Submission to Protecting and promoting patients' interests - licensing providers of NHS services

HOMELESS HEALTH CARE
A Community Interest Company
partnership between
Great Chapel Street
and St Mungo's

St Mungo's
Opening doors for homeless people

WHO WE ARE

St Mungo's has been opening doors for homeless people since 1969. We currently run over 100 projects, providing accommodation for more than 1,700 people every night and helping thousands more who are rough sleeping or at risk of homelessness. St Mungo's delivers a range of residential services from emergency shelters to semi-independent flats, as well as non-residential health, education and employment services. We also prevent homelessness through our housing advice programmes.

St Mungo's services are based on a recovery approach and we aim to work in partnership with clients in a personalised, effective way. Our clients often have complex problems that cause, or are caused by, homelessness; we deliver holistic support to help people rebuild their lives.

Homeless Healthcare Community Interest Company (CIC) is a social enterprise established in 2011 as a partnership between St Mungo's and Great Chapel Street Surgery, which is London's longest established clinic dedicated to providing quality primary care to homeless people. Homeless Healthcare has started to deliver StreetMed, a nurse led service which works to ensure that rough sleepers' in London can access suitable health treatment, and plans to deliver more services.

TWO KEY ASKS FROM ST MUNGO'S

- St Mungo's believes that providers with less than £10 million NHS turnover, rather than less than certain number of staff, should be exempted from registering with Monitor. This would help protect small, specialist providers, which are usually staff intensive, such as St Mungo's/Homeless Healthcare from additional regulatory burdens. This would be consistent with established Government policy.

- A mechanism is needed for patients who feel adversely or unfairly impacted by services that fail to address their needs to complain to Monitor, and for Monitor to investigate and respond. At the moment there is little in the proposals to suggest how Monitor will make providers accountable to the patient.

Our response answers questions asked by the consultation that are relevant to our organisation and clients.

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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

Question 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 exempt from the requirement to hold a licence? No - Organisations with <£10 million NHS turnover should be exempted, regardless of how many staff they employ.

Question 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) or <£10m turnover)? Yes, <£10 million NHS turnover.

Question 6: On what basis should small and micro providers be exempt?

St Mungo's believes that providers with less than £10 million NHS turnover should be exempted, regardless of how many staff they employ. This would help protect small, specialist providers such as St Mungo's/Homeless Healthcare from additional regulatory burdens, which, as made clear in the consultation, is consistent with established Government policy.

We are a specialised provider, delivering health care to a client group where intensive engagement is a prerequisite of effective practice. To deliver this health care we need a high staff to patient ratio. We therefore think that NHS turnover is a better measure; a measure based on the number of staff could penalise us for providing intensive support.

If number of employees is to be used as a criterion for exemption then this should be the number of clinical staff, not total staff.

Question 7: Is there anything you want to add?

Ensuring that small and micro providers do not face an unnecessary regulatory burden is important in terms of promoting integrated care. Integration is often likely to come from social care providers in the community integrating small amounts of health care into social care and support networks. A requirement for regulation would inhibit these developments.

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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

Question 11: If so, do you think that 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? No

Question 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) or <£10m turnover) ? If so, which? Yes <£10 million NHS turnover

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

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? No

Question 22: Is there anything you want to add?

The proposal to introduce a supply threshold would give more power to the biggest providers. In practice it would mean that Foundation Trusts would be able to veto any changes that didn't suit their business interests. If this proposal was adopted it would act as an obstacle to the Quality, Innovation, Productivity and Prevention (QIPP) programme, the movement of services into the community, and patient as well as commissioner choice.

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

Homeless people are adversely affected by poor access to health and social care.[i] Monitor has an objective to tackle these barriers to care.

What is missing at the moment is a mechanism for those who feel adversely or unfairly impacted by services that fail to address their needs to complain to Monitor, and for Monitor to investigate and respond. At the moment there is little in the proposals to suggest how Monitor will make providers accountable to the patient.

ENDNOTES

[i] See Office of the Chief Analyst, Department of Health (2010) Healthcare for Single Homeless People http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250 and St Mungo's and Homeless Link (2012) Improving hospital Admission and discharge for people who are homeless http://homeless.org.uk/sites/default/files/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf