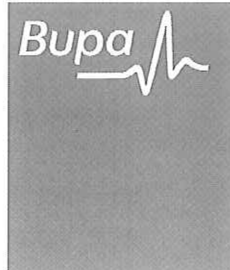
Licensing providers of NHS services – Bupa consultation response



Introduction

Bupa's purpose is longer, healthier, happier lives.

A leading international healthcare group, we offer personal and company health insurance, run care homes for older people and hospitals, and provide workplace health services, health assessments and chronic disease management services, including health coaching, and home healthcare.

- We work with more than 200 NHS hospitals and 50 PCTs providing healthcare at home to over 15,000 people
- The Cromwell Hospital treats over 10,000 patients a year
- Bupa cares for over 18,000 older people in the UK
- We have over 300 care homes in the UK, which provide specialist care to some of the country's oldest and most vulnerable people
- Over 70% of our UK care home residents receive state funding, including over 7,500 residents who receive some form of NHS funding.

With no shareholders, we invest our profits to provide more and better healthcare. We are committed to making quality, patient-centred, affordable healthcare more accessible in the areas of wellness, chronic disease management and ageing.

For more information, visit www.bupa.com.

General Comments

Bupa welcomes the opportunity to respond to this consultation. We have a long history of partnering with the NHS in a number of areas where we have expertise, particularly providing out-of-hospital care in patients' homes and in our own care homes. We also provide a small number of services in partnership with the NHS at The Cromwell Hospital and some of our dentistry centres.

It is not yet clear to what extent the licence conditions will affect the many thousands of providers of NHS services, from the public, independent and charitable sectors. Applying licence conditions that go significantly beyond current practice within other regulatory systems, particularly the regime operated by the Care Quality Commission, or entail significant additional investment in terms of capital and human resource will have an impact both on the cost to provide services for the NHS and the potential diversity of suppliers existing within the market.

Thought should be given to the potential administrative burden both on providers of NHS services of all services, and on Monitor's own capacity to effectively licence potentially thousands of providers.

To the extent that these conditions will cover a very large number of new entities, there would be significant disruption to these providers and Monitor as they look to incorporate the requirements into their business processes and systems. Monitor should aim not to repeat the difficulties CQC experiences when it introduced its new licensing regime.

In addition, means to more clearly define NHS turnover as referred to in the consultation document should be given further consideration. Distinctions are drawn between different types of turnover (such as for the provision of acute care) within the document. We believe it is important that the licence conditions are clear as to whether NHS Continuing Healthcare (otherwise known as Registered Nursing Care Contributions) are counted as NHS turnover at all in relation to particular exemptions.

Generally, until the final conditions of the Monitor licence are confirmed and it is clear how these will be implemented in practice, the impact on providers of NHS services of all sizes will not be apparent.

For these reasons, we believe a phased approach is the correct one and welcome the commitment to review the exemptions to the licence during the next Parliament. We believe that if diversity of supply to the NHS is to be retained and/or promoted, it would be sensible to exempt organisations for which NHS provision is a small proportion of their activity, at least in the first instance to allow providers to understand the impact that the licence would have on their ability to continue providing these services. This action should reduce the risk of providers withdrawing from providing NHS service because the costs of licensing are disproportionate to the size of the services provided to the NHS.

Q1 & Q2: 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?

We agree with the principle that the licence should be applied and enforced consistently across all providers by Monitor, unless an alternative body is able to take action to address failings. There must, however be a level playing field across providers of NHS services to mitigate anti-competitive behaviours and ensure a diversity of suppliers, so we would welcome clarification that any administrative or financial burden incurred as a result of the Monitor licence would be comparable for NHS trusts if exempted.

Q3: 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?

Q4: 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 £10million should be exempt from the requirement to hold a licence?

Q5: Alternatively do you think a *de minimis* threshold based on a provider fulfilling one of the two conditions would be more appropriate (eg. <50 staff (WTEs) <u>or</u> <£10milion turnover)?

We agree that in general private and voluntary providers of hospital and community services should be required to hold a licence rather than being exempt in order to support a fair playing field between private and voluntary providers and NHS FTs and NHS trusts. We also agree a *de minimis* exception is required.

We believe however that *de minimis* in this instance should be defined in terms of NHS turnover undertaken by a provider and not numbers of employees. This is because, if a threshold is set by reference to turnover for a *de minimis* exception, it should not be relevant whether the organisation providing that service has none or less than 50 employees. An example from our business is given below.

The Bupa Cromwell Hospital in London, the only hospital in the UK operated by Bupa, treated nearly 10,000 patients in 2011, less than 1% of which received NHS funding. The work that the Bupa Cromwell Hospital undertakes on behalf of the NHS is specialist and complex procedures at a very low volume and on an ad hoc basis. NHS turnover in 2011 was £1.2m, less than 2% of total turnover.

In particular since July 2003, the London Specialised Commissioning Group has recommended the Bupa Cromwell Hospital Gamma Knife Centre to provide radiosurgery for NHS patients. The Bupa Cromwell Hospital is one of only two hospitals in London with this facility, which has major benefits for patients as it is non-invasive, there is no incision; no need for head shaving; no scars to heal, there is no hair loss or nausea, treatment is relatively painless and in most cases a general anaesthetic is not needed, patients make a fast recovery and can usually resume their normal activities in a day or two.

If a Monitor licence represented a significant administrative burden and attracted large direct and indirect costs in order to comply, it is likely that the ability to continue to treat NHS patients at the Bupa Cromwell Hospital would be compromised given that this is not the core activity of the hospital.

Q8: 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 requirement to hold a licence from Monitor?

We agree with the suggested exemption and would welcome further guidance from the NHSCB with regards to any requirements necessary to meet standards equivalent to those included in the Monitor licence.

We operate dental services across 11 sites in the UK, one of which provides NHS treatment. NHS revenue represents less than 1.5% of total revenue at present. Where our NHS treatment falls under secondary dental services we would argue for a *de minimis* exemption based on the proportion of NHS activity.

Our focus for dental services is very much on private treatment and this will continue to be the case as we grow the business. We would not anticipate any more than 10% of the business being on NHS

treatment based on our current approved strategy. Most dentistry in the UK, both NHS and private, is provided by small independent dentists, and as such we would be concerned to ensure there was a level playing field as small independent dentists who may well fall below thresholds in terms of turnover or employee numbers would not face the additional costs of compliance with the new regulatory regime, allowing them to compete unfairly on price.

If a Monitor licence represented a significant administrative burden and attracted large direct and indirect costs in order to comply, coupled with non-compliance costs we would need to consider whether to continue providing NHS dental services.

Q10: 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?

Q11: If so, do you think that threshold should be fewer than 50 employees (FTEs) and income from the provision of NHS hospital and community services of less than £10million?

Q12: 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 (ie <50 staff (FTEs) or <£10M turnover)?

Q13: Do you know of any adult social care providers who also provider NHS services who would not fall below this specific *de minimis* threshold?

Q14: If you think there should be a different *de minimis* threshold, what is that threshold?

Bupa has over 300 care homes in the UK with over 18,000 residents. Approximately 7,500 of our residents receive some form of NHS funding either through continuing healthcare (CHC), registered nursing care contributions (RNCC) or through intermediate step-down care.

Our residents have high levels of dependency, with almost half both immobile and incontinent and over two thirds suffering from neurodegenerative diseases such as dementia, stroke or Parkinson's. For many their funding status will not remain static during their time in our homes and whilst they may not have been eligible for NHS funding when they first arrived as their needs change over time residents may have their care funded either partly or entirely through the NHS.

As a result the ratio and turnover of NHS provision within our care homes can be fluid and to some extent unpredictable. Staffing levels will also depend on the level of care required for individuals in a home at any one time.

We think that considering exemptions on the basis of turnover and staff numbers will be problematical due to the changing status of residents' funding and level of need over time. We would be concerned by exemption thresholds which could be breached by the deterioration of a small number of residents for a potentially short period of time if this led to a home having to acquire a licence with the associated burden and costs or face having to move a resident to another home.

We believe that exemption based on size of provider is inappropriate and could have unintended consequences for the residential and nursing care market. The majority of the care home market is made up of single home operators, many of which may employ fewer than 50 employees. If not faced with the costs of compliance with a Monitor licence, smaller homes would have an unfair advantage in being able to offer lower fees at a time when care budgets are tightly stretched. This could have the effect of ultimately limiting choice and creating a less diverse market, which is opposite to the proposals set out in the recent Care and Support white paper.

We recommend the alternative option of defining exemptions for providers that are generating at least 50% of their income from adult social care activities. We do not believe that many providers would fall into this category and that this would better reflect the nature of the care market and its provision.

Our recent report, Bridging the Gap, showed that the gap between the fair cost of care and the fees paid by local authorities in England now stands at just below £900m.[1]We therefore strongly recommend exempting providers of adult social care from the Monitor licence pending further review of cost and benefit, to ensure that already limited funding in the care sector is not diverted from the front line of providing care.

Our view is that this is the least disruptive approach and given that a review of the exemptions will be carried out after their introduction, it can be modified when the balance bweteen the impact and benefit of licensing is more certain.

Q16: Do you think a 20% threshold would be suitable for the standard condition modification objection percentage?

We have been encouraged by Monitor's engagement with the sector throughout the process of designing the licence and hope that they continue to engagement as the licence is modified over time.

We think a 20% threshold would be suitable for the standard condition modification objection percentage.

Q23: 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 turnover?

Turnover should be defined as NHS turnover only.

Q26: Do you have any evidence that the proposals in this document will impact adversely or unfairly on any protected groups?

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[1] Bridging the Gap, Bupa 2012 http://www.bupa.com/media/479673/bridging_the_gap_final.pdf

We do not have evidence that the proposals in this document will impact adversely or unfairly on any protected groups.

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