Healthcare (hereafter referred to as Hanover), made the complaint to the CCP that is the subject of this report. Hanover operates Hanover House, an independent hospital registered by the CQC in November 2009 as a mental health hospital where patients can be detained. Hanover House has 74 beds and is located in Widnes, Cheshire.

13. North West Specialised Commissioning Group (NWSCG), the respondent to Hanover’s complaint, is a joint sub-committee of the 24 Primary Care Trusts (PCTs) in the North West of England in accordance with Regulations 9 and 10 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England) Regulations 2002. The 24 PCTs have delegated responsibility for commissioning specialised services, including out of area placements for patients requiring secure mental health services, to NWSCG. NWSCG is supported in this work by the North West Specialised Commissioning Team

(NWSCT). In the remainder of this report we do not distinguish between NWSCG and NWSCT but refer generally to NWSCG.

JURISDICTION

14. On 2 June 2010, the CCP decided that the submission made by Hanover regarding NWSCG's conduct met the CCP's acceptance criteria for a conduct inquiry. That is:
 - i. the subject matter came within the ambit of the Principles and Rules;
 - ii. the CCP was the most appropriate body to consider the matter;
 - iii. Hanover had made available the necessary information for the CCP to decide whether to accept the case and to commence its analysis;
 - iv. no legal proceedings had commenced in relation to this matter;
 - v. the dispute was not trivial or vexatious; and
 - vi. Hanover had engaged with parties at a local level, prior to raising the matter with the CCP.
15. The CCP therefore accepted the case on 2 June 2010. NWSCG and NHS North West subsequently raised a number of points in relation to the CCP's remit in this case. NHS North West submitted that the complainant had not used all reasonable endeavours to engage at a local level. It also submitted that the complaint included elements relating to procurement processes as well as conduct issues, and it would welcome clarification of how combined complaints are considered for acceptance by the CCP.
16. NWSCG stated that, in its view, it is illogical that where the rules lay down separate procedural requirements for separate issues (i.e. conduct and procurement), one of which is more stringent, a case covering both issues should be accepted by the CCP when it fails to satisfy those stricter requirements. NWSCG argued that: (i) where there is a conflict between sets of rules, the CCP should apply the stricter ones, and (ii) this particular case is predominantly concerned with procurement issues, not conduct, and therefore it makes sense to follow the requirements appropriate for procurement cases.
17. The CCP considers that, as a rule, procurement cases should be dealt with through formal dispute resolution processes at PCT and SHA level prior to being considered by the CCP, and conduct complaints should be subject to local engagement prior to consideration by the CCP (without having to go through formal dispute resolution processes at either the PCT or SHA level). Where a complaint raises both procurement and conduct related matters, this should not, in general, obviate the need for procurement concerns to be dealt with through PCT and SHA dispute resolution processes prior to consideration by the CCP.³
18. However, in this case, where the complaint raised both procurement and conduct issues, the CCP did not consider it appropriate to procedurally separate out procurement questions from conduct issues, and require the procurement issues to be subject to PCT and SHA dispute processes prior to consideration by the CCP, or for both the procurement and conduct issues to be considered by the PCT and SHA before coming to the CCP. There are three reasons for this.

³ See also Cooperation and Competition Panel, *Final draft rules of procedure* (January 2009).

19. First, NWSCG did not make a procurement dispute resolution process readily available to Hanover. Hanover stated that NWSCG took the view that its complaints procedure was not available to providers that had failed the PQQ, and NWSCG did not provide feedback to Hanover on why it was unsuccessful at the pre-qualification stage of the procurements. NWSCG's dispute resolution process is contained in its Establishment Agreement.⁴ The relevant section provides that facilitation and/or arbitration may be required if the Chair of the Specialised Commissioning Group (SCG) requests facilitation because an impasse has been reached between the SCG (or the Specialised Services Commissioning Team representing the SCG) and one or more providers of the service if the provider is not a Foundation Trust. The CCP understands that NWSCG interpreted this as meaning that the availability of its dispute resolution mechanism is limited to existing providers of services (thereby excluding potential providers such as Hanover).
20. It was not until March 2010 that Hanover was referred to the dispute resolution process of the host PCT, NHS West Cheshire. At that point the focus of Hanover's concerns was NWSCG's decision not to allow Hanover to contest the market. This issue relates to commissioner conduct which falls outside the remit of the PCT and SHA and comes directly to the CCP following appropriate local engagement.
21. Second, the approach taken by NWSCG meant that Hanover would first have needed to challenge the lack of feedback before it could potentially challenge NWSCG on the substantive issue of pre-qualification. In these circumstances, where the process for challenge has been obscure and relatively difficult and where the dispute resolution process of the PCT and SHA would not have dealt with all the issues, due process was best served by allowing Hanover to raise its procurement concerns alongside the conduct issues for consideration by the CCP.
22. Third, in this case the issues relating to procurement and conduct were, at the outset, difficult to disentangle, and it would not have been helpful to seek to separate these issues only for there to be duplication and delay between the PCT, SHA and CCP in looking at the various issues that had been raised. Our approach in this case has therefore been to consider both the conduct and procurement issues raised by Hanover's complaint.
23. Finally, in terms of local engagement, the CCP's *Draft interim guidance on the assessment of conduct* states that for the CCP to accept a case relating to anti-competitive conduct it must be satisfied (*inter alia*) that the complainant has used all reasonable endeavours to engage with parties at a local level, including appropriate engagement with the relevant SHA, prior to referring the matter to the Panel.⁵ In this case we considered that the requirement of engagement at local level had been met because there was ample evidence of correspondence between the complainant and NWSCG on the matter of commissioning of secure mental health services. In addition, we note that Hanover approached the SHA seeking its input to resolve Hanover's concerns, consistent with the CCP's requirements for local engagement prior to the CCP accepting a conduct dispute. Hanover was advised by the SHA to utilise its dispute avoidance and resolution process. There is, however, no requirement for a conduct complaint to go through an SHA's formal dispute resolution process before coming to the CCP.

⁴ NWSCG, *Establishment Agreement* (July 2007), paragraph 15.

⁵ CCP, *Draft interim guidance on the assessment of conduct* (January 2009), paragraph 3.9 (vi). These guidelines have now been superseded by the CCP's *Conduct Guidelines* (October 2010), available on www.ccp-panel.org.uk.

INVESTIGATION PROCESS

24. Following the formal acceptance of Hanover's complaint and the commencement of the CCP's inquiry on 2 June 2010, NWSCG provided its written response to Hanover's complaint on 2 July 2010. The CCP held separate meetings with representatives of Hanover and NWSCG on 17 June 2010 to discuss the complaint. Following these meetings, Hanover provided a supplementary submission to the CCP on 7 July 2010.
25. Having reviewed the complaint, the response and other relevant information, the CCP set out key issues raised by the complaint in a letter dated 7 July 2010 (the Issues Letter) to NWSCG and Hanover for their response. Having reviewed the responses to the Issues Letter, the CCP decided that it was not in a position to dismiss the complaint by Hanover at the end of Phase I. The CCP therefore announced on 28 July 2010 that it intended to proceed to a Phase II investigation. The deadline for the completion of Phase II was 18 November 2010. On 6 November 2010, the CCP received permission from the Department of Health to extend this deadline by four weeks to give interested parties an opportunity to comment on suitable remedies.
26. Having carefully evaluated all of the evidence received in the course of the case, the CCP sent a paper to Hanover and NWSCG setting out the staff's provisional views (the Staff Paper) on 28 September 2010. NHS North West also received a copy of the Staff Paper. On 5 October 2010, the CCP met with representatives from Hanover and NWSCG respectively. On 11 October 2010, Hanover submitted a written response to the Staff Paper; NWSCG submitted its written response on 13 October 2010. Following review of these responses and further analysis, the Panel members took the final decision on the case.
27. The CCP decision set out in this report was published on 19 November. At the same time, the CCP invited submissions on what would constitute a suitable remedy in this case (see www.ccpanel.org.uk). Following a review of submissions, the Panel members will decide, by 16 December 2010, which remedy to recommend to the Secretary of State. The Secretary of State will decide whether to accept the CCP's advice and what action, if any, is required as a result.

FRAMEWORK FOR ASSESSING THE COMPLAINT

28. Hanover's complaint, as set out above (Introduction), raised concerns under the Principles and Rules about NWSCG's procurement process for the two Framework Agreements. The complaint also raised issues about the conduct of NWSCG in commissioning secure mental health facilities through two Framework Agreements. In this report we set out our assessment of the procurement issues first, followed by the conduct issues.
29. In examining the procurement issues, we considered whether NWSCG's decisions were consistent with Principle 3. In assessing procurement matters under Principle 3, the CCP reviews the decision taken by the commissioner to determine whether it is reasonable under (i.e. consistent with) the Principles and Rules and the PCT Procurement Guide.⁶ This means that the

⁶PCT Procurement Guide for Health Services (May 2008). This guide has now been superseded by the Procurement guide for commissioners of NHS-funded services (30 July 2010). For the purpose of this case the CCP has referred to the PCT Procurement Guide unless otherwise indicated.

CCP considers whether the commissioner's decision was within the range of decisions that it could reasonably have taken, both in terms of substance and process, within the context of the Principles and Rules and the PCT Procurement Guide. The CCP does not consider whether the decision of a commissioner to award a contract to a particular provider was correct on its merits.

30. In examining the conduct issues, we assessed whether NWSCG's use of four year exclusive framework agreements breached Principle 4, Rule 2 of the Principles and Rules and, by extension, Principle 1. In carrying out our analysis we assessed whether any costs associated with this conduct are outweighed by benefits arising from it. This approach is consistent with that set out in the CCP's *Draft interim guidance on the assessment of conduct*.
31. Principle 1 states that commissioners should commission services from those best placed to deliver the needs of patients and populations. We interpret this as meaning that services must be commissioned from those that provide value for money.
32. Principle 3 provides that procurement and commissioning should be transparent and non-discriminatory. Where a commissioner treats some providers differently from others (without objective justification), or there is a lack of transparency, this may be inconsistent with Principle 3 and the PCT Procurement Guide.⁷
33. Principle 4 states that Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.
34. Principle 4 Rule 2 prohibits restrictions on choice via collusive behaviour or any other action. This Principle is not limited to patient choice but extends to commissioner choice. Therefore, even if patient choice is limited, as may be the case in secure mental health, conduct that restricts commissioner choice may have an adverse effect on patients or taxpayers when, as a result of reducing competition, it reduces the quality of services patients receive and/or increases the prices paid by commissioners.⁸ This principle applies to both unilateral conduct (i.e. conduct on the part of one organisation) and conduct agreed between two or more organisations. Conduct that is contrary to Principle 4 Rule 2 may also be in breach of Principle 1 (see above) since it may mean that services are not commissioned from providers who are best placed to deliver the needs of patients and populations.

BACKGROUND TO THE COMMISSIONING OF SECURE SERVICES

35. This section sets out relevant background information in terms of (i) national policy on the commissioning of secure mental health services; and (ii) the commissioning of these services in the North West.

⁷ Department of Health, *PCT Procurement Guide for Health Services* (May 2008), page 4: The key principles of good procurement and procurement strategy are: [...] non-discrimination – ensuring consistency of procurement rules, transparency on timescale and criteria for shortlist and award; and equality of treatment – ensuring that all providers and sectors have equal opportunity to compete where appropriate; that financial and due diligence checks apply equally and are proportionate; and that pricing and payment regimes are transparent and fair. Principle 3, Rule 1 states that commissioners must follow the guidelines set out in the PCT Procurement Guide.

⁸ CCP, *Draft interim guidance on the assessment of conduct* (January 2009), paragraph 6.9. These guidelines have now been superseded by the CCP's *Conduct Guidelines* (October 2010), available on www.ccp-panel.org.uk.

National Policy

36. Commissioning in the NHS is the process of ensuring that healthcare services effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, entering into contracts and managing service providers.⁹ There are several ways in which services can currently be commissioned:
- i. national commissioning by NHS Specialised Services;
 - i. regional commissioning by Specialised Commissioning Groups (SCGs); and
 - ii. local commissioning, for example by Primary Care Trusts (PCTs) and practice-based commissioning groups.
37. Specialised services are commissioned either nationally, or regionally by the ten SCGs on behalf of PCTs.¹⁰ In 2005 the Department of Health undertook an independent review of commissioning arrangements for specialised services in England (the Carter Review). The review looked at ways to improve the commissioning of specialised services to make the arrangements more robust and consistent and to ensure a good fit with the wider NHS system reform programme, the new organisational infrastructure for commissioning by the NHS and the changing role of the Department of Health. The Carter Review noted that key features of these specialised services are that they are high cost, have low patient volumes and require a critical mass of patients to be cost-effective. Currently, thirty-four services are categorised by the Department of Health as specialised, including secure mental health services.¹¹
38. In relation to medium and low secure mental health services, the Carter Review recommended that to maximise scarce commissioner capacity and take advantage of synergy with other commissioning activities, the commissioning arrangements for medium and low secure mental health services should be integrated with those for other specialised services and managed by regional SCGs. It also recommended formal designation of specialised services. Designation is a process of checking that specialised service providers deliver an agreed quality and level of care to their patients within clear financial and clinical standards. The process of designation for all specialised services was required to be completed by 2009/2010. West Midlands SCG, on behalf of the National Specialised Commissioning Group, developed a designation framework for medium secure services to be used by SCGs. There is as yet no similar framework for low secure services.
39. Secure mental health services are for patients who have been detained under the Mental Health Act 1983 (revised 2007) and who pose a risk to others. Secure services form part of comprehensive forensic/secure psychiatric services and are part of the care pathway for mentally disordered offenders and others who require care under conditions of security.

⁹ Department of Health website, commissioning pages.

¹⁰ About 60 highly specialised services are commissioned nationally by NHS Specialised Services. These are services that usually affect fewer than 500 people across England or involve services where fewer than 500 highly specialised procedures are undertaken each year. Examples of such services include heart transplantation (about 270 transplants each year) and secure forensic mental health services for young people (about 80 new patients each year). The remaining specialised services are commissioned regionally by SCGs in England.

¹¹ The Specialised Services National Definition Set describes these services.

40. There are important links between secure mental health services and criminal justice agencies, as many patients are or have been within the prison system and some are involved in active criminal justice proceedings. Patients admitted to secure services through the criminal justice system may have been placed under a restriction order pursuant to the Mental Health Act 1983 (revised 2007). This means that the Ministry of Justice must agree to any transfer between levels of, or out of, secure care.¹²
41. Secure services are provided at three levels: high, medium and low secure. Ashworth, Rampton and Broadmoor Hospitals provide all of the high secure services in England. In this report we focus on low and medium secure services because these are the subject of Hanover's complaint. Medium secure services are for patients with a mental disorder who pose a risk to others. The majority of patients admitted to medium secure services are from the criminal justice system. Low secure services are for those people who present a lower risk to others or who have longer term conditions which need treatment in a secure environment. SCGs are adopting standards for each of the levels of security based on national guidance.¹³
42. Currently, NHS patients requiring assessment or treatment for acute elective care, as well as some other services, are offered a choice of where to receive such care and from which provider, often including independent sector providers funded by the NHS.
43. NWSCG has stated that patient choice of services has not been implemented in respect of secure mental health services. Under the NHS Constitution the right to make choices about NHS care is excluded in respect of mental health services. In addition, the White Paper, *Equity and Excellence: Liberating the NHS* states that the government will begin to introduce choice in some mental health services in April 2011 and extend this whenever practicable.¹⁴
44. The Mental Capacity Act (2005) applies to patients who are detained under the Mental Health Act 1983 (revised 2007). It provides a statutory framework for people who lack capacity to make decisions for themselves, and sets out who can take decisions, in which situations, and how they should go about this. Department of Health training materials to support the implementation of the Mental Capacity Act (2005) explain that in practice this means that professionals must ensure that no one is considered to be unable to make a decision unless all practical steps to help them have been exhausted and shown not to work. Service users should be involved in the decision-making process and staff should facilitate their involvement wherever possible. This means that in certain circumstances where a choice of facility is available, it may be appropriate to permit the patient to exercise that choice wherever possible.
45. In practice, patient choice in secure mental health is currently limited, with clinical decisions on placements taken by third parties. These clinical decisions are constrained by the procurement decisions taken by the relevant commissioner of secure services. However, the Carter Review

¹² Ministry of Justice, Mental Health Act 2007: Guidance for the courts on remand and sentencing powers for mentally disordered offenders (March 2008).

¹³ See for example, Department of Health *Mental health policy implementation guide: National minimum standards for general adult services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments* (2 May 2002) and Department of Health *Best Practice Guidance: Specification for Adult Medium-Secure Services* (2007)

www.webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_078033 We note that revised national guidance on low secure services is being developed and NWSCG told us they would review their policies when this is published.

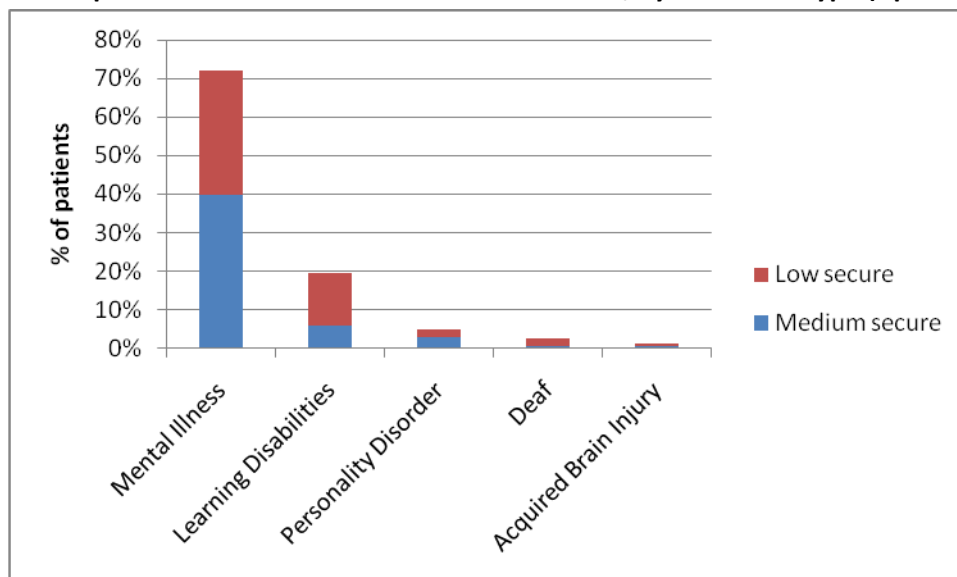
¹⁴ *Equity and Excellence: Liberating the NHS* (12 June 2010), page 17.

recommended that patient choice should, where appropriate, be extended to specialised services, stating: ‘The opportunities for patients to make choices regarding specific aspects of their care and treatment should be maximised with the proviso that choice of specialised services provider will be limited to designated providers.’

Commissioning of secure mental health services in the North West

46. This section describes the commissioning of secure mental health services in the North West and the role of NWSCG.
47. During 2007/2008, responsibility and oversight for all secure out of area placements of patients requiring secure mental health services was transferred from the 24 PCTs in the North West (excluding North Cumbria) to NWSCG.
48. In April 2010, NWSCG purchased low and medium secure services on behalf of 937 patients, of which around half required care in medium secure facilities. Around 72 per cent required treatment for a mental illness, around 19 per cent required treatment for learning disabilities and around five per cent required treatment for a personality disorder. The remaining four per cent of patients required more specialist care, including the treatment of deaf patients with a mental disorder and patients with a mental disorder as a result of an acquired brain injury. Male patients account for around 80 per cent of patients in secure care in total, although there is some variation between treatments.

Figure 1
Proportion of patients in low and medium secure services, by treatment type (April 2010)



Source: CCP analysis of NWSCG submission

49. The secure mental health system in the North West, as described below, has been established for a number of years and the current contractual arrangements to some extent reflect how this system has developed historically.

50. All patients identified as potentially requiring care and treatment in a secure facility are referred in the first instance to their local catchment unit facility (see Figures 2 and 3 for a list of catchment units in the North West). Across the North West there are separate catchment units for secure mental health and learning disability services. Each catchment unit has a clearly defined geographic catchment area for each of the services it provides and all referrals are made according to these catchment areas.¹⁵ Catchment areas are determined by NWSCG. For secure mental health services, there are three medium secure catchment units for males and females, six low secure catchment units for males and three low secure catchment units for females. For secure learning disabilities services there is one medium secure unit for males and females, two low secure units for females and three low secure units for males.

TABLE 1 North West mental health catchment units

<i>Provider</i>	<i>Low secure</i>		<i>Medium secure</i>	
	Male	Female	Male	Female
Cheshire and Wirral Partnership NHS FT	●			
Greater Manchester West Mental Health NHS FT	●	●	●	●
Lancashire Care NHS FT	●	●	●	●
Mersey Care NHS Trust	●		●	●
Pennine NHS FT	●			
5 Boroughs Partnership NHS FT	●	●		

Source: CCP analysis of NWSCG submission

TABLE 2 North West learning difficulties catchment units

<i>Provider</i>	<i>Low secure</i>		<i>Medium secure</i>	
	Male	Female	Male	Female
Calderstones Partnership NHS FT	●	●	●	●
5 Boroughs Partnership NHS FT	●	●		
Cheshire & Wirral NHS FT	●			

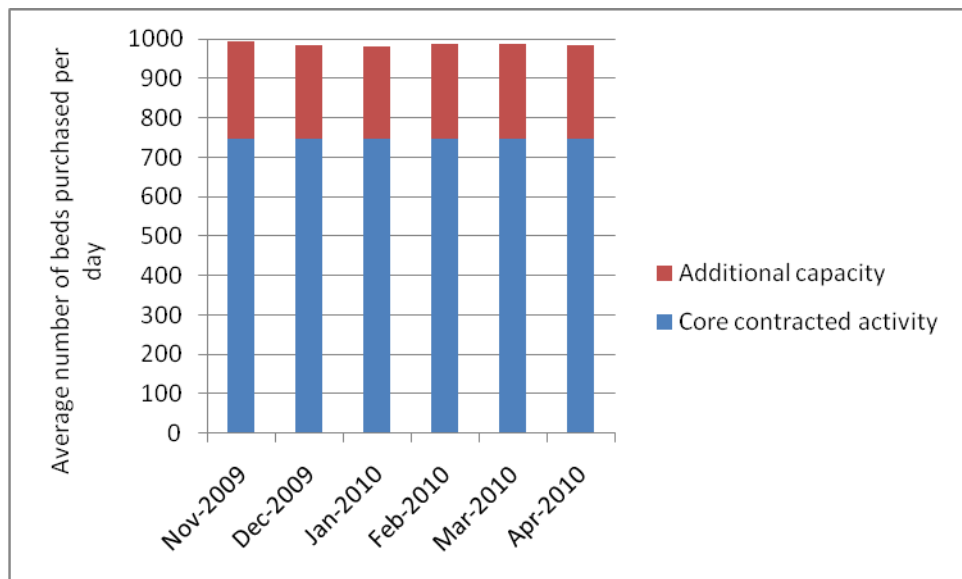
Source: CCP analysis of NWSCG submission

51. NWSCG told us that catchment units undertake a number of functions. First, each catchment unit acts as the gatekeeper for secure services on behalf of NWSCG. The purpose of the gatekeeper function is to ensure a consistent assessment of need so that only those needing secure care access it and to advise on the appropriate in-patient placement. Second, catchment units provide in-patient treatment in a secure setting and maintain links with other services, in particular the criminal justice system. They also provide outreach services, particularly into prisons and where patients are in transitional or step-down accommodation. Third, catchment units play an important role in the training of future consultant forensic psychiatrists and psychologists, and conduct research.

¹⁵ Referrals may come from clinicians (either for patients on a pathway from, for example, high secure to medium secure facilities, or from local mental health services) or from criminal justice routes, such as from prison in-reach teams. Referrals may be routine or urgent, dependent upon the circumstances. For example, in cases of homicide where the alleged offender is in a police cell and where mental disorder is potentially an issue, there may need to be an urgent response.

52. NWSCG’s policy is that, wherever possible, patients are admitted to the in-patient services of the local catchment unit.¹⁶ If there are no suitable beds available at the local catchment unit when the referral is accepted (either due to a lack of capacity or need for a specialised environment) then the catchment unit must consider, along with the referrer, whether the person can be placed on the unit’s waiting list and managed in their current placement. Where the risks are such that this would be unsafe, the catchment unit will refer the patient back to NWSCG to secure funding for an additional bed. If NWSCG accepts that urgent need for a bed has been demonstrated, then an additional bed will be sought with another provider with a block contract.¹⁷ If there are no such beds, then a bed will be sought from a provider appointed to one of the Framework Agreements that are the subject of Hanover’s complaint. NWSCG views such placements as temporary, with an expectation that the patient will transfer back to their local catchment unit as soon as a suitable bed becomes available in that unit.

Figure 2
NWSCG demand for secure mental health services (number of beds per day)



Source: CCP analysis of NWSCG submission

53. Around 75 per cent of NWSCG’s total demand for low and medium secure mental health services is purchased under block contracts.¹⁸ We refer to this as core contracted capacity. The vast majority of core contracted capacity (around 94 per cent) is purchased from NHS organisations operating the catchment units.

54. Greater Manchester West NHS FT was the largest provider of core contracted mental health capacity to NWSCG over the six month period to April 2010, providing 35 per cent of NWSCG’s

¹⁶ We note that the Reed Report, Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring similar Services, Final Summary Report, Home Office (1992), refers to the importance of care being provided close to home.

¹⁷ Under a block contract capacity is purchased in advance of the service being required. The contract specifies the services to be provided, including the number of beds available for use by the commissioner, and the total cost to the commissioner is broadly fixed, irrespective of the level of actual bed occupancy. Block contracts are currently held by each of the NHS providers operating the various catchment units as well as one independent sector provider.

¹⁸ The proportion of capacity purchased under block contracts in the North West is relatively high compared to other regions. For example, whilst the North East region purchases around 85 per cent of capacity in this way, other SCGs told us that they purchase between 30 and 60 per cent of their capacity using block contracts.

capacity.¹⁹ Partnerships in Care – the only independent sector provider of core contracted capacity – provided six per cent of NWSCG’s core contracted capacity. Calderstones NHS Trust is the main provider of core contracted learning disabilities capacity in the North West, providing over 85 per cent of NWSCG’s secure learning disabilities capacity.

TABLE 3 Core contracted capacity purchased by NWSCG over 6 month period to April 2010

<i>Provider</i>	<i>Total bed days purchased</i>	<i>% of bed days</i>
<i>Mental health</i>		
Greater Manchester West FT	33,304	35%
Lancashire Care NHS Trust	24,254	26%
Mersey Care NHS Trust	15,928	17%
Pennine Care NHS Trust	7,964	8%
5 Boroughs Partnerships	5,430	6%
Partnerships in Care	5,430	6%
Cheshire & Wirral NHS Trust	2,715	3%
Total	95,025	
<i>Learning disabilities</i>		
Calderstones NHS Trust	34,752	86%
5 Boroughs Partnerships	2,715	7%
Cheshire & Wirral NHS Trust	2,715	7%
Total	40,182	

Source: CCP analysis of NWSCG submission

55. In addition to core contracted capacity (purchased using block contracts), NWSCG purchases around 25 per cent of its total demand for low and medium secure services on the spot or through use of cost and volume contracts.²⁰ We refer to this as ‘additional capacity’.

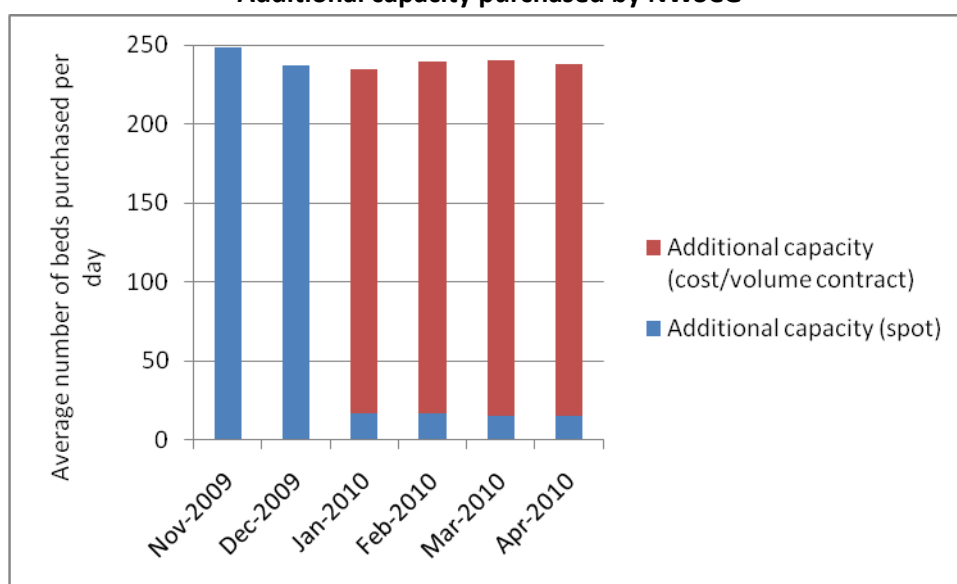
56. The introduction of the two secure services Framework Agreements by NWSCG in 2009 led to a fundamental shift in how NWSCG purchases additional capacity.²¹ Prior to the Framework Agreements, all additional capacity was purchased on a spot basis. Upon the introduction of the Framework Agreements those providers that were appointed to the Framework Agreements (and who, in many cases, were previously providing capacity on a spot basis) were awarded cost and volume contracts from the Framework Agreements. Around five per cent of additional capacity is still purchased on a spot basis outside the Framework Agreements. This purchasing relates to those patients that had been placed with providers prior to the Framework Agreements being put in place, where those providers were not appointed to the Framework Agreements. NWSCG told us that it intends to make all future purchases from providers appointed to the Frameworks for the four year duration of the Framework Agreements and will be making no further spot purchases. That is, it regards the Framework Agreements as exclusive purchasing arrangements with the providers that have been appointed to them.

¹⁹ NWSCG told us that the Manchester area also had the highest morbidity and use of secure services.

²⁰ Under a cost and volume contract, terms for purchasing beds are negotiated in advance of the service being required. The contract stipulates the price (and may provide for volume discounts), but not the number of beds purchased. The total cost to the commissioner will depend on the total volume of beds purchased. With these contracts, as capacity is not purchased in advance, the commissioner runs the risk of beds not being available at the time capacity is required, but only pays for beds that are occupied. With spot purchasing the commissioner procures a bed on an *ad hoc* basis, paying the rate that it negotiates with the relevant provider for that particular placement. With cost and volume contracts, price is negotiated in advance, whereas with spot purchasing price is negotiated at the time a purchase is made.

²¹ NWSCG told us that the Framework Agreements were set up to enable the purchasing of additional capacity in an efficient and flexible way.

Figure 3
Additional capacity purchased by NWSCG



Source: CCP analysis of NWSCG submission

57. Over the six months to April 2010, NWSCG purchased around 98 per cent of additional capacity from independent sector providers, with the remaining two per cent purchased from NHS organisations. Partnerships in Care was the largest provider, providing around 43 per cent of all additional capacity in the North West. Whilst there were only four providers that provided more than five per cent of NWSCG’s additional capacity requirements, over the six months to April 2010 NWSCG purchased additional capacity from 19 different providers.²²

TABLE 4 Additional capacity purchased by NWSCG over 6 month period to April 2010

<i>Provider</i>	<i>Total bed days purchased</i>	<i>% of bed days</i>
Partnerships in Care	18573	43%
Alpha Hospitals	12068	28%
St Georges	3772	9%
Priory	2488	6%
St Andrews	1530	4%
Care Principles	1029	2%
Optima	860	2%
Jedheath	821	2%
Other (11 providers in total)	2218	5%
Total	45577	100%

Source: CCP analysis of NWSCG submission

Note: The total bed days purchased reflects both mental health and learning disability services

58. The average number of beds purchased per day each month was broadly stable over the six months to April 2010. NWSCG told us that following efforts by it to reduce the use of secure services, the number of patients receiving treatment in a secure bed had declined. NWSCG told us that over the period April to August 2010 the number of patients treated in secure care

²² This includes additional capacity purchased from providers not appointed to the Framework Agreements because the patient was placed before the Framework Agreements were in place.

declined by 91 to 846. They subsequently told us that by September 2010 the number of patients had reduced by a further 29 to 817. NWSCG told us that this 13 per cent reduction in the use of secure services had been achieved through the development of step-down services, robust case management and more focus being placed on developing appropriate local services to reduce the flow of patients requiring in-patient care.

DECISION NOT TO ADMIT HANOVER TO THE FRAMEWORK AGREEMENTS

59. We first considered whether NWSCG had acted in a manner which was inconsistent with Principle 3 of the Principles and Rules in the context of the procurement of secure mental health services in the North West when it decided that Hanover's bids for the Framework Agreements should not proceed past the PQQ phase, and subsequently not to provide feedback to Hanover on the reasons for this decision.
60. As set out above, in assessing procurement matters under Principle 3, the CCP reviews the decision taken by the commissioner to determine whether it is reasonable under (i.e. consistent with) the Principles and Rules and the PCT Procurement Guide. This means that the CCP considers whether the commissioner's decision was within the range of decisions that it could reasonably have taken, both in terms of substance and process, within the context of the Principles and Rules and the PCT Procurement Guide.

Exclusion of Hanover at the qualification stage

61. NWSCG ran two competitive tenders for the purchasing of additional capacity for secure services in the North West in 2008/9. The first tender commenced in November 2008 and related to low secure services for women. The second tender commenced in February 2009 and related to all other low and medium secure services in the North West.
62. The process of deciding which firms are eligible to participate in a tender is known as qualification; potential providers are asked to submit responses to a pre-qualification questionnaire (PQQ). The purpose of this stage of a tender is to eliminate potential providers at an early stage of the tender process if, for example, they lack financial standing or capability and therefore present a risk that the contract will not be completed. Hanover was eliminated at this stage of the tender processes.
63. Feedback was not provided at the time that Hanover was informed that it was unsuccessful but NWSCG subsequently provided a number of different explanations as to why Hanover failed at the PQQ stage of both tenders.
- A letter dated 18 March 2009 from NWSCG to Hanover stated that Hanover was unsuccessful because it was unable to establish that it had "the necessary economic and financial standing and demonstrate that [it had] sufficient capacity and capability to meet the requirements laid down in the specification."²³
 - Hanover's notes of a meeting with NWSCG on 18 May 2010 showed that Hanover was told that it was not invited to tender as NWSCG had concerns about capacity and capability, that

²³ Letter dated 18 March 2010 from NWSCG to Hanover.

Hanover was not registered with the CQC, had no track record and had not provided sufficient financial information.²⁴

- In its response to Hanover's submission to the CCP, NWSCG commented that 'it was the Applicant's submission that did not provide sufficient evidence that capability would be in place in time to meet the timescale for let of contracts.' The response also stated that the main reason Hanover was not invited to tender was its lack of CQC registration, draft documents and policies, lack of clinical staff and lack of evidence to support its capabilities. When the CCP raised the issue of Hanover's failure at the PQQ stage in the context of Hanover's financial standing with NWSCG in the Issues Letter,²⁵ NWSCG replied: 'The Applicant's tender submission, Section C, had given details of the bank and authority to undertake a credit rating check. This was not actioned by the panel as a failure to meet the legal requirements is an automatic fail and therefore other aspects of the submission would not be pursued.'²⁶
- NWSCG's response to the Issues Letter also stated that: 'the onus is on the bidder to provide the necessary information within their submission, as stipulated within the methodology clearly set out in the pre qualification questionnaire. This includes text and where appropriate supporting documentation. The bidder could have provided, within their submission, a statement from their bank as they did not have audited accounts. The panel could then have asked for a clarification question if necessary. It is not the role of the evaluating panel to seek additional information to support the bidder's progress through the tender process. [...] The guidance indicates that a bidder may ask clarification questions pre PQQ submission stage, however, none were received from any of the bidders, including Hanover House.'

64. At this point of the CCP's investigation it remained unclear precisely why Hanover had been unsuccessful at the PQQ stage. The various responses from NWSCG on this point were vague and inconsistent. Having considered all the evidence, CCP staff reached the provisional view that there were two main reasons for NWSCG's decision not to permit Hanover to qualify: (i) Hanover's lack of CQC registration and their response to question B5 regarding the mandatory and discretionary grounds for rejecting a potential bidder; and (ii) Hanover's response to the questions regarding financial information. This view, and the implications that flowed from it in terms of the Principles and Rules, was put to the parties in the Staff Paper. It is summarised in the following paragraphs.

CQC Registration

65. In relation to CQC Registration, the CCP provisionally concluded that it may be inconsistent with Principle 3 of the Principles and Rules to impose a requirement of CQC registration where this discriminates against new entrants without objective justification.

66. There was no absolute requirement in the PQQ for an organisation to be registered with the CQC at the time responses were submitted, or for bidders to provide information in relation to current or pending registrations. Annex B of the PQQ states that 'a potential bidder **may be deemed** to be ineligible to tender where it: [...] is not in possession of the necessary licence,

²⁴ Hanover's notes of a meeting with NWSCT, Tuesday 18 May 2010 at 3:30 pm at NWSCT offices.

²⁵ Letter dated 7 July from CCP to NWSCG and Hanover.

²⁶ Response from NWSCG, Paper 3, page 4.

authorisation or professional qualification required for the provision of primary care services [sic] covered by this Procurement' (emphasis added).²⁷

67. Question B5 of the PQQ asked potential bidders to confirm that none of the mandatory and discretionary grounds for rejecting a potential bidder listed in Section L of the PQQ were applicable to the organisation. The reference to Section L appears incorrect since Section L of the PQQ was the declaration of consent. The mandatory and discretionary grounds for rejecting a potential bidder were listed in Annex B, *Ineligibility conditions summary*. In response to the question B5, Hanover replied: 'N/A'. In its response to Hanover's submission to the CCP, NWSCG stated that Hanover was asked a clarificatory question in relation to their registration with the CQC. Hanover responded that it was progressing its registration but was not yet registered.
68. To ensure compliance with the Principles and Rules, commissioners should consider in advance whether or not qualification requirements may discriminate against new entrants. In relation to CQC registration it would be relevant for the commissioner to take into account when the relevant services will be provided, how long it is likely to take a potential provider to obtain its registration and whether or not the commissioner would have the opportunity at a later stage to verify that the requirement had been met before the contract is awarded.
69. If it is appropriate for a commissioner to insist that an organisation is registered with the CQC at the PQQ stage, this should be stated clearly in the PQQ. Otherwise there is a risk that potential bidders will incur the cost of participating in the PQQ process without any prospect of being successful. In circumstances where requiring CQC registration at the PQQ stage is not appropriate, the PQQ should state which information unregistered bidders are expected to provide in order to comply with the requirement for CQC registration once service provision commences. This goes to the requirement of transparency in Principle 3.
70. Hanover was registered with the CQC on 13 November 2009. Provision of services under the first framework agreement commenced on 1 July 2009; under the second framework agreement, service provision commenced on 1 January 2010. It would therefore have been possible for Hanover to provide services under the second Framework Agreement if it had not been excluded at the PQQ stage and if it had subsequently been successful at the invitation to tender (ITT) stage. It would have been possible for NWSCG to allow Hanover to obtain and provide evidence of its CQC registration at a later stage, for example before the award of contract (assuming always that Hanover would otherwise have been successful at the ITT stage).

Financial Information

71. In relation to the PQQ requirements regarding financial information, the CCP provisionally concluded that it would be contrary to Principle 3 for commissioners to require financial accounts if this discriminated against new entrants without objective justification. The aim of the PQQ process is to eliminate firms that lack financial standing such that there is a risk that the contract will not be completed. If it is possible for new entrants to demonstrate the adequacy of their financial standing by means other than financial accounts, for example by providing bank statements and financial forecasts, then the PQQ should permit this.

²⁷ PQQ, page 20.

72. The PQQ requested bidders to provide audited financial accounts (or unaudited financial accounts or management accounts) for three years where the potential bidder is a limited company, partnership or sole trader with a trading history. Where the potential bidder did not have sufficient trading history to be able to provide the required information for three years, it was asked to provide the information for as many years as available (for a minimum of one year) and an explanation of why the information was not available for the full three years. Where the bidder was unable to provide this information, the PQQ stated that identity and solvency would be confirmed by means of third party credit checks. Such bidders were therefore asked to provide information (name, address and date of birth) to enable NWSCG to carry out a credit check. It appeared from this that NWSCG would actively take steps to obtain the relevant information.
73. In its responses to the PQQs, Hanover stated that since the organisation had just been incorporated and was not yet fully operational, it had no accounts. Hanover therefore provided the name and address of its bank and the name of a contact person. Hanover also confirmed that it consented to NWSCG obtaining references from the third party.
74. The Staff Paper stated that we agreed with NWSCG that it is generally not the role of the evaluating panel to seek additional information to support the bidder's progress through the tender process, however, where the PQQ states that the commissioner will pro-actively seek information then it must do so in order to comply with Principle 3.

Retrospective evaluation of Hanover's response to the PQQ

75. At the meeting of CCP staff and Panel members with NWSCG on 5 October 2010, NWSCG explained that it had carried out an internal review of responses to the PQQ following receipt of the CCP's Staff Paper. NWSCG explained (and subsequently confirmed in writing) that it had concluded that Hanover had failed the preliminary compliance review at the PQQ stage because it had failed to answer all the questions and not for the reasons previously advanced. NWSCG also said that Hanover's bid did not inspire confidence and there were concerns over quality and standards. NWSCG's retrospective evaluation also included a benchmark analysis of other potential providers' responses to the PQQ. The CCP reviewed the retrospective evaluation and carried out its own benchmarking against responses submitted by three bidders randomly selected by the CCP that had been admitted to the Framework Agreements.
76. The PQQ for both procurements stated that the information supplied in the responses by each potential bidder would be checked for completeness and compliance with the requirements of the PQQ before responses were evaluated. This 'preliminary compliance review' involved checking to ensure that submissions:
- answered all questions (or explained satisfactorily if considered not applicable);
 - identified the proposed Clinical Service Suppliers(s);
 - were made in the format, medium and quantity requested; and
 - had been delivered with a signed declaration.²⁸
77. The PQQ stated that where in the opinion of NWSCG a response was non-compliant the potential bidder might be excluded from further consideration. Failure to provide a satisfactory

²⁸ It is not clear to which declaration this statement relates.

response (or any response) to any element of the PQQ might result in NWSCG not proceeding further with that potential bidder.

78. In its retrospective assessment, NWSCG came to the following conclusions.
79. For the first Framework Agreement, NWSCG considered that in total there were ten points on which Hanover's response failed at the preliminary compliance stage. There were nine questions where Hanover's response was unsatisfactory. In addition, Hanover had not submitted a signed health and safety statement.
80. The CCP reviewed NWSCG's assessment and noted that there were six responses where Hanover answered the question but NWSCG considered it unsatisfactory. In addition, there were three questions to which Hanover had failed to provide a response.²⁹ In relation to the six questions that Hanover had answered but NWSCG had considered the reply unsatisfactory, the CCP's high level evaluation indicated that the replies were not comprehensive. In relation to one of the six questions (D5), Hanover had noted that this was a composite question, consisting of different elements and having a 600 word limit for the response. It considered that the word limit was unrealistic, that the wording of the question was unclear and that there was a lack of clarity about how the answers would be scored. The CCP noted that, in its view, the question was sufficiently clear, but there was a lack of clarity about how much weight each element carried and therefore how respondents should structure their answer. Although this was unfortunate, it would not have affected Hanover more than other potential bidders.
81. In relation to the health and safety statement that potential bidders were asked to submit, the CCP agreed with NWSCG's conclusion that Hanover's statement was in draft and not signed. However, the PQQ stated that where a potential bidder does not yet have health and safety policies in place, it should describe the arrangements that it proposes to have in place. The PQQ also noted that potential bidders who were shortlisted to proceed to the ITT stage would be required to submit comprehensive health and safety policies. We concluded it was therefore not necessarily inconsistent with the requirements stated in the PQQ to submit a draft policy that was not signed and disqualification on this ground alone might be disproportionate.
82. According to NWSCG's benchmarking exercise one other potential bidder failed to answer all questions and this potential bidder had also not been invited to submit a bid.
83. For the second Framework Agreement, NWSCG considered that there were 11 points where Hanover's response failed at the preliminary compliance stage. The CCP reviewed this evaluation and found that there were eight questions where Hanover had provided a response but NWSCG considered it unsatisfactory and there was one unanswered question. As above, the health and safety statement was in draft and unsigned. Hanover also failed to submit a conflict of interest declaration.
84. According to NWSCG's benchmarking exercise, six other potential bidders had failed to answer all questions and none of these had been invited to submit a bid. NWSCG submitted the PQQ

²⁹ Hanover's responses to questions D6 and D7 refer only to an annex but this was not included in Hanover's response, and there was no response to Section I (environmental management).

response from a successful bidder. The CCP reviewed this and concluded that this was generally of a higher standard, and in respect of the questions that Hanover had failed, almost all of this potential bidder's replies were more comprehensive. However, this potential bidder's health and safety statement was also not signed, although it was in final form (which was to be expected given that it related to an organisation already providing secure services).

85. The CCP carried out its own additional benchmarking exercise against three randomly selected potential bidders (who were subsequently appointed to the Framework Agreements) and found that the quality of the responses was higher than Hanover's, in particular in respect of most of the points on which NWSCG considered that Hanover's response had failed at the preliminary compliance stage.
86. We noted that at the relevant time NWSCG was subject to the Principles and Rules and the PCT Procurement and Guide and that it was unfortunate that NWSCG had to engage in a retrospective review of its reasons for not inviting Hanover to tender for the contracts. However, we concluded that its explanation was plausible and the decision not to permit Hanover to proceed to the next stage of the process in each of the tenders fell within the range of reasonable decisions that it could have taken. In these circumstances we found that NWSCG had not breached the Principles and Rules in deciding that Hanover should not be invited to tender for the two Framework Agreements.
87. Finally, we noted that this case demonstrates that procurement processes and decisions must have a clear audit trail that can stand up to external scrutiny if required. We note that the *Procurement guide for commissioners of NHS-funded services* states at paragraph 1.26 that commissioners should maintain an auditable documentation trail that is transparent regarding any key decisions, which provides clear accountability and could be subject to review.³⁰

Feedback to Hanover following its exclusion

88. In its application to the CCP, Hanover submitted that NWSCG had failed to provide any reasonable rationale for Hanover failing the PQQ stage.³¹ NWSCG responded that there was no specific legal requirement to notify unsuccessful potential bidders at the PQQ stage of the reasons for them not progressing to the next stage of the tender process.³² In a letter to Hanover, NWSCG noted that it had been advised by North West Collaborative Commercial Agency (NWCCA)³³ that formal feedback is only usually provided to organisations from the ITT stage.³⁴ NWSCG also pointed out that in relation to the first procurement exercise, a letter was sent to all bidders after the PQQ stage of the process stating that unsuccessful bidders had been advised that NWSCG would not be in a position to provide individual bidders with feedback on the reasons why they had been unsuccessful until the Framework Agreement had been awarded. One unsuccessful applicant took this up and was provided with individual feedback in July 2009. In

³⁰ Department of Health (30 July 2010). See also paragraph 4.21 of the PCT Procurement Guide.

³¹ Hanover's application to the CCP, paragraph 6.8.

³² NWSCG, Paper 3, page 13.

³³ NWCCA provides commercial and contracting services to its 53 Member Trusts who own and fund the organisation. These are mainly located in the North West. In addition, NWCCA provides services to its 57 'associate members' which it defines as 'public sector bodies who pay a one-off annual fee to NWCCA for access to a particular contract or Framework(www.nwcca.nhs.uk).

³⁴ Letter from NWSCG to Hanover dated 18 March 2010.

addition, NWSCG pointed out that at the relevant time there was ambiguity surrounding the need to give feedback pursuant to the Public Contracts Regulations 2006.

89. Principle 3 provides that commissioning and procurement should be transparent and non-discriminatory. The PCT Procurement Guide states that transparency is a key principle of good procurement³⁵ and that it is good practice to provide feedback to unsuccessful bidders.
90. The Office of Government Commerce (OGC) has published a *Debriefing Guidance Template* which describes good practice for providing feedback at the end of the pre-qualification process. This is available on the OGC's website: www.ogc.gov.uk.³⁶ The guidance describes the process for written and telephone debriefings and clarifies that feedback need only be provided to those organisations that specifically request it and that any subsequent challenge to the pre-qualification process should not inhibit the commissioner's ability to continue with the tender process.
91. There are a number of reasons why giving feedback is good practice. It allows potential providers to ascertain the reasons why they were unsuccessful and thereby gives them an opportunity to improve their performance for the next tender process. It increases transparency, which in turn impacts positively on commissioners' evaluation processes and helps to ensure these are fair and non-discriminatory. It allows unsuccessful bidders to challenge bad practice, which over time will lead to improved commissioning. Finally, it helps to establish or maintain the reputation of the relevant commissioner as a fair and open organisation. These reasons apply to feedback given at the PQQ stage as well as feedback given at the ITT stage.
92. Although giving feedback, including at the end of the PQQ stage, is regarded as good practice by the OGC, the PCT Procurement Guide did not state that feedback should be provided at the PQQ stage. We therefore concluded that not providing feedback to Hanover at the end of the PQQ stages was within the range of reasonable decisions that NWSCG could have taken and therefore NWSCG did not breach the Principles and Rules in not providing feedback to Hanover at the end of the PQQ process.
93. In light of our conclusions on Hanover's failure to qualify and the issue of feedback, it would be inappropriate for Hanover to be admitted to the Framework Agreements retrospectively.

DECISION TO USE FOUR-YEAR EXCLUSIVE FRAMEWORK AGREEMENTS

Background to NWSCG's decision

94. In 2008 and 2009 NWSCG put in place the two Framework Agreements for the purchasing of additional capacity. These Framework Agreements set out the general terms and conditions, such as price per bed, under which specific contracts can be awarded (called off) over the term of the Framework Agreements. They enable NWSCG to award both block and cost/volume contracts and cover the full range of secure services purchased by NWSCG. Between three and 15 providers

³⁵ PCT Procurement Guide for Health Services (May 2008), paragraph 4.9.

³⁶ OGC confirmed that the relevant website page was last updated on 16 November 2007, it was therefore publicly available at the relevant time.

were appointed to each individual service lot in the two Framework Agreements.³⁷ NWSCG told us that appointed providers have sufficient capacity to meet expected demand over the four year period of the Framework Agreements.

95. There is strong evidence that NWSCG will need to purchase additional capacity until 2014 (i.e. for the period covered by the Framework Agreements). First, even accounting for a recent decline in secure bed usage across the North West, NWSCG's total demand for secure services continues to be around 12 per cent higher than current core contracted capacity.³⁸ Second, formal admissions into NHS and independent mental health facilities across England over the period 2003/04 to 2008/09 have grown by between one and two per cent each year indicating that the recent decline in secure bed usage in the North West may not be sustained.³⁹
96. The duration of both Framework Agreements is four years, although each Framework Agreement covers a slightly different period. The Framework Agreement for low secure females covers the period 1 July 2009 until 30 June 2013, while the Framework Agreement for medium secure males/females and low secure males covers the period 1 January 2010 until 31 December 2013. OGC general guidance on the use of framework agreements states that four years is generally regarded as the maximum duration of such agreements.
97. NWSCG decided to tender and operate both Framework Agreements on the basis of exclusivity. This has two intended effects. First, no additional providers can be admitted to the Framework Agreements during their four year terms. Second, all contracts for services falling within the scope of the Frameworks Agreements are awarded to providers appointed to those two Framework Agreements. This means that any providers not appointed to the Framework Agreements, such as Hanover, and all future new entrants (which by definition could not have been appointed to the Framework Agreements) will be unable to compete for contracts to provide services in the North West until the Framework Agreements expire at the end of 2013, at the earliest.
98. This approach contrasts with the actual terms of both Framework Agreements which state that no form of exclusivity or volume guarantee has been granted by NWSCG.⁴⁰ These contractual terms are consistent with OGC guidance on the use of framework agreements, which explains that framework agreements set out the terms and conditions for subsequent call-offs but place no obligations on the purchaser. The guidance states: *'The benefit of this [i.e. non-exclusivity] is that, because authorities are not tied to the agreements, they are free to use the frameworks*

³⁷ A service lot refers to a specific treatment, for example the treatment of males with a personality disorder in a low secure environment.

³⁸ Prior to April 2010, NWSCG's total demand for secure services was around 25 per cent more than its core contracted capacity.

³⁹ Source: In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment: 1998-99 to 2008-09, NHS Information Centre (2009)

⁴⁰The terms of the Framework Agreements state that they are not exclusive: "The Provider acknowledges that, in entering this Framework Agreement, no form of exclusivity or volume guarantee has been granted by the Authority and/or Other Contracting Bodies for Services from the Provider and that the Authority and/or Other Contracting Bodies are at all times entitled to enter into other contracts and arrangements with other providers for the provision of any or all services which are the same as or similar to the Services." In this document, when we refer to the Framework Agreements as 'exclusive' we mean that NWSCG has decided to operate them on an exclusive basis.

*when they provide value for money, but to go elsewhere if they do not.*⁴¹ It is therefore clear that using framework agreements on an exclusive basis is contrary to OGC guidance.

99. NWSCG's decision to operate the two four year Framework Agreements on an exclusive basis restricts competition between providers of secure services to patients in the North West until 2014.⁴² As such, this conduct may be inconsistent with Principle 4, rule 2, which prohibits restrictions on choice via collusive behaviour or any other action. In this case, NWSCG's decision restricts its ability to choose between providers over the four year period. This decision by NWSCG may also be in breach of Principle 1 which requires commissioners to commission services from those providers best placed to deliver the needs of patients and populations.

100. Whether NWSCG's conduct is consistent with the Principles and Rules depends on whether the costs associated with the restriction of choice and competition are outweighed by the benefits arising from the restriction. The following paragraphs set out our assessment of the costs and benefits to patients and taxpayers arising from NWSCG's conduct.

Costs to patients and taxpayers of NWSCG's conduct

101. Competition between providers is a dynamic process of rivalry that leads to continuous improvements in quality. NWSCG's decision to use exclusive four year Framework Agreements has three effects. First, any competition for contracts during the period of the Framework Agreements is limited to those providers appointed to the Framework Agreements, but the scope for competition between those providers is also limited since NWSCG has chosen not to use mini competitions under the Framework Agreements, instead contracts are awarded based on the ranking secured by providers at the time of the Framework Agreements. Second, it prevents NWSCG from being able to take advantage of any improvements in the service offer of providers not appointed to the Framework Agreements. Third, it prevents such improvements from happening at all.

Competition for contracts limited to providers appointed to the Framework Agreements

102. The use of exclusive framework agreements restricts competition for contracts to those providers identified as providing the best value for money when the Framework Agreements were tendered (i.e. those providers admitted to the Framework Agreements).⁴³ Further, where competition between providers on the Framework Agreements is weak, for example because of the way in which contracts are called off, the incentive that Framework providers have to maintain or improve their service offer over time declines.

103. Framework agreements provide for two contract award procedures. 'Standard services' are awarded, without re-opening competition, to the provider offering the most economically advantageous offer under the original award criteria. 'Competed services' are awarded following a mini competition between those suppliers appointed to the Framework Agreements capable of

⁴¹ OGC, *Framework Agreements – OGC Guidance on Framework Agreements in the Procurement Regulations*, paragraph 2.2 (September 2008).

⁴² The low secure Framework for females expires in July 2013. However, as more than 90 per cent of patients are likely to be placed using the second Framework Agreement (based on current patient placements) and which expires at the end of 2013, for ease of reference we refer to the Frameworks expiring at the end of 2013.

⁴³ We use the terms 'best value for money' and 'most economically advantageous offer' interchangeably.

meeting the particular need.⁴⁴ NWSCG explained that secure service contracts are ‘standard services’; the price/quality offer established when the Framework Agreements were tendered is used to rank providers in terms of most economically advantageous offer. This ranking, based on offers in 2009, will be used to award contracts until 2014.

104. The lack of competition between providers appointed to the Framework Agreements until 2014, combined with the four year exclusive period, reduces the incentives of providers appointed to the Framework Agreements to maintain or improve their quality.⁴⁵ This is because changes in quality will not materially affect a provider’s chances of providing services to NWSCG. In certain circumstances it may also mean that providers are able to lower their service quality without suffering repercussions. The four year exclusive nature of the Framework Agreements, combined with the way contracts are called off, reduces the levers available to NWSCG to maintain and improve quality, with NWSCG having to rely on enforcing quality standards through contractual mechanisms rather than using competition to create the incentives for providers to improve.

NWSCG unable to take advantage of improvements in the service offer of providers not appointed to the Framework Agreements

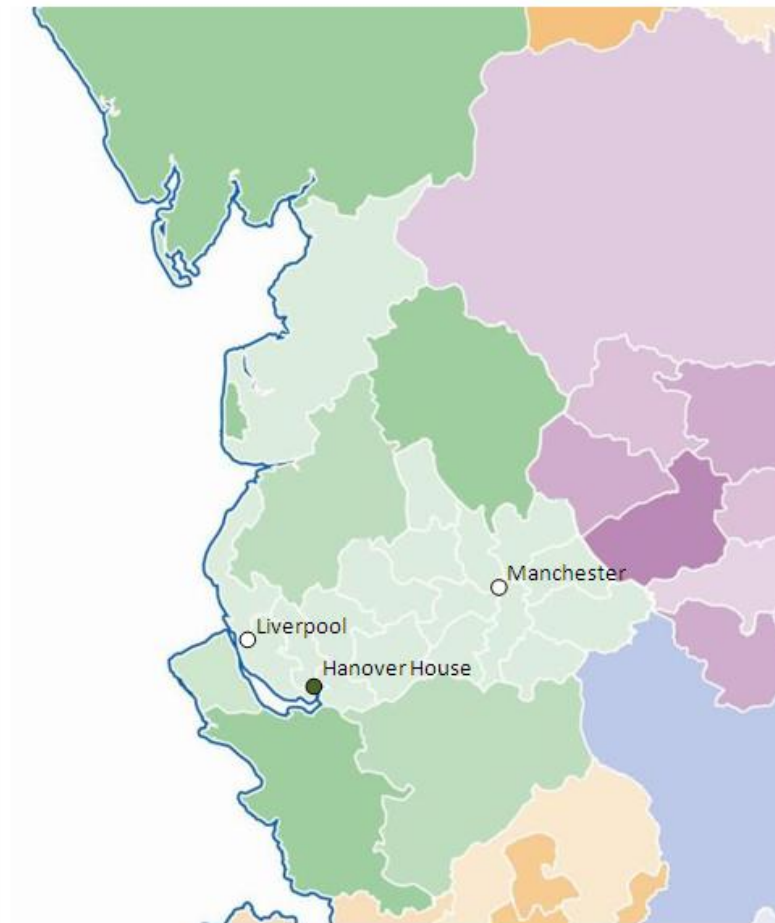
105. The restriction inherent in the exclusive four year term means that NWSCG is unable to take advantage of improvements in the service offer of providers not appointed to the Framework Agreements (including any new entrants) until 2014, even where these providers offer better value for money than providers appointed to the Framework.

106. The development of Hanover House demonstrates the changing nature of secure service provision in the North West. Hanover House is a new, purpose-built 74 bed secure unit located in Widnes, lying approximately mid-way between the population centres of Liverpool and Manchester. The development of Hanover House started before NWSCG announced its intention to use framework agreements to purchase additional capacity and Hanover, for reasons discussed earlier in this report, was not appointed to the Framework Agreements.

⁴⁴ Services are often competed where the terms laid down in the framework agreement are not precise or complete enough for the particular call-off.

⁴⁵ Changes in quality can arise in a number of ways, for example through changes to the clinical team of a provider or through the opening/closure of a ward. Prices are fixed for the term of the Framework so any changes to the service offer are likely to result from changes in quality.

Figure 4
Location of Hanover House



Note: The green shaded PCT areas correspond approximately to the PCTs for which NWSCG purchases secure services.

Source: CCP

107. NWSCG told us that in early 2009, at the time of the framework tenders, Hanover House did not meet the required standards for secure care. Hanover has since made considerable progress. It completed its registration with the CQC on 13 November 2009, enabling it to admit patients detained under the Mental Health Act 1983 (revised 2007). NWSCG told us that over the first half of 2010, through both the medium secure designation process (which we discuss later in the report) and the low secure audit, improvements were made.⁴⁶

108. There is strong evidence that Hanover now meets the required standards for the treatment of both low and medium secure patients. Hanover admitted its first low secure patient in April 2010 which means that commissioners other than NWSCG considered Hanover's low secure service offer to meet the required standards.⁴⁷ Given the improvements which Hanover has made in

⁴⁶ In particular, NWSCG told us that when it first visited Hanover House in January/February 2010 it was not confident regarding physical security. NWSCG wrote a report on this and Hanover addressed the issues identified. NWSCG also had concerns regarding the experience and qualifications of clinicians in post to treat medium secure patients at that time. Hanover told us that it had already recognised this weakness and begun the process of recruiting a more experienced medical team which is now in post.

⁴⁷ All of the patients admitted to date are low secure patients from outside the North West.

relation to medium secure care, which resulted in NWSCG awarding Hanover 'interim' designation for medium secure services in July 2010, it would also appear NWSCG considers Hanover's medium secure service offer now meets the required standard.⁴⁸ Hanover also told us that it has focused on developing its personality disorder services, which NWSCG explained are currently only purchased from one independent sector provider [§<].

109. The development of Hanover's services in the period since the tendering of the Framework Agreements illustrates how a provider that initially may not have been suitable for inclusion on the Framework Agreements can develop its services such that it offers a service that is comparable with, and has the potential to be better than the services of providers appointed to the Framework Agreements.

110. A further aspect of how new providers can offer an improved service relates to the location of their facilities. The development of a new secure unit will always improve access for some patients and where NWSCG does not incur the set up costs of entry, any accessibility improvement associated with new entry comes at no cost to taxpayers.⁴⁹ NWSCG recognises the benefits of having services located close to patients' homes and stated that its objective is to place patients as close as possible to their existing social networks, subject to the placement being appropriate.

111. We considered the improvements in secure service accessibility resulting from the development of Hanover House to illustrate the costs to patients of NWSCG deciding not to purchase from any new facilities during the period of the Framework Agreements. We focused on mental illness and personality disorder services and calculated the proportion of the total population that lives within 10km distance of Hanover that has access to at least one non-catchment unit Framework provider.⁵⁰ We excluded providers appointed to the Framework who operate catchment units from our analysis as these are operating at (or close to) full capacity and many have waiting lists for admission which restricts their ability to be awarded contracts under the Framework Agreements.

112. We found that without access to Hanover House, between 0 and 40 per cent of the population living within 10km of Hanover House can access at least one other facility within 10km for each of the service lots included in the Framework Agreements. When we extended the search area to 25km we found that between 13 and 100 per cent of the population within 10km of Hanover House can access at least one provider for each of the service lots (see Figure 9).⁵¹ For example, this means that 87 per cent of females living within 10km of Hanover House, who require low secure services, would have to travel more than 25km for treatment because Hanover's services

⁴⁸ NWSCG explained that Hanover can only receive 'full' designation once it has admitted medium secure patients as without patients it is not possible to assess relational security and a number of other requirements have been satisfied.

⁴⁹ This does not mean it is always desirable to open new facilities, particularly if large development and running costs are incurred.

⁵⁰ We focused on mental illness services because these account for the majority of secure service placements and personality disorder services because Hanover has recently developed these services. For the purposes of our analysis, we consider 10 km is a reasonable distance to review. Hanover is located within Halton & St Helens PCT and very close to Knowlsley PCT. These PCTs have between 5 and 7 patients per 100,000 of local population that require secure mental health services. This means that of the 430,000 people living within 10km of Hanover House we might expect between 21 and 30 to require the types of services provided by Hanover. This analysis, by considering the proportion of the population with access to at least one provider, identifies the minimum distance a patient would have to travel to access a secure unit.

⁵¹ When we extend our search area to 50km, we find that all patients can access a secure mental health facility.

are not available to patients. By definition, when we include Hanover, 100 per cent of the population can access services within 10km.

TABLE 5 Proportion of the population within 10km of Hanover who can access at least one unit operated by a non-catchment unit

	Framework provider							
	<i>Mental illness</i>				<i>Personality Disorder</i>			
	Female		Male		Female		Male	
	Low	Medium	Low	Medium	Low	Medium	Low	Medium
within 10km	0%	42%	0%	42%	0%	42%	0%	42%
within 25km	13%	100%	84%	100%	13%	100%	64%	100%

Source: CCP analysis

Note: Within 50km all patients can access at least one provider.

113. As well as existing providers improving their service offer, improvements may arise from the entry of a new provider. If entry can take place in less than four years (i.e. the period of the Framework Agreements), and the new entrant is able to provide a better service than Framework providers, then NWSCG is depriving itself (and patients) of the use of these new facilities in the period up until the expiry of the Framework Agreements. We were told that the development of a new secure unit can take from around 14 months to more than four years. NWSCG told us that as part of a tender exercise in 2006/07, Partnerships in Care, an independent sector provider, developed a new medium secure unit in the North West within 14 months. Hanover told us that it had taken St Andrews Healthcare, an independent sector provider appointed to secure service Framework Agreements in the North West and West Midlands, 18 months to construct a secure unit in Mansfield (or 36 months including acquiring a site and obtaining planning approval) and Hanover estimates that a development of a new secure unit in Northampton will have taken around 24 months when it is completed in December 2010 (again around 36 months from site acquisition).

114. Hanover House took more than four years to develop and open, although NWSCG explained to us that the development took longer than usual because it was originally approved by the Local Authority for use as a residential home. However, by the time the building was complete in 2007 a new planning requirement for C2a (secure) planning consent had been introduced in respect of secure units, and, by this time, NWSCG understood that the developers had decided to change the use of the building from residential to secure services. This led to a public planning inquiry which delayed the development.

115. In conclusion, improvements in the services available to patients may arise within the four year period of the two Framework Agreements through improvements by existing providers not appointed to the Framework Agreements (including new entrants). The exclusive nature of NWSCG's Framework Agreements prevents it from purchasing from providers that are in a position to offer better services to patients and better value to taxpayers than those providers appointed to the Framework Agreements.

Affects the investment incentives of providers not appointed to the Framework Agreements

116. As set out above, the exclusive four year Framework Agreements prevent NWSCG from being able to take advantage of improvements in the service offer of providers not appointed to the Framework Agreements, even where they offer better value for money. This restriction may also operate in a more dynamic way, and affect the incentives of providers not appointed to the Frameworks, including potential new entrants, to undertake investments in secure services in the North West that would benefit patients and taxpayers.
117. In particular, we considered the effect on investment by these providers resulting from the framework-based system for purchasing additional secure services. Inclusion on framework agreements in the North West would be important to the viability of any new investment in the North West – not only because of the business gained from it, but also due to the signal that being included on the framework agreements sends to commissioners of secure services in other regions.⁵² If providers not on the Framework Agreements were to form the expectation that the existing exclusive Framework Agreements were to be followed by a further set of exclusive four-year framework agreements towards the end of 2013,⁵³ then any new investment would need to be timed to ensure that the resulting facilities would be available to support a credible proposal by the provider for inclusion in the subsequent framework agreements. This would require a potential provider to align the uncertain timescales of a development, involving a number of different steps not always under its control, with the fixed, narrow window of that part of the procurement exercise towards the end of 2013 that runs from the date of the advertisement of the framework agreement to the deadline for responding to the PQQ .
118. The risks of a development not occurring to the required timetable, and as a result, the provider not having the facilities available to support a credible proposal during the narrow window that would be open for the next four year framework agreements are such that investment in the North West by providers not appointed to the Framework Agreements is in our view likely to be adversely affected. These providers, including new entrants, would be likely to seek less risky opportunities in other regions.
119. Deterring investment in the North West by providers not appointed to the Framework Agreements will have an adverse impact on patients and taxpayers if it results in NWSCG being unable to secure value for money in future tenders. This would be the case if, for example, it resulted in a potential provider with a better service offer than existing providers in the market not entering. There are a number of factors which contribute to the service offer of a provider and hence affect its value for money. These include the provider's location relative to patients, the range and quality of clinical and non-clinical services it provides, the way it operates those

⁵² Hanover told us that admitting patients from the North West was critical to their long-term success and before making the investment in Hanover House had anticipated that up to 50 per cent of patients to come from the local region. Furthermore, Hanover told us that it is important to secure placements from the local area as this provides commissioners from other regions, who would normally be less familiar with the service, with a certain degree of assurance on quality. It follows that NWSCG's refusal to use a local service may impact negatively on the ability of that provider to secure patients from other regions. Hanover told us that in the absence of business from NWSCG it is currently treating five patients from regions outside the North West, which represents a bed occupancy rate of around seven per cent; [3<]. Given this evidence, we consider that the ability to win business from NWSCG is important to the commercial viability of investments in the North West.

⁵³ NWSCG have provided no indication on their future procurement method and so from a provider's perspective it would be realistic it to expect a subsequent exclusive four year framework agreement and to reflect this in its decision about whether invest in the North West.

services and the price it charges.⁵⁴ We consider, on the balance of probabilities, potential providers with a better service offer than existing providers are likely to be deterred from entering.

120. Deterring investment by providers not currently on the Framework Agreements could also have an adverse effect on patients and taxpayers if it reduced the extent of competition for secure service contracts in the North West in the future. In the past there has been a large number of credible bidders for secure services contracts in the North West (with the possible exception of some highly specialised services).⁵⁵ We assume this has resulted in a satisfactory level of competition but we have not analysed this in any detail during this investigation as it has not been a key focus of our work. If a deterrence of investment by non-Framework providers is to contribute to a lessening of competition, then this would also need to occur in combination with either: (i) incumbent providers of secure mental health services who offer good value for money exiting the market and no longer competing for contracts;⁵⁶ and/or (ii) incumbent providers explicitly or implicitly agreeing not to compete with one another for contracts.⁵⁷ These agreements could include, for example, an implicit understanding between the incumbent providers that they will not bid against one another for contracts to provide certain services or an understanding not to compete on certain aspects of the service offer, such as price. This would reduce the intensity of competition.

121. In our view, NWSCG's conduct is likely to deter investment by providers not appointed to the current Framework Agreements, including potential new entrants. It is more likely than not that this will ultimately give rise to material costs to patients and taxpayers through deterring entry by a potential provider with a better service offer than existing providers. We considered whether costs to patients and taxpayers were also likely to arise because of a lack of competition emerging

⁵⁴ For example, the layout and fabric of a modern building can improve quality of life for patients and assist in providing high quality care and security.

⁵⁵ Of the 27 providers which responded to the PQQ for the second tender (which provides services for more than 90 per cent of patients treated under the two Framework Agreements), 17 were invited by NWSCG to submit a full tender. With the exception of the highly specialist deaf service, between five and 13 providers were appointed to each service lot and of these between three and 11 providers operate secure units located in the North West. Each of these 17 organisations was then appointed to one of five service lots, with each lot further divided into four sub-lots. A service lot relates to the specific treatment (mental illness, learning disabilities, personality disorder, deafness, acquired brain injury) and a sub-lot refers to the level of security and sex of the patient that a provider can admit. Three providers have been appointed to mental health and deafness service although only one of these is located in the North West. As they have been admitted to the Framework we assume that these providers offer value for money and most would be credible competitors in future tenders, though we note that it has not been possible for the CCP to undertake its own assessment. Prior to the two Framework tenders, NWSCG had run three competitive tenders for the provision of low and medium secure services in the North West. These services were; 30 medium secure beds in Cheshire and Merseyside area; 20 medium secure beds in Manchester area; and, 20 low secure beds in Manchester area. Each tender attracted between five and ten bidders, of which between three and five operated secure units in the North West.

⁵⁶ NWSCG told us that [redacted] closed their medium secure unit in the North West approximately three years ago. They also told us two providers appointed to the Framework Agreements had closed services in the North West very recently; [redacted] closed their male low secure service earlier this year and [redacted] closed a male low secure ward two months ago.

⁵⁷ An explicit agreement not to compete is known as a cartel. It is unlawful for organisations subject to the Competition Act 1998 or Article 101 of the Treaty on the Functioning of the European Union to enter into this type of agreement. An implicit agreement is not unlawful but may nonetheless have harmful effects on choice and competition. Three conditions must be satisfied for such implicit agreements to arise and be sustained. First, providers must be able to reach and monitor terms of coordination. For example, they must each be able to reach a mutual understanding that they will each bid only for certain contracts. Secondly, there is some form of credible deterrent mechanism that can be activated if deviation is detected. Finally, there must be little chance of coordination being undermined by competition from third parties, for example new entrants. One factor that can be especially valuable in identifying coordinated effects is the number of providers in the market because coordination tends to be more likely in markets with fewer providers. We note that there is a small number of providers for individual secure mental health services in the North West. The incentives to sustain coordination will be higher with fewer firms in the market. This is because detection of firms deviating from coordination is more likely when there are fewer firms in the market. In addition, each firm is more likely to be detected if deviating from coordination as the gains are greater, therefore deviation has a more significant effect and is more likely to be punished.

in particular service lots or the facilitation of collusion (explicit or implicit) between some providers. On the evidence available to us, we were unable to form an expectation that it was more likely than not that competition would be lessened in this way.

Conclusion – Analysis of costs to patients and taxpayers

122. In conclusion, we found that NWSCG's decision to use four year exclusive Framework Agreements for purchasing additional capacity for secure mental health services imposes material costs on patients and taxpayers. These costs arise from NWSCG's limiting competition to providers appointed to the Framework Agreements for the duration of the Framework Agreements, and therefore restricting its ability to purchase from non-Framework Agreement providers, which may have developed a superior service offering since the Framework Agreements were put in place. Material costs to patients and taxpayer also arise from NWSCG calling off services under the Framework Agreements based on rankings awarded at the time of the tender rather than using mini competitions between providers appointed to the Framework Agreements. Finally, NWSCG's conduct gives rise to material costs to patients and taxpayers by deterring the possible entry of a new service provider with a better service offer than existing providers.

Benefits of the conduct

123. Given that we have found that material costs are likely to arise from the conduct, in this section we consider the benefits that NWSCG believe flow from using four year exclusive Framework Agreements. NWSCG have not been able to provide us with written records documenting the reasons for its decision to use four year exclusive Framework Agreements and the factors discussed below appear to have been developed by NWSCG following a retrospective review of its decision.

124. NWSCG told us that the decision to offer exclusivity was based on efficiency, to ensure it was in a position to commission services from the best providers and to obtain best value for money. In particular, NWSCG told us that a key issue it had identified was the 'risk to patient health and the wider society if the provision of mental health services are not carefully controlled and managed to ensure that those providing the services are, and remain suitably qualified and experienced. The experience element is, however, only possible to achieve if providers have a sufficiency of patients under their care'.

125. NWSCG also told us that the decision to adopt a four year period of exclusivity was taken because:

- i. secure patients have long lengths of stay;
- ii. it is important to ensure patient continuity;
- iii. it was consistent with procurement law and guidance that permits framework agreements up to a maximum of four years;
- iv. it is not excessive having regard to the long lead-in times needed for a new unit [...];
- v. the Carter Review considered five years to be the appropriate length for designation, which has certain similarities with framework agreements;
- vi. the exercise would provide the North West region with sufficient additional capacity for the relevant services,[...], from which to draw down services on the basis of need;

- vii. independent providers were more likely to apply if the revenue return was sufficiently high and this was more likely to be achieved with longer contracts; and
- viii. in terms of administrative savings for NWSCG, the cost benefits of a four-year cycle were more worthwhile.

126. When evaluating the potential benefits arising from the two four year exclusive Framework Agreements, we considered their validity and whether these benefits could have been achieved through a less restrictive approach (e.g. through a non-exclusive framework agreement and/or shorter term agreements).

127. We concluded that points i, ii, iii, iv, v, and vi above are not relevant to exclusivity. The fact that some secure patients have long lengths of stay⁵⁸ and the fact that continuity of care is important, does not mean that Framework Agreements must be exclusive. Not all patients have long lengths of stay and placing new patients with new providers would not impact on continuity of care even for long term patients. If cost/volume contracts are in place, doing this will not increase costs for commissioners. Procurement law guidance states that a four year duration for framework agreements is acceptable, but it also provides that framework agreements should not lead to restrictions of competition and it is generally assumed that framework agreements are not exclusive. Long lead times for developments also do not justify a four year exclusive period – to the contrary, where there are long lead times for developments, exclusive four year agreements can deter entry (see Costs of NWSCG’s conduct to patients and taxpayers). The Carter review may have considered a five year period for designation to be appropriate, but this is unrelated to the duration of framework agreements. Finally, the fact that the Framework Agreements provide NWSCG with sufficient capacity is not the most important consideration; the Framework Agreements would also have provided NWSCG with sufficient capacity if they were non-exclusive and the important consideration is that NWSCG is obtaining the best quality services for patients that are the best value for money for taxpayers.

128. We focused our analysis on the benefits raised in points vii and viii, that is:

- four year exclusivity may enhance competitive rivalry for appointments to the Framework Agreements resulting in NWSCG getting higher quality services at lower prices (*Conduct enhances competitive rivalry for contracts*); and
- four year exclusivity may reduce the transaction costs associated with having to tender more frequently (*Conduct reduces transaction costs*).

Conduct enhances competitive rivalry for contracts

129. NWSCG told us that independent sector providers would be more likely to submit a bid if the revenue return was sufficiently high and that this would be more likely with longer term contracts. They also told us that the four year exclusive period was offered to encourage providers to offer price discounts.

130. First, it is important to distinguish between the Framework Agreement and the contracts called off under the Framework Agreements. NWSCG has not provided any volume guarantees to

⁵⁸ We have not investigated average lengths of stay in secure care because we consider that it is not relevant for the purpose of our assessment.

providers appointed to the Framework Agreements and even when contracts have been awarded, these have been cost/volume contracts which offer the provider no guarantee of volume. While being appointed to the Framework Agreements puts providers in a position to be awarded contracts, this is not the same as being offered guaranteed revenue. We therefore concluded that NWSCG's argument regarding the likelihood of higher bids for guaranteed revenue returns was not persuasive.

131. Second, a buyer will secure better value for money the stronger its bargaining position relative to sellers. The bargaining strength of a buyer or a seller will be determined by their alternative options, i.e. the extent to which they can credibly threaten not to contract with a particular seller/buyer. In this particular market, NWSCG is the main buyer of secure services across the North West and there are many providers operating secure units in the North West for whom obtaining business from NWSCG is important. NWSCG therefore has a very strong bargaining position regardless of whether or not it offers four year exclusivity.⁵⁹
132. We looked for evidence that NWSCG may have secured a better deal for patients and taxpayers (in terms of lower prices and/or higher quality services) by offering four year exclusive Framework Agreements compared with taking a less restrictive approach. This is difficult to assess because we do not know what deal NWSCG would have secured by offering non-exclusive agreements and/or shorter duration agreements. However, we observed that the prices that Hanover told us it would charge were in the range of prices secured in the tenders for Framework Agreements and for some services they are lower than the lowest priced Framework provider. This indicates that the exclusive four year Framework Agreements have not necessarily led to any benefits in terms of lower prices.
133. In terms of quality, we discussed above (see Costs of NWSCG's conduct to patients and taxpayers) that NWSCG's decision to use four year exclusive Framework Agreements means that it relies on contractual levers to maintain and improve quality, rather than also being able to rely on competition. However, the contractual levers that NWSCG can use to maintain or improve quality are identical regardless of whether or not the relevant contracts are exclusive or have a shorter duration.
134. Finally, we have not seen any evidence to indicate that the use of four year exclusive Frameworks is necessary to encourage appropriate levels of investment in secure services. In particular, NWSCG told us that the secure market is adequately supplied in the North West, with approximately 1,200 medium and low secure beds, of which over 500 are from the independent sector. The vast majority of this investment would have been undertaken prior to the introduction of the Framework Agreements.⁶⁰
135. Overall, we therefore concluded that it is unlikely that NWSCG would have enhanced competitive rivalry for contracts, thereby securing a better deal for patients and taxpayers (in

⁵⁹ This assumes NWSCG uses their bargaining strength to drive down costs and improve quality rather than protect incumbent providers from competition.

⁶⁰ In addition, each of the seven SCG's who responded to our information request told us that providers were developing appropriate services to meet their current and future needs and that no gaps in service provision had been identified, although some noted the limited capacity in highly specialised secure services, such as deafness services.

terms of lower prices and/or higher quality services), by offering four year exclusive Framework Agreements.

Conduct reduces transaction costs

136. Commissioners incur costs in running tenders and providers incur costs each time they submit a response to a tender. A benefit from operating four year exclusive Framework Agreements is that both commissioners and providers can avoid the transaction costs associated with a less restrictive approach. We have therefore assessed the transaction cost savings from not running another tender before 2014.

137. We first focused on benefits to NWSCG which can be considered as a benefit to taxpayers. NWSCG has run three competitive tenders for secure services to date. It told us that the first tender was for two discrete services and cost £150,000, the second tender was for the low secure female Framework Agreement and cost £77,000 and the third tender was for the Secure Services Framework Agreement and cost £73,000. We believe that the cost of the third tender is a realistic upper bound of the benefits from not running an additional tender as the cost of running tenders is likely to reduce as commissioners gain more experience and because not all the costs need to be incurred again (e.g. the design and development of the tender process/documents).

138. We asked NWCCA for their estimate of the costs of undertaking an additional competitive tender.⁶¹ NWCCA explained that it would be possible to run two tenders (with the level of complexity involved in the two Frameworks Agreements) on a concurrent basis at a total cost of approximately £50k and that such a procurement would typically take up to nine months. It told us that the process for tendering a framework or a contract for a single discrete service is essentially the same but the different lots and sub-elements add to the complexity of the framework tender.⁶² As a result, a tender for a discrete service would typically take up to six months. This implies the cost of a single tender would be in the region of £25,000.

139. We therefore estimated that the benefit to NWSCG of not running a tender was in the range of £25,000 to £73,000. On a conservative estimate, the required percentage reduction in daily rate that would equate to the cost of a tender lies in the range of 0.2 - 1 per cent.⁶³ The more beds that are purchased under the new rates the lower the required percentage reduction in daily rate in order for the tender to be cost neutral.⁶⁴

⁶¹ NWCCA provide procurement advice and expertise to NHS organisations within the North West and played a key role in the tendering of the two secure services framework.

⁶² For example, a lot refers to say mental illness and within this there would be sub-elements relating to a patient's sex and level of security.

⁶³ For the purposes of this analysis we assumed the costs of tendering the framework would be spread over the purchase of a fixed number of beds purchased each day for two years. We undertook the analysis separately for the purchase of 20 and 40 beds under the new terms. To put this in context, we estimated NWSCG was purchasing around 109 beds under the Framework Agreements in September 2010 (this estimate is based on 817 patients in total being treated and the assumption that the bed occupancy rate of core contracted capacity is around 95 per cent). We undertook the analysis on prices included in the Secure Services Framework for Mental Illness and Personality Disorder and the results were almost identical. We excluded non-catchment units appointed to the Framework Agreements from the analysis as these are operating at full capacity and this capacity has just been re-purchased for a further three years (see discussion in the next section on the use of block contracts).

⁶⁴ Our analysis of the benefits required for a cost neutral tender only looked at this from the perspective of required price reductions. A better comparison would be the additional value for money that would need to be delivered for the tender to be cost neutral. This is much more difficult to analyse and requires judgements on all aspects of value for money, such as quality. However, the pricing analysis demonstrates the modest magnitude of benefits required for a cost neutral tender, assuming all other aspects of value for money are held constant. We would expect quality to be an important factor and so it could be the case that a tender could be cost neutral even if no price reductions are achieved.

TABLE 6 Required price reduction to deliver a cost neutral tender

<i>Procurement cost</i>	<i>Bed days purchased each day for 2 years under new terms</i>	
	20	40
£73,000	1%	0.5%
£50,000	0.70%	0.35%
£25,000	0.40%	0.20%

Source: CCP analysis of NWSCG and NWCCA submissions

140. We also considered the benefits to providers of not having to submit bids because of the more frequent tenders that would take place in the absence of exclusive Framework Agreements. In our view, the costs of responding to a tender, including the cost associated with obtaining input of senior clinical staff, are likely to be significant when an organisation responds to a tender for the first time. However, with more frequent tenders for the same types of services to be provided to the same commissioner, bidders would only need to update tender documentation. Where a provider has undertaken improvements in its services between tenders, this would need to be reflected in revised tender documentation. Nevertheless, these changes should be marginal changes to tender documentation with significant amounts of tender documentation remaining constant from tender to tender. As a result, we found the costs associated with more frequent tenders for similar services to be modest. We also noted that this benefit would only arise for Framework providers where NWSCG elects not to use mini competitions between Framework providers.

141. In conclusion, we found that the conduct delivers some transaction cost savings but this benefit is modest.

Overall conclusion – balancing the cost and benefits of the conduct

142. The use of exclusive four year Framework Agreements to purchase secure services in the North West restricts competition and choice. This conduct would be inconsistent with Principle 4, rule 2, which prohibits restrictions on choice via collusive behaviour or any other action, if the costs of the restriction are not outweighed by the benefits associated with that restriction. This restriction may also affect NWSCG’s ability to commission services from those providers best placed to deliver the needs of patients and populations which may also be inconsistent with Principle 1.

143. The CCP did not consider that the modest benefits it identified offset the material costs associated with the conduct and has decided that the conduct breached Principle 4, rule 2 and Principle 1 of the PRCC when it decided to put in place two four year exclusive Framework Agreements for the purchasing of secure services in the North West.

WIDER ISSUES RELATING TO NWSCG’S COMMISSIONING PRACTICES

144. In this section we consider wider issues relating to NWSCG’s approach to commissioning low and medium secure mental health services and whether this gives rise to any costs to patients or taxpayers and, if so, whether there are any benefits.

145. Some of these issues were not specifically raised by Hanover in its complaint, but arose in the context of our investigation and are closely related to the conduct that is the subject of Hanover’s

complaint. In the following paragraphs we assess the consistency with the Principles and Rules of NWSCG:

- renewing and expanding of block contracts without competitive tendering;
- adopting different procedures for designating Framework and non-Framework providers; and
- supporting the development of NHS mental health facilities, but not providing the same degree of support to independent sector developments.

Renewal and expansion of block contracts without competitive tendering

146. As explained above, the current contractual arrangements for secure services in the North West to some extent reflect how this system has developed historically. In particular, each of the catchment units is operated by a local NHS provider under a block contract and NWSCG seeks to fully utilise block capacity before purchasing additional capacity from other providers.

147. The policy of having a designated catchment unit to assess all referrals from a fixed catchment area and then to place all patients that require treatment with that unit wherever possible is consistent with national guidelines on medium secure care published in 2007.⁶⁵ The 2002 national guidelines for low secure care do not specifically address these points, although they do recognise that ‘appropriate policies need to be developed and implemented locally’.⁶⁶ Accordingly, NWSCG developed a low secure specification with a referral policy reflecting that for medium secure care.⁶⁷ We note that revised national guidance on low secure services is being developed and NWSCG told us it would review its policies when this is published.

148. National guidelines on secure care do not indicate the type of organisation that should operate catchment units. We have only identified one catchment unit across all ten SCG’s that is operated by an independent sector provider.⁶⁸ Each of the NHS providers operating the catchment units in the North West were ‘nominated’ prior to the establishment of NWSCG in 2007. NWSCG told us that since 2007 it has worked with these providers to improve services and meet agreed standards. Many of the block contracts for mental health and learning disability services were renewed in April 2010 for a further three years. These were not subject to competitive tendering.

⁶⁵ Department of Health *Best Practice Guidance: Specification for Adult Medium-Secure Services*, page 27. See also the Reed Report, *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring similar Services*, Final Summary Report, Home Office (1992).

⁶⁶ Department of Health *National Minimum Standards for General Adult Services in PICU and Low Secure Environments* (2002).

⁶⁷ [Department of Health Low Secure Specification Final Draft \(October 2008\)](#).

⁶⁸ London Specialised Commissioning Group told us that of the 14 catchment units located across London one is operated by an independent sector organisation.

TABLE 7 Beds purchased by NWSCG under block contracts

<i>Provider</i>	<i>Security</i>	<i>Contract start</i>	<i>Contract end</i>	<i>Beds commissioned (2010/11)</i>
<i>Mental health services:</i>				
Partnerships in Care	Medium	Nov-07	Oct-12	30
Greater Manchester West FT	Low	Apr-08	Mar-11	30
Greater Manchester West FT	Medium	Apr-08	Mar-11	154
5 Boroughs Partnerships	Low	Apr-10	Mar-13	30
Cheshire & Wirral NHS Trust	Low	Apr-10	Mar-13	15
Lancashire Care NHS Trust	Low	Apr-10	Mar-13	66
Mersey Care NHS Trust	Low	Apr-10	Mar-13	32
Pennine Care NHS Trust	Low	Apr-10	Mar-13	44
Lancashire Care NHS Trust	Medium	Apr-10	Mar-13	68
Mersey Care NHS Trust	Medium	Apr-10	Mar-13	56
<i>Learning disability services:</i>				
Calderstones NHS Trust	Medium	Oct-10		192
5 Boroughs Partnerships	Low	Apr-10	Mar-13	15
Cheshire & Wirral NHS Trust	Low	Apr-10	Mar-13	15

Source: CCP analysis of NWSCG submission

149. In addition, since 2007 NWSCG told us it had commissioned an additional 110 beds of core contracted capacity – around 15 per cent of total core contracted capacity commissioned for 2010/11. With the exception of one 30 bed contract awarded to Partnerships in Care, each of the contracts was awarded to incumbent NHS catchment unit providers. NWSCG told us that the Partnerships in Care contract was tendered because Mersey Care NHS Trust was unable to secure the necessary funding to deliver the scheme that had been developed with the support of NWSCG in 2003 and so an alternative provider needed to be sought.

150. Of the 110 beds, a tender procedure was used to purchase 70 beds (including the 30 beds awarded to Partnerships in Care), and the women’s framework contract was used to award a contract for 10 low secure beds. NWSCG told us that four separate services over the period April 2009 to April 2010, comprising 30 beds in total (see table below), had not been competitively tendered and had been added to the existing block contracts held by each provider.

TABLE 8 Additional core capacity contracted since 2007

Service purchased	Tender	Date service commenced	Provider contracted to provide service
30 MSU beds in Cheshire and Merseyside area	Yes - restricted procedure (PQQ and ITT)	Nov-07 (advertised Dec-06)	Partnerships in Care
2 MSU beds	No - added to block contract	Apr-09	Greater Manchester West NHS Trust
14 MSU beds	No - added to block contract	Sep-09	Greater Manchester West NHS Trust
10 LSU beds for females	Yes - called-off women's framework agreement	Sep-09	5 Boroughs Partnership NHS Trust
20 MSU beds in Greater Manchester area	Yes - restricted procedure (PQQ and ITT)	Nov 2009 (advertised Jul-07)	Greater Manchester West NHS Trust
20 LSU beds in Greater Manchester area	Yes - restricted procedure (PQQ and ITT)	Nov 2009 (advertised Jul-07)	Pennine Care NHS Trust
12 LSU beds	No - added to block contract	Mar-10	Lancashire Care NHS FT
2 LSU beds	No - added to block contract	Apr-10	Mersey Care NHS Trust

Source: CCP analysis of NWSCG submission

151. NWSCG told us that in line with the 2008 Procurement Guide, which applied to procurement activity that commenced prior to April 2010, there was no requirement for NHS services to be subject to a formal procurement process i.e. competitive tendering. It told us that the guidance indicates that commissioners should evaluate their existing contracts in terms of performance, efficiency, demand and fitness, and their approach had been to work with existing providers, both independent sector and NHS. NWSCG explained that services provided under all NWSCG contracts, whether awarded under the Framework or not, were subject to a range of mechanisms to monitor and enforce performance and quality, including:⁶⁹

- Quality Indicators (CQUINS);
- Contract status reports against contract performance indicators;
- Quarterly meetings with all providers;
- Action plans agreed to address any perceived failure to improve;
- Self audit and evaluation by commissioners;
- Serious untoward incident protocol;
- Penalty clauses in the contracts; and
- North West best practice group to review lessons learnt from incidents and discuss best practice.

152. NWSCG told us at the meeting on 5 October 2010 that the relevant PCT would have taken the decision not to competitively tender block contracts and that NWSCG was merely an associate to the relevant contracts.

153. We took the view that the issue of block contracts being renewed without competitive tender is relevant to the analysis of the core issues in this case, but we did not investigate the issues fully, in particular since parties other than NWSCG seem to play a major role in the relevant commissioning decisions. Although we would question whether or not the relevant decision maker is able to demonstrate that the decisions are in line with obligations in PCTs' standing

⁶⁹ NWSCG's response to Issues Letter.

orders or NWSCG's Establishment Agreement to obtain value for money, and that they comply with Principles 1 and 3 of the Principles and Rules and the Procurement Guide, we reached no conclusions on these points in this case.

Adopting different procedures for designating Framework and non-Framework providers

154. Hanover alleged that providers admitted to the Framework Agreements were automatically designated as appropriate providers of medium secure mental health services, while those that are not admitted to the Framework Agreements had to follow a separate designation procedure. Hanover received interim designation for medium secure services in July 2010. Providers admitted to the Framework Agreement for medium secure services were designated as from January 2010 by virtue of being admitted to the Framework Agreements.
155. We considered whether or not this may be contrary to the requirement in Principle 3 for commissioning and procurement to be non-discriminatory. In addition, delaying designation may create barriers to entry and impact on the number of providers and therefore on choice and competition. This may be contrary to Principle 4, Rule 2 where a commissioner unilaterally restricts its choice of provider and Principle 1 where a commissioner fails to commission services from those best placed to deliver the needs of patients and populations.
156. The Carter Review recommended that SCGs should be given powers to designate specific providers to provide specific specialised services. According to the Review, there should be a robust, transparent process for designating potential providers, run on a five yearly basis. Specialised commissioning groups should have the power to withdraw designation status during the five year period.
157. The Review stated that designation of specialised service providers by SCGs would secure an appropriate concentration of clinical expertise and activity at designated centres, located to maximise geographical access. Designation would safeguard patient access to high quality, cost effective services and prevent unsafe and/or unplanned proliferation of services. Service designation would enable patients, who wish to be able to choose from a range of service providers to do so secure in the knowledge that a 'designated provider' offers a high quality, safe specialised service. Designation would also make it easier to identify specialised service activity; target any national tariff supplements for such activity; assure financial viability of some relatively small and vulnerable services and plan developments and/or changes in service provision.⁷⁰
158. The review envisaged that a formal designation programme would be quickly established and that all services would have been through the process for the first time by 2010. It was suggested that organisations providing specialised services under contracts with specialised commissioners would be provisionally designated.⁷¹

⁷⁰ Department of Health, *Review of commissioning arrangements for specialised services* (May 2006), Section 4.

⁷¹ Department of Health, *Review of commissioning arrangements for specialised services* (May 2006), Section 4, paragraphs 122-124.

159. NWSCG explained that the National Specialised Commissioning Group has the lead role in relation to designation. NWSCG received the designation tool for medium secure services⁷² in January 2010 and then formally adopted it for use in the North West on 29 January 2010.⁷³
160. At the meeting on 29 January 2010, NWSCG also agreed that providers accepted onto the recently completed Framework Agreements would receive medium secure designation as they had already addressed the relevant requirements as part of the tender process. NWSCG also stated that the requirements for designation are the same for Framework and non-Framework providers. In support of this, NWSCG submitted a table comparing the requirements for Framework providers with designation requirements.
161. Where a provider was not automatically designated as a result of not being admitted to the Framework Agreements, NWSCG undertook a separate designation process. Following NWSCG's adoption of the designation process on 29 January 2010, NWSCG started considering Hanover's status on 4 February 2010. A number of meetings and visits took place to assess the facilities and ensure that requirements for designation were met. Hanover received 'interim' designation on 15 July 2010. It could not receive full designation, *inter alia* because some of the criteria which had to be met for designation could only be assessed when patients are using the facility. However, as patients were unable to use the facility without it being designated, an 'interim' designation was given, allowing patients requiring medium secure facilities to be treated at Hanover House.
162. The consequences for Hanover of not being designated by NWSCG were that Hanover could not provide services to NWSCG (although since Hanover was not admitted to the Framework Agreements it was already unable to provide services to NWSCG). Two letters from NWSCG⁷⁴ indicated that the lack of designation was no bar to Hanover admitting patients from other regions. By implication, there was a bar to admitting patients from the North West. However, Hanover stated that it was difficult for them to provide medium secure services outside the region without designation because, as we discussed before, lack of designation is a significant barrier to securing referrals from others where the local commissioners refuse to commission services.
163. The Designation Framework for Medium Secure Services states that if a unit is not designated by the relevant SCG it will not be able to contract with PCTs for work. On the other hand, NWSCG has stated that whilst the principle behind designation as set out in the Carter report was that this would be the case, the delays in the systems to set up designation mechanisms across all services means that providers do not need to be designated in order to provide services. It said that, although the designation process for medium secure units was agreed by the National Specialised Commissioning Group, it has not been universally adopted across specialised commissioning areas so far, and therefore units which are not designated can be used by either the local SCG or any other SCG. NWSCG provided details of where the various SCGs are in the designation process, indicating that four have completed the process, four have not yet commenced and one has almost completed the process.

⁷² At the date of this report there was no agreed designation framework for low secure services.

⁷³ *Designation Framework for Medium Secure Services* (undated).

⁷⁴ Letters dated 13 April and 21 April 2010 from NWSCG to Hanover.

164. Having carefully reviewed the available evidence, we concluded that NWSCG did not act in breach of the Principles and Rules in treating providers not appointed to the Framework Agreements differently to providers appointed to the Framework Agreements. Based on the evidence provided, we concluded that the requirements for providers admitted to the Framework Agreements and those not admitted to the Framework Agreements were not materially different. In terms of the timing, while Framework providers were designated before Hanover (and other non-Framework providers), Hanover's designation process was not unduly delayed. It began promptly following agreement of the designation framework and took five and a half months. During this time, a number of issues were identified and resolved.
165. For all organisations to be treated in the same way, it would have been necessary for providers admitted to the Framework Agreements to be subject to a separate designation process on a similar timetable as Hanover. This would have resulted in duplication and inefficiency. In these circumstances we concluded that there was an objective justification for treating Hanover (and others in a similar position) differently from organisations admitted to the Framework Agreements.
166. Overall, we therefore did not find a breach of Principle 3. In addition, we noted that the designation process was carried out in line with the Carter Review and its effect on patient/commissioner choice and competition outside the North West region⁷⁵ was likely to be minimal given the large number of alternative providers. We therefore did not find a breach of Principles 1 and 4 of the Principles and Rules.

Supporting the development of NHS facilities, but not providing the same degree of support to independent sector developments

167. Hanover alleged that NWSCG lowers the costs and risks associated with development of new capacity/improvement of facilities by NHS providers, including through supporting the planning applications of NHS providers. To assess whether this difference in treatment may be contrary to the non-discrimination requirement of Principle 3, the CCP first considered whether NWSCG sponsored or supported developments, if so which ones.
168. Hanover pointed to two instances where, in its view, there was evidence that commissioners in the North West had supported the development of NHS capacity by approving business cases for capital funding from the relevant SHA. Having reviewed the information provided, the CCP concluded that there could be no question of discriminatory treatment because: (i) obtaining NHS capital funding from the SHA is an issue that is only relevant to NHS providers; and (ii) the two instances predated the introduction of the Principles and Rules and the PCT Procurement Guide (as well as the establishment of the NWSCG).
169. Hanover also pointed to one instance where, in its view, there was evidence that NWSCG had supported a planning application for development of an NHS organisation. This related to the development of a step-down unit from secure care. The relevant planning statement attached a letter from NWSCG expressing support for the development. NWSCG stated that the

⁷⁵ Hanover's lack of designation within the North West region has no effect on competition there because NWSCG had decided not purchase services from Hanover since they had not been admitted to the Framework Agreements.

development of these services was a core component of the pathway from secure services. The CCP concluded that the available evidence did not support a finding of discriminatory treatment of Hanover, or private sector providers more generally.

170. Overall, the CCP concluded that there had not been a breach of Principle 3 of the Principles and Rules.

Provider Board membership

171. In the course of this investigation it became clear that Greater Manchester West Mental Health NHS Foundation Trust's (Greater Manchester West) board of governors has a representative from NWSCG (Director of Secure and Specialised Mental Health and Learning Disabilities Commissioning) as an appointed governor. Monitor requires Foundation Trusts to have Appointed Governors, who are from partner organisations locally, and we noted that this is considered good practice. We are aware that Greater Manchester West is not alone in having commissioning representatives as appointed governors on the Board.

172. The CCP's view is that in certain circumstances, these types of arrangements may lead to a conflict of interest and can give rise to a breach of Principle 1 where, as a result, services are not commissioned from those best placed to meet the needs of patients and populations. They can also give rise to a breach of Principle 3, where conflicts of interest lead to discrimination or a lack of transparency.

173. NWSCG, however, told us that it has a clear governance system in place to ensure that any arrangements, including the type of appointments described above, do not lead to any conflicts of interest. This means that declarations of interest are made by NWSCG and team members; there are also declarations of interest from individual members of staff on projects such as tenders. In addition there is an annual review of declarations of interest by the Audit Commission and an independent internal audit review of compliance with host PCT standing orders and standing financial instructions. NWSCG also explained, and provided some evidence, that the Director of Secure and Specialised Mental Health and Learning Disabilities Commissioning who is a member of the board of governors of Greater Manchester West completed the relevant declaration of interest form and informed the Chief Officer and other Directors at NWSCT that there was a conflict in the context of the evaluation of Greater Manchester West's bid to provide services under the Framework Agreement for women's low secure services.

174. In the circumstances of this case, there was insufficient evidence to indicate that any potential conflicts of interest were not appropriately managed. We have therefore concluded that there has not been a breach of the Principles and Rules in this regard.

CONCLUSIONS

175. The CCP has assessed whether NWSCG's conduct was in breach of the Principles and Rules. We found that NWSCG's decision to use four year exclusive Framework Agreements for purchasing additional capacity for secure mental health services imposes material costs on patients and taxpayers. These costs arise from NWSCG's decision to limit competition to providers appointed to the Framework Agreements for the duration of the Framework Agreements, and therefore restricting its ability to purchase from non-Framework Agreement providers which may have developed a superior service offering since the Framework Agreements were put in place. Material costs to patients and taxpayer also arise from NWSCG calling off services under the Framework Agreements based on rankings awarded at the time of the tender rather than using mini competitions between providers appointed to the Framework Agreements. Finally, NWSCG's conduct gives rise to material costs to patients and taxpayers by deterring the possible entry of a new service provider with a better service offer than existing providers.
176. These costs were not outweighed by any benefits that NWSCG submitted were associated with four year exclusive Framework Agreements. In particular, the CCP found that, given NWSCG's powerful position as a buyer of the relevant services in the North West, long term exclusivity did not materially enhance NWSCG's bargaining position and therefore did not lead to material benefits to patients or taxpayers in terms of higher quality services or lower prices. In addition, we found that the benefit of administrative cost savings associated with not holding another competitive tender for four years was modest at best. Overall, we concluded that the costs of having four year exclusive agreements were not outweighed by the modest benefits we identified and we therefore concluded that NWSCG had breached Principle 4 Rule 2 and Principle 1 of the Principles and Rules.
177. The CCP will provide this report containing its advice to the Secretary of State for Health in relation to this case. In due course we will also make a recommendation to the Secretary of State for Health on suitable remedies. The Secretary of State for Health will decide whether to accept the CCP's advice and what action, if any, is required as a result. The recommendations will include an appropriate remedy for the breach of the Principles and Rules.
178. Before providing its advice the Secretary of State for Health, the CCP is consulting with relevant parties on how the breach of the Principles and Rules may best be remedied. The CCP aims to recommend remedies that are effective in dealing with the harm identified and proportionate to the breach in terms of the costs imposed on the taxpayer and on private organisations. A statement of suggested remedies is available on the CCP's website at www.ccp-panel.org.uk. Interested third parties are invited to submit written observations on suitable remedies by close of business on Monday, 29 November to consultation@ccpanel.gsi.gov.uk.

Cooperation and Competition Panel

19 November 2010