the voice of NHS leadership

NHS CONFEDERATION RESPONSE TO THE DEPARTMENT OF HEALTH CONSULTATION ON PROTECTING AND PROMOTING PATIENTS' INTERESTS - LICENSING PROVIDERS OF NHS SERVICES (OCTOBER 2012)

1. ABOUT THE NHS CONFEDERATION

1.1 The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services. We speak for the whole of the NHS on the issues that matter to all those involved in healthcare. We also reflect the diverse views of the different parts of the healthcare system.

1.2 We welcome the opportunity to contribute to the Department of Health's consultation on the new license regime. As noted in our responses to previous stakeholder engagement on licence conditions, the proposed arrangements are complex and important. Even though we are much further in understanding the reforms, there are still many practicalities to be explained. Further clarification might allow us to be more positive about the ability of the licensing regime to be both effective and proportionate in practice. It could also give us a clearer indication that the new system is going to have the sufficient flexibility to adapt to changing circumstances and new evidence.

1.3 Our response primarily highlights concerns and issues in relation to the new NHS provider licence relating to:

- Bureaucratic burden
- Ensuring a level-playing field for providers
- Alignment with other bodies and processes.

1.4 This document forms part of our overall response to the new regime for sector regulation. It should be read alongside our responses to Monitor's current consultations on the licensing regime, which provide the detail for how the licensing regime will operate. It should also be considered together with the response from NHS Partners Network, which represents independent sector providers of NHS services and is part of the NHS Confederation.

2. GENERAL COMMENTS ON THE CONSULTATION

2.1 The NHS Confederation supports many components of the proposed regime in principle, but much will depend on their implementation. Our responses to the Monitor consultations on the proposed licence and commissioner requested services highlight our concerns about some aspects of the practical operation of the new regulatory regime. In responding to this Department of Health consultation, which sets out the overarching architecture of the new licensing regime, we set out some concerns about aspects of the proposed new provider license.

2.2 In particular, we are uneasy about establishing a new regulatory regime before it is clear exactly how the NHS is likely to develop over the next few years. This uncertainty not only stems from the Health and Social Care Act reforms, but also the significant restructuring and innovations of services that are likely to occur in response to changing

healthcare demands and the current financial pressures on the NHS. Not least, we do not yet know how the market for NHS care will develop in response to increased competition.

2.3 To allay this unease, the Department must aim to embed sufficient flexibility into the new licensing regime to ensure that it remains appropriate and effective in delivering the objectives of protecting and promoting patients' interests, and proportionate in the burden and costs it imposes compared with the benefits it delivers. We also suggest that the Department should monitor the changing nature of the market for NHS care and its relationship to the proposed licensing regime. This flexibility will be especially important because any modifications to the proposed licensing architecture will take time as they will require new regulations to be laid before Parliament.

2.4 We are particularly keen that the proposed licensing regime does not create advantages or disadvantages for any particular type of provider. Ensuring a fair playing field between all types of provider will be especially important as competition for NHS services is opened more generally to other providers and there are new entrants to the market.

2.5 The new licensing regime will be an additional requirement on providers that will inevitably add costs at a time of significant financial pressures. Particular consideration should therefore be given to understanding the burden and costs that the regime could potentially pose, and their relationship to the benefits it may bring. Although exemptions are important to ensure that smaller providers are not overly burdened, we are wary of the potential to allow an exemption where one is not necessary.

2.6 Finally, the new Monitor licensing regime will be an additional regulatory and oversight process for a sector that is already subject to significant oversight and regulation. It will be essential in making the new system work to ensure that there is greater co-ordination and alignment between the different bodies and their processes to minimise the burden on individual providers but also to support effective local healthcare systems for patients.

3. RESPONSES TO CONSULTATION QUESTIONS

NHS trusts

3.1 Do you think NHS trusts should be exempted 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 NHS Trust Development Authority?

3.1.1 It is proposed that all NHS foundation trusts be licensed with Monitor but that NHS trusts be exempted from this obligation. Rather than licensing directly through Monitor, it is expected that NHS trusts would be obliged to fulfil relevant obligations through the NHS Trust Development Authority (NHSTDA), which will be tasked with providing governance and accountability for NHS trusts in England and delivering the FT pipeline. The NHS Confederation thinks it is sensible to arrange the new system in a way that prevents unnecessary duplications between different bodies but believes that further clarification is needed as to how the relationship will work in practice. We recognise that discussions are currently ongoing as to how the strategic partnership between Monitor and the NHSTDA

will develop, but we maintain that the outcomes of these need to be clear and unambiguous.

3.1.2 However, recent changes to the role envisaged for the NHSTDA have caused confusion about its role in relation to NHS trusts, and therefore their relationship to the licensing regime. Originally, the responsibilities of the NHSTDA were identified as providing leadership, support and development for NHS trusts to help them meet the requirements to become FTs or to develop alternative solutions for those trusts unable to achieve FT status. It is now apparent from these current proposals and the recent amendment to the NHSTDA directions, that a much more active role is envisaged for the NHSTDA in regulating on finance.

3.1.3 In addition, close attention will need to be paid to ensuring that the NHSTDA has the sufficient resources to regulate NHS trusts on finance issues, in addition to quality and capacity. This arrangement would need to be assessed earlier than the full government review intended for the next Parliament given that the objective is for all NHS trusts to become NHS foundation trusts by 2014, although it is already becoming apparent that many NHS trusts may not in fact be ready and will continue to need regulating through the NHSTDA.

3.2 Is there anything you want to add?

3.2.1 Nothing further to add.

Private and voluntary providers of hospital and community services

3.3 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?

3.3.1The Department will need to ensure that the regulatory burden imposed by Monitor's licence regime will not hinder the ability of providers to deliver their services. This is particularly important for smaller providers for whom only a marginal burden could provide an obstacle to their ability to deliver services effectively. The NHS Confederation agrees that there is not a reasonable justification to impose statutory requirements on small and micro-businesses, in line with Government policy on protecting such businesses.

3.3.2 However, maintaining this position will mean that Monitor forgoes any direct influence over these organisations to enable integration and address anti-competitive behaviour. Although their size and scope may mean that this is not necessarily problematic, it is important to contemplate providers that may be small nationally but are a key part of the local health economy, e.g. a specialist provider or a GP providing additional services to basic primary care services. Additionally, it will be important to ensure that private and voluntary providers of hospital and community services do not develop artificial constructs to ensure that they are outside the requirements of the licensing regime. Underlining all of these concerns is an eagerness not to allow one set of providers to be advantaged and another disadvantaged, and to allow a fair playing field to be a central feature in the new licensing regime.

3.4 If so, do you agree that providers of NHS services with fewer than 50 employees (FTEs) and income from the provision of NHS hospital and community healthcare services of less than £10 million should be exempted from the requirement to hold a licence?

3.4.1 It is difficult to know if the impact of exempting small and micro-businesses to this level will be beneficial without an accurate assessment of the numbers likely to be affected. We recognise why the Department would at first look to the definition of a small business, as defined by the European Union, of less than 50 employees and with less than €10 million turnover. However, we would advocate the development of a more bespoke definition with regards to these specific circumstances. This would need to accommodate for the fact that the EU definition relates to turnover, instead of an isolated income figure from NHS services, and is specified in Euros, rather than Pounds.

3.4.2 If the purpose of the *de minimis* exemptions is to ensure that providers are not overly burdened with regulation disproportionate to their operating capacity, then it could potentially allow for some consideration of the total turnover of a provider as a factor in this capacity.

3.4.3 Certainly, we would not want to see a circumstance where a medium-sized private or voluntary provider of hospital or community services, capable of managing the licensing requirements and thus fulfilling the necessary obligations, was exempted because they generated less than £10 million specifically from NHS services.

3.4.4 It is difficult to assess how likely a scenario this is, without a reliable assessment, although we recognise the fair playing field concerns that could stem from this also. Therefore it may be necessary for the *de minimis* threshold identified to be used as a starting point but with the intention of further review once the full picture of providers begins to emerge.

3.4.5 It would also be important for the *de minimis* threshold to be seen as a moving target for purposes of accommodating the competing factors of cost inflation and imposed price deflation, as part of the National Tariff, which will have a big impact on NHS turnover over the coming years.

3.5 Alternatively, do you think a *de minimis* threshold based on a provider fulfilling one of the two conditions would be more appropriate (i.e. <50 staff (FTEs) <u>or</u> <£10m turnover)? If so, which?

3.5.1 The concerns that we have raised above indicate unease that more providers than necessary may be deemed to be small or micro-businesses and thus exempted from Monitor's regime and the obligations that this would entail. The basis for this is the importance we attach to ensuring a fair playing field and making certain that those providers with the capacity to deal with the Monitor licence are not given an advantage over most providers, who will be required to be licensed.

3.5.2 Given this position, we do not see any real justification for altering the requirements in a way that would naturally allow more providers to be exempt. As above, however, we reiterate the importance of reviewing the *de minimis* thresholds in light of further assessment as the regime develops, within which the effect of such a consideration could

certainly be included. We suggest that a review should be undertaken within two years of the full licensing regime being in operation (i.e. by March 2016).

3.6 If not, on what basis should small and micro providers be exempt?

3.6.1 One possible alternative that we believe could be worth considering, given our comments above, is to accommodate total turnover in addition to simply NHS turnover. Whist this need not be set necessarily at £10 million, it should be set at a level so as to exempt only those businesses that could appropriately be deemed small in their capacity to cope with Monitor obligations.

3.6.2 In addition, installing a more sophisticated threshold, which accommodates differing factors likely to change such as cost inflation and price deflation, would probably create a more accurate assessment, albeit at the expense of a more clear rudimentary one.

3.7 Is there anything you want to add?

3.7.1 Nothing further to add.

Family Health Services

3.8 Do you agree that providers of primary medical services and primary dental services under contracts with the NHS Commissioning Board should initially be exempt from the requirements to hold a licence from Monitor?

3.8.1 The NHS Commissioning Board will be adequately placed and obliged, like Monitor, to ensure that primary medical services and primary dental services protect patient choice, prevent anti-competitive behaviour and enable the integration of care. As such, it is important that Monitor does not overstep its boundaries in undertaking its regulatory role, not least because of the already anticipated workload for the organisation and the potential for duplicating obligations on commissioners. However, it will be important to see how the NHSCB develops as a organisation, particularly given the resources it has and the extent of its new roles.

3.8.2 That said, Monitor will still need to ensure that it establishes a clearly defined relationship with the NHSCB so that the achievement of both their primary objectives relating to integrated care and patient choice are secured. As mentioned earlier, the anticipated review into the full licensing regime should reassess whether this exemption needs to remain in light of what has emerged in the opening years of implementation.

3.8.3 Where we do have concerns about the proposed exemption of family health services is in relation to the changing nature of services provided particularly by primary medical care providers. The current policy thrust is to shift more and more services out of hospitals into community settings. In many circumstances, GP practices will be providing services that are in direct competition with existing NHS providers of acute and community services (NHS or independent sector) and potential new entrants to the market. While some might be exempt under *de minimis* requirements, there may well be confusion about these requirements, particularly the extent to which family health services income counts as NHS income.

3.8.4 We would also be concerned if the proposed licensing requirements also acted as a disincentive to some of the service reconfiguration and changes that are likely to be in the best interests of patients. This is clearly a complex area which will need careful assessment and monitoring to ensure that the licensing regime and requirements:

- are clear and easily understood in their practical operation
- do not give any particular type of providers an advantage (or disadvantage) in competing for services
- do not act as a perverse incentive/ disincentive to necessary service changes

3.8.5 If primary medical and dental services are to be exempt from the provisions initially, we welcome the commitment to review this in the next Parliament. This would not only take account of the operation of the licensing regime and development of the market, but changes in the ways that services are provided.

3.9 Is there anything you want to add?

3.9.1 Nothing further to add.

3.10 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?

3.10.1 It is clearly important to maintain an exemption for adult social care services until we have more clarity from the Government about their intentions for reforming social care and their proposals for changing arrangements for oversight of the social care market. In principle, we are not opposed to the inclusion of adult social care providers as we are keen to ensure that these essential services are protected in the same way that NHS services will be through the licensing system. We also have concerns about the burden that a licence would pose to these providers, if they were to be included, though these are the same concerns we have for all providers.

3.10.2 Once we have a clearer indication of the Government's plans, we will be in a better position to consider the costs and benefits of extending the licence to adult social care services. In the meantime, Monitor would be wise to ensure that they have a good enough understanding of the adult social care market, or else conduct an assessment, so that any future proposals can be evidence-based.

3.11 If so, do you think the threshold should be fewer than 50 employees (FTEs) and income from the provision of NHS hospital and community healthcare services of less than £10 million?

3.11.1 As highlighted earlier in the consultation, we believe that the *de minimis* threshold needs further refinement. However, we see no clear reason why an accurate threshold should not be applied to adult social services in the same way it is applied to all providers.

3.12 Alternatively, do you think a *de minimis* threshold based on an adult social care provider fulfilling one of the two conditions would be more appropriate (i.e. <50 staff (FTEs) <u>or</u> <£10m turnover)? If so, which?

3.12.1 We do not support this alternative method for exempting small and micro-business, as identified earlier in the consultation.

3.13 Do you know of any adult social care providers who also provide NHS services who would not fall below this specific *de minimis* threshold?

3.13.1 We certainly expect that there would be adult social care providers that would not fall below the *de minimis* threshold and so would be required to hold a licence. However, we note that it is difficult to accurately assess how many without a more specific definition of what Monitor would consider as NHS-funded care for social care providers. If Monitor is referring only to care provided under continuing healthcare arrangements, there would likely be a different number of licences required than if they included other areas of NHS-funded care as well, such as NHS nurses treating patients on the site of a provider. Such considerations could be included as part of the market assessment that we have recommended Monitor undertake above, before put forward any proposals for adult social care providers.

3.14 If you think there should be a different *de minimis* threshold what is that threshold?

3.14.1 We have identified potential alternatives earlier.

3.15 Is there anything you want to add?

3.15.1 Nothing further to add.

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

3.16.1 Where Monitor is looking to change licence conditions, it is important that providers are given an opportunity to make representations when they think it may unfairly hinder their ability to provide services. The proposed threshold of 20% is in line with other regulators and so seems a sensible starting point at which to work from.

3.16.2 However, as with the *de minimis* threshold, this should not be seen as fixed and the Department would do well to review the impact of the threshold to ensure it is remains effective.

3.17 If not, what figure do you think would be suitable?

3.17.1 Not applicable.

3.18 Is there anything you want to add?

3.18.1 Nothing further to add.

3.19 Do you think that 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?

3.19.1 The NHS Confederation believes that it is sensible for the share of supply threshold to be weighted by NHS turnover. However as indicated above it may be worth considering overall turnover if the consideration is based around a need to lower the administrative burden for small businesses.

3.19.2 The incremental costs of imposing additional regulatory requirements on medium providers, who may have an NHS turnover below any stated threshold, may not be too much of a hindrance and could allow obligations to be met without too much of a burden.

3.20 Do you think the threshold itself should be 20% as with the objections percentage?

3.20.1 As mentioned above, without clear data it is difficult to assess if 20% is a reasonable threshold to establish in regards to the share of supply. Whilst we are content to allow 20% be a sensible starting point, we recommend that the Department and Monitor prioritise establishing a more accurate and evidence-based threshold for the NHS as soon as possible.

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

3.21.1 There should be some consideration of variations in cost, although the feasibility of doing so may need to be assessed. This should also be considered as part of implementing the new pricing system with both Monitor and the NHS Commissioning Board, so that prices set take these factors into account.

3.21.2 An accurate consideration of the costs of providing NHS services will form an important part in establishing a fair playing field in the new licensing and pricing system.

3.22 Is there anything you want to add?

3.22.1 Nothing further to add.

3.23 Do you think the calculation of turnover for the purpose of the variable monetary penalty maximum should be based on turnover from provision of NHS funded services?

3.23.1 As mentioned above, it may be sensible to consider total turnover particular to make sure that penalties hold a proportionate weight throughout the health system. However, we are wary that it may be unfair to penalise some providers for their non-NHS income, raising further fair playing field concerns.

3.24 If not, how do you think turnover should be calculated?

3.24.1 Nothing further to add.

3.25 Is there anything you want to add?

3.25.1 Nothing further to add.

3.26 Do you have any evidence that the proposals in this document will impact adversely or unfairly on any protected group?

3.26.1 Nothing further to add.