HFMA response
April 2019

HFMA evidence to the Health and Social Care Committee's NHS long term plan: legislative proposals inquiry

Who we are

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. For the past 60 years, it has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Summary

This submission is based on the views of our members and draws on recent HFMA publications and research.

Key points:

- In our opinion, the legislation should provide guiding principles and overarching objectives, rather than prescribing how they will be achieved.
- Setting principles and overarching objectives, along with long term financial settlements, would allow for necessary long-term planning to achieve the objectives set out in the *NHS long term plan* (the Plan).
- Considering the principles and objectives and allowing the service the flexibility to determine how they will be achieved should mean that the primary legislation will not need to be revisited as the way healthcare is delivered changes over time.

- Legislative changes need to take into account the whole NHS and social care system. They should be subject to consultation and debate within Parliament but also with the NHS, and those involved with it, to guard against any unintended consequences. This is particularly the case where very specific, detailed changes are proposed.
- Any change to the existing legislation needs to address the current tension between organisational objectives and statutory duties, and meeting system wide objectives. Consideration needs to be given to the number and layers of organisations within the NHS – more organisations and more complexity will demand greater amounts of time and resource to navigate.
- The proposals for legislative change do not address critical issues relating to primary care, value added tax (VAT) and local authorities.
- Some of the issues facing the NHS are not going to be resolved by legislation. However, there is some non-NHS specific legislation, particularly in relation to workforce and taxation, which is having a detrimental impact on the sector.

Detailed response

1. The additional funding announced by the Prime Minister in June 2018 was a welcome boost for a healthcare system struggling to meet demand within the current funding envelope. Equally welcome was the indication that legislative change may be possible to allow for the changes set out in the Plan to be delivered.

2. The HFMA and its members support the vision of the Plan and the intention to create a sustainable NHS that is fit for the future. We recognise that the statutory framework that the NHS in England currently operates within can be a barrier to transformation.

3. The HFMA plans to submit a detailed response to NHS England and NHS Improvement's consultation *Implementing the NHS long term plan: proposals for possible changes to legislation* (the consultation). This submission does not repeat the detailed comments we will make in that response, but instead focuses on the strategic issues that our members would like any legislative changes to address.

Legislation fit for the future

4. The Plan sets out a vision for the NHS over the next 10 years. As accountants, we understand the difficulties of accurate forecasting and the fact that the further ahead a forecast looks, the less accurate it becomes. If we look back 10 years, the healthcare services being delivered were different – medical practices and treatments have changed as have the pressures on the service. The wider public sector and political landscape that the NHS works within has also changed.

5. Changes to legislation should not be made to only address today's problems. The changes need to support the NHS as it develops in the future. Some things will not change, such as rising demand for services, an aging population, staff shortages, health inequalities and a desire to make a patient's pathway through 'the system' as seamless as possible. None of these issues can be addressed by a change in legislation alone.

6. However, we acknowledge that NHS bodies are creatures of statute and need to operate within their statutory boundaries. Ideally, the legislation will be drafted in such a way as to allow for the way the NHS operates to change and develop to meet as yet unknown challenges, but within a regulatory framework which allows for good governance and the best possible stewardship of public sector resources to meet the objectives set for the NHS.

7. One of the difficulties with the current legislation is that it is prescriptive about how the system will work. For example, the way that tariff will be set, the services it can be set for and how and when it can be changed. We would suggest that the legislation should be amended to remove

the specific requirements and, instead, set out the over-arching objectives to be achieved, and the principles upon which the system should work.

8. While we understand, and support, the desire to avoid wholescale reorganisation, there is a risk to only amending parts of the existing legislation. The legislative basis of the NHS is complex, and the current structure of the NHS has been developed over time. It is important to determine and understand the impact of any changes to avoid unintended consequences. Our concern is that amending parts of the legislation which are causing difficulties now, has the potential to move problems to elsewhere in the system.

9. For example, the 2012 Act already requires NHS bodies to cooperate both with each other and with local authorities. There is very little current focus on what this duty means in practice. As far as we are aware, NHS bodies do not assess whether they have met the requirement and neither do any of the regulatory bodies. This may be because system wide cooperation is incompatible with the competition requirements of the 2012 Act. We believe any legislative changes should avoid any apparently conflicting requirements such as this.

10. It would be helpful if Parliamentary scrutiny focused on the overall picture and how the proposed changes would affect the way that the NHS works as a whole and as part of the wider machinery of government.

Organisational or system objectives

11. In our evidence to the Public Accounts Committee inquiry into NHS financial sustainability, submitted in February 2019[1], we identified the boundaries of legislation as one of the barriers to implementing the Plan and achieving system wide collaboration. Specifically, the statutory obligations on individual NHS organisations regarding governance and financial accountability.

12. These obligations are different depending upon whether the organisation is a trust or foundation trust or a clinical commissioning group (CCG). The HFMA considers that this creates an unnecessary level of bureaucracy and that best practice should be applied consistently to the provider sector. The current proposals are to introduce a new type of NHS body, the integrated care trust rather than reduce the complexity of the system that currently exists.

13. The Plan also anticipates NHS bodies working together. However, this assumes that the boards of statutory bodies will be willing to give up budgetary control to partnership boards while still being held to account for the financial performance of their own statutory body. It is not certain that they will be willing to do this and to a large extent it depends on the quality of local relationships.

14. System working is largely based on voluntary partnerships. The move towards system control totals provides more flexibility for NHS systems to work together to manage funding for local needs but, under the current architecture, accountability remains with individual organisations. Joint control totals and system objectives are a potentially dis-incentivising and high-risk proposition for organisations in financial balance, who may be financially disadvantaged through being tied to a system in overall deficit. The current proposals do not address this issue.

15. An ongoing concern for the HFMA's members is the implementation of effective governance arrangements in an integrated system and how this interacts with the statutory obligations of individual bodies. From our work with non-executive directors, we know that they are concerned about their lack of involvement and scrutiny in the development of the governance structures of sustainability and transformation partnerships (STPs) and they are concerned that this will continue as STPs develop into integrated care systems (ICSs).

[1] HFMA, *Written evidence submitted to the Public Accounts Committee's inquiry into NHS financial sustainability*, February 2019

Primary care

16. The current proposals to amend the legislation will affect NHS Improvement, NHS England, CCGs, NHS trusts and NHS foundation trusts. However, primary care services are fundamental to the success of the Plan, with the development of primary care networks cited as a key measure to integrate services in the community. The proposals do not address the legislative barriers to the delivery of primary care.

17. The provision of primary care is complicated – it sits within the NHS and from a patient's perspective it is absolutely part of the NHS, but it is provided by independent contractors. For primary care services to be provided by NHS trusts or NHS foundation trusts, there has to be subcontracting of primary care contracts or the establishment of subsidiary bodies. We are aware that this is working successfully, for example in Dudley, but it is a complicated route which requires time and resource to establish effectively.

18. The legislation concerning who can deliver primary care services and how they are administered may restrict the ability of the NHS to deliver some of the objectives set out in the Plan.

Local authorities

19. Health and social care are inextricably intertwined, and we accept that the complexities of the differences between NHS bodies providing healthcare services and local authorities providing social care services are not going to be addressed by any changes in legislation in the short term. However, we are concerned that the Plan, and the proposed legislative changes, all focus on the NHS part of the system with an expectation that local authorities will engage with this NHS led initiative. Without the involvement of local authorities, the Plan is unlikely to be successful.

20. There are some clear legislative barriers to joint working between NHS bodies and local authorities. The differing VAT regimes between the NHS and local authorities present unnecessary cost and administrative pressures when seeking to work collaboratively to deliver a service that is subject to different rules depending upon hosting arrangements. This can create financial obstacles to the development of joint working, introduce perverse incentives and distract management time and effort away from improving patient services towards seeking VAT gains at the organisational level (which balance out at the national level).

21. We welcome the announcement, in the Spring Statement, of the development of a policy paper exploring a potential reform to VAT refund rules for central government. However, we are concerned that local government will be excluded from this paper as this is a major barrier for the joined-up provision of health and social care.

22. We will also recommend in our response to the consultation that the secondary legislation supporting pooled budgets should be reviewed as some of the requirements in relation to accounting and auditing also cause practical difficulties when establishing joint working arrangements.

23. Our members are aware that local authorities have been affected by austerity to a much greater degree than the NHS. As the successful implementation of the Plan rests on managing demand, we are concerned that responsibility for public health commissioning lies outside of the NHS and will be a barrier to success. The consultation does not make recommendations about responsibility for public health, but it would make planning for services more straightforward if it was brought back into the NHS. We recognise the impact services such as housing and education have on public health and the rationale for it being a local authority function. However, wherever the responsibility lies, public health services need to be adequately funded.

24. Transferring the responsibility for public health would also resolve a VAT issue discussed in the next section.

VAT implications of commissioning

25. The NHS divisional registration means that VAT is not charged on transactions between NHS bodies. However, as soon as either the commissioner or provider role moves outside of the NHS, VAT can become chargeable depending on the service. This is also the case when NHS bodies establish subsidiaries or joint arrangements.

26. Our members have experience of providing services which are paid for by CCGs but, because the current legislation requires some services to be subject to competitive tender, are commissioned by third party organisations sitting outside of the NHS. The service therefore falls outside of the NHS divisional registration which means the NHS provider incurs irrecoverable VAT costs.

27. Public health services commissioned by local authorities under the 2012 Act have a similar cost impact. The services are paid for by funds from the Department of Health and Social Care but, as the funding leaves the NHS before it reaches the NHS provider, it falls outside of the NHS divisional registration.

28. VAT is not addressed in the consultation but is an example of legislation having unintended consequences.

Workforce

29. The challenges facing the NHS workforce are widely documented. The ability of organisations and systems to make the changes required to develop a sustainable NHS through the aspirations of the Plan, are severely limited by the lack of qualified workforce to draw upon.

30. Most of the workforce issues facing the NHS cannot be resolved by legislative change. However, there are legislative requirements, particularly in relation to taxation and other charges, which do have an impact on workforce:

    - The introduction of the apprenticeship levy has resulted in a cost pressure for many NHS bodies, especially in these early stages, as there are not enough apprenticeship courses available for NHS staff to join
    - The amendments to the off-payroll requirements (known as IR35) in the public sector, but not the private sector, has made the NHS a less attractive place to work, particularly in the information technology sector
    - The introduction of the tapered annual allowance for pension savings is resulting in senior clinical staff reducing their hours or taking early retirement as the tax implications mean that it is not worth them working. At a time when workforce is in short supply, this is an additional avoidable pressure.

31. These issues demonstrate the impact on the NHS of legislation originating in other parts of government. However, we understand that these matters are outside the remit of the Health and Social Care Committee.

Contact

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