

Liberating the NHS: Regulating healthcare providers

The Department of Health published its fourth consultation document on the *White Paper* on Monday (26 July), on the subject of regulating healthcare providers. The consultation document covers the future role of Monitor and the future regulation of NHS foundation trusts. It is important to note that this is a consultation document. Some of the questions are wide and open, which means this consultation could see even more lobbying than usual, some of which has already started.

The consultation closes on 11 October 2010 and the Department says it will publish its response to views raised before the Health Bill is introduced in the autumn.

Monitor as an economic regulator

As set out in the consultation document, Monitor's role as the economic regulator of health and adult social care in England will extend to services but not to the supply of products or pharmaceuticals. The proposal is that Monitor will be obliged to exercise its role in a manner consistent with the Secretary of State's duty to promote a comprehensive health service in England. This means that it may sometimes need to balance its obligation to foster competition with its obligation to support service continuity. Monitor will be required to set out the reasons for its conclusions, which increases the risk of judicial review.

Monitor's four roles will be:

- o to license providers of NHS-funded health services - with general or special conditions;
- o to fix prices for NHS health services - where required (within the framework being set by the National Commissioning Board);
- o to promote competition in health and adult social care, by weeding out anti-competitive behaviour, supported by research into the market; and
- o to support service continuity in NHS-funded health services - through the making of special rules and, where necessary, special administration.

In addition to these four main roles, Monitor will continue as the assessor for NHS foundation trusts, although its role will change (as noted below) to reflect its wider remit.

The document explains the intended link between Monitor's licence and the CQC's licence. If a provider loses its CQC licence, it will automatically lose Monitor's licence too.

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It is also suggested that in future Monitor could raise fees to cover its licensing role from those it licenses (as is normal in other sectors), rather than this activity being funded centrally. However, it would not be appropriate for all of Monitor's funding to come from licence fees, because Monitor's role in relation to competition regulation extends beyond NHS services to all providers of health care and adult social care.

The Government expects that Monitor's licence will require providers to supply the information Monitor needs to operate effectively and other rules to protect patients' and taxpayers' interests. Monitor will also be able to set special conditions which might look something like the undertakings the Co-operation and Competition Panel has been taking when approving vertical integration.

Although Monitor will remain an independent NDPB, it will not be entirely free. As now, it will be answerable to Parliament for the value for money it delivers. In addition, it will have an obligation to consider periodically whether the regulatory burden can be reduced and before introducing new rules (except in relation to competition) it will have to consult stakeholders and conduct an impact assessment. When setting prices, it will be obliged to have regard to making best use of the limited public funds available and must avoid unlawful state aid.

It is proposed that Monitor will arbitrate in pricing disputes and that its own pricing decisions could be referred to the Competition Commission by providers or the NHS Commissioning Board.

One further development in the Government's thinking on price-setting is that Monitor may after all have a role to play in establishing the framework for tariffs, because structure as well as price can have distorting effects on competition.

Monitor's role in relation to competition is to police anti-competitive conduct and to investigate complaints about commissioning practice. However, complaints about commissioning will have to be referred to the NCB first. From the consultation document it also appears that complaints about barriers to entry will instead be investigated by the Competition Commission and the question whether mergers are anti-competitive will be decided by the Office of Fair Trading and Competition Commission together. The consultation document also invites responses as to what might be required in order to create a level playing field.

The proposals for supporting continuity build on the existing "mandatory services" rules that apply to NHS foundation trusts. Under the new regime, it is suggested that any provider of "additionally regulated services" would have to give notice of any intention to change or cease provision of those services, and would be obliged to continue providing the services during the notice period. Monitor could require an "extensive" notice period where services were difficult to replace. Where the proposal arose in the context of an insolvency, Monitor could invoke the special administration procedure and secure the assets required to provide the service.

The consultation document does not describe the special administration procedure in detail, but the key elements appear to be:

- o it will apply to all providers of NHS funded services in relation to the licensed services;
- o special administration can be invoked at Monitor's discretion without political interference to protect essential services;
- o the special administration procedure will take priority over any other insolvency regime, which will be suspended for 14 days while Monitor decides whether to intervene; and
- o the cost of trading whilst in administration will probably be funded from a pool to which all licensed providers will be required to contribute based on their size and likelihood that they will need to call on the fund (but this is for Monitor to decide).

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The consultation document is silent on whether foundation trusts will now be able to charge their assets, or whether this is one of the restrictions the department will impose in its capacity as investor. However, as private sector providers are able to charge the assets they use to provide NHS services, the special administration procedure will need to look at restricting the rights of security holders and, of course, landlords, if the Government is to achieve its goal of ensuring those essential assets can be available both during and, if still required, after the period of special administration.

The future for NHS foundation trusts

Above, we used the full legal name of foundation trusts, but nowhere in the consultation document are FTs referred to as NHS foundation trusts, which begs the question whether after these changes foundation trusts will be considered part of the NHS or not.

The themes for this section of the consultation are encapsulated in five concepts:

- The coalition's belief that "the natural condition of organisations ought to be one of freedom rather than being shackled".
- Specific controls where required should come through licensing and contracting.
- Providers should compete on a level playing field (note, level rather than fair playing field, which was Labour's phrase).
- Foundation trusts "are already effectively social enterprises".
- It is inappropriate for Monitor to protect the public investment in foundation trusts.

From the detail, it is clear that there is less appetite for conferring freedom in some areas than in others. Whilst the Government can see the sense in removing the private patient cap, removing some of the obstacles for foundation trust mergers and allowing foundation trusts to borrow freely, the consultation document is less bullish than the White Paper on organisational form. The consultation document suggests that the advertised employee-led model might be available only for small providers of community services or for providers who have very few assets. Others might have to earn the trust of the public as (conventional) foundation trusts, having the opportunity to increase employee say only after three years as a foundation trust, retaining public membership and governor representation even after the change and only making this transition if they have the support of a positive vote by their board of governors. This means most NHS Trusts will still be expected to prepare to become foundation trusts under the current rules.

There is also mention of increasing the regulation in other areas: allowing governors to call meetings and ensuring that constitutional changes are made only with the approval of the governors and the directors (some FTs do not currently require a governor vote on changes). This is justified because it is envisaged that Monitor's role as the governance regulator of foundation trusts will diminish, so that Monitor's consent will not be required for changes to constitutions. The consultation document notes that constitutions will still need to comply with legislation, so for example the principal purpose (to provide goods and services for the purposes of the NHS in England) could not be changed. This contrasts sharply with the position of a private company engaging in health care, whose objects (principal purpose) can be very wide.

Finally, in recognition of the financial investment in foundation trusts and the changing role of Monitor, the consultation document proposes that the Department of Health should have some investor rights. Whilst the proposals are not detailed, this would be the first time the Department would have had rights over foundation trusts (however limited). The consultation document says these rights might be exercised by the Department directly or by a third party on their behalf.

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