Protecting and promoting patients' interests – licensing providers of NHS services

Summary of responses to the consultation

Notice of intent to make regulations given under section 83(4) of the Health and Social Care Act 2012

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Document Purpose	For information
Gateway Reference	18782
Title	Protecting and promoting patients' interests - licensing providers of NHS services. Summary of responses to the consultation. Notice of intent to make regulations given under section 83(4) of the Health and Social Care Act 2012.
Author	DH / Sector Regulation
Publication Date	**01 March 2013**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , PCT Cluster Chairs, NHS Trust Board Chairs, Directors of Finance, Allied Health Professionals, GPs
Circulation List	
Description	This is the formal response to the document Protecting and promoting patients' interests - licensing providers of NHS services.
Cross Ref	http://healthandcare.dh.gov.uk/consultation-licensing/
Superseded Docs	
Action Required	
Timing	
Contact Details	Sector Regulation Unit Room 235 Richmond House 79 Whitehall London SW1A 2NS
For Recipient's Use	

First published March 2013
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

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1. Introduction

1.1 The Health and Social Care Act 2012 (the 2012 Act) created a new role for Monitor. In future, it will regulate all providers of NHS services, with the primary duty of protecting and promoting the interests of people who use NHS services by promoting economy, efficiency and effectiveness in the provision of healthcare. A key way by which Monitor will achieve this is by establishing a provider licensing regime, which it will use to:

- support commissioners to secure continuity of NHS services;
- enforce prices for NHS services;
- address anti-competitive behaviour by providers of services that is against patients' interests;
- enable integrated care; and
- oversee the governance of NHS foundation trusts.

1.2 Monitor published its provider licence on 14 February[1]. The licence contains seven sections[2], some of which will apply to all licence holders, some only to certain types of licence holders, for example NHS foundation trusts (FTs), and some only to providers providing certain types of services, for example providers of commissioner requested services.

1.3 The 2012 Act provides that the Secretary of State can make regulations to grant exemptions from the requirement to hold a Monitor licence. Such exemptions may relate to particular types of providers or to providers of particular types of services. DH consulted on proposals about the possible content of exemptions regulations from 15 August to 22 October 2012.

[1] *The New NHS Provider Licence*, pub. Monitor, 14 February 2013. Accessible at http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishLicenceDoc14February.pdf

[2] Which are: 1. General conditions; 2. Licence conditions setting obligations about pricing; 3. Licence conditions setting obligations around choice and competition; 4. Licence conditions to enable integrated care; 5. Licence conditions that support continuity of service (CoS); 6. Governance licence conditions for foundation trusts; 7. Interpretation and definitions

2. Notice of Intent to Make Regulations

2.1 This document summarises the responses to that consultation and details the content of the regulations that the Secretary of State now intends to make. It includes the proposed effect of those regulations and the Secretary of State's reasons for them. As such, this document also constitutes a notice under section 83(4) of the 2012 Act. As required by the Act, it has been sent directly to the NHS Commissioning Board, Monitor, the Care Quality Commission (CQC) and the Healthwatch England committee, and has been published on the DH website.

2.2 Representations about the intentions contained in this document can be made to:

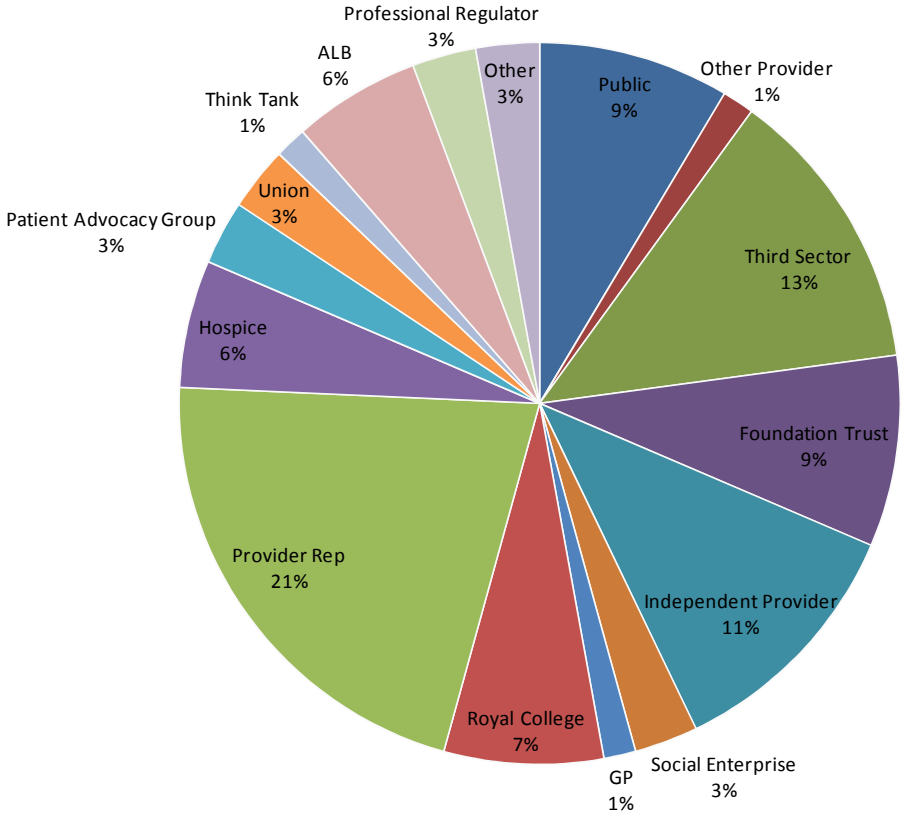
licence.exemptions@dh.gsi.gov.uk

Any such representations must be made no later than **30 March 2013.**

3. Responses to the Consultation

3.1 Seventy organisations and individuals responded to the consultation. Figure 1 below shows the breakdown of responses by type of respondent. We were particularly pleased by the numbers of providers and provider representative organisations who took the time to respond to the consultation. A full list of respondents is at Annex A.

Figure 1: Consultation responses by type[3]



3.2 Most respondents focused on the issues raised by the consultation document that were most relevant to them. In the following sections, where percentages are given they refer to the proportions of those who answered the specific question, rather than to the total number of respondents to the consultation as a whole.

[3] Using only numbers of responses from each type of respondent, not weighted for size, scale or impact.

4. DH approach to licensing in the consultation

4.1 In considering whether and, if so, how to use the power to grant exemptions from the requirement to hold a Monitor licence, DH proposed in the consultation, and continues to intend, that the starting principle be that sector regulation should establish equivalent safeguards to protect patients' interests, irrespective of who provides those services.

4.2 This will depend on a comprehensive set of rules that are applied and enforced consistently across all providers. The Department proposed a targeted and phased approach to implementation based on the following objectives:

- **realise the benefits** of sector regulation to protect the safety and quality of healthcare services, and deal with the problems of poor access to services, high and inconsistent prices, inadequate information and ineffective integration of services, to the detriment of patient care;
- **ensure consistency and transparency** in applying the principle of the new sector regulation system fairly so that providers can be confident that they are being held to account equally, whether they are NHS bodies, private businesses, social enterprises, charities or any other kind of organisation;
- **prioritise providers**, where this is appropriate, for example, to focus resources where they are most needed and will give the most benefit;
- ensure there is **alignment and fit** in the ways in which various bodies carry out their roles and functions in the new system, so as to avoid duplication and unintended gaps in regulation; and
- make sure any **new regulatory burdens are necessary and proportionate**, particularly for small enterprises and providers that may be subject to other forms of regulation.

4.3 In considering the responses to the consultation, we have continued to be guided by these objectives, necessarily making judgements about relative priorities where responses offered competing perspectives or proposals.

5. Overarching exemptions propositions

5.1 The consultation document identified a number of issues where we were clear that certain principles should apply. These were as follows.

Overriding requirements to protect continuity of services

Background

5.2 We took the view that where a provider is providing a service that has been specified as a "commissioner requested service" (CRS) through the process set out by Monitor in its guidance on CRS[4], the importance of Monitor being able to exercise its functions to secure continuity of that service should the need arise is such that this should override any eligibility for exemption from the licensing requirement that might otherwise apply. Thus, a provider of a CRS should always be required to hold a licence, even if it would otherwise meet the criteria for one of the exemption categories set out in the consultation document.

What people told us

5.3 Most respondents to the consultation agreed with the principle behind this proposition, although a small number expressed concern about the potential for disproportionate burdens to be placed on small providers of specialised services. Whilst we have given this argument careful consideration, we believe that these risks are relatively small, and do not outweigh the importance of allowing Monitor to do its job in relation to protecting the continuity of CRS in the interests of patients.

Intention

5.4 It therefore remains the Secretary of State's intention that no one providing a CRS will be eligible for exemption from the requirement to hold a licence.

Licensing and the Care Quality Commission

Background

5.5 In the consultation document we set out our proposition that a provider who is not required to be registered with the CQC should also be exempt from the requirement to hold a licence. This was based on the view that protecting patient safety is the paramount consideration when determining the scope of healthcare regulation. Additional protections

[4] Monitor consulted on its guidance to commissioners on designating services which should be protected last year. The final version of the guidance will be published later this year.

for patients from licensing providers that have been determined as not requiring CQC registration seem small, and unlikely to justify the additional regulatory burden.

What people told us

5.6 Most respondents who commented on this proposition understood and accepted this view, although a few advocated a maximalist approach that would see all providers of NHS services licensed from the outset, irrespective of size, scope or type of organisation. Whilst the reasoning behind this view is understandable, it was difficult to marry that with our wider objectives of prioritising and ensuring proportionality in implementing licensing.

Intention

5.7 It therefore remains the Secretary of State's intention to exempt from the requirement to hold a licence any provider who is not required to be registered with the CQC in respect of the NHS funded services it provides (unless the provider is providing a CRS, in which case they will require a licence, as set out in paragraph 5.4 above).

Keeping exemptions under review

Background

5.8 In the consultation document we set out our intention to carry out a full review of how licensing – including, of course, the exemptions regime – was operating during the next Parliament. The objective would be to establish whether licensing was achieving the intended objectives in the light of operational experience. We made clear that it was possible that this could result in providers initially exempted being subsequently brought into the scope of licensing.

What you told us

5.9 Respondents almost universally welcomed the commitment to review the operation of the licensing regime. No one suggested that it was a bad or unnecessary proposal, and many people emphasised that their support of one or more particular exemptions propositions was predicated on the assurance that it would be subject to review within a relatively short time.

Intention

5.10 The Government remains fully committed to carrying out a full review of licensing. We will aim to conduct this review during 2016-17, when licensing and the exemptions regime will have been fully in place for two years.

6. Exemption propositions relating to specific types of provider

NHS Trusts

Background

6.1 The 2012 Act provides that FTs must effectively be licensed automatically.[5] The consultation document noted that there is a strong case for prioritising NHS trusts for licensing because they provide a similar range and scale of services as FTs. However, NHS trusts, which are all moving towards becoming FTs, will be overseen and supported by the NHS Trust Development Authority (NHSTDA). The NHSTDA will operate a bespoke performance management regime, on behalf of the Secretary of State and supported by the Unsustainable Provider Regime for NHS trusts.[6] The existence of the Unsustainable Provider Regime would make it inappropriate to apply licence conditions relating to continuity of services to NHS trusts, because this would make them subject to two sets of processes. The NHSTDA will also oversee all other aspects of governance and performance in relation to NHS trusts and intends to exercise its functions so as to ensure that the requirements that apply to NHS trusts are equivalent to the requirements in Monitor's licence, with the exception of requirements about securing continuity of services.

6.2 The consultation document therefore proposed that NHS trusts should be exempt from the requirement to hold a Monitor licence, on the basis that the NHSTDA would operate a regime that would set similar requirements for NHS trusts to those contained in Monitor's licence. Agreements between the DH and Monitor and the NHSTDA respectively, and a memorandum of understanding between Monitor and the NHSTDA, would underpin these arrangements.

What people told us

Question 1 – Do you think NHS trusts should be exempt from the requirement to hold a licence, but expected to meet equivalent requirements to those in the general, pricing (where appropriate), choice and competition and integrated care sectors of Monitor's licence, overseen by the NHSTDA?

Yes: 56% **No:** 44%

[5] Section 88 provides that where an NHS trust becomes a Foundation Trust, it is to be treated as having applied for and met the criteria for holding a licence. It also provides that where a Foundation Trust is in existence on the day section 88 comes into force, it is to be treated in the same way.
[6] The Unsustainable Provider Regime for NHS Trusts was established under the 2009 Health Act and does not involve Monitor.

6.3 Many respondents emphasised the importance of minimising duplication and additional burdens. The NHS Confederation said it was "sensible to arrange the new system in a way that prevents unnecessary duplications", but also highlighted the importance of Monitor and the NHSTDA developing a strong "strategic partnership", with clarity about the NHSTDA's role and responsibilities in this area.

6.4 The NHSTDA noted that: "because of legal distinctions between NHS Trusts and NHS Foundation Trusts, not all aspects of the licence could reasonably be applied to NHS Trusts…as such, any application of the licence could only be partial". It also stated that it is "committed to working with its partners to ensure that an effective system is in place and that a coherent and consistent regime is created". That close partnership working is already well under way.

6.5 The Foundation Trust Network emphasised that the proposition represented a temporary situation, as all NHS trusts are currently working towards achieving foundation trust status, either in their own right or through merger, reconfiguration or other arrangements. So, in time, there will no longer be any NHS trusts, and all FTs will be licensed.

6.6 Although the data suggests that a significant proportion of respondents did not support the proposition, a good number of these were in the context of an overarching opinion that there should be no exemptions at all, rather than disagreement with the specific proposition.

Intention

6.7 Given the arguments set out in the consultation document and the broadly supportive responses to the consultation**,** the Secretary of State intends to propose to Parliament regulations that would exempt NHS trusts from the requirement to hold a Monitor licence. This will avoid the risks of multiple and possibly inconsistent regulatory requirements and of unnecessary bureaucratic burdens being placed on NHS trusts.

Small and micro providers

Background

6.8 The consultation document explained that most independent provision of NHS funded hospital services is highly concentrated amongst a relatively small number of larger providers. However, there are around 1,200 independent healthcare providers registered with the CQC. Many of these organisations are small and micro-businesses.

6.9 It is established Government policy to protect small and micro-businesses from additional regulatory burdens. The Department could not identify a compelling justification to impose a statutory requirement on small and micro-businesses to hold a licence from Monitor, but sought the opinion of stakeholders in the consultation. We also asked for views on how small and micro-businesses should be defined in the context of NHS services if we were to establish a *de minimis* threshold for exemption.

What you told us

Question 3 – Do you agree that it is not appropriate to license small and micro providers of NHS funded services, at this stage, pending further review of costs and benefits?

Yes 78% **No** 22%

6.10 A high proportion of respondents to this question were in agreement with the proposition that small and micro providers should not at this stage be subject to licensing. The comments from Social Enterprise UK were typical: "Additional regulatory burdens inevitably place a disproportionate effect on smaller providers. We also fear that this could discourage new entrants into the market…"

6.11 A number of respondents, including the British Medical Association, highlighted that, even if a small or micro-business was exempt from the requirement to hold a licence, it would (in all but a few cases) still be covered by the arrangements for registration with CQC which would help ensure that patients received quality care.

6.12 Some respondents warned of the importance of protecting against possible conflict of interest and anti-competitive behaviour where a provider is not subject to licensing. However, there will be safeguards in the system against such behaviours through regulations made under the 2012 Act which place obligations on the NHS Commissioning Board and clinical commissioning groups to protect against anti-competitive behaviour and conflicts of interest. Monitor will have powers to act where those obligations are not met. Other respondents raised concerns that some small providers can have significant influence in local health economies, and that there will need to be protection against providers gaming the system (eg by splitting up businesses to get NHS turnover below the agreed threshold).

6.13 Although relatively few people answered the questions about how the *de minimis* threshold should be set, those who did were overwhelmingly in favour of a threshold based only on annual NHS turnover of £10 million or less. Evidence from engagement activities carried out during the consultation suggested that using staff numbers for the threshold (either alone or with NHS turnover) would risk not exempting some small and micro providers, because:

- staffing ratios are higher in healthcare than in most sectors, so there would be many cases where staffing numbers would exceed 50, but the provider would nevertheless be a small business and, if the turnover limit were also used, significantly below the £10 million threshold; and
- it would be extremely difficult to differentiate between staff delivering 'healthcare' or 'social care' in a normal working environment.

6.14 During the consultation, the Department also asked out-of-hours providers of GP services; independent and voluntary sector providers; providers of social care who also provide NHS services; and GPs and dentists providing services <u>other</u> than primary (general medical/dental) services to complete short, voluntary questionnaires. These surveys were to help the Department understand better the impact of the proposals in the consultation document, particularly in relation to small and micro providers. 113 organisations responded. Over 75% of the respondents were charities, social enterprises and private providers.

6.15 The survey found that only 12 of the 113 respondents had an NHS turnover of over £10m, yet 50 had 51 or more employees, reflecting the fact that healthcare is an employee-intensive sector. This suggests strongly that an exemption based on NHS turnover and number of employees may catch a disproportionate number of small and micro providers, against the policy intention.

Intention

6.16 The Secretary of State intends to propose regulations to Parliament that would exempt from the requirement to hold a licence providers whose turnover from supplying NHS services is less than £10 million a year. This proposal reflects the Government's commitment to impose additional regulatory burdens on small and micro businesses only where necessary. The exemption proposal takes account of the responses to the consultation, wider engagement during the consultation and the findings from the surveys.

Primary medical/dental service providers

Background

6.17 The consultation document explained that the NHS Commissioning Board (NHSCB) will be responsible for commissioning primary medical services and primary dental services, and will hold the contracts with providers of these services. The NHSCB is therefore well placed to enforce standards equivalent to those included in Monitor's standard licence conditions. Furthermore, the NHSCB itself will be under obligations to protect patient choice, avoid anti-competitive conduct and enable integration. It will need to ensure that contracts with providers of the services include provisions allowing it to meet those obligations.

6.18 The consultation therefore proposed to exempt primary medical and dental practices from the licence, subject to the review during the next Parliament, with the intention that the NHSCB will make similar requirements to some of those in the licence through its contracts with these providers. An agreement between Monitor and the NHSCB would underpin these arrangements. The consultation sought stakeholder input on these proposals.

What you told us

Question 8 – Do you agree that providers of primary medical services and primary dental services under contracts with the NHSCB should initially be exempt from the requirement to hold a licence from Monitor?

Yes 63% **No** 37%

6.19 The proposal that providers of primary medical and dental services should be exempt from the licence was well supported. It was recognised as a sensible short-term measure pending review in 2016-17. There was also some strong support for making the exemption permanent from the outset, in order to provide primary care providers with certainty and stability.

6.20 Prior to the consultation, stakeholders had expressed particular concerns about ensuring that GP practices comply with requirements on patient choice, and this was also reflected in responses to the consultation. Similarly the Foundation Trust Network expressed concerns about conflicts of interest/anti-competitive behaviour by GPs, who will provide services as well as, through clinical commissioning groups, commission them.

6.21 DH considered these all these concerns carefully, but it remains the case that no evidence of such behaviours happening in practice was presented. Furthermore, there are safeguards in place as described above to protect against them occurring in the new health and care system.

Intention

6.22 The Secretary of State intends to propose regulations to Parliament that would exempt providers of primary medical and dental services under contracts with the NHSCB from the requirement to hold a licence.

6.23 GPs and dentists providing other types of services (whether separately or alongside primary medical/dental services) would be required to hold a licence in respect of those services, unless they were exempt under the proposal for exemptions for small and micro-businesses. This reflects the arguments in the consultation document and the responses to it, as well as the fact that GPs will soon have to register with CQC, along with the existing requirements for professional registration by both GPs and dentists.

Adult social care

Background

6.24 The consultation document explained that adult social care is currently outside Monitor's statutory remit, although there are provisions in the 2012 Act to allow the Secretary of State, subject to approval by Parliament, to extend certain Monitor functions to providers of such services. However, a significant and increasing number of adult social care providers also attract NHS funding for the provision of nursing care, for example nursing homes and residential care homes. Some also provide other types of NHS-funded services that are not connected to social care, for example diagnostic services or independent acute hospital services. The 2012 Act is written in such a way as to require all such providers to hold a licence, unless they are exempt.

6.25 In considering whether providers of adult social care who also provide NHS-funded healthcare should be required to hold a licence, a key issue for the Department has been that a significant number of adult social care providers are small or micro-businesses. Thus it seems likely that the majority would be exempt under the *de minimis* exemption proposals discussed above, although it is impossible to predict accurately how many that would cover in practice.

6.26 The consultation therefore sought feedback as to the likely impact on this group of providers of the proposals for *de minimis* exemptions. We also discussed an alternative option of defining an exemption for providers that generate at least 50% of their income from adult social care activities. Finally, we also made clear that we would consider

responses to this part of this consultation alongside the consultation on market oversight arrangements in the adult social care sector that had been announced, but not yet begun, at the time this consultation was published.

What you told us

Question 10 – Do you think providers of adult social care who also provide NHS services should be required to hold a licence, unless they fall below a *de minimis* threshold?

Yes 72% **No** 28%

6.27 Although respondents who answered this question indicated a preference for this proposition, a high proportion of respondents did not express a view. Of those who answered the related questions about how to define a *de minimis* threshold for this group of providers, there was a preference for the same threshold of less than £10m NHS-funded income as for small and micro providers.

6.28 The English Community Care Association, Care UK and a number of other respondents argued strongly that no decisions on licensing should be made before the outcome of the consultation on market oversight in social care was known. There were also powerful arguments put forward that funding for the provision of nursing care in the context of adult social care is materially different from other NHS-funded services. Income from NHS continuing care (CHC)[7] and NHS funded nursing care (FNC)[8] is attracted only because of the type of overall residential social care package being provided. It was therefore unfair to include funding from these sources in assessments of NHS income.

6.29 On the other hand, SEQOL, a social enterprise responding to the consultation, argued that, in light of the problems at Southern Cross, all providers of adult social care should be licensed. However, provider failure in social care is the subject of the aforementioned consultation on market oversight in adult social care and, furthermore, nursing care would be highly unlikely to be made a commissioner requested service and, thus, covered by the continuity of services conditions in the Monitor licence. Some respondents were also concerned about the potential negative influence of exemptions on provider behaviour such as splitting larger organisations up to create smaller, and thus exempt, businesses.

Intention

6.30 We have listened very carefully to the range of arguments put forward on this issue. At the current time, the benefits of applying the Monitor licence to nursing care provision for people receiving those services are unclear. In addition, the consultation on adult social care market oversight began last December[9], and we have taken into consideration the proposals contained in that, and looked at the implications for licensing this group of

[7] NHS Continuing Healthcare (CHC) means a package of ongoing care that is arranged and funded by the NHS where the individual has been found to have a 'primary health need'. Currently around 57,500 people in England are in receipt of NHS continuing healthcare.
[8] NHS funded nursing care (FNC) is where the individual does not qualify for continuing healthcare, but needs some additional care from a registered nurse and it is determined that the individual's overall needs would be most appropriately met in a care home providing nursing care. The NHS therefore pays a flat rate contribution to care costs.
[9] The consultation document is available at http://caringforourfuture.dh.gov.uk/2012/12/03/provider-failure/

providers. It is clear that adopting a *de minimis* licensing exemption approach from April 2014 would risk pre-empting the outcome of the market oversight consultation, and could lead to duplication and unnecessary additional burdens being placed on some providers, without clear benefits and protections for people receiving nursing care. Taking all of these considerations together, we have come to the conclusion that a different approach is needed from that put forward in the consultation.

6.31 Consequently the Secretary of State intends to propose regulations to Parliament that would exempt from the calculation of a provider's NHS income, for the purposes of the £10 million *de minimis* threshold, any funding received in respect of the provision of NHS continuing healthcare and/or NHS-funded nursing care as an integral part of a social care package.

6.32 This exemption will be time limited to April 2015 in the regulations. Prior to the expiry date, it will be subject to a full review in the context of decisions having been made on adult social care market oversight. The exemption could then be retained, removed or amended to align with the market oversight decision.

6.33 Providers who provide other NHS-funded healthcare services in addition to CHC and FNC would be subject to licensing in relation to those services, but also eligible for the *de minimis* exemption. So, for example, a provider who has a total of £12 million NHS income per year, of which £2.5 million comes from CHC and FNC payments will be exempt from the requirement to hold a licence until at least April 2015, because disregarding the CHC and FNC payments will take the provider's NHS income from other sources below the £10 million *de minimis* threshold. If, however, only £1.5 million comes from CHC and FNC payments, and the remaining £10.5 million is from other sources, the provider would require a licence from April 2014 (unless the other NHS services provided attract an exemption in their own right, eg primary medical services).

7. Other licensing regulations

Objection percentage threshold in the context of licence condition modifications

Background

7.1 The consultation document explained that the 2012 Act provides for relevant licence holders to object to any proposals by Monitor to modify standard licence conditions. The 2012 Act defines 'relevant licence holder' as:

- any licence holder, where a proposed modification is to a standard condition that applies to all licences; or
- any licence holder to whom the condition applies, where a proposed modification relates to licences of a particular description (so, for example, licence holders could only object to a proposed modification to conditions on pricing regulation if the condition in question was active in their licence).

7.2 The 2012 Act also provides that Monitor must consult on any proposals for modifications and, where the percentage of objections by relevant licence holders exceeds either or both of two thresholds that must be set in regulations by the Secretary of State, Monitor cannot proceed with the proposed modification. It would be open to Monitor to re-consider its proposal: it could abandon it, make a different proposal or re-consult on the original one. Alternatively, Monitor would be able to make a referral to the Competition Commission to make a determination on whether the modification was in the public interest and should be allowed to proceed.

7.3 The first of these thresholds is a straightforward objection percentage that gives all relevant licence holders an equal voice. The Department considered a range of possible percentages for the objection threshold, in each case assessing how well it would achieve the balance between giving licence holders a meaningful voice and mitigating risk of abuse. The Department proposed an objection percentage threshold of 20%, which had previously been employed by OFGEM in the energy market.

What you told us

Question 16 – Do you think a 20% threshold would be suitable for the standard condition modification objection percentage?

Yes 92% **No** 8%

7.4 Amongst those that responded on this issue, there was strong support for the 20% objection threshold. A number did however highlight the need to keep the percentage under review, so that any issues can be recognised and remedied.

7.5 Social Enterprise UK, whilst supporting the 20% threshold, also noted the importance of context. They stated that as NHS trusts and FTs dominate the market in the supply of

most health services, social enterprises might have difficulty in objecting to any licence modifications that disadvantage them.

Intention

7.6 The Secretary of State intends to propose regulations to Parliament that would set the percentage of relevant licence holders who would have to object to a proposed licence modification by Monitor in order to trigger re-consideration of the proposal, or a referral to the Competition Commission, at 20%. This reflects the arguments in the consultation document and the responses to it.

Share of supply objection percentage in the context of licence condition modifications

Background

7.7 The second threshold provided for in the 2012 Act relates to the share of supply of relevant licence holders. The intention is to weight objections to take account of licence holders' scale and share of the market. As well as setting a separate share of supply percentage threshold, regulations must define how providers' shares of supply would be calculated.

7.8 In the consultation, the Department proposed that the share of supply threshold be set at 20% (the same level as for the objections threshold). It also proposed that providers' share of supply be calculated according to their turnover from supplying NHS services. Finally we asked for views on whether this calculation should be adjusted to take account of local cost variations, and committed to carrying out further work to explore the feasibility of making such adjustments.

What you told us

Question 19 – Do you think the share of supply threshold should be calculated by defining share of supply as the number of licence holders affected by the proposed modification, weighted by NHS turnover?

Yes 74% **No** 26%

Question 20 – Do you think the share of supply threshold itself should be 20% as with the objection percentage?

Yes 79% **No** 21%

Question 21 – Do you think variations in the costs of providing NHS services should be taken into account when calculating share of supply?

Yes 76% **No** 24%

7.9 Although the percentages suggest clear support for the propositions in the consultation, the responses to these questions were mixed. The share of supply proposal did have support from a number of stakeholders. However, a number of stakeholders, particularly those representing the voluntary or private sector, such as the Independent Mental Health Services Alliance, noted the importance of preventing unintended consequences, such as the rules inadvertently shutting out the views of small providers. Many felt it important that big, urban FTs, did not have unfair influence in challenging Monitor's proposals for licence modifications.

Intention

7.10 The Secretary of State intends to propose regulations to Parliament that would define share of supply as the number of licence holders affected by the proposed modification, weighted by NHS turnover. The regulations would also propose that the threshold for triggering further consideration of Monitor's proposals would be 20%.

7.11 However, initially at least, local cost variations will not be taken into account in calculating share of supply. The Department and Monitor have done further work, which has suggested that it would be far from straightforward to take account of these variations in a way that would have any significant beneficial effect. Moreover, it is not clear that, for example, the Market Forces Factor would be the most appropriate means of taking account of cost variations, given that it does not apply uniformly across incomes.

7.12 We understand that this will be a disappointment to those stakeholders who were understandably keen to have as refined a weighting mechanism as possible from the outset. However, the review of licensing to which we have committed will examine how all aspects of licensing are operating, including the arrangements for objecting to proposals to modify licence conditions, objections thresholds and weighting. It is our intention, if possible, to develop mechanisms to refine the weighting element in the light of experience.

Turnover calculation for variable monetary penalty

Background

7.13 As the consultation document explained, the 2012 Act provides for Monitor to take action against a provider who: breaches a licence condition; fails to hold a licence when required to; or fails to provide Monitor with information it has requested. Monitor will have three possible options in these circumstances[10], including the ability to impose a 'variable monetary penalty' or fine. Monitor would determine the amount of any such penalty, to a maximum of 10% of a provider's turnover in England. The Act provides for the Secretary of State to define, in regulations, how turnover for the purposes of determining the maximum amount of any penalty should be calculated.

[10] Health and Social Care Act 2012 section 105(2)

7.14 DH considered a number of different options, taking account of issues including equal treatment, transparency, proportionality and the need for a simple mechanism that would be easy for providers and Monitor to operate.

7.15 The consultation document proposed defining turnover for the purposes of variable monetary penalties as being turnover related to the provision of NHS services by the provider in question. A definition based on total turnover was considered, but the consultation suggested that this would be neither fair nor proportionate.

What you told us

Question 23 – Do you think the calculation of turnover for the purposes of the variable monetary penalty maximum should be based on turnover from provision of NHS-funded services?

Yes 82% **No** 18%

7.16 Relatively few respondents expressed a view on this question. Again, although the percentages give a clear preference, views were quite divergent. Some stakeholders, such as the NHS Partners Network, suggested that turnover should be calculated just on NHS turnover, because using overall turnover would not be in line with the development of a fair playing field for providers. But others were equally supportive of using overall turnover. The Independent Ambulance Association argued that the level of the fine should be preset, with the severity of the fine varied in proportion to the seriousness of the action being penalised.

7.17 A number of provider respondents made clear that, whilst they support the use of fines in theory, it was important that such fines do not become excessive. The Foundation Trust Network particularly emphasised this point.

Intention

7.18 The Secretary of State intends to propose regulations to Parliament that would define 'turnover' for the purposes of calculating variable monetary penalties as turnover from provision of NHS funded services in England. This reflects the arguments in the consultation document and the responses to it.

Equalities Issues

Background

7.19 In developing the proposals in the consultation document, the Department took account of relevant equalities issues. It did not identify any potential adverse impacts. However, as part of the consultation, it asked for views on this.

What you told us

Question 26 – Do you have any evidence that the proposals in this document will impact adversely or unfairly on any protected groups?

7.20 Very few respondents raised concerns that the proposals in the consultation would adversely or unfairly impact upon any protected group.

7.21 A small number of respondents did highlight that many small and micro providers provide services solely to protected groups, and it is therefore important that these small providers are protected.

Intention

7.22 The Government will continue to monitor closely the impacts of its policies on exemptions in terms of equalities.

ANNEX A

ALPHABETICAL LIST OF ORGANISATIONS WHO RESPONDED

Members of the public who responded on an individual basis have not been listed below.

Acorns Children's Hospice
Arthritis Care
Barchester Healthcare
Boots UK
Bradford Teaching Hospitals NHS Foundation Trust
British Dental Association
British Medical Association
British Society of Hearing Aid Audiologists-BSHAA
BUPA
Care Quality Commission
Care UK
Central and North West London NHS foundation trust
Central Homecare
Chesterfield Royal Hospital NHS Foundation Trust
Community Links (Northern)
Cotswold Care Hospice
Diabetes UK
Eden Valley Hospice
English Community Care Association
Federation of Irish Societies
Foundation Trust Network
General Osteopathic Council
General Pharmaceutical Council
Help the Hospices
Humberside Group of Local Medical Committees
Independent Ambulance Association
Independent Mental Health Services Alliance
InHealth Group Limited
Katharine House Hospice
Lesbian & Gay Foundation
McKeown Psychology Associates-MPA Ltd
National LGB&T Partnership
Newbridge Care Systems Ltd.
Newlife Foundation for Disabled Children
NHS Commissioning Board
NHS Confederation
NHS Partners Network
NHS Protect
NHS Trust Development Authority
North East Ambulance Service NHS Foundation Trust
Nottingham CityCare Partnership CIC (social enterprise)
Nuffield Health
Nuffield Trust

Optical Confederation
Patient Liaison Group of the Royal College of Surgeons of England
Patients Association
Pharmacy Voice
Regional Voices
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Ophthalmologists
Royal College of Radiologists
Royal Orthopaedic Hospital NHS FT
Royal Pharmaceutical Society
SEQOL
Social Enterprise UK
South Warwickshire NHS FT
St John Ambulance
St Mungo's
Sue Ryder
The Practice
United Kingdom Homecare Association
Weight Watchers