NHS Improvement

Oversight of NHS-controlled providers: consultation response

February 2018

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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1. Introduction

NHS Improvement published a consultation on proposals for oversight of NHS-controlled providers that ran between 13 September and 12 October 2017.

The consultation used a combination of ‘yes/no/undecided’ and open-ended questions covering in detail our proposals and associated impact assessment. We received responses from NHS trusts and foundation trusts, membership organisations and arm’s length bodies.

The main themes that emerged from consultation responses were:

- proportionality of oversight
- regulatory and administrative burden
- clarification of the scope of proposed oversight.

Section 2 explores these themes and how we will mitigate concerns raised.

Section 3 summarises how we will take forward the proposed changes.

Annex A answers some specific technical questions raised by respondents.

Annex B outlines case studies of hypothetical NHS-controlled providers.

Annex C sets out the NHS-controlled provider licence condition.

2. The main themes from consultation responses and our response

2.1 Proportionality of oversight

Respondents generally supported increasing oversight of providers delivering patient-facing healthcare, particularly where they deliver integrated care and are controlled by two or more NHS organisations. However, some respondents suggested that oversight should be proportionate to the nature of the services delivered by a provider. For instance, a wholly-owned subsidiary delivering only small amounts of pathology services compared with a joint venture that holds a contract with a large and mixed service scope.

Our response

We will apply the principles of proportionality in our oversight of NHS-controlled providers. In determining the level of oversight an NHS-controlled provider will be subject to, we will consider, among other factors, the scope of the services it provides, size of turnover and whether it is a wholly owned subsidiary or is jointly owned by a number of providers. We will be clear at the start with NHS-controlled providers about the oversight to which they will be subject, although this could change if there are any changes to its activities.

Some NHS-controlled providers, for instance small providers of pathology services, will be overseen using an adjusted approach under the *Risk Assessment Framework for independent providers of NHS services* (IP RAF) and will only experience lighter touch oversight and monitoring of their finances, likely on a quarterly basis. The IP RAF sets out the framework for monitoring independent providers of commissioner requested services, ie services a commissioner would find hard to replace if the existing provider stopped providing them. We will monitor this group of NHS-controlled providers using the IP RAF regardless of whether they are providers of commissioner requested services.

The second group of NHS-controlled providers will be overseen under the *Single Oversight Framework* (SOF) alongside NHS trusts and foundation trusts and will therefore be subject to greater levels of oversight across the five themes of the SOF – quality of care, operational performance, finance and use of resources, strategic change, and leadership and improvement capability. These providers will be placed in one of the four SOF segments to reflect the extent of their support needs. The SOF contains further flexibilities in terms of how we work with a given provider and to what extent monitoring under a certain theme applies. For instance, monitoring of a provider's A&E performance under the operational performance theme applies only where they deliver A&E services. How often we meet with a provider and how intensively we work with them also varies depending on their support needs as identified through our monitoring.

When we update the IP RAF and SOF guidance we will amend them to reflect the inclusion of NHS-controlled providers.

As part of this approach to oversight of NHS-controlled providers, we have made an amendment to the NHS-controlled providers licence condition (CP1) to enable us to request a statement from the NHS parent(s) confirming that the NHS-controlled provider has taken all the actions set out in its corporate governance statement applicable to the past financial year (please see NHS-controlled provider licence condition CP1(8)(b) in Annex C). This statement will give us further insight into how well the NHS-controlled provider is delivering on the requirements of good governance outlined in the NHS-controlled provider licence condition. We would expect the NHS parent(s) to want this assurance itself in any case. The statement will be particularly important for NHS-controlled providers overseen under the IP RAF, given that we will explicitly monitor only the finances of these providers.

2.2 Regulatory and administrative burden

Some respondents expressed concern that the regulatory and administrative burden associated with our oversight might increase running costs and thereby reduce the competitiveness of organisations set up by NHS foundation trusts, particularly in relation to independent sector organisations. Some respondents also felt the publication of NHS Improvement's judgements in the form of segmentation might further contribute to reducing the competitiveness of NHS-controlled providers.

Our response

The existing regime, in which there is greater oversight of NHS trusts and foundation trusts, creates a situation where independent providers and NHS trusts already face different levels of oversight. Extending increased oversight to NHS-controlled providers does not alter this, as it is consistent with the current system.

The increased oversight applied to NHS foundation trusts stems from their unique governance structure, importance in the NHS and accountability to the public. NHS foundation trusts also sit on the government's balance sheet. The licensing regime for NHS foundation trusts was subject to extensive consultation when it was introduced.

As explained in the consultation, our proposals for oversight of NHS-controlled providers are based on the fact that these providers deliver care on behalf of, and are ultimately controlled by, NHS providers (ie NHS trusts and/or foundation trusts). We believe that this is more pertinent to how these providers are overseen than their legal form. In summary, we want to maintain consistent oversight of NHS services delivered directly and/or controlled by NHS providers.

As explained in section 2.1, in implementing our proposals we will also be making sure that our oversight, and therefore the regulatory burden, is proportionate and does not impose undue burden or cost.

2.3 Clarification regarding the scope of proposed oversight

From the consultation responses it emerged that there was some confusion about the precise scope of our proposed oversight changes, in other words, which organisations would be included in the definition of NHS-controlled providers and how they would be overseen.

Our response

The oversight of NHS-controlled providers outlined here will affect providers where three conditions hold.

1. **They are not themselves an NHS trust or an NHS foundation trust.** We already oversee NHS trusts and foundation trusts under the SOF and are not making any changes to this oversight.

2. **They are already required to hold an NHS provider licence.** We are not making changes to which providers require a licence. Our oversight therefore only applies to the group of providers already required to hold a licence.

   All providers registered with the Care Quality Commission (CQC) and providing £10 million or more of NHS healthcare services are required to hold a licence unless exempt.

   Providers that are exempt from the requirement to hold a licence (subject to any overriding licence requirements, such as commissioner requested services) include:

   - NHS trusts
   - providers not required to register with CQC
   - small providers with less than £10 million applicable turnover
   - providers of only primary medical and dental services commissioned by NHS England or under delegated authority from NHS England (eg general practices or general dental practices that do not provide any other NHS services)
   - providers of only NHS-funded nursing care or continuing healthcare (eg care homes that provide no other NHS healthcare services).

   Please refer to the licence exemptions regulations for more detail on which organisations are required to hold a provider licence and which are exempt.

3. **They are ultimately controlled by one or more NHS providers (ie NHS trusts and/or foundation trusts).** The options for which definition of 'control' we should use as the basis for identifying NHS-controlled providers were:

   - International Financial Reporting Standard (IFRS 10)
   - European System of Accounts (ESA 10) implemented by the Office for National Statistics
   - Companies Act 2006.

No clear preference emerged from the consultation responses.

Our preferred option is IFRS 10 because it is consistent with how NHS providers prepare their accounts and submit their returns to us and is therefore familiar to providers.

To help clarify to which organisations our proposed changes in oversight will apply, we have outlined some case studies in Annex B.

For more detail on how IFRS 10 works in practice, please consult the published guidance,[1] but broadly speaking, directing the investee's financial and operating policies (either directly or by appointing the majority of the board of directors, or equivalent) indicates control.

Majority ownership (by one or more investors) would normally indicate control. Where there is no majority investor(s), a significant minority investor may exercise control where its power/rights are sufficient for it to unilaterally direct relevant activities.

Relevant activities could include:

- selling and purchasing goods or services
- managing financial assets
- selecting, acquiring or disposing of assets
- researching and developing new products or processes
- determining a funding structure or obtaining funding.

Where two or more investors have rights to direct different relevant activities, the investor with the current ability to direct the activities that most significantly affect the returns has power of control.

We will not include a definition of 'NHS controlled' in the licence itself but will make it clear when we publish the new licence that the basis for determining NHS control is IFRS 10.

[1] For instance *Under Control? A Practical Guide to IFRS 10 Consolidated Financial Statements*.

3. Summary of our position on oversight of NHS-controlled providers and next steps

Following consultation and detailed consideration of the main themes coming out of the consultation, our oversight of NHS-controlled providers is described below.

3.1 What are NHS-controlled providers?

NHS-controlled providers are providers that:

- are not themselves NHS trusts or NHS foundation trusts
- are required to hold a provider licence and
- are ultimately controlled by one or more NHS trusts and/or foundation trusts, where 'control' is defined on the basis of IFRS 10.

3.2 How will NHS-controlled providers be overseen?

NHS-controlled providers will be required to hold the provider licence, including the NHS-controlled provider licence condition, which mimics the NHS foundation trust licence condition and imposes requirements around good governance (set out in Annex C). They will be overseen either using an adjusted approach under the IP RAF or under the SOF, taking into consideration such factors as the scope of the services the provider delivers, the size of its turnover and whether it is a wholly owned subsidiary or is jointly owned by a number of providers.

3.3 Which powers of intervention apply in our oversight of NHS-controlled providers?

Our enforcement powers in respect of NHS-controlled providers remain unchanged and are set out in sections 105 and 106 of the Health and Social Care Act 2012 ('the Act'). Section 111 does not apply, as it applies only to NHS foundation trusts.

Section 105 of the Act describes 'discretionary requirements', which may include compliance requirements, restoration requirements or variable monetary penalties imposed if a provider is found in breach of its licence conditions. We may also accept 'enforcement undertakings' as described in section 106 of the Act. These are actions that providers commit themselves to taking and which we may decide to accept.

For more information please see the enforcement guidance.

3.4 What is expected of NHS-controlled providers and when will oversight 'go live'?

Alongside this consultation response summary, we have published some guidance outlining our oversight of NHS-controlled providers along with the new licence.[2]

We will approach providers that hold a licence and meet the accepted definition for NHS control with a request to revoke their current licence and to apply for the new licence, including the NHS-controlled provider licence condition outlined in Annex C. Our oversight will formally 'go live' from April 2018. We will discuss with the affected providers what this means in practice before this date. Any NHS-controlled providers formed after April 2018 will need to apply for the new licence.

We will keep under review our oversight approach to NHS-controlled providers, including the definition of 'control', to ensure it remains appropriate and fit for purpose given any potential changes in the provider landscape or the nature and scope of NHS-controlled providers that emerge in the future.

If you have any questions, please contact NHSI.NHScontrolledproviders@nhs.net

[2] https://improvement.nhs.uk/resources/oversight-nhs-controlled-providers

Annex A: Technical questions from respondents

1. Is the information-sharing as part of data returns to NHS Improvement breaching competition legislation?

We already collect information in relation to NHS trusts and foundation trusts for the purposes of our regulatory functions and not for sharing, except where there is a lawful or regulatory purpose. Where we do publish any information, we do so either in a consolidated form, so that information relating to a specific provider cannot be identified, or in a way that does not give any competitive advantage. This would also be the case for NHS-controlled providers and is in line with competition legislation.

2. Will NHS-controlled providers incur fees under these proposals?

No. We are not introducing fees.

3. Does the definition of NHS-controlled providers include subsidiaries that provide corporate services, looser arrangements, such as unincorporated joint ventures, or organisations that do not provide CQC-regulated activities?

No. NHS-controlled providers only include organisations required to hold a provider licence, as set out in section 2.3 of the consultation response summary. The examples listed in this question would not be required to hold a licence, because such providers must:

- be distinct legal entities
- deliver or subcontract more than £10 million of NHS healthcare services, which does not include corporate services
- be registered with CQC.

4. Is it appropriate to use IFRS 10 as the basis for the defining the scope of NHS-controlled providers, given that NHS Improvement is also seeking to cover bodies captured by IFRS 11?

IFRS 10 and IFRS 11 apply to the parent entity preparing its accounts. We are seeking to define the scope of NHS-controlled providers in terms of who controls the sub-entity in question. In saying “controlled by one or more NHS bodies”, the construct is theoretical: for a body controlled by three NHS providers, for example, there is no single set of accounts for those three providers that consolidates the entity under IFRS 10. We are taking the term ‘control’ as defined by IFRS 10 in terms of power to direct relevant activities as defined by that standard. In this example, the NHS providers together do control the entity. Each individual NHS provider will apply IFRS 11 in accounting for its share.

Annex B: NHS-controlled providers: case studies

Case study	Does the organisation qualify as an NHS-controlled provider?			Does our proposed change affect oversight of this organisation ?
	1. They are not an NHS trust/ foundation trust	2. They are required to hold a licence[3]	3. They are controlled by one or more NHS providers	
NHS trust	×	×	×	No
NHS foundation trust	×	✓	×	No
Corporate joint venture **Controlled by NHS providers** (ie one or more NHS trusts and/or foundation trusts) Delivering or subcontracting **>£10 million** of NHS healthcare (eg community/mental health/acute/ pathology services)	✓	✓	✓	Yes
Corporate joint venture **Controlled by NHS providers** Delivering or subcontracting **<£10m** of NHS healthcare (eg delivering social/primary care)	✓	×	✓	No
Corporate joint venture **Controlled by GPs/independent sector providers** Delivering or subcontracting **>£10 million** of NHS healthcare (eg community/mental health/acute/ pathology services)	✓	✓	×	No
Corporate joint venture	✓	×	×	No

[3] Whether, in each case study, the organisation is required to hold a licence is subject to any overriding licence requirements, such as commissioner requested services.

Controlled by GPs/independent sector providers Delivering or subcontracting **<£10 million** of NHS healthcare (eg delivering social/ primary care)				
Contractual joint venture (ie no new organisation formed) Controlled by NHS providers	✓	×	✓	No
Organisation delivering non-healthcare services, eg estates and facilities, procurement Controlled by NHS providers	✓	×	✓	No

Annex C: NHS-controlled provider licence condition

Section 8: NHS-controlled providers

Condition CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

    a. have regard to such guidance on good corporate governance as may be issued by Monitor from time to time and

    b. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

    a. effective board and committee, or equivalent, structures

    b. clear responsibilities for its Board (or equivalent), for committees reporting to the Board and for staff reporting to the Board and those committees and

    c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).

5. The Licensee shall establish and effectively implement systems and/or processes:

a. (to ensure it operates efficiently, economically and effectively

b. for timely and effective scrutiny and oversight by the Board (or equivalent) of the Licensee's operations

c. to ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)

e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee (or equivalent) decision-making

f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence

g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery and

h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level, or equivalent, to provide effective organisational leadership on the quality of care provided

b. that the planning and decision-making processes of the Board, or equivalent, take timely and appropriate account of quality of care considerations

c. the collection of accurate, comprehensive, timely and up to date information on quality of care

d. that the Board, or equivalent, receives and takes into account accurate, comprehensive, timely and up to date information on quality of care

e. that the Licensee including its Board, or equivalent, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources and

f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board, or equivalent, where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place 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 this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

a. a corporate governance statement by and on behalf of its Board, or equivalent, confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

b. if required in writing by Monitor, a statement from its auditors or controlling NHS organisation(s) either:

i. confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its

corporate governance statement applicable to the past financial year, or

ii. setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

Follow us on Twitter @NHSImprovement

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