HFMA response
April 2019

Proposals for possible changes to legislation

Implementing the *NHS long term plan*

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.

Our comments

Background information

Name
Debbie Paterson

In what capacity are you responding? [Please tick]
Professional representative body ✓

Are you responding on behalf of an organisation?
Yes

Organisation name
Healthcare Financial Management Association (HFMA)

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Should the law be changed to prioritise integration and collaboration in the NHS through the changes we recommend?

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Should the law be changed to prioritise integration and collaboration in the NHS through the changes we recommend?				✓	
Do you agree with our proposals to remove the Competition and Markets Authority's functions to review mergers involving NHS foundation trusts?				✓	
Do you agree with our proposals to remove NHS Improvement's powers to enforce competition?				✓	
Do you agree with our proposals to remove the need for contested National Tariff provisions or licence conditions to be referred to the CMA?			✓		
Do you agree with our proposals to free up procurement rules including revoking section 75 of the Health and Social Care Act 2012 and giving NHS commissioners more freedom to determine when a procurement process is needed, subject to a new best value test?				✓	
Do you agree with our proposals to increase the flexibility of the national NHS payments system?				✓	
Do you agree that it should be possible to establish new NHS trusts to deliver integrated care?			✓		
Do you agree that there should be targeted powers to direct mergers or acquisitions involving NHS foundation trusts in specific circumstances where there is clear patient benefit?		✓			
Do you agree that it should be possible to set annual capital spending limits for NHS foundation trusts?		✓			

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Do you agree that CCGs and NHS providers should be able to create joint decision-making committees to support integrated care systems (ICSs)?				✓	
Do you agree that the nurse and secondary care doctor on CCG governing bodies be able to come from local providers?		✓			
Do you agree that there should be greater flexibility for CCGs and NHS providers to make joint appointments?			✓		
Do you agree that NHS commissioners and providers should have a shared duty to promote the 'triple aim' of better health for everyone, better care for all patients and to use NHS resources efficiently?			✓		
Do you agree that it should be easier for NHS England and CCGs to work together to commission care?				✓	
Which of these options to join up national leadership do you prefer?	Combine NHS England and NHS Improvement				
a) combine NHS England and NHS Improvement					
b) provide flexibility for NHS England and NHS Improvement to work more closely together					
c) neither of the above					
Do you agree that the Secretary of State should have power to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs, with appropriate safeguards?				✓	

If you have any specific comments or additional information to provide, please provide in the relevant text box.

1. Promoting collaboration. This includes the following proposals:

a. Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts

- Agree

The move towards greater system working, particularly with the introduction of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) means that competition is no longer the mechanism used ensure that patients get the best possible care. Our members therefore support this proposal.

As all the CMA's reviews, other than the first one, have resulted in approval of the merger, it is highly unlikely that removing the CMA's functions in relation to mergers of NHS foundation trusts will have any practical impact. Our members support any initiative to reduce any additional bureaucracy and unnecessary costs associated with transforming services.

Having said that, it is important that any proposed organisational changes are subject to rigorous review to assess whether they are likely to achieve their objectives. This can be achieved by good management and governance rather than legislative requirements.

b. Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour

- Agree

As collaboration is a key component of implementing the *NHS long term plan* (the plan), and in the light of the proposal in relation to the CMA, it would seem reasonable to remove NHS Improvement's functions in relation to competition.

c. Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

- Neutral

Removing these requirements would mean that there would be no independent arbiter for disputes between NHS provider bodies and NHS Improvement.

Having said that, as far as we are aware, NHS Improvement has not taken recent or widespread action under the current arrangements and the CMA powers only affect foundation trusts seeking to merge. Based on the information on the CMA's website there have only been seven reviews of mergers and the tariff was only objected to once.

As time in the legislative calendar is limited, we would prefer that time to be focused on areas that are causing day to day problems and/or impeding the pace of change in many parts of the NHS, such as the complexity of the current VAT regime and the lack of accountability, and therefore decision making power, in some joint working arrangements.

2. Getting better value for the NHS. This includes the following proposals:

a. Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which they are made, subject to a new best value test

- Agree

We support the relaxation of procurement requirements – it is difficult to work collaboratively when services must be subject to competitive tender. The movement of service provision between providers (both in the NHS and outside of the NHS) is unsettling for staff and patients and does not necessarily result in an improved patient experience.

However, we are concerned that the consultation sets out only high-level details of the requirements of the new best value test and what impact it might have on NHS bodies, their staff and patients. It may be that the new requirements are more onerous/ bureaucratic than the existing procurement requirements and would not result in an improved experience for patients. It is also not clear whether the best value test would be the same in all circumstances and which organisation would be responsible for developing/ administering the test and then monitoring whether the outcome of the

best value tests resulted in the appropriate decision. If the best value test was not met, what would the consequence be?

Currently, procurement law allows for providers to challenge procurement decisions. The proposals are not clear whether there will be any mechanism for challenge to the outcome of the 'best value' assessments.

Whatever the best value test is, it must be open and transparent so that all parties to the transaction are clear on the proposal and its implications. Ideally, this means that any challenge process would never be needed. When developing the best value test consideration needs to be given to the fact that what seems to be best value at the time of making a decision may, with the benefit of hindsight, not be. While it is impossible to predict the future, the best value test does need to allow for changes to be made without having to re-test the whole process.

It is also important that appropriate system-wide data is available to all organisations to manage and monitor whether best value is being met. Until we understand what data will be required it is not possible to identify the gaps and assess whether the data that is available is in an easy to use form and is able to be readily shared across organisations.

b. Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test

- Neutral

We are not experts in procurement law, but it is not clear to us how and whether this proposal will affect the current EU procurement law.

It would be helpful to understand which NHS bodies will be covered by these new requirements, for example, are community interest companies, established to provide community services, part of the NHS for this purpose? Or would the services that they provide be subject to competition?

It is not clear how or whether these proposals will affect those services which are currently provided on a fixed term contract as a result of a procurement exercise. At the end of that contract, will it have to be subject to a procurement process or the new best value test?

Finally, what are the implications of these changes for staff who now work in the private sector as a result of their roles have been transferred under TUPE because of a procurement exercise? And will the TUPE rules apply to a service transferred as a result of a best value assessment rather than a procurement exercise?

3. Increasing the flexibility of national NHS payment systems. This includes the following proposals:

a. Remove the power to apply to NHS Improvement to make local modifications to tariff prices, once ICSs are fully developed

- Neutral

We agree that, once all ICSs are working effectively, the current power for provider bodies to apply to NHS Improvement for local modifications to tariff prices should not be needed, as all parties in the ICS should be in agreement. As far as we are aware, this power is only used where there is a dispute between provider and commissioner so it would become redundant in a fully operational ICS but would mean that, in statute, the balance of power between providers and commissioners would be inequitable.

This power should only be removed when all ICSs are fully developed and are operating as expected across the country. It is not at all clear when this will be, whether it will ever happen or how the judgement will be made that it has happened. Until that point, ICSs will have to work within the

current legislative requirements – it should be explicit what this power currently means for them and how they can work within the existing legislation.

b. Enable the national tariff to include prices for 'section 7A' public health services

- Agree

We agree that it would be simpler for the national tariff to include all services provided in a patient pathway. Where, as is the case with screening in the maternity pathway, it is an obstacle to joined up commissioning reflecting the patient's journey through the system, we support this proposal.

c. Enable national prices to be set as a formula rather than a fixed value, so prices can reflect local factors

- Neutral

It is not clear to us how this would vary from the way that national prices are currently set. The application of the market forces factor (MFF) effectively means that a formula is applied to the average cost of a service to determine a price which reflects local factors.

d. Enable national prices to be applied only in specified circumstances

- Agree

We agree that where ICSs are working effectively, this would mean that they agree local arrangements to achieve the best outcome for the population.

However, it is important that the national tariff is retained so that where services are commissioned and provided across ICS borders by organisations who have no working relationship, there is a clear contracting arrangement and price to be applied. Without this, more time and effort would be spent ensuring that services are appropriately paid for.

It is not clear what this proposal would mean for specialised services that are commissioned nationally by NHS England. The nature of these services means that we would expect that there would be a nationally set price for them. However, we are concerned that, combined with the proposals for NHS Improvement and NHS England to become one organisation, the new joint body will have a conflict of interest as they set prices as well as commission specialised services.

e. Enable selected adjustments to tariff provisions to be made within a tariff period (subject to consultation)

- Strongly agree

We support this proposal as long as mid-tariff period adjustments are used only when there are developments which make the original tariff unworkable. This would be particularly important when a multi-year tariff is set.

4. Integrating care provision. Enable the Secretary of State to set up new NHS trusts to provide integrated care.

- Neutral

We support any measure that will allow NHS bodies to work in an integrated manner to provide patient focused care. However, establishing new organisations is resource heavy and creates uncertainty. Also, the establishment of a new organisation may not remove all of the barriers to integration. For example, there will be boundaries to the patients/ service users that it works with and there will always be services such as ambulance services and specialised healthcare which will be provided by organisations outside of that boundary. Patients and service users may want to be treated by organisations outside of the ICS or the new integrated care provider.

However, establishing a new integrated provider body may remove some barriers to integration. A statutory body has very clear functions and lines of accountability which removes some of the

uncertainty which surrounds STPs and ICSs. A particular example of where a barrier is removed is in relation to information sharing and information governance. A single provider of services would, presumably, be able to use data relating to patients/ service users internally to better manage the service provided to them. If integrated providers are not standalone organisations but remain an alliance of different organisations, then the issues relating to data sharing and information governance will need to be addressed. This may be by ICSs being recognised as a single organisation by the Information Commissioner's Office, the Caldicott requirements, data protection legislation and the public.

There is very little detail in the consultation and there are areas where additional information is needed:

- It is not clear what would be different about the statutory basis for the new NHS trusts or whether they would be, in statute, NHS trusts or NHS foundation trusts or another new type of NHS provider. In our experience, the current statutory differences between NHS trusts and NHS foundation trusts, result in a system which is not equitable (for example, NHS trusts have limits on their capital expenditure which NHS foundation trusts do not have). Introducing another type of NHS body may simply complicate the system still further.
- It would be helpful to see more information on the governance arrangements for these new NHS trusts – if the new organisation is based on an existing NHS trust or NHS foundation trust model then the accountability and governance arrangements would be clearly understood. However, clarity is still required on how their boards would be established to bring together representatives of primary and secondary care providers.
- NHS providers can currently provide a mixture of acute, community and mental health services – it would be useful to have clarification of whether this new type of organisation must also provide primary care, public health services and/or social care. In other words, which elements (out of primary, secondary, tertiary, mental health, community, social and palliative care), need to be provided for an NHS organisation to qualify as an integrated care trust? And should there be a de minimis overall monetary value to qualify? If not, it is not clear to us how the new organisation differs from existing provider bodies and therefore why a new type of organisation is needed.
- Currently, NHS provider bodies are not able to directly provide primary care services. It is not clear whether the new integrated trusts would have that flexibility – a more straightforward solution may be to amend the statutory functions of existing NHS providers to include primary care functions under specified conditions.

The consultation does not make it clear what the difference between the new integrated provider and current provider bodies would be. Under s77 of the Health Act 2006, NHS trusts, NHS foundation trusts and CCGs can apply to become care trusts which have local authority health-related functions delegated to them by agreement. We are not sure whether these powers are currently in use. Would this proposal allow for care trusts to have primary care functions delegated in the same way?

We remain concerned that this proposal does not address the barriers to integration between NHS bodies and local authorities. The *NHS long term plan* and this consultation are very focused on the NHS and we are concerned that local authorities are not fully engaged, which may mean integration becomes more difficult. The delay of the social care green paper means that the NHS is moving at a faster pace than its local authority colleagues.

5. Managing the NHS's resources better. This includes the following proposals:

a. Give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits

- Disagree

Experience shows that mergers of NHS bodies take time and resource and, above all, cooperation. Where there are clear patient benefits we would expect that the NHS foundation trusts involved would accept that this was the case and would therefore agree to merge without it being imposed upon them.

The consultation document indicates that this power would only be used where there is a serious failure or risk of failure. As far as we are aware the current equivalent powers in relation to NHS trusts have rarely been used. It is not clear what the benefit of extending these powers would be and in what circumstances they would be used.

It would be useful to have more information how this new power works alongside the proposals in section 4 to establish new integrated care trusts. We assume that if NHS Improvement directs the merger of an acute trust with a mental health or community provider the new organisation would not automatically become an integrated care trust.

b. Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

- Disagree

As capital is a scarce resource, we welcome any proposals to allow it to be managed equitably across the healthcare system in England and allow decisions on funding to be made on a timely basis. We welcome the opportunity to work closely with NHS Improvement in developing the detail of this provision.

We understand the rationale behind this proposal is to ensure that all of the capital resources allocated to the NHS through the Department of Health and Social Care's capital departmental expenditure limit (CDEL) are used in each financial year. In 2017/18, there was a £0.4bn underspend against the CDEL – mainly as a result of the actual spend by NHS provider bodies being less than they had forecast. This proposal is intended to reduce the uncertainties at the departmental level over the capital expenditure which NHS foundation trusts will incur.

However, setting spending limits addresses only one part of the problem and may not be the appropriate solution:

- NHS trusts currently have a capital resource limit (CRL) and we assume that the proposal is to introduce a CRL for foundation trusts. In 2017/18, all NHS trusts stayed within their CRL. However, what is not clear is whether this is because they did not have access to the funds to incur more capital expenditure or whether they were managing their expenditure to ensure that they remained within the CRL.
- NHS trusts currently have a statutory duty to break-even but in 2017/18, 40 (50%) NHS trusts were referred to the Secretary of State for failing to meet that duty. Just because NHS bodies have a statutory duty or a spending limit, it does not necessarily mean they will meet it.
- It would be helpful to understand what, if any, penalties are proposed if the limit is breached.
- Currently, the key constraint for many provider bodies is access to capital funding – as the consultation explains, NHS Improvement and the Department are constraining access to funding in order to manage the national position. We would be more supportive of the extension of NHS Improvement's powers if it was linked to the availability of funding so that capital programmes can be delivered on a timely basis. However, we understand that this will not address the problem of the, dwindling, number of NHS foundation trusts who have internal resources incurring expenditure over which NHS Improvement and the Department have no control.

Finally, it is not clear why a change in legislation is needed to develop agreed annual capital spending limits with NHS foundation trusts – the current control total arrangements operate alongside

the current legislative regime and neither NHS trusts nor NHS foundation trusts have a revenue resource limit.

6. Every part of the NHS working together. This includes the following proposals:

a. Enable CCGs and NHS providers to create joint committees

- Agree

We support the addition of powers to allow CCGs and NHS providers to create joint committees where they decide that it would be the most appropriate way forward. However, this would only be the case where it is the decision of the local bodies to create such a committee and not a requirement for them to do so. Joint working requires trust and cultural change which cannot be imposed by governance structures.

b. Give NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them

- Neutral

We accept that any new joint committees will need appropriate governance structures and delegated decision-making powers. We would suggest that there is sufficient best practice already available that any powers for NHS England to produce guidance should be light touch rather than prescriptive.

c. Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers

- Disagree

We agree that there are advantages to allowing the registered nurse and non-GP doctor on a CCG governing body to come from an NHS body that the CCG commissions care from. Not least, particularly in rural areas, the travel times for individuals who work for providers who do not have commissioning arrangements with the CCG would be prohibitive. However, as the consultation points out, this does result in a conflict of interest which will need to be managed.

The conflict is slightly different to the one which GPs have, as CCGs only have delegated powers to co-commission primary care, whereas they are directly responsible for commissioning secondary healthcare.

An alternative solution is that the local knowledge and insight could be provided in an advisory capacity rather than as full members of the CCG governing body or perhaps the option of using designated staff from a local provider should only be used in exceptional circumstances where other options are impractical.

d. Enable CCGs and NHS providers to make joint appointments

- Neutral

Joint appointments to a CCG and an NHS provider would also result in conflicts of interest. We would want to understand how conflicts will be managed, particularly in the event of a dispute between provider and commissioner. It is this lack of clarity about the arrangements to manage such conflicts that have resulted in us being neutral on this proposal. We are supportive of joint working, but only where the proper arrangements are in place.

We are aware that there is at least one joint appointment to a CCG and an NHS provider at the moment at Frimley Health NHS Foundation Trust and East Berkshire CCG. On this basis, it is not clear to us whether legislative change is required.

There are currently a small number of individuals who currently hold a joint CCG and local authority post – if they were also able to be appointed to a provider organisation, this would be a very wide-

ranging post with considerable responsibility. Consideration needs to be given to whether there should be a limit on the number of organisations who can be party to a joint appointment.

7. Shared responsibility for the NHS. Create a new shared duty for all NHS organisations to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS

- Neutral

We agree that this triple aim supports the current developments in the NHS to move towards a cooperative, system based delivery of healthcare with patients at its heart both in terms of treating those that are ill but also in helping the population remain well for longer. We fully support the ambition behind the 'triple aim'.

However, we are not convinced that there needs to be a new statutory duty to do this. Under section 72 of the NHS Act 2006, NHS bodies (including NHS England, Health Education England and NICE) have a duty to cooperate in the exercise of their functions. As the triple aims are also each individual NHS body's aim it is not clear why, and how, a new duty will avoid 'less joined up' decision making. How will a conflict between a decision which will promote the triple aim but potentially at the detriment of one organisation's functions/ duties be resolved? The existing requirement to cooperate, along with each organisation's current duty to achieve value for money and the legally binding requirements of the NHS Constitution should be sufficient to meet this duty.

It is not clear how NHS bodies will demonstrate that they have achieved or taken decisions to work toward the achievement of this triple aim. We are not sure what data would be required to demonstrate achievement and whether it is available. Our concern is that additional management time and resource will be diverted from patient centred service delivery to demonstrating that this new responsibility has been achieved.

We suggest that shared responsibility could be achieved through policy and guidance rather than legislation.

8. Planning our services together. This includes the following proposals:

a. Enable groups of CCGs to collaborate to arrange services for their combined populations

- Strongly agree

Having said that, none of these proposals will address the 'postcode lottery' as different commissioners decide on different services and access criteria for their populations.

b. Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'

- Agree

We understand that this will allow CCGs to work together to commission primary care. Subject to proper arrangements being in place to manage conflicts of interests, we agree that joined up commissioning of primary care will allow for proper planning across wider geographical areas than is currently possible.

c. Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions

- Agree

d. Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs

- Agree

e. Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services

- Agree

We broadly agree with all of the above proposals to allow CCGs and NHS England to collaborate and pool funds. However, these proposals assume that the boards of the statutory bodies will be willing to work together and pool funds, while still being held to account for the financial performance of their own statutory body. It is not clear how any conflicts between these two requirements would be resolved – it is likely that the accountability for each statutory body will be the deciding factor which could undermine the joint arrangements.

From an accounting perspective, pooled funds are not straightforward and the current regulations underpinning section 75 of the NHS Act 2006 in relation to pooled funds are not necessarily helpful. We understand that this consultation is focusing on primary legislation but the secondary legislation which supports the existing arrangements needs to be considered as well. We would expect that any proposals to extend pooled budget arrangements would be based on section 75 arrangements.

The current regulations set out governance arrangements which need to be in place when pooling funds, which is helpful but require additional memorandum accounts to be maintained and audited. These memorandum accounts sit outside of the statutory accounts prepared by the entities involved. We suggest that any new requirements should align with the requirements of *International financial reporting standards* and the DHSC's *Group accounting manual*. The regulations currently require specific audit work on the pooled budget. The audit requirements currently in place for the financial statements are sufficient. The additional requirements imply that pooled budgets have greater importance than other arrangements entered into by NHS bodies.

9. Joined up national leadership. This includes the following proposals:

a. Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together

- Combine NHS England and NHS Improvement

We welcome NHS England and NHS Improvement working more closely together, and we recognise that the current statutory arrangements do not allow for this to happen in a streamlined manner. We do not have a view on the legislative mechanism used to allow NHS England and NHS Improvement to work together.

Closer working arrangements are welcomed where it means that all regulatory bodies are speaking with a single voice, which is clearly understood throughout the whole of the NHS. This should result in streamlined reporting without any duplication and regulatory decisions which are not contradictory.

Our members are concerned about the consequences of this closer working – especially as there is a very different regulatory arrangement between NHS England and CCGs and NHS Improvement and provider bodies. We understand that bringing together Monitor and the NHS Trust Development Authority (NHS TDA) was not without difficulty as Monitor was established and operated as an arm's length regulator while the NHS TDA was established to support NHS trusts as they developed into foundation trusts. Aligning these two ways of working was not straightforward and we can see that the same issues will arise when bringing NHS Improvement, which is still a regulator, with NHS England which is, essentially, the parent organisation for the clinical commissioning groups.

We offer this finance-based example to illustrate our point. All CCGs are required to use the Integrated Single Finance System (ISFE) as their financial ledger. The coding structure and management of the ISFE is managed nationally by NHS England who can access each CCG's financial information. On the other hand, provider bodies are responsible for their own arrangements in terms of financial management and reporting, but are required to report to NHS Improvement through the completion of monthly returns.

There would be benefits to adopting the NHS England model across the whole of the NHS – this would allow for better data analytics, streamlined transactions and less time spent on submitting returns to the central regulatory bodies. However, it could also result in additional work being done by local bodies to give them the financial information they require outside of the central coding structure as well as loss of local knowledge and understanding of service provision. It would not resolve the issue of closer working with local authorities. Changing to this model would also be time consuming and cause disruption and distraction.

There are always consequences, both positive and negative, to all changes. Our support for closer working arrangements is therefore tempered until we understand exactly what it means in practice.

b. Enable wider collaboration between ALBs

- Agree

As above, we welcome any proposal which removes the potential for confusion and mixed messages from the system. We would also hope that wider collaboration between ALBs might result in more agile decision making.

Other comments?

Most of these proposals are welcomed, where we are not supportive it is partly because there is not enough detail in the proposals to understand the reason that they are being proposed and the consequences of the changes. We would welcome the opportunity to continue to comment on proposed changes as they develop into legislation. In particular, we would welcome clarity on the expected impact of these proposals on the day to day functions of the NHS and local authorities, particularly in clarifying responsibilities and lines of accountability.

In our evidence to the Public Accounts Committee in February and to the Health and Social Care Committee in April, we welcomed the possibility of legislative change. However, we did highlight two areas which are not mentioned in this proposal.

Firstly, as we indicated in our response to question 4, we are concerned that these proposals do not address the barriers to closer 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. We understand that HM Treasury is starting to work on the policy paper announced in the Spring Statement on VAT simplification and the public sector. It may be that this policy paper will propose the changes which would reduce the cost and administrative burden of the current arrangements.

The national tariff only applies within the NHS in England and this, in itself, can be a barrier to integration. For example, the requirement to comply with the Mental Health Investment Standard (MHIS), CCGs are required to add an uplift to prices for mental health contracts. However, where CCGs are working with local authorities to jointly commission mental health services with the local commissioner, the local authorities are not required to comply with MHIS or the uplift their prices in the same way. This has inevitably caused difficulties when negotiating and managing joint contracts. We are not suggesting that this issue can, or should be solved, by legislative change but it is

something that the Government and national bodies need to be aware of when setting policy that cuts across both sectors.

Secondly, 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. However, the legislation concerning who can deliver these services and how they are administered may restrict the ability of the plan to deliver on these objectives. Other than the establishment of new trusts to provide integrated care and joint committees, these proposals do not mention primary care.

Beyond what you've outlined above, are there any aspects of this engagement document you feel have an impact on equality considerations?

No