Consultation on our oversight of NHS-controlled providers: impact assessment
We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.
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1. Summary

Context

NHS foundation trusts are able to set up subsidiaries and joint ventures for the purposes of, or in connection with, their functions. With the advent of new care models we anticipate that joint ventures and subsidiaries may become more common and be used as the vehicle to hold contracts or deliver care on behalf of one or more NHS foundation trusts; for instance to deliver multispecialty community provider (MCP) or integrated primary and acute care systems (PACS) care models or hold an accountable care organisation (ACO) contract. Joint ventures are also likely to be used to collaborate with independent providers and general practice. These entities are currently classed as ‘independent providers’.

NHS providers (NHS trusts and NHS foundation trusts) and independent providers currently have different regulatory coverage under NHS Improvement’s licence, with a lighter touch approach for independent providers. As outlined in the consultation document, this distinction, based on legal form, does not make sense where NHS care is carried out on behalf of, and ultimately controlled by, NHS providers.

We therefore propose to introduce a new set of licence conditions that, as far as possible and appropriate, replicate NHS provider oversight for organisations controlled by NHS providers.

Scope of the impact assessment

NHS Improvement\(^1\) has a duty under section 69 of the Health and Social Care Act 2012 (the Act) to carry out an impact assessment when it proposes to do something likely to involve a major change in the standard conditions of licences.

This impact assessment compares the costs and benefits of NHS Improvement’s proposals with a ‘do-nothing’ scenario.

The [provider licence]\(^2\) contains seven licence conditions. Sections 1-5 and 7 apply to all licence holders. Section 6 applies only to NHS foundation trusts. Under our

\(^1\) In this document, references to NHS Improvement are to Monitor and the NHS Trust Development Authority (TDA).

\(^2\) The [provider licence] contains seven licence conditions. Sections 1-5 and 7 apply to all licence holders. Section 6 applies only to NHS foundation trusts. Under our
proposals, we would add a section, the NHS-controlled providers licence condition, that would apply only to NHS-controlled providers.

Given that conditions 1 to 5 of the provider licence will already apply to licensed NHS-controlled providers and no change is proposed to these conditions, this impact assessment focuses on the incremental impact of the NHS-controlled provider licence condition. It replicates the NHS foundation trust governance condition and is a key part of NHS Improvement’s oversight of NHS providers. We are therefore assessing the impact of the proposed oversight of NHS-controlled providers as comparable to the impact of our current oversight of NHS providers.

To estimate this impact, we have taken account of NHS Improvement’s activities carried out to reduce risks, as well as those undertaken to promote improvements at NHS providers and across the sector. The former tend to be expressed as a cost that could be avoided under the proposals, while the latter are generally a quantification of the benefit of discrete programmes to the NHS. We would not carry out either set of activities in a ‘do nothing’ scenario, while introducing the proposed new licence condition enables NHS Improvement to carry these out for the proposed group of NHS-controlled providers. We based the assessment on a combination of quantitative and qualitative evidence given the nature of the impacts and available data.

To collect evidence about and assess the likely nature and scale of the impacts expected to arise from the proposed licence condition we have engaged with various stakeholders, including colleagues in NHS Improvement, other arms’ length bodies, membership organisations, NHS trusts and NHS foundation trusts, and independent providers. Over the course of each meeting and workshop, the proposals and expected impacts were discussed. We then held more workshops to discuss in detail all the extra pieces of guidance, reporting and possible interventions that would apply to NHS-controlled providers and the likely impact of each. We then gathered further evidence through a review of relevant research. We will also consider evidence of impacts gathered through the consultation.

**Estimate of the number of providers that will be affected**

To be able to estimate the impact of the proposed licence condition, we have tried to estimate the number of providers that will be affected over a period of up to five

years. This estimate remains the same under each option for defining ‘control’ as outlined in the consultation document.

As of September 2017, there are two licensed providers that would be subject to the NHS-controlled provider licence. A third provider is likely to require a provider licence in the coming months, thereby coming into the proposed scope.

We anticipate that some providers will wish to set up joint ventures to support the development of new care models and, in particular, to hold ACO contracts in partnership with primary care or independent sector providers. We have based our estimate on the current total of 23 PACS and MCP vanguards. Current VAT rules mean that we expect the number of providers wanting to set up a joint venture to fulfil the role of prime contractor to be low. Therefore we estimate that over the next five years approximately 10% of new care model vanguards will set up a joint venture (ie approximately two to three joint ventures), which will fall within the scope of the proposed licence condition.

We estimate that a total of six providers will be affected over a five-year period.

Q1: Do you agree with our estimate of the number of providers likely to require the NHS-controlled providers licence over the next five years?

**Impact on different groups of providers**

The impact assessment also considered how the proposed licence condition would affect different groups of healthcare provider, in particular as defined by type and size of provider. The consultation document outlines the scope of the proposed licence condition so we know it will apply to providers that are required to hold an NHS provider licence (ie are not exempt under the licence exemptions regulations) and are ultimately controlled by one or more NHS providers (ie NHS trusts and/or NHS foundation trusts).

The oversight of all other providers will not change. This includes providers that currently fall within the independent provider regime and are not required to hold a provider licence, for example because of the type of care they provide or the size of
turnover, and/or are not ultimately controlled by one or more NHS bodies, ie providers that are ‘truly’ independent from NHS bodies.

We are also not proposing to change how we oversee NHS trusts and NHS foundation trusts. However, we recognise that NHS-controlled providers are likely to have strong ties to their parent organisations and we are committed to ensuring that any analysis of problems or identification of support needs arising at one organisation will be done in the context of the other.

The proposed licence condition would not be expected to give rise to any adverse impact on equalities. We also do not anticipate it would cause variation in the proportion of services provided by private or public providers. This is because, whether an NHS provider choses to deliver care directly or through a majority-controlled subsidiary or joint venture, both would be subject to equivalent oversight under our proposals. The proposals outlined here and in the consultation therefore would not affect whether care were provided by private or public providers, although, on the other hand, a ‘do-nothing’ scenario might. As for the award of contracts by commissioners, when making a choice between a truly independent and an NHS-controlled provider for instance, we consider it unlikely that procurement decisions would be made on the basis of the level of oversight an organisation is subject to.

Q2: Do you agree that our proposals are unlikely to cause variation in the proportion of services provided by private or public providers?

**NHS Improvement’s duties**

NHS Improvement has an obligation to explain how the implementation of this proposal secures its general duties as set out in sections 62 and 66 of the Act. These have been met in various ways, described below.

Overall, the proposals are in line with our duty to exercise our functions in a manner consistent with the Secretary of State’s duty to promote a comprehensive health service by aligning with NHS Improvement 2020 objectives outlined in our remit letter from December 2016.
NHS Constitution

NHS Improvement must have regard to the principles, values, rights and commitments of the NHS Constitution. Overall, the provider licence and the way it is implemented in terms of NHS Improvement’s oversight takes these into full account. In particular, General condition G6 of the provider licence obliges licensees to have regard to the NHS Constitution in providing healthcare services for the purposes of the NHS.

Choice and Competition licence conditions and fair playing field

The Act places a duty on NHS Improvement to exercise its functions with a view to preventing anti-competitive behavior in the provision of healthcare services for the purposes of the NHS which is against the interests of people who use such services. NHS Improvement is also under a duty not to purposely cause a variation in the market, which these proposals do not. The Choice and Competition licence conditions in the provider licence aim to support patients’ rights to make choices about their healthcare provider by obliging providers to make information available and to act in a fair way. They also prevent providers from behaving in any way that may prevent, restrict or distort competition where it is against the interests of patients.

Integrated Care licence condition

NHS Improvement has a duty to enable integrated care where this improves quality or efficiency or reduces inequality, and in doing so, must have regard to the way in which NHS England and clinical commissioning groups carry out their duties to promote integration. The Integrated Care licence condition enables NHS Improvement to intervene in cases where a particular provider is preventing integrated care from being delivered locally. It stipulates that the licensee shall not do anything that reasonably would be regarded as against the interests of people who use healthcare services by being detrimental to enabling it to co-operate with other providers of healthcare services.

The overarching policy of extending NHS Improvement’s oversight of NHS-controlled providers, together with other policies in areas such as pricing and competition, is aimed at enabling the integration of care by mitigating certain risks of setting up a joint venture or subsidiary to support closer working between providers.
NHS-controlled provider licence condition

NHS Improvement’s main duty is to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services that are economic, efficient and effective. It must also have regard to:

- the need to maintain the safety of people who use healthcare services and the desirability of securing continuous improvement in the quality of NHS healthcare services and in the efficiency of their provision
- the need for NHS commissioners to ensure that access to NHS healthcare services operates fairly and effectively for people who require such services and to make the best use of resources when doing so
- the need for high standards in the education and training of healthcare professionals who provide NHS healthcare services
- the need to promote research into matters relevant to the NHS by persons who provide NHS healthcare services.

The NHS-controlled provider licence condition encapsulates obligations around good governance. For instance, these include expectations on the licensee to establish and effectively implement systems and/or processes to ensure:

- it operates efficiently, economically and effectively
- effective financial decision-making, management and control
- timely and effective scrutiny and oversight by the board (or equivalent)
- compliance with healthcare standards
- clear accountability for quality of care throughout the licensee’s organisation
- personnel on the board, or equivalent, reporting to the board and within the rest of the licensee’s organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the provider licence.

Under our proposed oversight, NHS-controlled providers would also have access to all NHS Improvement tools and improvement support in relation to workforce, education and research.
Patient and public involvement and clinical and public health advice

NHS Improvement has a duty to involve patients and other members of the public to an appropriate degree and to obtain appropriate professional clinical and public health advice. When developing the proposals and impact assessment, NHS Improvement has engaged with NHS providers, independent providers, membership bodies and colleagues internally. However, we consider this public consultation on the proposals and impact assessment is the key way of engaging appropriate stakeholders and gathering clinical and public health advice.
2. Impact assessment

Overall, the benefits of the proposed licence condition are expected to outweigh the costs. This conclusion is based on assumptions about the number of providers that will be affected by the proposed licence condition and how providers and other stakeholders are expected to react to the condition.

The licence condition sets out NHS Improvement’s expectation regarding the governance of NHS-controlled providers to ensure the provision of high quality, efficient and sustainable care for patients. The licence condition does not define what effective governance systems and processes should look like in detail. However, NHS-controlled providers would be expected to comply with guidance relevant to the licence conditions and duties outlined there, the most significant of which is NHS Improvement’s Single Oversight Framework\(^3\) (SOF). NHS-controlled providers would also be able to access improvement tools available to NHS providers.

Rationale for intervention

NHS foundation trusts’ principal purpose is to provide goods and services for the purposes of the NHS in England. They are not-for-profit, public benefit corporations created to devolve decision-making from central government to local organisations and communities. They are not directed by government and so have greater freedom to decide, with their governors and members, their own strategy and the way services are run. NHS foundation trusts are accountable to their local communities through their members and governors, their commissioners through contracts, Parliament, the Care Quality Commission and NHS Improvement.

NHS foundation trusts have a unique governance structure which is substantively different from that of other providers and means the public are effectively their shareholders. They also sit on the government’s balance sheet. Furthermore, NHS foundation trusts (alongside NHS trusts) are deemed by Parliament to hold an important position in the provision of NHS healthcare services.

\(^3\) [https://improvement.nhs.uk/resources/single-oversight-framework/](https://improvement.nhs.uk/resources/single-oversight-framework/)
Based on these defining characteristics NHS Improvement monitors NHS foundation trusts’ governance and performance through the SOF across five themes: quality, operational performance, finance, strategic change and leadership and improvement capability.

NHS foundation trusts are able to set up subsidiaries and joint ventures for the purposes of, or in connection with, their functions. In other words, they can carry out their principal function of delivering healthcare for the purposes of the NHS through a subsidiary or joint venture. The advent of new care models means that these joint ventures or subsidiaries may become more common as a vehicle for delivery of care on behalf of one or more NHS foundation trusts.

NHS providers (NHS trusts and NHS foundation trusts) and non-NHS providers currently have different regulatory coverage under the provider licence, with a lighter touch approach for non-NHS providers. This distinction, based on legal form, does not make sense where care is being carried out on behalf of NHS providers and for the purposes of the NHS. Organisations controlled by NHS providers and delivering significant amounts of services for the NHS (ie providers with applicable NHS turnover of over £10 million, in line with the licence exemptions regulations) should for the purposes of oversight be classified as NHS providers and therefore overseen as such. NHS Improvement proposes therefore to introduce licence conditions that, as far as possible and appropriate, replicate NHS provider oversight for organisations controlled by NHS providers.

Policy objective

As outlined above, this work aims to ensure consistent and robust oversight of care provided both directly by NHS trusts and NHS foundation trusts and care provided on their behalf by a joint venture or subsidiary.

Options

The options considered by NHS Improvement were:

1. Overseeing NHS-controlled providers in the same way, as far as possible, as NHS providers by adding a set of licence conditions replicating NHS provider oversight (as outlined in the consultation document).
2. ‘Do nothing’, where NHS-controlled providers would continue to be overseen under the Independent Providers regime.

A number of independent providers experience financial oversight under the Continuity of Services licence conditions applicable when the provider’s services are designated commissioner requested services (CRS) by the commissioner. This option was not pursued because where an independent provider holds a licence but does not provide CRS, only very light touch oversight applies under the General, Pricing, Choice and Competition and Integrated Care licence conditions. As outlined in the previous two sections, such oversight is not deemed appropriate and sufficient for NHS-controlled providers.

3. Extending NHS providers’ obligations in relation to their subsidiaries and joint ventures to be able to monitor NHS-controlled providers through their parents.

This option would also include the ability to require improvements of the NHS provider at its subsidiary or joint venture. This option was not taken forward as it is not feasible within the current legal framework and it was deemed disproportionate to seek the relevant legislative changes. Furthermore, this option would not have applied to joint ventures that are majority controlled by more than one NHS provider.

4. Amending guidance on CRS to incorporate large new care model contracts (ie ACO contracts).

This would bring these services within NHS Improvement’s oversight under the Continuity of Services licence conditions. This option was not taken forward, because oversight of such providers is limited to financial performance and excludes oversight of quality, leadership and operational performance. Furthermore, clinical commissioning groups (CCGs) have discretion as to how they follow the guidance on CRS, which means that designations may not cover all relevant providers, for instance excluding NHS-controlled providers not holding an ACO contract.

5. Introducing additional safeguards and oversight into the contracting process for ACOs.
This option was not taken forward because, although it would have enabled CCGs to monitor providers’ performance, it would establish no formal powers for NHS Improvement to regulate NHS-controlled providers. In particular, NHS Improvement would not be able to require improvements from providers or offer targeted support. It would also exclude NHS-controlled providers that did not hold an ACO contract.

Expected costs

The cost to NHS-controlled providers is assessed as being low because these providers are likely to share expertise and staff with their NHS parent organisations. This cost includes:

- time required for providers to understand the new obligations and associated guidance
- cost to providers of ongoing compliance activities, including monthly financial submissions, relationship meetings and internal reporting (trusts will often use measures in the SOF as the basis of internal reports).

There would also be costs where NHS Improvement may offer support or intervene where the provider is in risk of breaching its licence. Our main programmes and interventions are outlined below. They are all estimated to have a net benefit to providers, with numerical estimates provided where they have been able to be quantified.

The cost to NHS Improvement of implementing the extra oversight is assumed to be low because NHS Improvement staff are already familiar with the guidance and oversight, given the publication of the SOF in September 2016.

Furthermore, the number of providers that this extra oversight would apply to is low and these providers would already be subject to most licence conditions as ‘independent providers’. Oversight added through the introduction of the proposed NHS-controlled provider licence condition would have an incremental impact beyond the oversight that they are currently subject to.

The estimates are summarised in the table below.
### Table 1: Estimates of expected cost and magnitude

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<thead>
<tr>
<th></th>
<th>Expected cost</th>
<th>Estimated magnitude</th>
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<tbody>
<tr>
<td><strong>Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time required to understand the new obligations and associated guidance</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Monthly financial submissions</td>
<td></td>
<td>Medium</td>
</tr>
<tr>
<td>Relationship meetings</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Internal reporting</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td><strong>NHS Improvement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time required to understand the new obligations and associated guidance</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Receive and review monthly financial submissions</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Relationship meetings</td>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>

### Expected benefits

NHS Improvement’s regulatory oversight aims to:

- a. drive up standards
- b. identify issues and problems early and thereby mitigate against the risk of failure
- c. help solve problems as they arise.

To attempt to quantify these benefits we have largely focused on (b) and (c).

In estimating the benefit of (b), we have drawn on the costs of failure of the UnitingCare Partnership contract, which did not fall under Monitor’s licensing regime at the time. We use it as a case study of the sort of organisation that may, under our proposals, be subject to the NHS-controlled provider licence condition and the potential costs of an absence of oversight of NHS-controlled providers.

If the joint venture had fallen under Monitor’s licensing regime, our assumption is that the magnitude of risk within the contract could have been identified early, and therefore failure avoided, reducing or avoiding the monetary and time costs.
Case study: UnitingCare Partnership

The National Audit Office in its Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough concluded:

“Monitor is the regulator for foundation trusts but its remit only covered part of the transaction. UnitingCare Partnership was a limited liability partnership. As a separate legal entity it was subject to company law and was not regulated by Monitor. Monitor’s approach to risk-assessing new transactions led it to consider the implications of the contract for only one of the two trusts comprising the partnership, Cambridgeshire and Peterborough NHS Foundation Trust.

Neither the Department of Health, nor NHS England, nor Monitor was responsible for holding a holistic view of the contract, or assessing whether the anticipated benefits would merit continued support of this innovative approach. The wasted cost to the NHS of the contract set-up and bidder costs was £8.9 million.”

As for meeting our aim under (c), NHS Improvement helps to solve problems as they arise at trusts through the SOF, which it uses to monitor providers’ performance and identify and address support needs. We have collated programmes tailored to address a variety of support needs, including programmes to improve quality of care, special measures for quality and financial reasons, agency controls and the Financial Improvement Programme.

Improvements in the quality of care: NHS Improvement offers support to trusts to improve their quality of care, such as the Patient Safety Collaborative programme that provides training and support to trusts on improving patient safety. Trusts themselves are, of course, responsible for the general improvement in quality (as measured by CQC ratings) across the sector. We have seen 24 providers rated as ‘inadequate’ or ‘requires improvement’ at the start of 2016/17 achieving a ‘good’ or ‘outstanding’ rating during the year. We believe the support NHS Improvement offers has contributed to their success.
An incremental benefit of extending this support will be that NHS Improvement can provide support to NHS-controlled providers where required. Only a subset of NHS-controlled providers is likely to require and access such support to provide high quality care, so it is estimated that this programme would have a ‘medium’ impact on the quality of care provided by NHS-controlled providers.

**Special measures for quality reasons**: NHS Improvement provides mandated support to challenged providers and those in special measures for quality. Such support includes buddy support from other trusts focusing on key clinical areas, leadership and governance reviews, bespoke leadership and organisational development packages, project management office support and various reviews and audit. Nine trusts exited special measures for quality during 2016/17 and five trusts exited special measures for quality during 2015/16.

An incremental benefit of extending this support will be that NHS Improvement can provide support to NHS-controlled providers where required following a CQC inspection. Only a small subset of NHS-controlled providers is likely to require and access such support so it is estimated that this support would have a ‘low’ impact on the quality of care provided by these providers.

**Special measures for financial reasons**: NHS Improvement helps to ensure that trusts’ financial systems and controls operate effectively, trusts improve efficiency and productivity, and the way they manage their workforce and plan rotas, and ensure they get paid appropriately for their work. The trusts in special measures for financial reasons showed an improvement of £95.8 million in 2016/17 outturns compared to forecast outturns when they entered the programme. There is potential for greater financial benefits in 2017/18 than in 2016/17 due to the full year effect of the programme – plans may take time to implement and recurrent savings may follow in the years ahead.

An incremental benefit of extending this support will be that NHS Improvement can provide support to NHS-controlled providers where their financial situation requires it. This may be the case not only for providers delivering care themselves, but also where the provider subcontracts the care delivery, so the impact on the finances of these providers is estimated to be ‘medium’.

**Agency controls**: NHS Improvement has introduced a variety of measures to curb spending on agency staff. The agency rules include trust expenditure ceilings, price
caps, maximum wage rates and mandatory use of approved framework agreements. Agency controls have led to a £700 million reduction in agency expenditure in 2016/17 compared with 2015/16.

There will be an incremental benefit of extending this programme to all NHS-controlled providers by supporting them to curtail spending on agency staff. Therefore extending the agency controls to NHS-controlled providers is estimated to have a ‘medium’ impact on their agency spend.

Financial Improvement Programme: The Financial Improvement Programme’s key objective is to provide support to trusts to reduce costs materially, thereby significantly improving outturns while maintaining delivery of safe care. The net benefit of the Financial Improvement Programme in 2016/17 was £75 million.

Only a subset of NHS providers takes part in the Financial Improvement Programme. Under our proposals, if NHS Improvement’s oversight is extended to NHS-controlled providers, enabling them to access the Financial Improvement Programme, only a subset is likely to participate. The incremental impact of the programme on the finances of NHS-controlled providers is therefore estimated to be ‘low’.

The table below summarises the estimated incremental impact of NHS Improvement programmes, as outlined, to improve quality of care, special measures for quality and financial reasons, agency controls and the Financial Improvement Programme.

Table 2: The estimated incremental impact of NHS Improvement programmes

<table>
<thead>
<tr>
<th>Programme</th>
<th>Estimated magnitude of benefit</th>
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<tbody>
<tr>
<td>Improvements in the quality of care</td>
<td>Medium</td>
</tr>
<tr>
<td>Special measures for quality reasons</td>
<td>Low</td>
</tr>
<tr>
<td>Special measures for financial reasons</td>
<td>Medium</td>
</tr>
<tr>
<td>Agency controls</td>
<td>Medium</td>
</tr>
<tr>
<td>Financial Improvement Programme</td>
<td>Low</td>
</tr>
</tbody>
</table>
Q3: Do you think we have appropriately captured the costs and benefits of the oversight we are proposing to extend to NHS-controlled providers?

Key risks and assumptions

The key risk around the impact of this licence condition is the level of reporting on governance and finance required. We continue to work with NHS England, the Department of Health, CQC and NHS Digital to evaluate and rationalise the reporting requirements on all providers, aiming to achieve a clear reduction in burdens over time. This work would include NHS-controlled providers under our proposals.

Programme governance arrangements include risk management to ensure that policy development and implementation take account of any risks. The significant residual risks that will require ongoing attention include:

- Deterring involvement of general practice in new care models: The policy might deter GP involvement in the creation of new care models by increasing the burden of regulation on GPs. The policy does not aim to increase oversight of primary care. However, if GPs enter into a joint venture with an NHS trust or NHS foundation trust, they may face greater demands on their time due to the greater regulatory oversight that will apply to such providers. The reasons for the difference in oversight are outlined above and, we believe, outweigh the increase in regulatory burden. Individual GP practices are excluded from NHS Improvement oversight under the licence exemptions regulations.

- Failing to successfully implement the policy: Benefits from the proposed policy would be reduced if the associated monitoring and oversight arrangements were not implemented properly.

- Insufficient support: A lack of support for the proposals during consultation may mean that NHS Improvement does not adopt the policy.
Conclusions and next steps

NHS Improvement estimates that the benefits of our proposals to extend our oversight of NHS-controlled providers will outweigh the costs. To reach this conclusion, we have included NHS Improvement’s activities carried out to reduce risks, as well as those undertaken to promote improvements at NHS providers and across the sector. Neither set of activities would be undertaken in a ‘do nothing’ scenario, while introducing the proposed new licence condition enables NHS Improvement to carry these out for the proposed group of NHS-controlled providers.

NHS Improvement’s consultation on our proposals for oversight of NHS-controlled providers will remain open until 12 October 2017. Any comments on this impact assessment would be very welcome and will be considered before NHS Improvement finalises the proposal for licensing. Please feed back on the proposed licence and this impact assessment here.4

4 www.research.net/r/NHScontrolledproviders
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