Consultation on proposed updates to the risk assessment framework for independent sector providers of NHS services

February 2020

NHS England and NHS Improvement

Contents

1. Introduction

This consultation document proposes updates to the risk assessment framework for independent providers of NHS services (IPRAF), which was published in April 2014 at the same time as the regulatory and oversight regime for independent sector providers of NHS services started.

The consultation is aimed mainly at licensed independent providers of commissioner requested services (CRS), but also contains important information for all other licensed independent providers, including NHS-controlled providers[1] that have been told they will be regulated under the IPRAF. The proposed updates have no implications for our oversight of NHS trusts or foundation trusts.

Since April 2014, certain independent sector providers of NHS services have been subject to NHS Improvement's regulatory and oversight system (in this document, references to NHS Improvement[2] are references to Monitor). Independent providers of NHS services must hold an NHS provider licence (unless exempt) and must comply with its conditions.

Section 5 of the licence sets out conditions for monitoring and safeguarding essential healthcare services, known as commissioner requested services. CRS are services that commissioners have formally told us need the protection of Section 5 continuity of services provisions because those services would be hard to replace if the CRS provider got into difficulty; removing them would increase health inequalities and/or make other related services unviable. A provider is not subject to Section 5 unless it provides CRS.

Providers of CRS are subject to financial oversight by NHS Improvement, which aims to reduce their risk of failing financially and reduce the impact on patients if a provider does fail. The IPRAF describes how these providers are monitored.

[1] https://improvement.nhs.uk/resources/oversight-nhs-controlled-providers/
[2] NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority and several other bodies.

2. Rationale for the proposed updates and expected benefits for providers

Since 2014 our regulation of the independent healthcare sector and our understanding of the drivers of financial risk have matured and evolved. As a result, we can improve our monitoring approach and benefit the providers we oversee.

In designing the proposals, we were aware of the opportunity to create benefits for providers and where possible reduce the burden of regulation. In our view, the proposals will benefit providers by:

- focusing information requirements where they add most value to a risk assessment
- providing valuable downside risk analysis into Year 2, which will also support the going-concern assessment required by auditors
- streamlining our approach to ensure it is timely, efficient and – at busy times of year for providers – less likely to clash with external audit activities
- reminding the sector that licensing and regulation of independent providers of NHS services remains a legal function of NHS Improvement.

3. Summary of proposed updates for providers of CRS

Under the current IPRAF, a continuity of services risk-rating (CoSRR) score is determined for each provider of CRS, using two financial metrics. A score of 1 represents the highest level of risk, and a CoSRR score of 4 is the lowest level of risk (see Section 4 for more detail).

Table 1 summarises the proposed updates to existing provisions in the IPRAF covered in this consultation.

Table 1: Summary of proposed updates

Making changes to our metrics	Balance our approach to risk assessment by: • introducing an operating margin CoSRR metric • recognising zero debt in the capital services capacity ratio scoring • creating an average risk rating but with two overriding rules.
Refocusing outer-year monitoring	For all providers, reduce the number of years' forward-looking data in our standard templates to one. For providers delivering >£5 million of CRS, collect a board-approved downside risk analysis in management's own format for Year 2.

Widening the range of factors that may be considered as part of the overall risk assessment	To include: • the value of liquid investments • group treasury policies • the materiality of contracts due for reprocurement • where relevant, sudden drops in the share price of the parent/ ultimate controller/monitored entity • a charity's own reserves policy.
Adjusting annual plan review (APR) timescales	Align the APR budget collection template submission with the Q4 template submission, one month after year end.
Monitoring frequency for CoSRR 3 and 4	Make routine monitoring quarterly in frequency.
Monitoring frequency for CoSRR 2	Introduce flexibility to monitor providers either quarterly or monthly, depending on the underlying reasons for the risk-rating score.

The reason for each proposed update, the expected benefits, and consultation questions are set out in sections 4 to 8.

4. Making changes to our metrics

Introducing an operating margin CoSRR metric

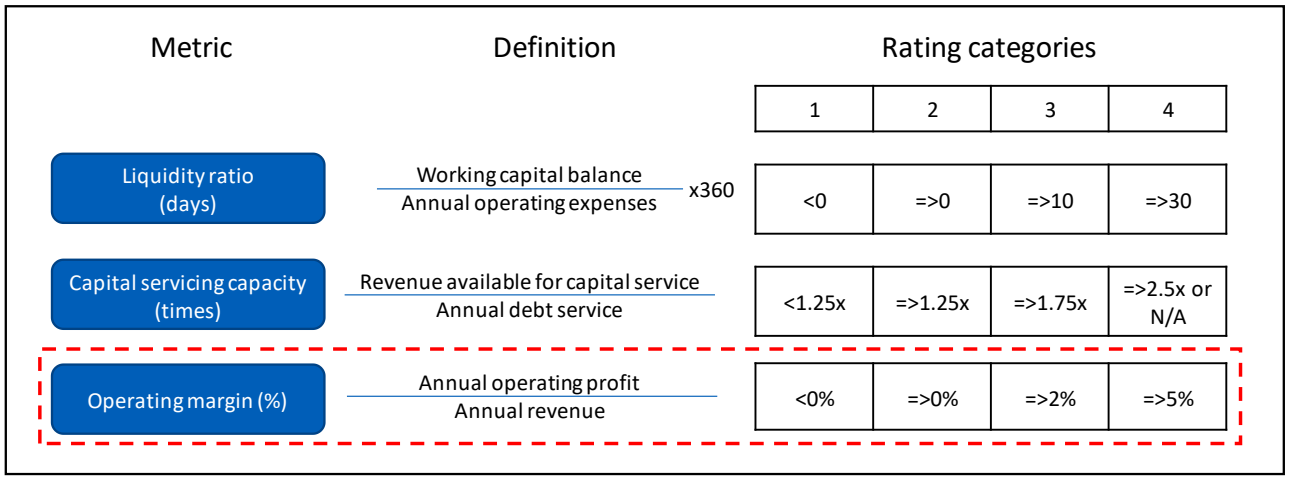
There is an opportunity to balance our approach to risk assessment to ensure that risk ratings better reflect the level and distribution of risk we believe exists across the providers of CRS we oversee. Under the current assessment framework, only two CoSRR metrics are calculated. These are liquidity and capital servicing capacity, as shown in Figure 1.

Figure 1: Continuity of services risk ratings under the current IPRAF

Metric	Definition	Rating categories			
		1	2	3	4
Liquidity ratio (days)	Working capital balance / Annual operating expenses x360	<0	=>0	=>10	=>30
Capital servicing capacity (times)	Revenue available for capital service / Annual debt service	<1.25x	=>1.25x	=>1.75x	=>2.5x

However, these metrics alone do not reveal relative performance period to period or whether performance is stable or deteriorating. This is likely to be a key area of interest to us, to spot potential issues early. We therefore propose to introduce a third CoSRR metric for operating margin, as shown in Figure 2 below.

Figure 2: Proposed introduction of an operating margin CoSRR metric



This change will:

- ensure the CoSRR captures deteriorating financial performance earlier, enabling earlier escalation where appropriate
- highlight whether the provider is generating cash to cover costs of capital
- better highlight situations of concern, specifically (1) where a provider has a strong balance sheet, but the financial position is being weakened by trading performance and (2) where a provider has a weak balance sheet and its going-concern status is sensitive to changes in operating profit.

It is important for providers to understand that when looking at operating margin, our main concern is the erosion of reserves, not profit generation or profit motive. The operating margin CoSRR thresholds have been set to reflect this in recognition that some organisations lease rather than own buildings and/or may operate on a not-for-profit strategy that we would not wish to influence or penalise.

In most cases (ie for companies), operating margin will align to normalised EBITDA. The way we will calculate this for companies and charities is shown in Figure 3 below.

Figure 3: Calculating operating margin

For charities	£	For companies	£
Total service revenue	X	Total service revenue	X
Revenue grants	X	Other operating income	X
Voluntary income donations	X	Staff costs	(X)
Voluntary income legacies	X	Property and asset rentals	(X)
Activities for generating funds	X	Defined benefit pension scheme service cost	(X)
Other incoming resources	X	Building repairs and maintenance expense	(X)
Staff costs	(X)	Other operating expenses	(X)
Property and asset rentals	(X)		
Defined benefit pension scheme service cost	(X)		
Building repairs and maintenance expense	(X)		
Other resources expended	(X)		
Operating margin (numerator)	**X**	**Operating margin (numerator)**	**X**
Total service revenue	X	Total service revenue	X
Revenue grants	X	Other operating income	X
Voluntary income donations	X		
Voluntary income legacies	X		
Activities for generating funds	X		
Other incoming resources	X		
Total income (denominator)	**X**	**Total income (denominator)**	
Operating margin (%)	**X%**	**Operating margin (%)**	**X%**

Q1: Do you agree or disagree with the introduction of the proposed operating margin metric?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

Q2: Do you agree or disagree with the proposed thresholds for the operating margin CoSRR?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

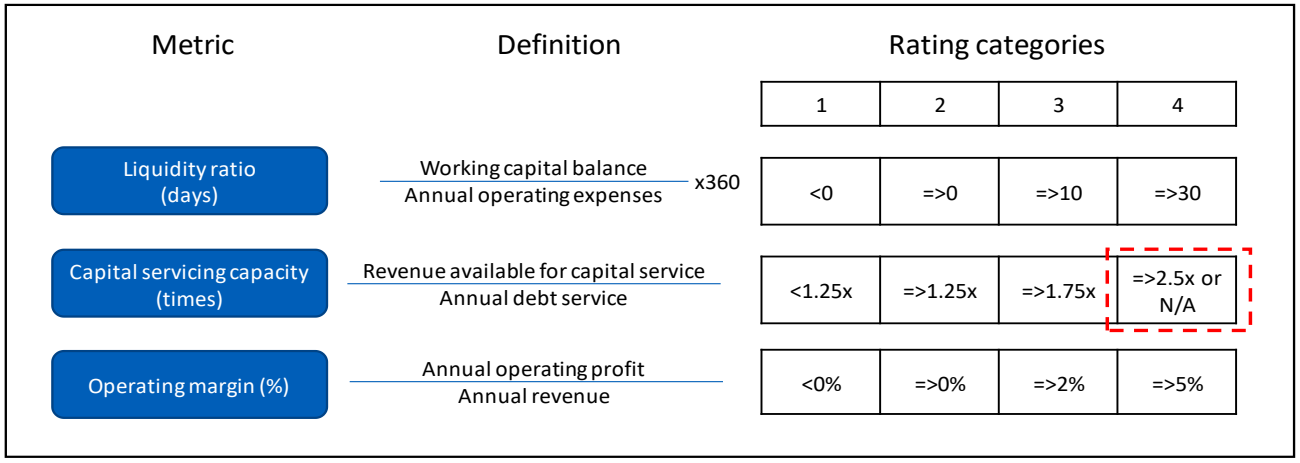
Recognising zero debt in the capital servicing capacity ratio scoring

Providers' CoSRR calculations need to formally reflect the lower-risk profile that carrying no debt brings, to ensure our risk ratings are truly balanced.

Under the current framework, providers with no debt or equivalent capital servicing requirements are excluded from being assessed under the capital servicing capacity CoSRR. Instead they are solely assessed under the liquidity CoSRR. This means the calculated CoSRR does not reflect their lower-risk attribute of carrying no debt.

We therefore propose to give providers with no debt the benefit of a CoSRR 4 capital servicing capacity rating, as shown in Figure 4. As previously stated, a CoSRR of 4 represents the lowest level of risk.

Figure 4: Proposed recognition of zero debt under capital servicing capacity CoSRR metric



Making this change will ensure our risk assessment through the CoSRR calculations reflects the lower-risk nature of carrying no debt. This change would also mitigate unintended consequences, such as a provider taking on a small amount of debt to improve its overall CoSRR.

Q3: Do you agree or disagree with the proposed CoSRR 4 rating for providers with zero debt or equivalent obligations such as finance leases?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

Creating an overall risk rating with two overriding rules

Because we want to create more balanced risk assessments, we need to formalise the approach to averaging providers' CoSRR scores.

Under the current framework, separate CoSRRs are generated for providers' liquidity and, if applicable, capital servicing capacity. The current framework is silent on whether CoSRR scores should be aggregated.

However, we note that by not averaging scores it is not possible to provide a single view of risk. We also note feedback from providers that our approach is not clear.

We therefore propose to calculate an average risk rating for each provider based on an average of the three CoSRR scores. Each score would have equal weighting.

Averaging scores is consistent with the approach adopted under the current Single Oversight Framework for NHS trusts and foundation trusts.

We also propose to introduce two overriding rules to the aggregated risk rating:

- if a provider scores a CoSRR 1 on one metric, its overall rating cannot be greater than a CoSRR 2
- if a provider scores two CoSRR 1s, its overall rating cannot be greater than a CoSRR 1.

The reason for introducing overriding rules is that they ensure an average score supported by one strong performing metric does not mask emerging risk. Mathematically this is necessary with the introduction of a third metric.

Q4: Do you agree or disagree with the proposed calculation of an overall CoSRR score with underpinning overriding rules?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

Interpreting your risk rating – update to risk-rating consequences

Given the proposed changes to our metrics, we need to make minor changes to the description of risk-rating consequences. The current provision is shown in Figure 5 with the updates reflected in Figure 6.

Figure 5: Risk-rating consequences under the 2014 IPRAF

Risk rating	Description of consequences
4	Low risk – Monitor continues to monitor performance based on the size and risk
3	Emerging or residual financial concern – we may perform monthly monitoring
2	The financial position is such that the provider may be subject to investigation of its CoSR licence conditions. We may also start taking an active role in ensuring continuity of services using provisions in the relevant licence conditions, e.g. requesting the co-operation of the provider to assess risk to services; preventing the disposal of assets use in the provision of CRS.
1	As level 2 above and in addition in extreme cases Monitor may consider the level of risk represents financial distress and initiate contingency planning and/ or other action to ensure continuity of services and access.

Figure 6: Proposed risk-rating consequences under the updated IPRAF

Risk rating	Description of consequences
4	**Low risk –** NHS Improvement will continue to review performance on a routine quarterly basis.
3	**Residual risk –** the financial position is such that where we have residual concerns we may request additional information and/ or hold more detailed conversations but routine quarterly monitoring will be maintained.
2	**Structural but stable risk** - the financial position is stable but lacks resilience. We are likely to request additional information and/ or hold more detailed conversations but routine quarterly monitoring is likely to be maintained. *Or…* **Emerging concern** – where sudden or sustained deterioration of one or more CoSRR metrics is observed we are likely to initiate **monthly monitoring** and may consider opening an investigation to determine whether there has been a breach of continuity of services licence conditions. If an investigation finds that a breach has taken place we may take action against a provider to require it to put remedies in place. In some cases we may also start taking an active role in ensuring continuity of services using provisions in the relevant licence conditions, e.g. requesting the co-operation of the provider to assess risk to services; preventing the disposal of assets use in the provision of CRS.
1	**Actual concern** - providers in this category are highly likely to be experiencing financial stress sufficient for NHS Improvement to open an investigation and consider taking an active role in ensuring continuity of services as set out under 'emerging concern' above. Providers scoring CoSRR 1 will be placed on monthly monitoring.

This change will ensure providers are clear about the level of risk we believe their organisation presents to continuity of services and the possible action we may take.

Providers should be aware that in setting these risk ratings it is not our intention to routinely require providers to aspire to a 'low-risk' rating.

We recognise that some organisational forms such as social enterprises may naturally operate at steady state as a CoSRR 2 (structural but stable risk) or CoSRR 3 (residual concern). This is appropriate because of their non-profit and community-focused intentions, but a CoSRR 2 score is a reminder of such organisations' resilience to financial stress.

Because the portfolio of licensees is a non-homogenous set of legal and corporate forms with differing access to capital, in some cases the calculated risk rating may show a higher degree of risk than is actually present: for example, in a debt-financed group with comparatively low levels of balance sheet reserves or liquidity but access to other sources of capital.

The opposite may also be true, and there may be examples of providers rated 3 or 4 that have lost a major contract for which enhanced oversight is appropriate during periods of restructuring, etc.

As such, providers should bear in mind that the calculated CoSRR is our starting point for assessing risk to continuity of services, and we consider a range of risks or mitigations. This is discussed in Section 6.

To understand the impact on monitoring frequency of the updated risk-rating consequences, see sections 7 and 8.

5. Refocusing outer-year monitoring

There is an opportunity to refocus our information requirements by collecting less but better-targeted risk-focused information.

Under the current framework, the number of years' forward-looking data that we collect is dictated by the value of CRS delivered and the CoSRR score as shown in Table 2. For providers delivering more than £5 million of CRS, this can mean collecting up to three years of forward-looking data.

Table 2: Forward planning and monitoring frequency under the 2014 IPRAF

		Risk rating (liquidity and/or capital servicing capacity)			
CRS value	**Forward-looking**	**4**	**3**	**2**	**1**
>= £15 million	3 years	Quarterly	Quarterly/ monthly	Monthly	Monthly
<£15 million	2 years	Six-monthly	Quarterly	Monthly	Monthly
<£5 million	12 months	Annually	Six-monthly	Monthly	Monthly

We propose, for all providers, to reduce the number of years' forward-looking data collected in our standard templates to one.

For providers delivering more than £5 million of CRS per year, we propose to replace the collection of a forecast base case for Year 2 and in some exceptional cases Year 3 with a board-approved downside risk analysis for Year 2 only, as shown in Table 3.

Table 3: Proposed updates to forward planning and monitoring frequency

		Risk rating (liquidity and/or capital servicing capacity)			
CRS value	**Forward-looking**	**4**	**3**	**2**	**1**
>£5 million	2 years*	Quarterly	Quarterly	Quarterly/monthly	Monthly
<=£5 million	12 months	Quarterly	Quarterly	Quarterly/monthly	Monthly

*Year 1 in standard template and Year 2 as a board-approved downside risk analysis in management's own format.

The board-approved downside risk analysis for Year 2 will comprise management's income and expenditure and cash base case in their own format, plus the impact of a reasonable set of downside factors. This may include, for example, the loss of contracts due for reprocurement. As part of our discussions with management, we may ask questions on the impact of such factors on net earnings, reserves and cash and, where appropriate, any mitigating actions.

We are making this change in response to providers' feedback about the high-level assumptions needed to land on a single forecast in their submissions to us for two or three years ahead. Such assumptions may be highly uncertain – eg whether key contracts due for re-procurement are retained and on what terms, or what the run rate will be entering Year 2.

By collecting a board-approved downside risk analysis instead, we believe this change will result in a more insightful and valuable assessment of Year 2 risks. It will not create an additional regulatory burden, as it is likely to be consistent with management's preparation of a going-concern assessment required by external auditors.

We would also reasonably expect such analysis to be readily available in providers that deliver essential services at scale and for similar conversations to form a key part of the organisation's own board assurance process.

For clarity, while we are removing the routine requirement for some providers to submit a Year 3 forecast, we retain the right to request this in exceptional circumstances – for example, where a provider is delivering a longer-term strategic recovery plan.

Q5: For providers delivering more than £5 million of CRS, do you agree or disagree to replacing Year 2 and Year 3 base case forecasts with a board-approved downside risk analysis for Year 2 only?

Agree/ Neither agree nor disagree/ Disagree/ Don’t know

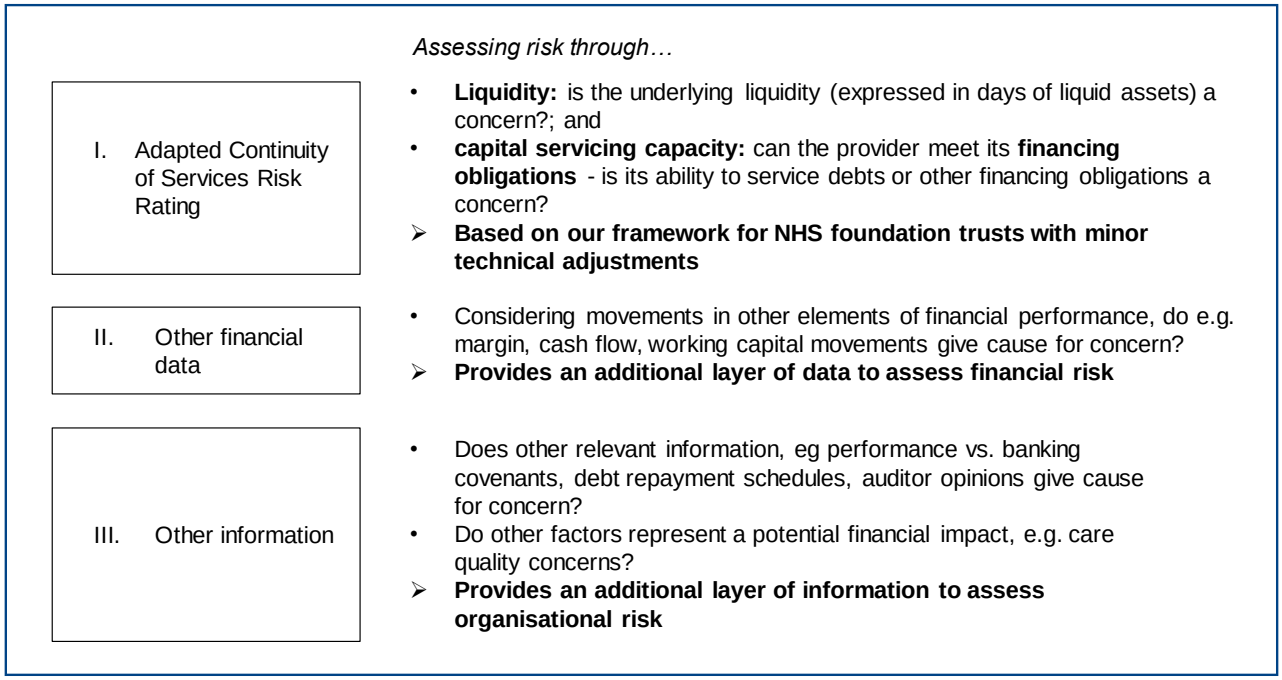
Please explain your answer or provide any other comments you have about this proposal.

6. Widening the range of factors considered in the overall risk assessment

We would like to be clearer about the full range of factors we may consider in our overall risk assessment.

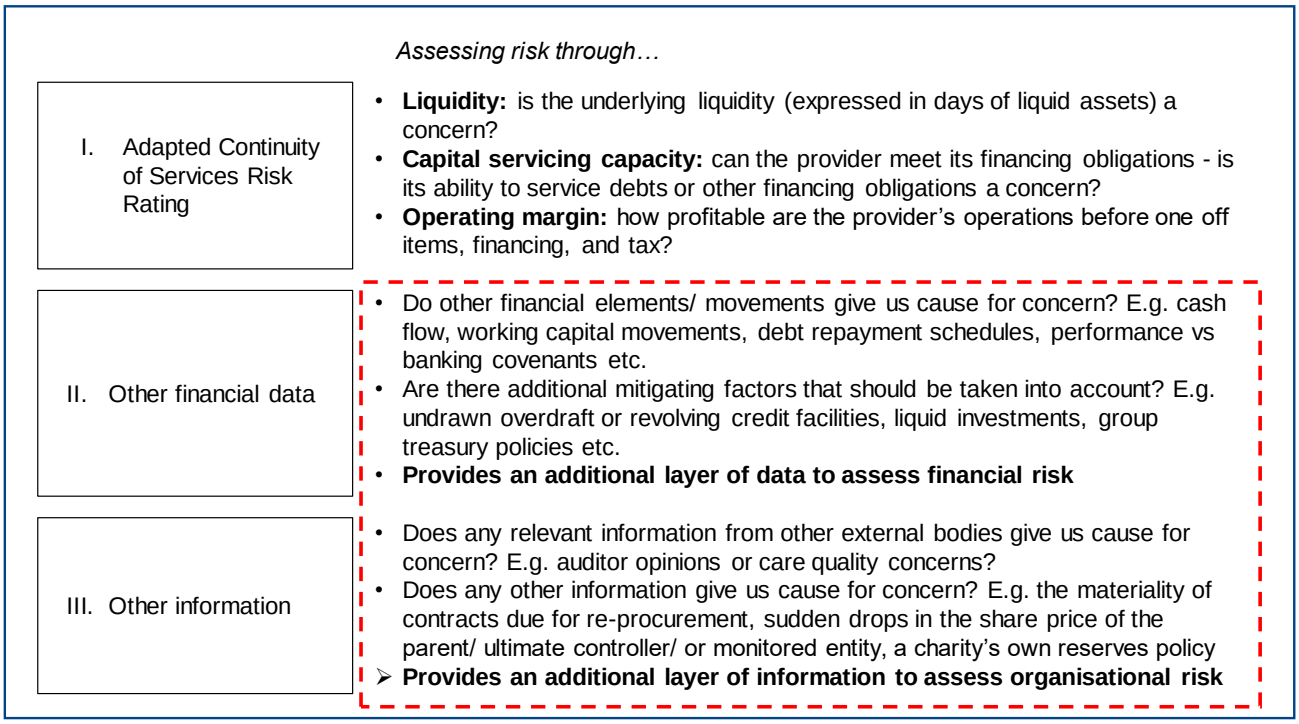
Under the current framework, in addition to calculating a liquidity CoSRR and a capital servicing capacity CoSRR, we share factors that may have a financial impact on an entity and its going concern status, as shown in Figure 7.

Figure 7: Current approach to assessing risk under the 2014 IPRAF



We propose to add to the list further factors we routinely consider as part of the risk assessment process, as shown in Figure 8.

Figure 8: Proposed updates to assessing risk under the IPRAF



The reason for updating our approach is to be transparent with providers about the factors we routinely consider and deem to be relevant to our wider risk assessment.

7. Monitoring frequency for CoSRR 3 and 4

There is a need to simplify monitoring frequency for providers rated residual or low risk – ie scoring CoSRR 3 and 4 – and formally align the IPRAF to current practice.

Under the current framework, providers scoring a CoSRR 3 or 4 can be monitored annually, six-monthly or quarterly depending on the value of CRS delivered, as shown in Table 2 above. This is potentially confusing for providers and does not align to current practice, which is to conduct routine monitoring on a quarterly basis.

We therefore propose to formally establish quarterly monitoring as routine in the IPRAF, as shown in Table 3 above.

This proposal reflects our view that annual and six-monthly monitoring represents too great an interval in which to have no early sight of emerging or actual risks to continuity of services. Other reasons for maintaining regular contact include finding out about material transactions, changes in ultimate controller, and discussing the impact of national policy changes.

Keeping in contact with providers' positions quarterly also allows lighter-touch monitoring than if we received only six-monthly or annual returns. For lower-risk providers this may mean fewer queries, shorter calls and in some cases no call at all.

Q6: For providers scoring CoSRR 3 or 4 do you agree or disagree with the proposal to make routine monitoring quarterly in frequency?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

8. Monitoring frequency for CoSRR 2

We need to acknowledge that providers can be higher risk and score a CoSRR 2 for structural rather than performance reasons, but where financial performance and financial position are currently and historically stable, this may present no imminent financial risk.

Under the current framework, any provider scoring a CoSRR 2 will be monitored monthly.

However, monthly monitoring may be unnecessarily burdensome where a provider's CoSRR 2 status can be directly linked to structural factors (eg high levels of investment in infrastructure) but financial performance and financial position are currently stable and have been so historically.

We therefore propose to introduce flexibility to monitor CoSRR 2 providers quarterly or monthly, according to the nature of risk presented.

This change enables us to adjust the intensity of monitoring, depending on whether risk factors for financial stress are present. It will mean that providers receive a proportionate level of monitoring, with monthly monitoring reserved for situations where clear risks to continuity of services emerge.

Q7: For providers scoring CoSRR 2, do you agree or disagree with the proposal to introduce the option to monitor them either quarterly or monthly at NHS Improvement's discretion?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

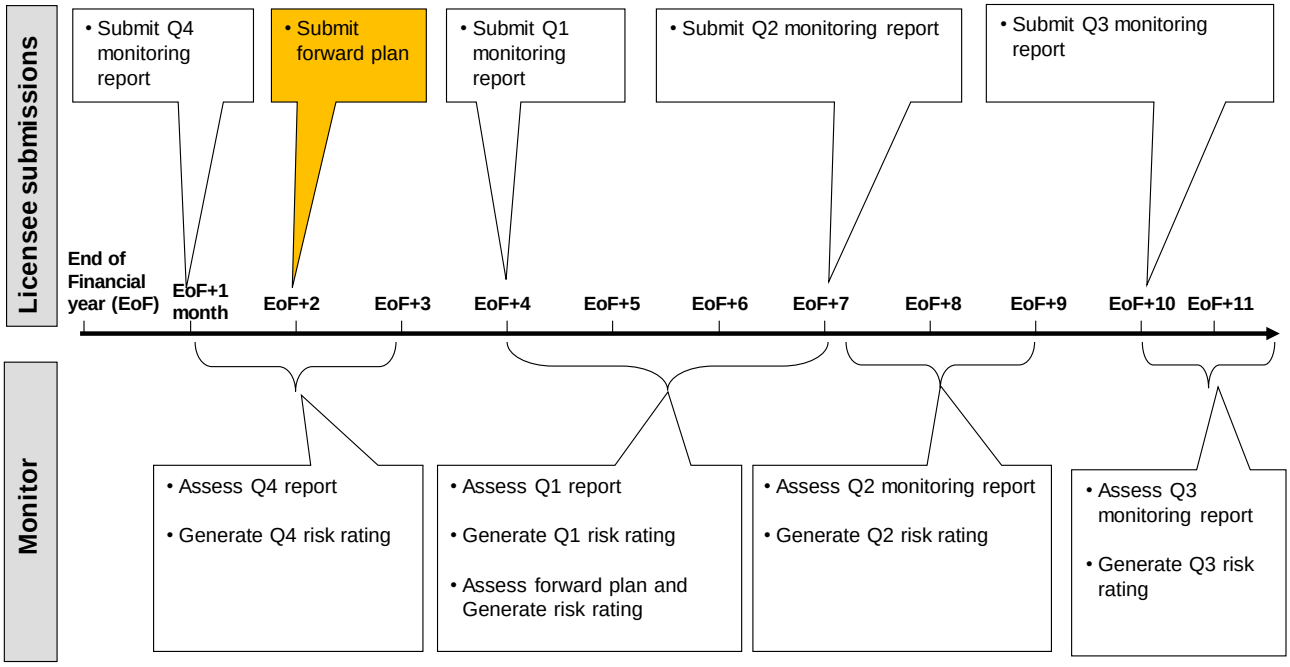
Please explain your answer or provide any other comments you have about this proposal.

9. Adjusting annual plan review timescales for providers of CRS

There is an opportunity to reduce the number of conversations we hold with providers at their year-end.

Under the current framework, the deadline for submitting the forward plan template for providers on a quarterly monitoring cycle is two months after the end of the financial year, as shown in Figure 9.

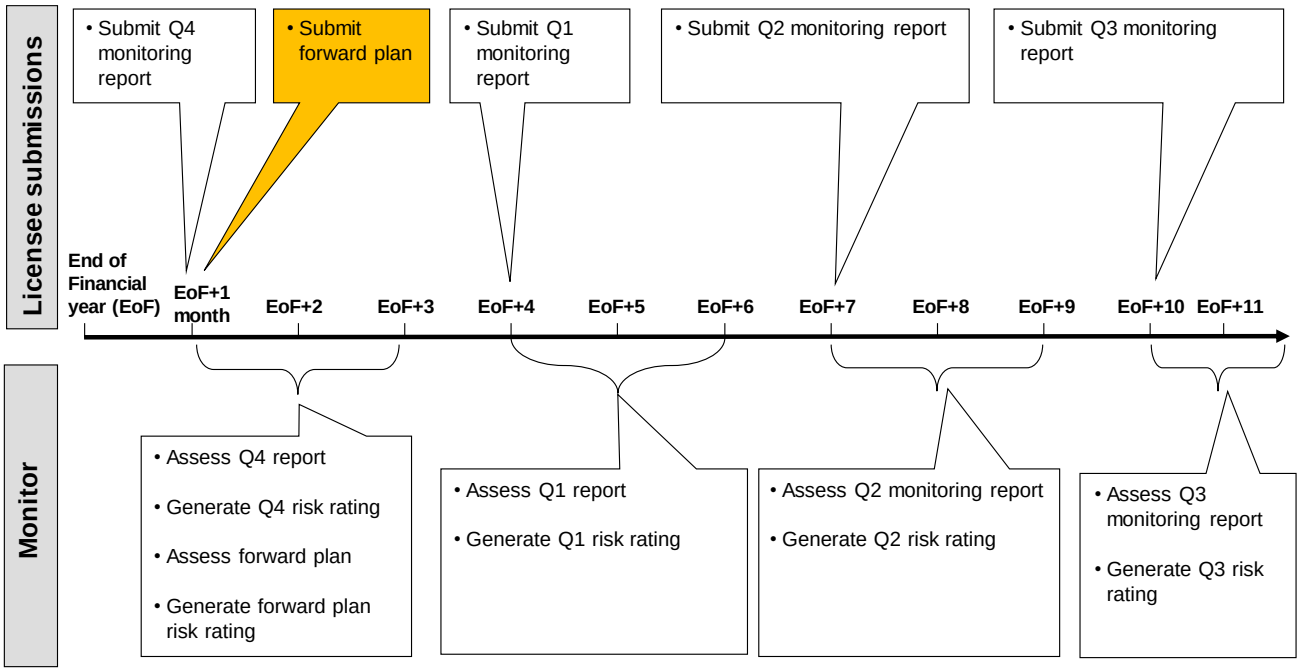
Figure 9: Annual plan submission deadline under the 2014 IPRAF



However, this is close to the Q4 template submission deadline of one month after year end and means we have two conversations in close succession. It can also mean that the annual plan review (APR) meeting may clash with external audit.

We therefore propose to combine the Q4 and APR process to start one month after the financial year end, holding one conversation rather than two, as shown in Figure 10.

Figure 10: Annual plan submission deadline under proposed changes



As well as streamlining our approach, this has the added benefit of bringing forward the APR meeting and making it less likely to clash with external audit activities.

It also enhances the effectiveness of our oversight. By holding annual plan conversations as early into the new financial year as possible, we gain the earliest sight of emerging financial risks and ensure our conversations remain meaningful and relevant: ie before any in-year reforecast has taken place.

We considered proposing to collect the forward plan template on the first day of the new financial year, but providers told us this could be too early as key contracts may not have been agreed, making the budget subject to change.

Q8: We propose to set the annual submission deadline to one month after a provider's year end to align with Q4 submissions. Do you agree or disagree with this proposal?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

10. Licence Condition G4: Fit and Proper Persons (for all licensed providers)

For all licensed independent providers, not just those providing CRS, NHS Improvement does not routinely monitor licence Condition G4: Fit and Proper Persons. Licensees are required only to certify compliance at the point of licensing but not thereafter.

We propose an annual self-certification against Condition G4 to bridge this gap in ongoing monitoring of regulatory compliance. The certification of compliance would be due annually within two months of the financial year end, which would be consistent with our approach to regulating other licence conditions, specifically Condition G6: Systems for compliance with licence conditions and related obligations, and CoS 7: Availability of resources.

There are wider benefits to encouraging boards to regularly consider whether they remain fit and proper, and this is appropriate in light of the Kirkup review.[3]

Q9: Do you agree or disagree with the proposal to collect an annual self-certification against licence Condition G4: Fit and Proper Persons?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

[3] https://www.england.nhs.uk/wp-content/uploads/2019/09/LiverpoolCommunityHealth_IndependentReviewReport_V2.pdf

11. Other proposed updates not subject to consultation

We intend to include four new sections in the updated version of the IPRAF:

- We will set out our standard approach and legal powers for monitoring CRS providers that are part of a larger group, where collecting information at a parent level may provide a better view on financial risk. This clarifies our established approach based on existing legal powers and is therefore not subject to consultation.
- Following the introduction of the NHS-controlled provider licence in April 2018, we will make clear how we regulate NHS-controlled providers where it is appropriate to do so under the IPRAF. This clarifies existing policy and is therefore not subject to consultation.
- We will include a dedicated section to clarify for all licensees the annual requirements for compliance with the provider licence. This relates to existing powers in the licence and is therefore not subject to consultation.
- Following the coming together of NHS England and NHS Improvement on 1 April 2019, we will clarify how regulatory decisions will be made by joint appointments (decision-makers who are jointly appointed across NHS England and NHS Improvement) and our controls to ensure licensees' business-sensitive information remains confidential.

12. Next steps and timeframes

We will analyse your responses and then publish a response summary after the conclusion of this consultation. We will then determine the updates to the IPRAF that are to apply.

We will aim to publish an updated IPRAF in March 2020 for implementation from 1 April 2020, subject to any appropriate transitional arrangements.

Q10: Do you agree or disagree with the proposed approach to implementing the updated IPRAF?

Agree/ Neither agree nor disagree/ Disagree/ Don't know

Please explain your answer or provide any other comments you have about this proposal.

13. Responding to the consultation

We look forward to receiving views on the questions above. You can respond to the consultation via our survey.[4] The consultation closes at **midnight on 28 February 2020**.

Please email nhsi.ipraf-consultation@nhs.net if you have any difficulty accessing the survey.

Please let us know if your response (or part of it) is confidential so that we can exclude this from our published summary of responses. We will do our best to meet all requests for confidentiality, but because NHS Improvement is a public body subject to the Freedom of Information Act, please note we cannot guarantee that we will not be obliged to release your response or part of it, even if you say it is confidential.

[4] https://engage.improvement.nhs.uk/independent-providers/consultation-on-proposed-ipraf-updates/

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