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

Q1: 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 sections of Monitor's licence, overseen by the NHSTDA?

This is an acceptable approach only on the basis that government policy is that the NHS trust model will be phased out in the coming years and this is therefore an interim measure. The end point of the policy should be that all providers are subject to the Monitor regime and we would be concerned if parallel systems were allowed to operate indefinitely.

Q2: Is there anything you want to add?

For clarity of policy objectives, the sector regulation system delivered by the licence should be kept separate from the commissioning process delivered by the contract. For this reason, we do not agree that it would be appropriate in the long term for the NHS Commissioning Board to perform functions mirroring Monitor's approach for primary care and primary dentistry, either using a contract mechanism, or operating a regulatory mechanism in parallel to a contract mechanism.

<u>*De minimis* exemption for small and micro businesses</u>

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 £10m should be exempt from the requirement to hold a licence?

This approach may be acceptable in a small number of circumstances. However, we consider that there will be very strong reasons why some providers that may fall within this *de minimis* category should be licensed. In particular, where a provider organization comprising GPs is being commissioned by a CCG comprising the same, similar, or a subset of the same GPs, or GPs sharing a commercial interest with the first group of GPs (e.g. working from the same GP practice), the GP provider organization should be required to hold a licence, and, in particular to adhere to the competition portion of the licence requirements.

Q5: 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)? If so, which?

and

Q6: If not, on what basis should small and micro providers be exempt?

We believe that the scale of NHS turnover is the crucial factor, and the staffing level figure is likely to be less important. The de minimis threshold seems acceptable, subject to exceptions, as set out in our answer to Q3.

Q7: Is there anything you want to add?

No

Family health services exemption

Q8: Do you agree that providers of primary medical and dental services should initially be exempt from the requirement to hold a licence from Monitor?

and

Q9: Is there anything you want to add?

As indicated earlier, we believe it important that regulatory functions and contractual functions should be kept separate. Therefore we do not think this arrangement would be appropriate in the long term. We suggest that a more proportionate, slimmed down licence could be devised for these providers, enabling them to remain within the one regime. We are particularly unconvinced by the argument that the Co-operation and Competition Panel has not in the past identified anti-competitive behaviour in GPs performing their gatekeeper role as a basis for not expecting such behaviour in future. Just because this has not happened in the past does not mean it cannot happen in the future, and as GPs take on a dual role with budgetary responsibility for commissioning, we have concerns that the risk of anti-competitive behaviour at the point of referral may increase. Clearly this will need to be kept under review.

We also believe that GPs' commissioning responsibilities create a direct conflict of interest where they are providing services outside the GMS/PMS contractual framework which they could legitimately be commissioning themselves. We believe that the *de minimis* exemption will be insufficient in such cases and serious thought should be given as to whether a form of licence should be used for those providers. We address this risk in our response to Q3 and in our response to the DH's consultation on 'Best value for NHS patients: Requirements for commissioners to adhere to good procurement practice and protect patient choice'.

Adult social care

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?

Yes, as this would bring them into line with all other NHS services.

Q11: 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 £10m?

and

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? If so which one?

and

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

Our answer would be the same as for Qs 4-6.

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

We do not hold this information.

Q15: Is there anything else you want to add?

No

Objection and share of supply percentages in the context of licence modifications

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

and

Q17: If not, what figure do you think would be suitable?

We think a 20% figure would be suitable.

Q18: Is there anything you want to add?

No

Q19: Do you think 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

Q20: Do you think the threshold itself should be 20% as with the objections percentage?

Yes

Q21: Do you think variations in the costs of providing NHS services should be taken into account when calculating the share of supply?

Yes, if possible

Q22: Is there anything you want to add?

No

How Monitor will enforce licence conditions

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 services?

No, as this would vastly disadvantage public providers, and would potentially lead to large amounts of taxpayer funding not being used for the purpose for which it was identified initially and being removed from providing health care to NHS patients. For instance, a district general hospital model FT with an annual turnover of £260m would be at risk of losing £26m under these proposals. We do not consider this appropriate. We consider that in light of changes to the licence regime which mean that it no longer applies equally to all providers, and that FTs in particular face extensive regulation which it is not proposed to apply to other sectors, the case for applying fines to public providers no longer applies.

Where independent providers, subject to fewer areas of regulation under the licence regime, are providing a small number of services, we can see that applying a fine would allow the regulator a degree of weight which it would not be able to exert via the regulatory provisions available to it. But such fines should only apply in these cases.

We appreciate that the Department of Health views the rationale for penalties as outside the scope of its consultation. However, we consider it is not possible to consider the quantum of fines without also addressing the appropriateness of the fine mechanism.

Q24: If not, how do you think turnover should be calculated?

Nothing to add

Q25: Is there anything you want to add?

We have some serious concerns about how fines have been used in relation to contracts in the past. We would wish to see a clear rationale from Monitor about how it proposes to impose fines, and an explicit commitment not to do so where the short, medium or long term sustainability of providers of NHS services could be affected.

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

No

FTN, October 2012