MILLS & REEVE

briefing

February 2018

Update on the Single Oversight Framework and new rules for the NHS-controlled providers from April

It is three months since NHS Improvement last updated the Single Oversight Framework, so what difference has it made? And what about these new rules that will apply to Trusts' and Foundation Trusts' subsidiaries and joint ventures from April?

Although the revised Single Oversight Framework (SOF) goes further than its predecessor in emphasising the importance of Sustainability and Transformation Partnerships (STPs) (adding "assessment of system-wide leadership" as a measure of "Strategic change"), in practice we are not (yet) seeing STPs cited as the ground for intervention. This is perhaps slightly surprising given that the SOF already required NHS Improvement (NHSI) to consider providers' engagement with local partners and contribution to addressing system-wide challenges and it seems unlikely that there are no problems anywhere.

STPs need to ensure a system-wide approach to working

Even in Bristol, where the talismanic power of the STP had already been invoked once, the threat of intervention has receded. Back in October 2016, NHSI said "in Bristol… the STP process is indicating the benefits to service and financial sustainability of developing shared leadership arrangements across the acute providers." Now we are all smiles, although this may all be down to North Bristol NHS Trust's excellent work in turning itself around.

This may change, of course, but it may not need to change. It seems that peer pressure may be sufficient to plug the gap. For example, the Government's recently-published response to the Naylor review of NHS property and estates again emphasises the importance of system-wide working and means that the STP may not get the capital it desires unless everyone plays their part. If Trusts opt not to play nicely with others, the Framework clearly says NHSI will consider "the nature of providers' relationships with local partners, their role in any agreed service transformation plans, and how far these plans have been implemented" in rating their performance under the "Strategic change" theme.

New rating under the Use of Resources assessment framework

The revised SOF also introduced a new Use of Resources (UoR) assessment framework. Non-specialist acute providers are the first to receive this new rating, so specialist acute, mental health, community and ambulance trusts will not have been assessed yet. This raises the question what benchmarks would call for intervention where the provider has not yet been assessed for UoR. The approach adopted by the SOF in such cases is to use the provider's finance score together with "other evidence of whether a provider is making optimal use of its resources." What this might mean is probably indicated by the following trigger of potential support: "any other material concerns about a provider's finances or use of resources arising from intelligence gathered by or provided to NHS Improvement."

Well-led framework is a further reminder of the need to participate fully in the local economy

The last major structural change is the introduction of the joint well-led framework by NHSI and the Care Quality Commission (CQC).

Guidance under this head includes a further reminder of the need to participate fully in the success of the local health economy as well as NHSI's own well-led guidance (from June 2017). The three triggers under this theme (leadership and improvement capability) are a CQC well-led rating of "requires improvement" or worse, concerns from trends in organisational health indicators, and "other material concerns about a provider's governance, leadership and improvement capability, arising from third-party reports, developmental well-led reviews or other relevant sources.". The organisational health indicators are staff sickness, staff turnover, the annual staff survey and the proportion of temporary staff (for which the measure is agency costs/total pay bill).

The difficulty in assessing the impact of any of these changes derives from the opacity of provider segmentation process. While we might know that a Trust is in segment three (and thus being offered "mandated support"), from the published data it is not easy to determine how it got there. So it may be that these changes are already working through the system, but that their effect will only really be known in any given case when things have reached such a head that NHSI has to go into print about its reasons for intervention.

Cunning Trusts may be wondering whether all of this hassle could be avoided by transferring services into a company, either wholly-owned or shared with other NHS bodies. As reported by the *Health Service Journal* recently, this has certainly become much more common than when we established the first such companies over ten years ago.

April sees another regulatory change for NHS-controlled providers. This has implications for joint ventures and subsidiaries.

Another regulatory change which will come into effect in April will make NHS-controlled providers subject to the same oversight through Monitor's provider licence as FTs and NHS Trusts. This is a crucial point.

An IT joint venture, like the one between The Royal Marsden and Chelsea and Westminster FTs will not be affected, because it does not provide clinical services and therefore does not need a provider licence. A pharmacy subsidiary may also be exempt, depending on what services it offers. A pathology provider structured as an NHS joint venture or subsidiary of an NHS Trust of FT, on the other hand, will be affected by these changes (subject to the turnover threshold) because it is already required to hold a provider licence (and register with the CQC).

While this levels the competitive playing field as between Trust-delivered and subsidiary-delivered services, it actually has the opposite competitive effect between NHS-controlled and private sector-controlled providers, who are subject to the lighter touch independent sector licensing regime.

NHS-controlled providers who are below the turnover threshold (but would otherwise be required to register) will be subject to a modified version of the risk assessment that applies to independent sector providers, but even this is not parity because that framework only applies to services commissioners have designated as "commissioner requested services" – essentially, services that are too important to be allowed to fail.

Unlike NHS-controlled providers with similar attributes, independent providers who are below threshold and do not deliver commissioner requested services are exempt from the NHS provider licence regime. This presents an interesting challenge. As a result of the Lansley reforms, the Secretary of State has a duty (under section 1G of the National Health Service Act 2006) to monitor whether providers of NHS-funded health care are being treated fairly.

For the time being (well, from April) the new NHS-controlled providers regime will apply and Trusts and FTs should be considering now what the implications will be for their joint ventures and subsidiaries.

Tim Winn
Partner
T +44(0)121 456 8355
tim.winn@mills-reeve.com