English Community Care Association

PROTECTING AND PROMOTING PATIENTS' INTERESTS – LICENSING PROVIDERS OF NHS SERVICES

A response from the English Community Care Association

1 Introduction

1.1 The English Community Care Association (ECCA) is the leading representative body for community care in England. Our members provide a wide range of services for adults with care and support needs including residential and nursing settings, homecare, housing and community-based support. Our members also deliver specialist care home services such as rehabilitation, respite, palliative care and mental health services.

1.2 We very much regret that this document should have been published in advance of the forthcoming consultation on oversight of the adult social care market, particularly insofar as the latter may involve an extension of Monitor's functions to that sector. Above all, we find it odd that a Department, one of whose priorities is the integration of health and social care, should have fragmented the consultation in this way. We believe it would have been better to consider, first, whether there is a case for extending Monitor's remit to adult social care providers, perhaps examining if the full array of conditions need be applied, or if partial licensing – requiring providers to conform to specified conditions – may be more appropriate. Thereafter, the exemption issue, including qualifying criteria, could be explored. At the very least, given the overlap of issues, the documents should have been published contemporaneously, if not as part of the same consultation.

1.3 Implicit within the consultation is the suggestion that there should be one Monitor regime for homes providing NHS-funded healthcare (as to the definition of which, see 2 below) and another, or perhaps none at all, for the remainder. In the consultation, exemption from a requirement to be licensed by Monitor is defined by reference to the scale of the undertaking, measured by staff headcount and/or the value of NHS services provided. We believe this to be largely unworkable to try and separate out the holistic care of an individual into different sections depending on the care given or the funding received. Put simply, for care home residents their accommodation is their home – a fundamental that seems to have been lost amid discussion of *de minimis*

thresholds set against staff numbers and turnover. Care homes are units which should be regulated in a unitary fashion.

1.4 We believe Questions 1 to 9 to be beyond our sphere of interest; as such, they have not been answered.

1.5 For the reasons set out at 1.2 and 1.3 above, **the answers provided to Questions 10 to 15 should at this stage be regarded as provisional**.

2 The provision of NHS services

2.1 We now understand that, for the purposes of defining exemption from Monitor licensing, the DH intends to include FNC – and therefore Registered Nursing Care Contributions (RNCC) – within the turnover of NHS-funded healthcare delivered by adult social care providers. We are deeply disappointed by that decision, given that, first, RNCC is only a contribution towards the funding of one element (the registered nurse care) of the total care delivered in care homes, and, second, placements of non-CHC patients in care homes are either commissioned by local authorities (the overwhelming majority) or arranged by self-funding individuals. They are not commissioned by the NHS.

2.2 The contrast between CHC and FNC is stark. We believe that the inclusion of RNCC in the NHS services equation is an unnecessary complication, akin to counting cash values for NHS supplies like incontinence products or peg-feeding sets.

2.3 We believe that turnover derived from the provision of NHS services should, in this context, be limited to those services that are funded fully and solely by the NHS – NHS continuing healthcare.

3 Consultation questions

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?

3.10.1 In our response to last year's discussion paper on oversight of the social care market, we made it clear that, inter alia – and there were many others – consideration should be given to making Monitor responsible for conducting initial checks on the financial viability of providers who by virtue of their size etc, pose a risk (particularly at a local authority level by virtue of local share of the market eg over X%), for mid- and post-failure management of the consequences of failure. We would be happy to discuss with the DH and others what an appropriate % locally might be. The rigour of these checks, we felt should be determined by the level of risk that is presented. We proposed that adult social care providers should be subject to a running programme of re-assessment only in so far as it ensured that providers' plans to manage the

consequences of business failure ("living wills") remain up to date. We want to emphasise that we stand by the fundamentals of that position.

3.10.2 However, now that we are familiar with the extent of Monitor's operational reach, its risk assessment framework and the range of conditions with which licence holders must comply, we have qualified our views. We are unable to understand the reasoning that requires adult social care providers who also provide some NHS-funded services to comply with all of the general conditions (although we accept that some will be essential), as well as those around choice and competition and integrated care (albeit that the conditions are currently subject to a Monitor consultation).

3.10.3 Given that the possibility of giving Monitor some responsibilities for oversight of the adult social care market was predicated on the need to protect the wellbeing and interests of the patients/residents and secure continuity of service – and no more than that – we do not believe it is either necessary or appropriate for the full toolkit at Monitor's disposal to be applied to the sector. Picking up on the statement in paragraph 49, "We are considering **whether** such providers should be licensed under this regime", therefore, our answer to Q.10 is: we do not believe providers of adult social care services should routinely be required to hold a licence, irrespective of the existence of de minimis thresholds (but see also 3.15.1).

3.10.4 The Department should be aware that our members have a number of concerns:

- The possibility of unfair competition. This could arise from the burden of additional costs – measured in human resources as well as cash terms – associated with licensing, or the advantage deemed to come with licensing, when an exempt provider is bidding for a CHC contract against a licensed provider;
- The uncertainty faced by larger providers that deliver a range of different NHS services, each of which may be managed by a separate legal entity, albeit within the same group, in respect of how their turnover will be treated for the purposes of exemption from Monitor licensing. For example, will turnover from hospitals and care homes be separated or consolidated?
- The fear that the additional burden they already bear as a result of CQC registration monitoring being duplicated by commissioners' contract compliance will be exacerbated by Monitor's licensing regime. They would appreciate an assurance that that will not be the case.

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?

3.11.1 We understand why, having approached exemption from the standpoint of seeking to minimise regulatory burdens on small and micro businesses – the

Department should have favoured exemption criteria that seek to capture these types of businesses. However, having proposed the adoption of these EU measures the Department does not make it sufficiently clear whether the aim is to exempt small-scale undertakings, small-scale provision of NHS-funded services, or a combination of both – there is no necessary link between the two thresholds. That lack of clarity was underlined by responses from departmental officials during the webchat with the DH on September 13.

3.11.2 More importantly from our point of view, by using the EU thresholds – which, it should be noted, were developed for completely different purposes – the Department treats care homes primarily as though they were manufacturers of widgets or providers of financial services when their function is actually to care for people, in numbers that are readily identifiable at each location. In our view, the vulnerability of either the residents/patients in question or the service itself – the former reflecting the here and now, the latter the ability of the healthcare economy to continue to meet the needs of local people for the foreseeable future – should not be expressed in such terms. Since the protection of individuals and the service they are receiving should be the focal point of licensing for the adult social care sector, we believe it is logical to extend that focus to exemption criteria. Unfortunately, we know of no universally accepted correlations that could combine the Department's preferred options with our suggested focus – that is, between patients/residents and either staff numbers or turnover.

3.11.3 As a general point, there is uncertainty over precisely which employees would count – (a) all employees or (b) only those that are involved exclusively in the provision of NHS-funded healthcare. That uncertainty reflects the confusion referred to in 3.11.1. Should the criterion of all employees be used, that may successfully capture small and micro businesses, but it may not identify those that provide small volumes of NHS-funded healthcare. It should be added that distinguishing the group at (b) would at best be extremely difficult, and mostly unworkable.

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?

3.12.1 See 3.10.3.

Question 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?

Option 1: For fewer than 50 employees and income <£10m?

3.13.1

Option 2: For fewer than 50 employees only?

3.13.2

Option 3: For income <£10m only?

3.13.3

Question 14

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

3.14.1 Although we regard the issue of de minimis thresholds to be largely irrelevant in this context, we believe the proposal (in paragraph 56) – that exemption could be defined for providers that are generating at least 50% of income from adult social care activities – to be preferable to the other thresholds proposed (but see 3.15.1).

Question 15

Is there anything you want to add?

3.15.1 Recognising that exemption, however it is triggered, can be overridden, we want to suggest an alternative approach, one in which the salient factor is not the size of the provider per se, no matter how it is measured, but its size and influence relative to the local market(s) in question (the market power referred to in Annex C, paragraph 2). Rather than applying a blanket approach to licensing nationally, for example, requiring a provider with a group of care homes that may be spread across the country to routinely hold a licence, bearing the associated cost burden, it would be more effective and less onerous were that requirement to be prompted solely as a result of a service supplied by that provider at a specified site(s) being designated as a Commissioner Requested Service. Thereafter, in order to avoid the imposition of a disproportionate cost burden arising from the application of the licence conditions, such providers should be subject to modified conditions, retaining only those necessary, and in the relevant proportion, to enable Monitor to discharge its responsibility to secure continuity of service. To be clear it will be the whole organisation that would be licensed, albeit in respect of the service provided at a specific site. Finally it is important to remember however, that local commissioners have their own role to play as market shapers and that their commissioning practices, in terms of volumes and price levels, may be more influential on the market than any particular provider.

Question 16

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

3.16.1 Subject to our comments in Section 1, yes, we do.

Question 17

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

3.17.1 N/A

Question 18

Is there anything you want to add?

3.18.1 Not at this stage.

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?

3.19.1 Subject to our comments in Section 1, in principle, yes we do.

Question 20

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

3.20.1 Subject to our comments in Section 1, yes, we do.

Question 21

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

3.21.1 Subject to our comments in Section 1, we believe that would be a sensible, if potentially complex, approach.

Question 22

Is there anything you want to add?

3.22.1 We would add that while we welcome recognition of the principle of cost sensitivity in pricing – something that should be applied more widely in practice – we would stress that the fact of regional variations in prices paid does not necessarily signify that these prices accurately reflect regional variations in costs. Annex D implies that all providers of NHS services are remunerated to reflect regional variations in costs, in particular via the MFF and other local adjustments. That is not the experience of our members with respect to payments for NHS continuing healthcare.

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 turnover?

3.23.1 Subject to our comments in Section 1, we do.

Question 24

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

3.24.1 N/A.

Question 25

Is there anything you want to add?

3.25.1 Not at this stage.

Question 26

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

3.26.1 No.