BVCA response to Monitor, consultation on "Developing further Continuity of Services licence conditions: stakeholder engagement document (tranche 2)".

About the BVCA: The British Private Equity & Venture Capital Association (BVCA) is the industry body and public policy advocate for the private equity and venture capital industry in the UK. The BVCA Membership comprises over 250 private equity, midmarket and venture capital firms with an accumulated total of approximately £32 billion funds under management; as well as over 250 professional advisory firms, including legal, accounting, regulatory and tax advisers, corporate financiers, due diligence professionals, environmental advisers, transaction services providers, and placement agents. Additional members include international investors and funds-of-funds, secondary purchasers, university teams and academics and fellow national private equity and venture capital associations globally. As a result of the BVCA's lobbying and reputation-building efforts, private equity and venture capital today have a public face. Venture capital is behind some of the most cutting-edge innovations coming out of the UK and that many of us take for granted: the medical diagnostic services we use in hospitals, the chips in our mobile phones, the manufactured components of our cars, and the bioethanol fuels that may run them in the future. Likewise, private equity is behind a range recognisable High Street brands, such as Boots, Phones4U, Birds Eye, National Grid and RAC.

Private equity represents a significant subsector of private provision in health and social care, having invested £1.6bn since 2006. Our services range from supported living, specialist care for Dementia and more conventional residential care homes**.** Rather than new regulations on acceptable business models which would likely deter investment at the worst possible time, a comprehensive and universal failure regime should be consulted on and when devised, properly communicated to all stakeholders. This would be a more effective way of delivering continuity of service, without the same deterrent to would-be investors.

Executive summary

Monitor's proposals on the new licence conditions for providers of NHS-funded care, particularly in relation to Continuity of Services raises significant concerns. Notably, the proposals represent a disincentive for private investment in the sector, acts as a barrier to entry for new providers (which limits choice and competition) and therefore are not for the benefit of patients or taxpayers.

The proposed conditions appear inconsistent with the description of Monitor's role as licensor of providers of NHS Services (as opposed to "additionally regulated services") as set out in the Health and Social Care Bill and departmental policy statements, including *Liberating the NHS: Regulating Healthcare Providers*, and are disproportionate to Monitor's duty to protect and promote patients interests.

The consultation documents for the second tranche propose further stringent restrictions on licensees who are obliged to provide Commissioner Requested Services (CRS). The conditions impose a debt ceiling on providers, prevent the creation or maintenance of security over assets used to provide CRS, without prior approval, unless on "normal commercial terms and for the purpose of providing NHS-funded services", prohibit intra-company transfer of assets without prior consent and

prohibit "cross-default obligations", requiring a related company to pay or repay the debt if the original borrower defaults. Existing "cross-default obligations" may continue but only for a period of 12 months after the licence comes into effect

The second tranche of consultation documents do not address the distinction between public assets (held by Foundation Trusts) and private assets (held by IS providers). Public assets have been funded by the government (i.e. the taxpayer). Private assets are funded by other sources of finance, such as debt finance. The debt ceiling may be set at a level which is too low for private providers (and therefore is breached by these providers). The other restrictions will require IS providers to re-negotiate with their lenders on security (if not "on commercial terms" as determined by Monitor, presumably) and on cross-default clauses. Re-negotiation is costly in terms of finance and resource and will not be in the best interests of patients and tax payers, particularly if the lenders offer finance at higher levels of interest as a consequence of the increased regulatory burden.

Given the historical differences in funding between the publically owned and privately owned providers, the proposals will have a disproportionate effect on privately owned providers. Monitor may wish to consider whether their proposals are consistent with public procurement and competition law. As an example, the Public Contract Regulations 2006 (derived from EU law) says that "Contracting authorities must act in a transparent way and treat all potential providers equally and in a non-discriminatory way". In our view, a commissioner of NHS-funded services would fall within the definition of "Contracting authorities". The proposals (if enacted) would require commissioners to treat potential providers in a discriminatory way and are therefore in breach of procurement law.

Further, if a Commissioner requests a provider to deliver CRS, the licensee may refuse but only reasonably. There is no guidance on what is reasonable. Also it is not clear what the implications are if a provider does not provide CRS, from a commissioning perspective. Will unwilling providers face de-authorisation? Also, will commissioners be expected to prefer providers of CRS (i.e. Foundation Trusts) over other providers when placing patients?

The BVCA propose that rather than an "opt-out" process for providers, there should instead be an "opt-in" process. So providers cannot be compelled to provide CRS if they do not wish to.

Condition 8 – Availability of resources

1. Do you think that this condition is proportionate? Please give reasons for your answer.

We understand the need to ensure that adequate resources are available to deliver Commissioner Requested Services however we would question the proportionality of the measures to be included in the License. For example, the justification for additional annual reporting requirements is not yet clear, in particular the requirement for board level sign off stating that the company 'reasonably expects' to have the required resources. Our view is that it should be a working assumption that a company has the required resources unless they inform Monitor. For these measures to be deemed necessary, we need to see evidence that provision of such information complete with approval by auditors could have prevented past failures or would lead to a markedly more successful implementation of any failure regime – are there examples of companies who have been unable to provide details of working capital on an ad hoc basis having entered a period of financial distress? We also wonder whether Monitor has considered whether auditors will be prepared to give the statement and, if so, whether it will offer any real comfort over and above the assertions of the directors on which the auditors will be relying?

Furthermore, we believe that restrictions on distributions and additional requirements on working capital are unnecessary and counterproductive. We do not envisage situations where companies would make distributions which leave them unable to provide continuity of service but would view with interest, evidence to the contrary. The consultation mentions that it will reinforce the link between patient services and actions of management. It is our view that the only relevant benchmark is delivering continuous quality service, the balance sheet of the business is secondary.

Lastly, it is unlikely that a business, for existing regulatory reasons would be able to structure its NHS business, which would provide Commissioner Requested Services as a separate legal entity. So the notion of protecting assets only for NHS patients in receipt of such services is misguided.

2. What do you consider would be sufficient evidence to support the proposed annual certificate?

Monitor would need to demonstrate the realistic possibility that a licensee would not be forthcoming in informing them that continuity of requested services could not be delivered. The Consultation states "a further requirement of this condition is that licensees would have to inform us immediately if they become aware of any circumstances which cause them to believe that their most recent certificate is no longer valid". This is essentially the same as a rolling requirement to inform the regulator should a provider get into difficulty and goes someway to making the need for annual reporting redundant. Even in this context, the burden of proof remains with the regulator to make this a *requirement* of a licensee. It is not clear for example that this protection is not already afforded by reference to the Companies Act. Auditors are already required to certify that the client will be a going concern for the year hence.

3. Should 'operational resources' be explicitly listed in this condition, to capture important outsourcing arrangements?

No – it should be at the discretion of the licensee to determine management of operational resources and it should not be for the regulator to take on a risk management function regarding outsourcing or any other arrangements.

4. **Are there any reasons why distributions might not be paid within three months after they have been declared? Certificates for distributions required under our proposed condition would only be valid if the distribution is made within three months of it being issued.**

As stated above restrictions on distributions are wholly disproportionate and will infringe on the rights of providers to operate a flexible financial model that best suits concerns of efficiency rather than regulation. For example, declaration may flow from the date of annual general meetings, with payment to be determined by the cashflow requirements of the business . Again, distributions are also regulated by the Companies Act.

5. **What do you estimate to be the likely impact, if any, of this licence condition on your organisation's costs? Please provide details of the assumptions underlying your estimate.**

Potentially quite high. We think Monitor should engage with the main accountancy firms to help estimate the costs. There are some parallels with the auditors' statement (before the requirement was abolished in 2006) in relation to financial assistance given by private companies. That certificate was much narrower, in that it related to the directors' assessment of whether the company would be able to pay its debts as they fell due over the succeeding 12 months. This certificate, asking the auditors to make their assessment of the directors' opinion on availability of resources (effectively capacity to deliver CRS) generally, is likely to be much more expensive, assuming auditors feel able to give it.

6. Can you suggest more effective ways of achieving the same objectives?

What might they involve?

We remain of the view that there is need for the regulator to demonstrate that they do not have the necessary means to maintain continuity of service under existing company law and via existing legislation. The prevailing assumption is that a business is a going concern, confirmed by a statutory audit until the regulator is notified otherwise. These proposals simply duplicate existing provision. Where it may be necessary to seek existing protections, this should be done on a contractual case by case basis – step-in rights can be negotiated where it becomes necessary to take over a failing institution in order to maintain continuity of care.

Condition 9 – Limits on indebtedness

7. What are your views on how the debt ceiling should be calculated? Should different limits be set for different licensees? Should there be a single cap for the sector, or should there be variations between provider types (and if so, which ones)? Please expand on your preferred approach.

It is the view of the BVCA that there should be no debt ceiling imposed and we also reject the need for setting a wholly arbitrary leverage cap. Again it is of paramount importance that firms are permitted to run their financial affairs with as much flexibility as possible to maximise efficiency. If such restrictions were imposed we are confident that this would severely curtail private investment into the healthcare sector to the ultimate detriment of service users. Such restrictions take no account of the fact that some of the sectors concerned are extremely asset heavy and would make for poor business models if this regime were imposed.

It also discriminates unfairly against debt-funded businesses (the independent sector) and in favour of those funded by public dividend capital (PDC) (for NHS bodies).

The commentary that private lenders place restrictions on borrowing and dividends completely misses the point that those provisions are for the benefit of the lenders (and indeed investors) and that those funders would not likely accept fiduciary judgements being subordinated to Monitor's views. Monitor (and DH) has nothing invested in independent sector businesses and the majority of NHS providers are funded by PDC, so in practice they have little need to borrow. In addition, as Monitor is aware, DH already has a mechanism to impose its requirements as funder on foundation trusts through the Health and Social Care Bill proposals which allow for conditions to be attached to PDC.

It may be difficult or impossible to renegotiate existing cross-default obligations, and the non-availability of cross-default obligations may make group refinancing more expensive and/or impossible, to the detriment of the CRS provider and therefore also to taxpayers. If provisions cannot be renegotiated, a provider would presumably have to cease providing CRS, which does not seem to be in the interests of patients or the taxpayer.

Even with the attempted definition, the phrase "arms' length basis on normal commercial terms" remains vague and open to wide interpretation. We think Monitor should be clear about the rules it sets for providers.

Furthermore, it is not clear that the concerns implied by this consultation are not already addressed by existing law and regulation. The regulator can intervene where necessary; there is no demonstrable need for additional regulation. Notably, the proposals on the granting of security over assets for Commissioner Requested Services – ad hoc contractual protections can already be negotiated. But it is important to note that the consequences are not constrained to administrative cost. Without the ability to secure debt finance on assets, it is unlikely that providers could raise more finance for investment purposes, or without this option, the cost of capital would simply drive providers from the sector, curtailing much needed investment.

8. How might we address exceptional cases or outliers?

Please see response to Q7

9. Should we have discretion to vary limits?

Please see response to Q7

10.Do you foresee any tax consequences from the restrictions we are proposing in this condition? Please give examples in your answer

No comments

Condition 10 – Further restrictions in the event of financial distress

11.Do you think that our proposed condition is proportionate in the activities that would be prohibited if a licensee providing Commissioner Requested Services were in financial distress? Please give reasons for your answer.

As the bar is set so high (financial investment grade) we cannot help but conclude that the condition is disproportionate. As noted in our introduction, a number of substantial businesses would fail such a test and we would be surprised if many foundation trusts would pass without the artificial support provided by Secretary of State underwriting on dissolution. In the earlier consultation, it stated that

"the [credit] ratings would exclude government support, whether implicit or explicit, however this remains to be seen.

As noted above, the definitions of "arms' length" and "normal commercial terms" are vague and open to partial interpretation. We also see no justification in drawing a distinction between commitments entered into before and after the financial distress.

Condition 11 – Restrictions on lending

13.Do you think that the proposed investment criteria are proportionate? Might, for example, an investment grade requirement be sufficient? Please give reasons for your answer.

As drafted, the condition would not allow providers to hedge their currency risk on (for example) the purchase of expensive equipment from abroad or non-sterling denominated lending. We think this restriction should be removed.

14.Can you foresee any unintended consequences of our proposed condition?

For example, might it impact particularly on charitable organisations providing Commissioner Requested Services who have significant endowment investments? Could this be managed by operating Commissioner Requested Service provision at arm's length from the charity (e.g. through a wholly-owned subsidiary)?

We agree that implementation of these proposals will mean that providers (including NHS bodies as trustees of their charitable funds) will have to dispose of some of their investments. We do not see how this will benefit patients and taxpayers.

Furthermore, whilst a subsidiary company may be a normal way for a charity to trade in other contexts, Monitor should be aware that not all health charities trade in this way because the provision of healthcare is itself a charitable activity.