Classification: Official

Risk assessment framework and reporting manual for independent sector providers of NHS services

December 2020

Contents

About NHS Improvement

On 1 April 2019 NHS England and NHS Improvement began working in an aligned way as a single organisation, to better support the NHS and help improve care for patients.

This document is concerned with the statutory responsibilities of NHS Improvement for licensing and monitoring certain independent sector providers of NHS services (in this document, references to NHS Improvement[1] are references to Monitor).

Independent providers of NHS services must hold an NHS provider licence (unless exempt) and must comply with its conditions. They may also be designated by their commissioners as providers of commissioner requested services, making them subject to the continuity of services conditions in Section 5 of the licence and NHS Improvement's financial oversight. The aim of NHS Improvement's oversight is to reduce the risk of provider failure due to financial stress, and to reduce the impact on patients if a provider does fail.

[1] NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority and other bodies.

About this document

This *Risk assessment framework and reporting manual for independent sector providers of NHS services* sets out NHS Improvement's overall approach to regulating licensed independent providers. It supersedes the *Risk assessment framework for independent sector providers* published on 1 April 2014, and incorporates updates which were formally consulted on in February 2020.

By implementing these updates, NHS Improvement's primary aim is to improve its monitoring approach. This is designed to identify the signs of financial stress in providers early enough to take appropriate action to protect continuity of essential services for patients. NHS Improvement's expectation is that these changes will also create benefits for providers, and where possible reduce the burden of regulation, 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 its 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.

How this document is structured

This document has four parts:

- An introduction to the regulatory and oversight system, explaining NHS Improvement's responsibilities and powers for licensing and monitoring independent sector providers.
- The risk assessment framework for providers of commissioner requested services (CRS) – this sets out NHS Improvement's overall approach to monitoring financial risk.
- A summary of the annual reporting requirements all licensees must complete – including a new requirement to self-certify against Condition G4:

Fit and proper persons, effective for periods ending on or after 31 December 2020.

- Details of how regulatory decisions are made in relation to independent providers as of the start of aligned working by NHS England and NHS Improvement on 1 April 2019.

Principles guiding the regulatory approach

Under this updated risk assessment framework and reporting manual, NHS Improvement continues to be guided by the same regulatory principles as were originally set out in April 2014. It remains committed to a regulatory approach for independent sector providers that is:

- **patient-focused** – where issues are identified at licence holders, NHS Improvement will be guided by the interests of patients in assessing the risks and the need for action
- **evidence-based** – NHS Improvement will base its actions on the available and relevant evidence
- **proportionate** – NHS Improvement will ensure that its actions address solely the material risks identified so that it does not over-reach its regulatory remit
- **transparent** – NHS Improvement will strive to communicate clearly and openly to licence holders, commissioners and other stakeholders the reasons for any actions it takes in delivering the right outcomes for patients, commissioners and other stakeholders
- **co-operative** – NHS Improvement will work with other regulators and organisations and, to avoid duplication, will take their conclusions into account when deciding its regulatory approach wherever this is possible and appropriate.

NHS Improvement's intention remains to use as straightforward a framework as possible and to focus its resources on the providers of greatest concern in a proportionate fashion.

Part 1: Introduction to NHS Improvement's regulatory and oversight system for independent providers

The Health and Social Care Act 2012 (the 2012 Act) made changes to the way healthcare is regulated and gave Monitor, now part of NHS Improvement, the role of sector regulator for healthcare in England with a number of new responsibilities and powers. NHS Improvement's main statutory duty is to protect and promote the interests of people who use healthcare services.

These changes to regulation included the introduction of an NHS provider licence for NHS foundation trusts from 1 April 2013 and other eligible NHS service providers from 1 April 2014.

All providers of NHS services (unless exempt under the Exemptions Regulations[2]) are required to hold a licence and comply with its conditions.

A link to the licence application guidance can be found at https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/licensing/apply-for-a-licence-as-an-independent-provider/

A link to the standard conditions can be found at https://www.gov.uk/government/publications/the-nhs-provider-licence. This includes information on who should apply for a licence.

NHS Improvement monitors providers' compliance with licence conditions and has powers to require providers to remedy licence breaches where there is evidence that these have occurred.

Commissioner requested services

Among NHS Improvement's statutory duties is the assessment of risk to the continued provision of essential services, or 'commissioner requested services' (CRS).

[2] National Health Service (Licence Exemptions, etc) Regulations 2013

CRS are any services that commissioners have formally designated as needing the protection of the continuity of services provisions contained within Section 5 of the NHS provider licence. These are essential services that would need to remain in their area if a provider were to get into difficulty because:

- there is no alternative provider close enough
- and/or removing them would increase health inequalities
- and/or removing them would make dependent services unviable.

Guidance on how commissioners can designate services as CRS can be found at https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/information-for-commissioners/

The way NHS Improvement assesses risk to the continued provision of CRS by licensed independent providers is through a financially-focused oversight system of monitoring that is designed to:

- identify any signs a provider is getting into financial difficulty early enough for all concerned to take steps to safeguard the provision of CRS
- allow commissioners to concentrate on securing health services for NHS patients, confident that NHS Improvement will monitor risks to the continuity of CRS
- be proportionate: NHS Improvement does not want its risk reporting requirements to discourage providers from moving into new NHS services, expanding or innovating their existing NHS services to benefit patients or continuing to treat NHS patients.

Regulatory approach to safeguarding CRS

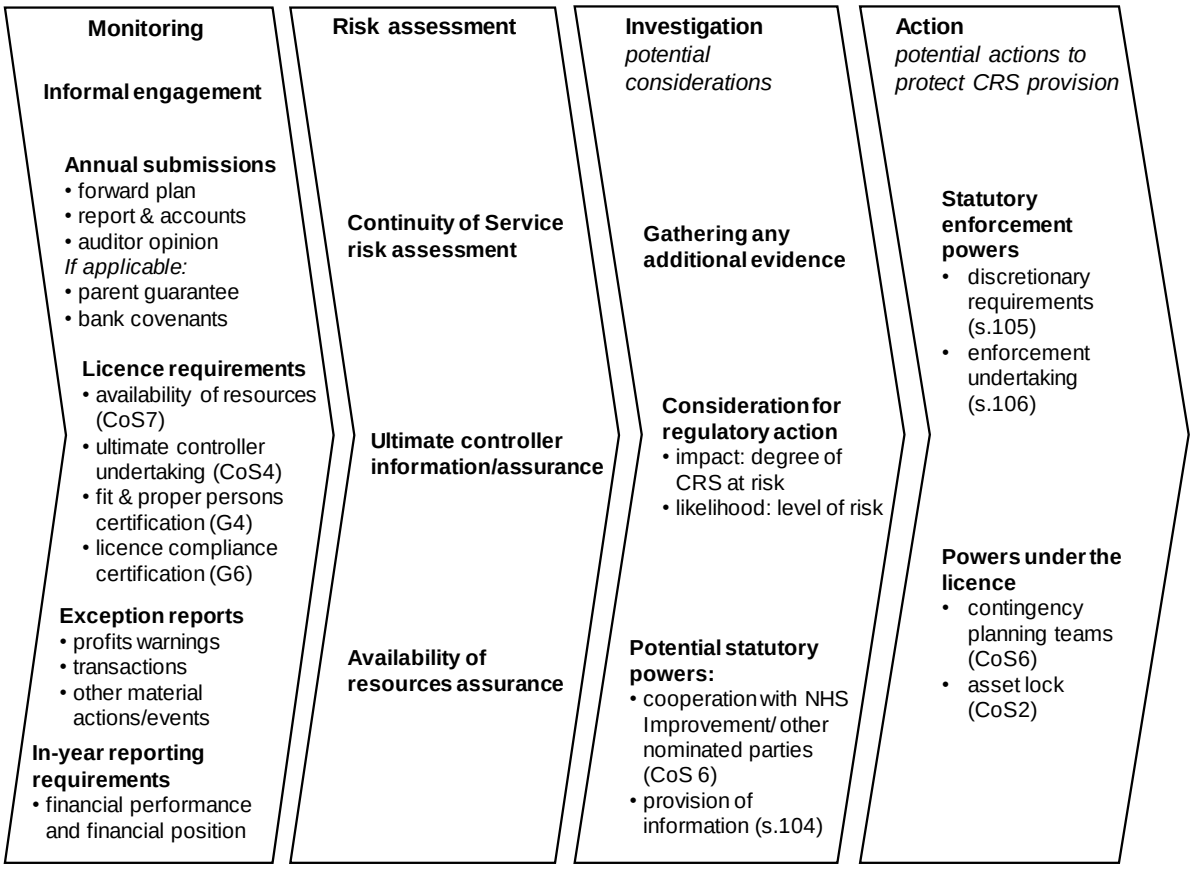
As well as placing a statutory duty on NHS Improvement to assess risk to the continued delivery of CRS, the 2012 Act also gives NHS Improvement powers to support the ongoing delivery of these services through enforcement of the Continuity of Service (CoS) conditions contained in Section 5 of the provider licence.

NHS Improvement may, where it judges the risk to the continued delivery of CRS is sufficiently serious, act to:

- use its powers to investigate whether there has been a breach and, if so, the extent of the breach of the CoS licence conditions
- depending on the outcome of an investigation, initiate enforcement action to address financial failure (see Enforcement guidance for more detail)
- appoint a person (or persons) who can assist in the management of the licensee's affairs. This person's primary objective is to ensure continuity of CRS for the patients that rely on them.

This overarching regulatory approach is summarised in Figure 1. Note: this flow is indicative. In some circumstances the order in which the events included under investigation and action may vary.

Figure 1: NHS Improvement's regulatory approach to ensuring continuity of services for independent providers of CRS



Licence conditions that relate to financial oversight of providers of CRS

NHS Improvement will primarily rely on three conditions in the NHS provider licence, ie CoS licence conditions 3, 4 and 7, in its oversight of a provider's ability to continue providing CRS.

- **CoS licence condition 3:** requires providers of CRS to maintain 'systems and standards of corporate governance and of financial management' considered suitable for providers of CRS, and which reasonably safeguard against the risk of the provider no longer being a going concern. In doing so, providers must take account of NHS Improvement's risk rating methodology and maintain a risk rating equal to or greater than the level NHS Improvement considers acceptable.
- **CoS licence condition 4:** independent providers of CRS may be part of larger corporate structures or have a single or majority shareholder who can influence the operations of the provider. This could be via intercompany guarantees or drawdown arrangements, for example. This licence condition enables NHS Improvement to gain assurance regarding the influence (or potential influence) of an 'ultimate controller' on the financial stability of the provider, and consequently on its ability to continue to deliver CRS. Where providers have such ultimate controller(s), NHS Improvement can use this condition to complement any direct risk assessment of the licensee.
- **CoS licence condition 7:** requires providers of CRS to inform NHS Improvement on an annual basis whether or not they have sufficient resources – including managerial, financial and physical resources – to provide these CRS. The assurance needs to be made after taking account of the provider's financial obligations (including dividend and interest payments). Providers should inform NHS Improvement immediately if the basis of this assurance changes during the year.

Licence conditions that safeguard continuity of CRS

CoS licence condition 1 does not permit a provider of CRS to cease to provide or materially alter the specification or means of provision except with the agreement in writing of commissioners of those services. This may include, by virtue of licence

condition G9(7), continuing to provide CRS on the terms of the contract if that contract has expired without extension or renewal being agreed.

In practice, NHS Improvement would expect, in the first instance, providers and commissioners to agree changes to the provision of CRS between themselves through the normal contract negotiation process. However, NHS Improvement can intervene if a disagreement cannot be bridged or a risk cannot easily be mitigated.

Where NHS Improvement is concerned about a CRS provider's ability to continue as a going concern and it has formally notified the provider of this, NHS Improvement can apply the following two licence conditions:

- **CoS licence condition 2** does not permit providers of CRS to dispose of, or relinquish control over, any relevant asset except with the written consent of NHS Improvement. Relevant assets are any items without which the licensee's ability to meet its obligations to provide CRS would reasonably be regarded as materially prejudiced (a full definition is set out in the licence condition).
- **CoS licence condition 6** requires the licensee to co-operate in the provision of information as NHS Improvement may direct to commissioners and others, to allow such persons as NHS Improvement may appoint to enter and inspect premises, and to co-operate with such persons as NHS Improvement may appoint to assist in the management of the licensee's affairs, business and property.

Other licence conditions

A link to the full set of licence conditions relevant to all licensees – covering general conditions, pricing, competition, integrated care and also the continuity of services conditions discussed above – can be found at https://www.gov.uk/government/publications/the-nhs-provider-licence.

Part 3 of this document sets out the annual reporting requirements that licensed independent providers must fulfil to comply with the terms of the NHS provider licence.

Part 2: Risk assessment framework for independent sector providers of CRS

The 2012 Act gives NHS Improvement powers to ensure the continued delivery of NHS services ('continuity of services' or 'CoS'). These powers are expressed by the inclusion of CoS conditions within Section 5 of the NHS provider licence, which only apply when a provider is confirmed as being a provider of CRS. The application of the CoS conditions also activates NHS Improvement's financial oversight of independent sector providers of CRS under the risk assessment framework (IPRAF).

This section describes how NHS Improvement will carry out this role at independent providers of CRS by setting out:

- Who does the IPRAF apply to?
- How are NHS controlled providers regulated?
- What is NHS Improvement's approach to assessing risk at independent providers of CRS?
- How are the continuity of services risk ratings (CoSRR) risk ratings calculated?
- Consequences of CoSRR scores.
- How the approach to risk assessment is implemented.
- Exceptions reporting requirements.
- Transactions reporting requirements.
- Ultimate controller undertakings and use of Condition CoS 4.
- Monitoring CRS providers that are part of a wider group.

Who does the IPRAF apply to?

The IPRAF applies to confirmed providers of CRS that are not NHS foundation trusts or NHS trusts, and NHS-controlled providers that have been told they will be regulated under the IPRAF (see below).

For NHS Improvement's purposes, 'confirmed' means either:

- A commissioner has formally designated one or more of the provider's services as CRS (and this has been accepted by the provider) and formally informed NHS Improvement of the designation. On receiving this information NHS Improvement has formally confirmed CRS status to the provider.
- A CRS review process has formally confirmed the CRS designation of one or more of the provider's services and NHS Improvement has formally confirmed CRS status to the provider.

Licence holders that do not provide CRS will not be subject to NHS Improvement's CoS regime as set out in this section.

How are NHS-controlled providers regulated?

NHS-controlled providers are providers that:

- are not themselves NHS trusts or NHS foundation trusts
- 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.

They are regulated either under the NHS Oversight Framework for NHS trusts and foundation trusts, or successor framework, or the IPRAF. This will depend on factors such as the scope of the services provided, size of turnover, and whether the provider is a wholly owned subsidiary or is jointly owned by a number of providers. A link to the oversight document which sets out NHS Improvement's approach to regulating NHS-controlled providers can be found at https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/monitoring-and-enforcement/

Where NHS Improvement decides to regulate an NHS-controlled provider under the IPRAF (as if they were a CRS provider), the default position is that the provider will be subject to the same approach to monitoring and risk assessment as set out in this document. However, where less frequent monitoring is assessed to be appropriate, NHS Improvement may adopt an adjusted approach. This will be

agreed on a case-by-case basis unless they also have services designated as CRS by a commissioner; in which case, it will be as set out in this document.

What is NHS Improvement's approach to assessing risk at independent providers of CRS?

NHS Improvement's monitoring and risk assessment will focus on the risk of independent providers of CRS no longer being a going concern, and therefore no longer being able to continue providing CRS.

NHS Improvement uses three main approaches to assessing financial risk:

i. **Three financial measures underpinning an overall continuity of services risk rating:**
   - **liquidity:** what is the fundamental working capital position of the organisation?
   - **capital servicing capacity:** what is the degree to which the provider can meet its financing obligations?
   - **operating margin:** what is the underlying financial performance of the organisation and is it sustainable?

ii. **An assessment of other financial data, including:**
   - forward-looking and in-year income and expenditure, balance sheet and cash flow information; plus (where applicable) debt maturity profiles and banking covenants, and the extent to which the provider is meeting these commitments
   - mitigating factors such as undrawn and committed overdraft or RCF, and liquid investments, which NHS Improvement will consider incorporating into the liquidity measure above.

iii. **Where applicable, other information, including but not limited to:**
   - annual reports and accounts (including auditors' opinions)
   - other information such as the materiality of contracts held by the provider that are due for re-procurement, sudden drops in share price of the parent/ ultimate controller/monitored entity, a charity's own reserves policy.

This information should be commonly available to boards and senior management teams. On designation of services as CRS, NHS Improvement will send providers templates setting out the information to be provided and the definitions to be used.

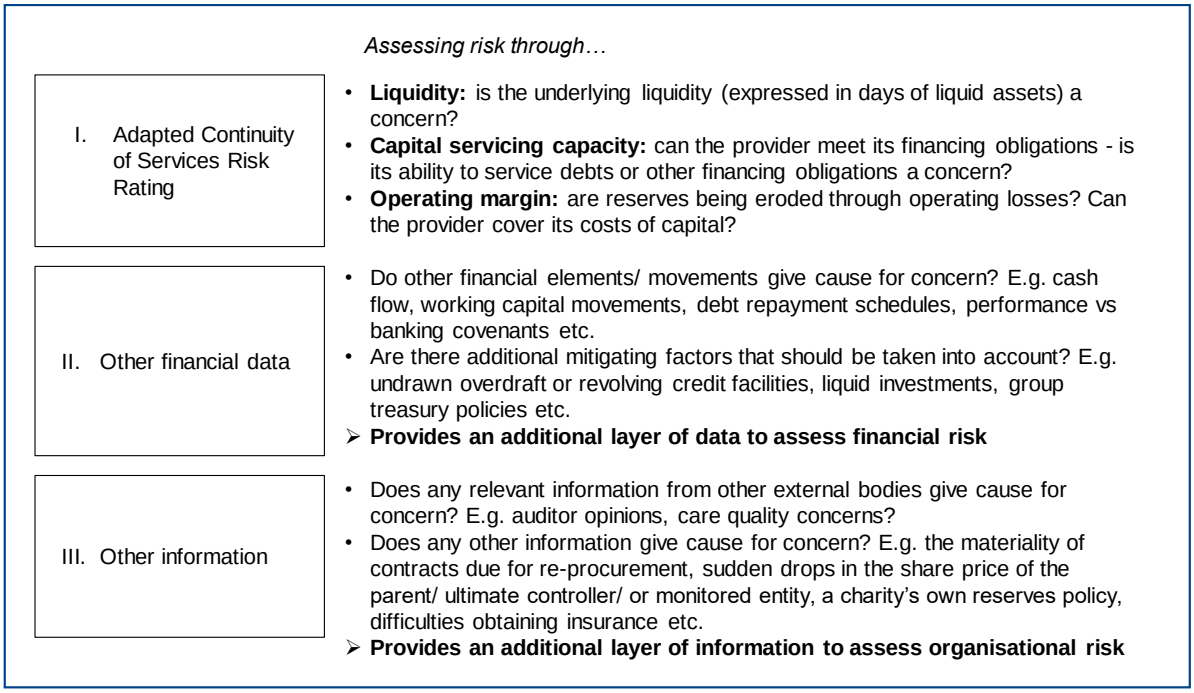
NHS Improvement's framework is intended to flag material concerns regarding the above information, or variance from planned projections. Where it has such concerns, NHS Improvement may, usually following discussions with the licensee, choose to investigate.

This approach is necessarily distinct from the monitoring frameworks applied to NHS trusts and foundation trusts. Independent sector providers represent a more diverse set of operating models than NHS trusts and foundation trusts, with varying levels of exposure to NHS funding streams and in many cases a wider range of customers in addition to NHS commissioners.

Unlike NHS trusts and foundation trusts, independent sector providers are not public bodies and will have different ownership and governance arrangements. Consequently, the drivers of financial risk are more likely to be broader and so an adjusted approach to financial risk assessment has been developed.

This approach is summarised in Figure 2:

Figure 2: NHS Improvement's approach to assessing risk at independent sector providers of CRS



How are the continuity of services risk ratings calculated?

An overall risk rating will be calculated based on an average of the three CoSRR scores for liquidity, capital servicing capacity and operating margin. The calculation method for each of these metrics is set out in Figure 3. Each CoSRR score carries equal weighting.

Figure 3: Calculating CoSRR

Metric	Definition	Rating categories			
		1	2	3	4
Liquidity ratio (days)	$\frac{\text{Working capital balance}}{\text{Annual operating expenses}} \times 360$	<0	=>0	=>10	=>30
Capital servicing capacity (times)	$\frac{\text{Revenue available for capital service}}{\text{Annual debt service}}$	<1.25x	=>1.25x	=>1.75x	=>2.5x or N/A
Operating margin (%)	$\frac{\text{Annual operating profit}}{\text{Annual revenue}}$	<0%	=>0%	=>2%	=>5%

To ensure that emerging risk is not masked by one or two strongly performing metrics, two overriding rules will be applied to the overall risk rating if they are triggered:

- 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.

Consequences of CoSRR scores

The CoSRR scores assign four levels of risk to continuity of services. A CoSRR score of ‘1’ represents the highest level of risk, and a CoSRR score of ‘4’ represents the lowest.

The consequences of these scores in terms of NHS Improvement’s regulatory approach, including potential regulatory action, are set out in Table 1.

Table 1: Consequences of CoSRR scores for NHS Improvement's regulatory approach

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 NHS Improvement has residual concerns, additional information may be requested and/ or more detailed conversations may be held, but routine quarterly monitoring will be maintained.
2	**Structural but stable risk –** the financial position is stable but lacks resilience. NHS Improvement is 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, NHS Improvement is 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 NHS Improvement 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.

How the approach to risk assessment is implemented

Monitoring frequency

NHS Improvement will vary the level of financial oversight of independent providers of CRS according to:

- **Level of CRS provided** – the greater the value of CRS a licensee provides, the more complex any effort to address the risk of financial failure of that provider is likely to be, with a corresponding need to identify issues sooner.
- **Level of risk** – where a provider of CRS is shown to have a greater degree of financial risk, NHS Improvement will require financial information on a more frequent basis or in greater detail.

Table 2 sets out the frequency of monitoring and the degree of forward-looking information NHS Improvement will incorporate in its assessment:

Table 2: Monitoring frequency/forward planning for independent providers of CRS

		Overall risk rating			
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 base case and board-approved downside risk analysis in management's own format.

Routine monitoring will be conducted on a quarterly basis. This will be applied to providers scoring an overall risk rating of CoSRR 3 and CoSRR 4, and some scoring CoSRR 2 that are assessed to have 'structural but stable risk'. Monthly monitoring will be applied to providers scoring an overall risk rating of CoSRR 1 and those categorised as 'emerging 'concern' under CoSRR 2 (see Table 1 above).

This approach is proportionate to the level of risk presented, with a more intense level of monitoring reserved for situations where clear risks to continuity of services emerge.

Monitoring requirements for independent providers of CRS

Annual submissions – the forward plan

On an annual basis, one month after the financial year end, independent providers of CRS are required to submit their board-approved budget (ie their forward plan) for the forthcoming year to assist NHS Improvement in assessing risks to the sustainability of the CRS they provide.

What NHS Improvement will do with this information

Where the forward plan, or any subsequent deviation from or adaptation of it, reveals potential risk to the continuity of those services, NHS Improvement may seek further information to understand the situation and any consequences for

CRS. This may involve using further financial information, over and above the three measures that inform the overall risk rating.

Annual submissions – outer year monitoring

For providers delivering more than £5 million of CRS per year, a board-approved forecast base case for Year 2 with downside risk analysis will also be collected alongside the forward plan template, one month after the financial year end.

The board-approved forecast base case for Year 2 will be in management's own format and will comprise income and expenditure and cashflow base case. The accompanying board-approved downside risk analysis will set out the impact of a reasonable set of downside factors; for example, the loss of contribution from contracts that are due to be re-procured.

In some exceptional cases NHS Improvement may require independent providers to supply this information for Year 3.

What NHS Improvement will do with this information

As part of NHS Improvement's discussions with management, it may ask questions about the impact of such factors on net earnings, reserves and cash and, where appropriate, any mitigating actions.

In-year submissions

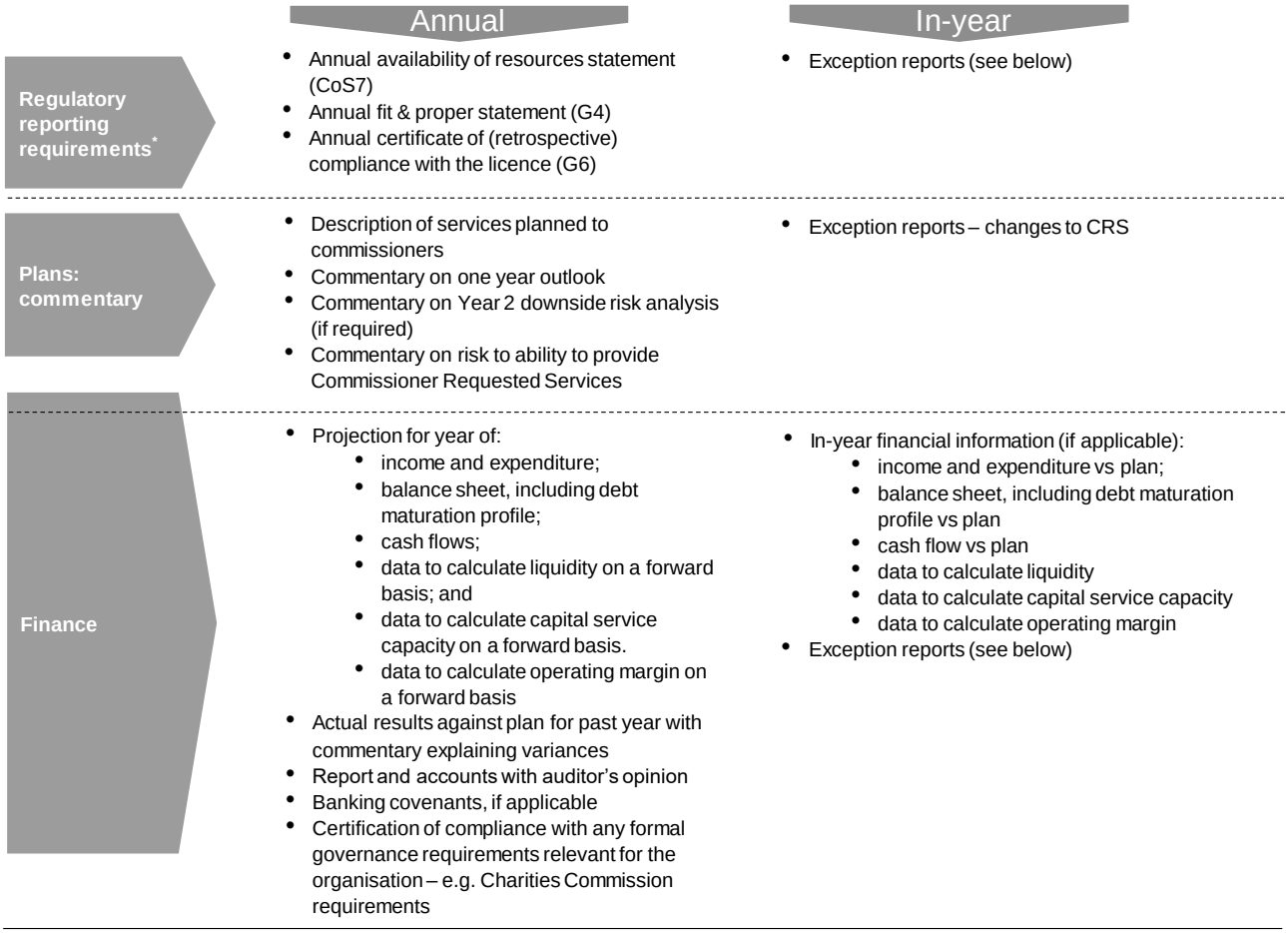
In year NHS Improvement will collect financial submissions from independent providers of CRS in accordance with the frequency in Table 2 above to calculate the year-to-date overall risk rating.

What NHS Improvement will do with this information

Where the actual rating for the past monitoring period is 1 or 2, or where other trends in financial data are of concern, NHS Improvement may consider whether further information or an investigation is appropriate.

The annual and in-year reporting requirements discussed above are summarised in Figure 4.

Figure 4: Monitoring requirements for independent providers of CRS



*In addition, CRS providers with an ultimate controller (as per Cos4) will need to submit a one-off ultimate controller undertaking

Format of financial submissions

For all independent providers of CRS on routine quarterly monitoring, budget and actual in-year results will be collected in NHS Improvement's standard templates, except for the board-approved downside risk analysis for Year 2, which will be in management's own format.

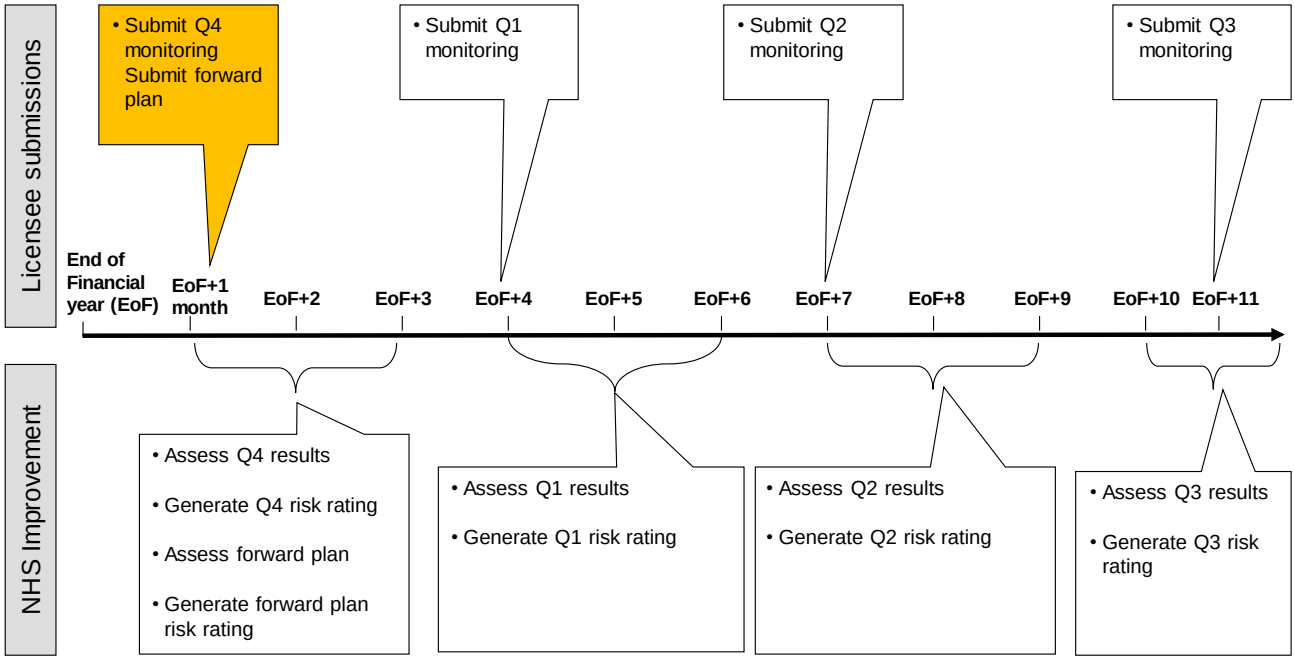
For providers that are subject to monthly monitoring, NHS Improvement will agree on an individual basis what format these submissions will take. This may, for example, include collecting monthly management accounts submitted to the board, subject to these being prepared in sufficient detail for NHS Improvement to undertake its risk assessment.

Monitoring cycle

Although some independent providers will have financial year ends and planning cycles that are aligned with those of NHS foundation trusts, ie 1 April to 31 March, not all do. NHS Improvement will collect in-year submissions based on the licensee's year end.

Figure 5 summarises the in-year and annual risk assessments for those independent providers of CRS subject to routine quarterly monitoring.

Figure 5: Annual planning and monitoring cycle for independent providers of CRS



For each provider that enters the CRS oversight regime, NHS Improvement will set out the required reporting frequency at the start of monitoring. Risk to continuity of CRS will then be assessed at three stages:

1. **annually**, when NHS Improvement receives historical and forward financial information from providers
2. **in-year**, when NHS Improvement receives year-to-date financial information in accordance with the frequency outlined in Table 2 above
3. **by exception**, if a provider of CRS informs NHS Improvement of a material financial event, or it receives relevant information through another source,

and which may lead to concerns regarding the provider's ability to continue providing CRS.

Exceptions reporting requirements

Material in-year changes in providers' financial and other circumstances can have significant implications for their financial stability. For example:

- Care Quality Commission warning notices or other regulatory requirements can require healthcare providers to spend significantly more to meet safety/quality requirements
- material transactions can have far-reaching consequences for revenues and costs
- losing a major contract (eg >10% of revenue) can leave a provider with significant 'stranded' assets and costs, at least for a period
- refinancing may affect a provider's ability to service its financing costs
- exceptional or one-off income may conceal the provider's actual financial position
- difficulties obtaining insurance.

In addition, providers may experience several smaller factors that may result, cumulatively, in greater risk to the ongoing provision of services. Where an independent sector provider of CRS is aware of anything that has or will have a material impact on its ability to provide CRS, it should inform NHS Improvement. Figure 6 below gives examples.

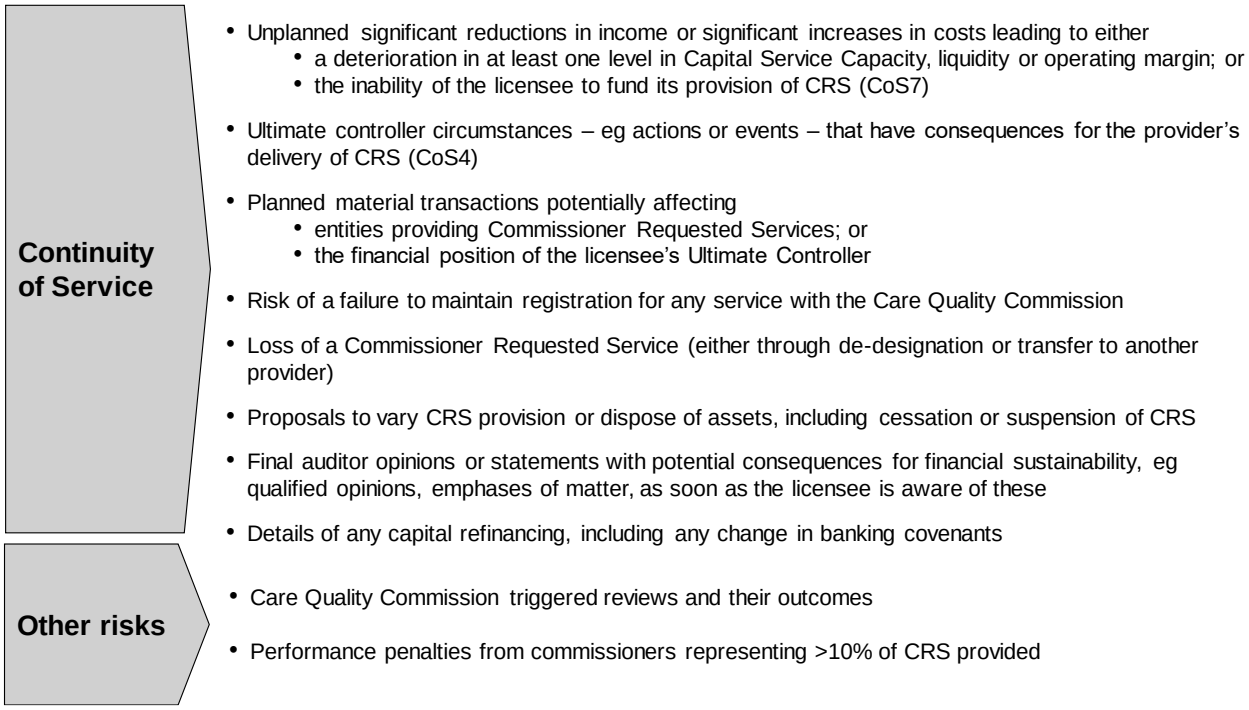
Providers making exception reports to NHS Improvement should, in the first instance, indicate:

- the amount of CRS affected
- the potential impact on the provider's income or costs, with reference to the provider's EBITDA[3] margin and cash flow
- any changes to the provider's ability to finance its operations, eg as a result of a change in cash flows, banking covenants or forward debt repayment profile.

[3] Earnings before interest, taxes, depreciation and amortisation.

Figure 6: Examples of exception reporting triggers (non-exhaustive)

(CRS providers should report to NHS Improvement any information that may, in their view, have material implications for financial risk and/or compromise their ability to continue providing Commissioner Requested Services)



What NHS Improvement will do with this information

NHS Improvement may request additional information to assess the appropriate actions to take and when. In each circumstance, it will consider what response would be appropriate.

Transactions reporting requirements

Independent providers of CRS should inform NHS Improvement of any transaction amounting to greater than 10% of its net assets, total revenue or capital.

What NHS Improvement will do following the receipt of an exception report

On receiving notification of an upcoming transaction, NHS Improvement may request further information to assess any risk to CRS. In each circumstance it will consider what response would be appropriate.

Ultimate controller undertakings

In some cases, licensees may form part of larger corporate structures or have a single or majority shareholder that can influence the operations of the licensee. In

such circumstances the assessment of that licensee's continued ability to provide CRS involves considering the extent to which intra-group financial and legal arrangements could affect the licensee's financial position.

Where there is such an ultimate controller as defined in CoS licence condition 4, this requires an undertaking from the controller(s) to refrain from any action that would be likely to cause the licensee to contravene its obligations in either the 2012 Act or the licence. The controller should also provide the licensee with any information that it possesses or can obtain to enable the licensee to comply with its obligation to provide NHS Improvement with information. NHS Improvement will consider the appropriate form of this for licensees and, if it considers it necessary, discuss the appropriate information required from specific licensees.

In any event, where a licensee has an ultimate controller for the purposes of CoS licence condition 4, NHS Improvement will request information on, among others:

- intercompany guarantees underpinning the liquidity of the licensee
- 'cash sweep' and other group treasury management practices affecting the cash and other liquid assets held by the licensee and
- any calls that the controller has over the assets (liquid or otherwise) of the licensee.

Guidance on the required format of the ultimate controller undertaking can be found at https://www.gov.uk/government/publications/independent-healthcare-providers-ultimate-controller-undertaking-template.

Monitoring CRS providers that are part of a larger group

As previously stated, where a licensee that delivers CRS forms part of a larger group structure, the assessment of that licensee's continued ability to provide CRS involves considering the extent to which intra-group financial and legal arrangements could affect the licensee's financial position.

Where NHS Improvement can link a parent company's information with the enforcement of the CoS conditions against the licensee, it will request (through Condition G1 of the provider licence) that the licensee provides information about its parent company.

In practice, this means NHS Improvement will collect the information set out in this IPRAF at a parent company consolidated level, and calculate the formal risk ratings based on this.

Part 3: Annual reporting requirements for compliance with the NHS provider licence

A link to the full set of licence conditions relevant to all licensees – covering general conditions, pricing, competition and integrated care – can be found at https://www.gov.uk/government/publications/the-nhs-provider-licence.

Tables 3, 4 and 5 below set out the annual requirements that all licensees must fulfil for compliance with the provider licence they hold. The annual requirements vary depending on the type of licence held (an NHS provider licence or an NHS-controlled provider licence), and whether the licensee delivers CRS (as described earlier in this document).

Note on Licence condition G4: Fit and proper persons

A new mandatory requirement to self-certify against Licence condition G4: Fit and proper persons will be introduced, effective for periods ending on or after 31 December 2020. It is for the board of each licensee to determine whether they have received sufficient assurance that directors and equivalents meet the definition of fit and proper in accordance with the wording contained in the licence.

Table 3: Mandatory requirements under the licence

Requirement	Non-CRS designated	CRS designated	Due
NHS provider licence holder (independent providers)	• Condition G6 systems for compliance with licence conditions and related obligations **self-certification**	• Condition G6 systems for compliance with licence conditions and related obligations **self-certification**	• Within two months of the licensee's year end
		• Condition CoS7 (availability of resources) **self-certification**	• Within two months of the licensee's year end
NHS-controlled provider licence holder	• Condition G6 systems for compliance with licence conditions and related obligations **self-certification**	• Condition G6 systems for compliance with licence conditions and related obligations **self-certification**	• Within two months of the licensee's year end

Requirement	Non-CRS designated	CRS designated	Due
		• Condition CoS7 (availability of resources) **self-certification**	• Within two months of the licensee's year end
	• Condition CP1 8(a): licensee corporate governance **statement**	• Condition CP1 (8a): licensee corporate governance **statement**	• Within three months of the licensee's year end

Table 4: Requirements requested at NHS Improvement's discretion

Requirement	Non-CRS designated	CRS designated	Due
NHS provider licence holder (independent providers)	• N/A	• N/A	• N/A
NHS-controlled provider licence holder	• Condition CP1 (8b): auditor or controlling NHS organisation(s) **statement**	• Condition CP1 8(b): auditor or controlling NHS organisation(s) **statement**	• Within three months of the licensee's year end

Table 5: Other information requested through Condition G1 of the licence and section 96(2) of the Health and Social Care Act 2012

Requirement	Non-CRS designated	CRS designated	Due
NHS provider licence holder (independent providers)	• Condition G4 Fit and proper persons' **declaration**	• Condition G4 Fit and proper persons' **declaration**	• Within two months of the licensee's year end
	• Turnover **declaration** for the most recent financial year	• Turnover **declaration** for the most recent financial year	• Within two months of the licensee's year end
NHS-controlled provider licence holder	• Condition G4 Fit and proper persons' **declaration**	• Condition G4 Fit and proper persons' **declaration**	• Within two months of the licensee's year end
	• Turnover **declaration** for the most recent financial year	• Turnover **declaration** for the most recent financial year	• Within two months of the licensee's year end

Part 4: Handling business-sensitive information under the NHS England and NHS Improvement joint operating model

From 1 April 2019 NHS England and NHS Improvement began working in an aligned way as a single organisation, to better support the NHS and help improve care for patients. This change has not impacted how the Independent Provider Team interacts with licensed independent providers of NHS services on a day-to-day basis.

As part of working as a single organisation, the senior management team is now jointly appointed to both NHS Improvement and NHS England. This means that certain decision-making committees taking regulatory decisions about independent providers may comprise of individuals who are appointed to both NHS Improvement and NHS England. These ways of working are underpinned by shared information governance arrangements.[4]

Regulatory decisions will continue to fall within the legal remit of NHS Improvement (only), even though taken by committees consisting of joint appointees. NHS England does not have a role with regards to regulation of independent providers except in limited ways as set out in the Health and Social Care Act 2012.

In practice this means that, at the point certain decisions need to be made, some of an organisation's information will be provided to individuals who are appointed jointly across both NHS England and NHS Improvement for the limited purpose of exercising NHS Improvement's legal powers in that instance.

[4] As part of the alignment, NHS Improvement and NHS England have established a single corporate information governance (IG) function that consolidates their respective data protection, information security and records management resources into a single function providing consistent policies, procedures and advice. Clear processes have been established to determine and manage the IG implications when NHS Improvement and NHS England are acting independently or together, respectively known in data protection terms as sole or joint data controllers – these include separations between their respective data stores and information where necessary. These processes are described in IG policies and procedures, to which all staff must adhere.

Strict controls are in place to ensure business-sensitive information of licensees remains confidential under the joint operating model:

- Business sensitive information collected for the purpose of financial oversight is not routinely shared with committees except for the purpose of regulatory decision-making.
- Information collected for the purpose of financial oversight will continue to be stored on a secure area of the servers that is only accessible to members of the Independent Provider Team. There will be no routine sharing of licensee's information outside the Independent Provider Team and the directors it reports to.
- The Independent Provider Team will maintain information barriers between itself and other teams within NHS England and NHS Improvement, including those responsible for commissioning and commissioning oversight.
- Confidential or business sensitive information about providers will be provided to committee members in cases where NHS Improvement is taking or lifting regulatory action for a suspected breach of licence, or where concerns about financial viability of a provider are such that a notice should be issued that the provider may no longer be a going concern.
- Recommendations for decisions to the committees will be made by the Independent Provider Team. Such cases are infrequent and detailed discussions with providers will likely precede any decision to take such action.
- All committee members will be reminded of the confidential and business sensitive nature of the content of any committee paper and asked to consider if they have any conflicts of interests in line with NHS England and NHS Improvement's internal policies.
- NHS Improvement will continue to treat market-sensitive information in accordance with its local policies, which include maintaining an insiders list and reminding recipients of the potential consequences of misuse of that information.

NHS Improvement will only share confidential information with NHS England and key stakeholders (including other regulators) where necessary, eg where it is required to by law (this includes the statutory duties on both NHS Improvement and

NHS England to co-operate and share information with each other), or where there is an overriding public interest to do so, or where it has consent to do so.

NHS Improvement is committed to its duty of confidentiality and will notify licensees if there are material changes in the way it processes information or makes decisions relating to information processing.

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