

NHS capital – a system in distress?



Contents

Summary	3
Background	3
A complex system	5
What does a healthy balance sheet look like?	11
What might a new capital regime look like?	12
Conclusions and future work	16
Appendix 1: Acknowledgements	17
Appendix 2: Performance metrics for NHS provider bodies	18

Summary

The NHS in England continues to be under financial pressure. In particular, our NHS provider members are reporting increasing concerns around access to capital funding and the impact that scarce capital funding is having on patient care.

In parallel to this, there is a concern that the recent focus on control totals as the key financial metric increases the risk that the financial position of NHS bodies as a whole is not properly understood and, therefore, is not being well managed.

This briefing is intended to feed into the current work being undertaken to develop the 10-year financial plan for the NHS. It uses an analysis of the development of the current capital arrangements regime to identify the characteristics a new capital regime should have and suggests some possible solutions to the current problems.

Background

The financial pressures in the NHS continue. 2017/18 proved to be another very challenging financial year for NHS organisations. Despite the government's announcement of additional funding the financial challenges are already continuing into 2018/19 with the provider sector planning to make a deficit of £519m this year¹.

NHS Improvement and NHS England have been tasked to produce a 10-year plan for the NHS, which includes reviewing the financial regime. This briefing is intended to be a helpful contribution to the review.

When considering the financial pressures on 'the NHS' it is worth bearing in mind that this is not one single organisation and, in England, the Department of Health and Social Care (DHSC) is a group of 462 separate entities². The provider sector makes up half of the group by number of entities and it is the net deficit of this part of the group which is attracting attention at a national level and resulted in the introduction of the control total as a key financial performance metric. However, it has been recently announced that control totals are unlikely to be a continuing feature of the NHS financial regime beyond 2019/20.

The revenue position of NHS organisations is important to the

A foundation trust applied to the Independent Trust Financing Facility (ITFF) for a loan to fund a programme of work in December 2016 to meet clinical demand and to address safety concerns. The foundation trust was informed by the ITFF that the loan was approved in January 2017.

After much chasing by the trust, 10% of the loan value was issued as a loan in September 2017. The remainder of the loan remains outstanding, on a list of loans awaiting clearance by the DHSC and is still being chased by the trust. The DHSC are asking for further prioritisation of the schemes due to their own capital constraints and are encouraging the foundation trust to request a lower figure than the outstanding 90%.

Due to the delay in accessing capital, the foundation trust's current capital programme has slipped, and some schemes have not progressed. This means that decant space is not available, so the foundation trust and its patients are experiencing an adverse impact on meeting clinical demand and access targets.

national performance of the DHSC. However, at individual organisation level, HFMA members are concerned that the current focus on surpluses, deficits and control totals increases the risk that potential problems that a balance sheet review³ would identify will be missed by boards. Members are also concerned about how capital projects are currently, and will be, financed and the impact the delay in capital programmes is having on patient care.

¹ NHS Improvement, *Performance of the NHS provider sector for the quarter ended 30 June 2018*, 2018

² Source: paragraph 307 of the *DHSC annual report and accounts 2017/18*

³ In this briefing, we will use the more widely understood term balance sheet, rather than statement of financial position

Looking beyond the bottom line, NHS bodies are facing the following issues:

- Surpluses are getting smaller and deficits are getting bigger year on year:
 - 45% of foundation trusts reported a negative income and expenditure reserve as at 31 March 2018
 - Two-thirds of foundation trusts reported a deficit in 2017/18⁴.
- Working capital is also becoming more of an issue year on year:
 - At 31 March 2015, 29% of foundation trusts reported negative working capital⁵. By 31 March 2018, this had risen to 36%.
- The estate needs more investment to keep it up to appropriate standards:
 - There has been a year on year increase in reported backlog maintenance from a constant £4bn per year between 2011/12 and 2013/14 to £6bn in 2017/18⁶.
- There is a perception that access to capital is becoming more difficult.

The recent report by PwC and the HFMA, *Making the money work in the health and care system*⁷, concluded that the current capital funding system needs to be redesigned and internal debt within the English health system should be restructured. The problems with the current capital regime are:

- Providers reporting deficits do not generate surplus cash which limits the funds that they have available to invest in capital.
- The current system for funding capital is complex and feels combative. This is partly because:
 - Each different NHS body is answerable for its own financial performance so there is little incentive to understand the wider picture or the impact on other entities within the DHSC group. System wide planning is being developed at the sustainability and transformation partnership (STP) level, but this is relatively new and is operating more effectively in some parts of the country than others
 - Financially challenged NHS providers are struggling to finance their own capital requirements
 - There is a finite resource envelope which is being managed centrally by the DHSC and NHS Improvement
 - Funding decisions do not always align with national or local policy/plans

From 1 October 2018, genomic testing in the NHS is being provided through a single national testing network, consolidating and enhancing the existing laboratory provision.

This will create a world class resource for the NHS and underpin the future genomic medicine service. It will also support the delivery of the government's life sciences strategy and the broader research and innovation agenda, building upon the NHS contribution to the 100,000 Genomes Project.

This new network will consist of seven genomic laboratory hubs (GLHs), each responsible for coordinating services for a particular part of the country. It will require major consolidation and infrastructure changes – for example, in estates, equipment and IT.

The host NHS bodies have been told that no capital monies are available for this. Only revenue has been provided, with the express statement that this money is not to be used for capital, even though some of the money will need to be spent on capital items. HFMA members are concerned that there is insufficient headroom in existing capital programmes to cope with this additional spending and therefore the delivery of a key strand of government policy will be at risk.

- The system of allocation and management of capital funding is not clear and is perceived as a barrier to investment.
- There is frustration that the flow of capital funding from the DHSC is slow and does not meet providers' needs:
 - That the delays in approvals make planning and managing capital programmes very difficult
 - In part this is due to the process of approving business cases which need to be clear and precise about why the funding is needed, supported by quality information
 - But it is also because controlling the flow of funds is the mechanism the DHSC has to ensure that it meets its statutory targets⁸.
- There is concern at the centre⁹ that there is capital money unspent at the year-end that could have been allocated and used. However, the quality of NHS bodies' forecasts during the year was not sufficient to allow those funds to be released because there was a risk that the capital departmental expenditure limits (CDEL) would be breached
- Some trusts that do have cash to spend on capital have to make a business case to be able to spend it, others do not have to make a business case but have no available cash

⁴ Source: HFMA analysis of *NHS provider accounts consolidation (TAC) data* for 2017/18 and 2015/16

⁵ We have calculated working capital simply as current assets less current liabilities, without any consideration of whether the liabilities include short term working capital loans

⁶ Source: HFMA analysis of *Estates returns collection (ERIC) – England 2015/16, 2016/17 and 2017/18*

⁷ PwC/HFMA, *Making money work in the health and care system*, June 2018

⁸ The statutory targets for the different types of NHS body are explained in the section headed 'A complex system'

⁹ Source: paragraphs 174 and 175 of the *DHSC annual report and accounts 2017/18* and questions 36 and 37 of the evidence by David Williams, director general, finance, DHSC to the public accounts committee on 17 October 2018

- The focus of financial regulation is not on balance sheets, but on control totals. This is increasing the risk that underlying financial issues may not be identified at an early stage.

There is also an underlying concern that long-term decisions about capital investment cannot be made because of the relatively short-term nature of allocations. For example, the capital budget for health, announced in the 2017 Autumn Budget¹⁰ is only up to 2020/21.

These issues are explained in more detail in this briefing and two key issues are considered – access to capital funding and the move away from using the balance sheet and associated metrics as a financial management tool. It is intended to feed the views of the HFMA and its members into the 10-year plan. It has been produced following two HFMA meetings – the attendees at those meetings are listed in **Appendix 1**.

The financial position of the whole NHS is challenging. However, this briefing focuses on the provider sector rather than the whole of the NHS in England which includes NHS England and clinical commissioning groups as well as other arm's length bodies. This is for two reasons:

- The provider sector accounts for almost 60% of the total capital expenditure in the NHS¹¹
- The system for allocating capital funds to the provider sector is different to, and more complex than, the system used for other bodies in the DHSC group.

The further work proposed at the end of this briefing – for example, best practice in board reporting – will be applicable to all NHS bodies.

A complex system

The NHS is, as we have said above, a complex system made up of many types of organisations with different statutory and administrative duties. As the structure of the NHS has changed, the funding and financial mechanisms have evolved accordingly over the past 70 years. The result is a patchwork of different arrangements that do not always work in a cohesive manner.

The key difficulty when considering the financial position of the NHS is that there are many different statutory and

administrative requirements that NHS organisations are expected to meet.

Departmental voted allocation

All government departments, including the DHSC, are required to keep their expenditure for the year within the resources voted to them by Parliament.

The voted allocation is split into four (see diagram below).

	Revenue (R)	Capital (C)
Departmental expenditure limit (DEL)	RDEL – expenditure on running costs which the organisation can plan and control. Performance against the two DEL metrics is considered to be 'manageable' by the Department and failure to stay within these limits will result in failure to stay within the vote. These are hard limits. Underspends against these limits are not automatically carried forward especially where they are unplanned.	CDEL – expenditure on items which have a useable life of more than a year – for example, buildings and equipment.
Annually managed expenditure (AME)	RAME – expenditure which cannot be reasonably subject to firm, multi-year limits - for example, pensions and welfare benefits. Performance against the two AME metrics is not considered to be manageable and therefore they are not hard limits.	CAME – expenditure on capital assets which cannot be managed by the organisation – for example, impairments due to changes in market values.

¹⁰ Source: table 1.8 of the *Autumn Budget 2017*. This excludes the element of the £3.5bn capital investment in estates announced at the same time, which will be allocated in 2021/22 and 2022/23

¹¹ Source: figure 21 on page 202 of the *DHSC annual report and accounts 2017/18*. It is worth noting that, at a national level, capital expenditure includes research and development, which would not normally be capitalised by NHS bodies. When research and development is excluded the provider sector accounts for 73% of capital expenditure

The DHSC is accountable for the consolidated performance of all 462 bodies in the DHSC group, including performance against each of the allocations set out above.

It is possible for the DHSC to agree with HM Treasury that amounts allocated for capital can be transferred to revenue – capital to revenue transfers. Such transfers have been used recently¹² to manage the group’s performance against RDEL.

Provider organisation financial regime

The history: 1990 to 2015

To understand the current issues, it is necessary to understand how the capital regime has evolved over recent years.

The structure of the NHS in England is always evolving and changing. The key changes that have had an impact on the NHS financial system today are:

- From 1 April 1991, the introduction of:
 - The internal market and the creation of NHS trusts and
 - Capital accounting and capital charges in the NHS
- From 1 April 2003, the introduction of payment by results for healthcare services¹³
- From 1 April 2004, the establishment of the first foundation trusts.

When NHS trusts were established, they were expected to be run as quasi commercial entities, which would have responsibility for managing their capital assets as well as making a revenue surplus year on year.

The capital charging system was designed to:

- Recognise and increase awareness of the cost of capital, which would promote the efficient use of assets
- Provide incentives for the efficient use of capital resources, which would improve decision making on asset acquisition and disposal.

When foundation trusts were established, there was a similar working assumption that they would be able to raise sufficient

income to cover their operating costs and, in part, finance capital investment. They were also permitted to borrow to finance capital investment, as long as they could demonstrate that they could repay the loans.

The key financial metrics used to monitor the financial performance of foundation trusts were set out in the:

- *Prudential borrowing code* (from 2005 until 2013)
- *Compliance framework* (from 2005 until 2013)
- *Risk assessment framework* (from 2013 to 2016).

These metrics are set out in detail in **Appendix 2**, along with our assessment of what they might mean for today’s provider bodies. Based on our analysis of 2017/18 annual accounts data, it is noticeable that few foundation trusts would currently achieve the metrics set out in the *Prudential code* or the *Compliance framework*.

The system for establishing and monitoring foundation trusts worked relatively well for a period, but not for all NHS providers. There were always some provider bodies that would not meet the necessary financial criteria to achieve foundation trust status, largely because the income that they could generate would never cover the costs that they incurred each year.

Between 2004 and 2012, the number of foundation trusts grew steadily but from then onwards, the number of foundation trusts increased by fewer than five per year. At 1 April 2018, 66% of NHS providers are foundation trusts (152), while the rest are NHS trusts (80).

This briefing does not address private finance initiative (PFI) schemes specifically, but it is worth noting that it was during this period that they were used as a mechanism to increase capital investment without necessarily impacting on CDEL¹⁴. It is noted that the buy-out and renegotiation of such schemes could have an impact on CDEL.

Recent history: 2015 onwards

In 2015/16, the Department of Health only met its statutory requirement to keep revenue expenditure within the funds voted by Parliament due to a technical issue in relation to national insurance payments.

¹² In 2017/18, £1bn was transferred from CDEL to RDEL (source: paragraph 170 of the *DHSC annual report and accounts 2017/18*). In his evidence to the public accounts committee on 17 October 2018, David Williams, director general, finance, DHSC said: ‘A judgment was taken at the time of the spending review 2015 that, exceptionally, it was better to put more money into day to day operations of the system at the expense of long-term investment through the capital budget ... with the application of new money through the long-term plan, we will not be making central capital revenue switches from 2019-20 onwards ... In the year covered by the accounts it was £1bn. This year our plan is £500m, and I think it will now be zero from 2019-20’

¹³ Department of Health, *Payment by results: background and history, 2007*

¹⁴ PFI assets are usually accounted for on the balance sheet of the NHS body in the same way as if they were purchased. The unitary payment made to PFI provider is then split between facilities charges and interest on the loan financing in the scheme. Dual accounting arrangements mean that the costs relating to PFI assets do not hit CDEL. Currently, assets financed using operating leases do not impact on CDEL as they are not accounted for on the balance sheet. However, from 2019/20, lessee accounting for leases will change and all leases will be shown as a right-of-use asset and lease liability on the balance sheet. The impact of this accounting change on performance against CDEL is being reviewed by HM Treasury and is therefore not considered in this briefing. It is a concern for NHS bodies that are currently using operating leases as a mechanism for accessing assets without incurring capital expenditure

Table 1: Single oversight framework financial metrics

Area	Weighting	Metric	Definition
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations
	0.2	Liquidity days	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
Financial efficiency	0.2	Income and expenditure margin	I&E surplus or deficit/total revenue
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to year-to-date plan I&E margin (surplus/deficit) on a control total basis
	0.2	Agency spend	Distance from provider's cap

The 2015 *Spending review* announced additional funds for the NHS, in particular the £1.8bn sustainability and transformation fund¹⁵. In December 2015, the publication of *Delivering the Forward View: NHS planning guidance 2016/17-2020/21*¹⁶ mentioned control totals for the first time. More detail on how the new system would work was given in July 2016 in *Strengthening financial performance and accountability in 2016/17*¹⁷. Control totals were intended to be a short-term measure to rebalance the financial position of the NHS and reverse the trend of more and more providers reporting deficits.

NHS Improvement also introduced the *Single oversight framework*¹⁸, which considered use of resources and finance as one of the five areas where NHS providers might need additional support.

The framework still considers two balance sheet metrics but gives equal weighting to metrics relating to income and expenditure as well as control totals and agency spend caps (see **Table 1**).

The letter to CCGs' accountable officers and provider bodies' chief executives from NHS Improvement and NHS England (dated 16 October 2018) on the approach to planning for 2019/20 and beyond states: 'Individual control totals are no longer the best way to manage provider finances. Our medium-term aim is to return to a position where breaking even is the norm for all organisations.' However, control totals will remain for 2019/20.

The financial framework in theory

Foundation trusts have no statutory financial duties and are not given any revenue or capital expenditure limits. There is

The availability of internally generated funds is a particular issue for those provider bodies with large PFI schemes. One foundation trust reported that 70%-80% of the cash balance generated by depreciation is used to pay the annual loan repayment of the PFI scheme, leaving very little internally generated resource to replenish the trust's owned assets.

In addition to the loan repayment, part of the unitary charge is to keep the PFI asset in 'day one' condition.

The trust therefore has no option but to seek loans from the DHSC to fund its capital programme.

As PFI schemes were all individually negotiated, their terms and conditions are very different. Therefore, the solution to assisting bodies in this position will have to be developed on an organisation by organisation basis.

an expectation that they will be financially viable, but this is not defined in statute. This means, in theory, that they can make a deficit in one year which will be recovered in future years – they can invest to save. They can also incur capital expenditure to the extent that they can pay for it with internally generated funds or by borrowing.

Internally generated funds are the result of the accumulation of depreciation charges. These are a non-cash charge to expenditure, which, in theory, help build up cash balances that can be used to replace capital assets once they are fully depreciated. However, this only works where the depreciation charges cover the replacement cost of the assets in use and does not take into account new capital developments. In 2017/18, on average the level of capital expenditure incurred

¹⁵ For 2018/19, the provider sustainability fund will be £2.45bn – see NHS England and NHS Improvement, *Refreshing NHS Plans for 2018/19*, 2018

¹⁶ NHS Improvement and NHS England, *Delivering the Forward View: NHS planning guidance 2016/17-2020/21*, 2015

¹⁷ NHS Improvement and NHS England, *Strengthening financial performance and accountability in 2016/17*, 2016

¹⁸ NHS Improvement, *Single oversight framework*, 2016

One HFMA member reported that they worked at an NHS trust that had sufficient cash balances to invest in capital expenditure but could not proceed until a business case was approved by NHS Improvement. There was insufficient headroom against the national CDEL to allow for the business case to be approved.

Neither could the trust lend its cash to another NHS body to invest in capital projects for the good of the local health system, again because of the possible impact on the national performance against the CDEL.

by NHS providers exceeded their depreciation charge for the year by approximately 50%¹⁹.

NHS trusts are given a capital resource limit (CRL), which is akin to the DHSC's CDEL. It means NHS trusts cannot incur capital expenditure above that limit and it is managed, in part, through the external finance limit (EFL)²⁰. NHS trusts do not have a resource limit on revenue expenditure but are, instead, required to break-even taking one year with another. The fact that this duty is a rolling duty rather than an absolute requirement means that there is some flexibility to spend to invest and incur a deficit which would later be recovered. However, in 2017/18, 40 NHS trusts (50%) failed meet this statutory duty²¹ over a three or five-year period.

The fact that NHS trusts have a CRL means that they cannot incur capital expenditure without submitting a business case to NHS Improvement even when they have the resources available to do so.

As NHS trusts have a CRL, they are required to obtain approval for any loans to finance capital expenditure. Foundation trusts can, in theory, borrow from outside of the public sector but in practice will access loans from the DHSC²². The process to access these funds is different for those foundation trusts deemed to be in financial difficulty to those that are not.

Some foundation trusts have been classified as 'in distress'²³. They are charged a higher interest rate for new borrowing to other bodies. Also, those provider bodies that have not agreed a control total may be charged a different rate of interest.

Those NHS bodies paying higher rates of interest on

borrowing are concerned that there is a detrimental effect on patient care. This may be the case for those individual bodies' patients and is a cause of frustration to those working at the affected bodies, but the interest paid to the DHSC will be reallocated elsewhere in the NHS, so will support patient care somewhere else in the system.

The system for prioritising capital programmes is unclear and is, in part, the result of the perceived importance of the service which the capital assets are servicing.

There is also some confusion as to whether capital programmes are reviewed and approved nationally or as part of a system. In 2017/18, STPs were required to prioritise and submit bids for capital funding on a system-wide, rather than entity, level. These bids were then approved nationally.

Capital receipts

The sale of non-current assets generates capital receipts. These receipts increase the total amount of capital that can be spent before the CDEL is breached.

Foundation trusts (unless they are in financial distress) are allowed to keep and spend all of the capital receipts that they generate. Foundation trusts in financial distress and NHS trusts are able to keep receipts up to a delegated limit. Keeping receipts over that amount is subject to approval by NHS Improvement, the DHSC and, possibly, HM Treasury²⁴.

NHS Property Services Ltd manages a large NHS estate property portfolio. As a wholly-owned subsidiary of the DHSC, its accounts are consolidated into the DHSC's accounts and its performance impacts on the CDEL. The company is able to reinvest its capital receipts from the sale of its assets²⁵.

This system means that some NHS bodies are able to benefit directly from the sale of their surplus assets, while others may not see that same direct benefit.

When NHS bodies sell non-current assets at a profit, this is recorded as income and improves performance against the control total. Overachievement against the control total results in additional sustainability and transformation fund (STF) income, which further improves their financial position. There is some disquiet in the sector that these 'windfall' gains are being rewarded in such a way.

¹⁹ Source: page 11 of the *Consolidated provider accounts 2017/18*

²⁰ The EFL is a control on net cash flows. A target EFL is set at the start of the financial year by the DHSC and the trust is expected to manage its resources to ensure it achieves the target. The target EFL can be positive, which means that the trust will need to draw on government funding or use its own cash balances to fund capital expenditure; or it can be negative, which means that the trust is required to repay government funding or to increase its cash balances

²¹ Source: page 28 of the *Consolidated provider accounts 2017/18*

²² Department of Health, Secretary of State's Guidance under section 42A of the *National Health Service Act 2006*, 2014

²³ NHS Improvement, *Special measures for finance reasons: guidance for trusts*, 2018

²⁴ NHS Improvement, *Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts*, 2016

²⁵ Source: page 12 of the *NHS Property Services annual report and accounts 2016/17*

The impact of working to different requirements

Managing these financial targets is further complicated by the fact that the measurement of performance against them is not aligned to reporting under international financial reporting standards (IFRS). For example, NHS bodies will establish provisions in accordance with IAS 37 *Provisions, contingent liabilities and contingent assets*. Under this reporting standard, the establishment of a provision will result in an increase in a liability with a charge to expenditure. Therefore, for NHS providers, this will reduce any reported surplus or increase a deficit – an adverse impact on performance. However, in terms of the DHSC's financial performance, the establishment of a provision will be charged to RAME, which is not a fixed limit. When the provision is discharged (by paying for the liability) then this has no effect on an NHS body's bottom line other than to take account of any differences between the estimated provision and the actual payment. For the DHSC, however, the payment is a charge to RDEL, which will impact on its performance against the vote.

The DHSC is required to meet a statutory spending duty without direct control of the entities that incur the expenditure, and which do not have the same statutory duty or report on a basis that measures performance against the duty. In terms of capital, and staying within the CDEL, it is dependent on accurate forecasts of capital expenditure by providers. This is the case for all capital expenditure, whether it is financed by the DHSC or not.

This caused real difficulties in 2017/18, when the forecast level of capital expenditure was more than the actual amount. In its year-end report on provider performance, NHS Improvement reported: 'Throughout the year the sector has been forecasting in excess of £3.3bn CDEL expenditure. However, at month 11 this forecast reduced and at draft accounts the expenditure was £3.074bn, an underspend of £256m, with no mechanism for the return of this funding in 2018/19.'²⁶

The impact on operations

All decisions, both financial and operational, need to be made for the benefit of patients and taxpayers. We know that when there is too much focus on financial performance and financial targets, patients can suffer, as clearly set out in

the introduction to the report on the public inquiry into Mid Staffordshire NHS Foundation Trust²⁷: 'In introducing the first report, I said it should be patients – not numbers – which counted. That remains my view. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and, in many cases, necessary. But it is not the system itself which will ensure that the patient is put first day in and day out. Any system should be capable of caring and delivering an acceptable level of care to each patient treated, but this briefing shows that this cannot be assumed to be happening.'

In any report on the financial position of NHS bodies, it is worth bearing that in mind. Indeed, at our first meeting to discuss this work, it was pointed out that it will be the patients who feel the impact of necessary capital work not being undertaken on a timely basis.

This report is intended to inform the debate on how the finite capital resource that is available can be distributed across the whole of the NHS in England in the most equitable way to maximise the benefit to patients.

Focus on the control total

Our members are concerned that the current focus on control totals is not best practice when managing finances, and welcome the recent announcement that it will not be used beyond 2019/20. There has been pressure on NHS bodies to 'squeeze' the balance sheet to benefit revenue performance, which will have consequences for future years²⁸.

Good financial management requires an understanding of the financial position as a whole, this includes the balance sheet as well as financial performance in terms of income and expenditure. By its very nature, double-entry bookkeeping means that the two are inextricably linked and a change in income or expenditure will impact on either assets or liabilities.

Commercial organisations, and their investors, will focus on and manage the balance sheet and associated metrics and only after that look at the profit or loss of the organisation.

It is worth noting that the *Conceptual framework for financial reporting standards*²⁹ defines income and expenditure in terms of movement in assets and liabilities: 'Income is increases in economic benefits during the accounting period

²⁶ Source: page 29 of the *Performance of the NHS provider sector for the year ended 31 March 2018*

²⁷ Report of the *Mid Staffordshire NHS Foundation Trust public inquiry*, 2013

²⁸ A letter from NHS Improvement to NHS provider bodies in January 2016 suggested that asset lives should be reviewed to reduce depreciation charges, assets should be revalued and prudence should be removed from the balance sheet. This was criticised by the NAO in their explanatory report on the, then, Department of Health's annual report and accounts 2015/16

²⁹ The IFRS foundation, *Conceptual framework for financial reporting*, 2018

	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5	Trust 6
Performance against A&E target (%)	97.7	96.8	96.1	94.6	94.3	93.4
2017/18 planned surplus/(deficit) (£'000)	10,105	765	(2,906)	138	7,074	6,393
2017/18 actual surplus (£'000)	26,058	3,764	899	21,966	25,620	12,296
Segment in accordance with the single oversight framework metrics	1	2	2	2	1	1
Long-term debt/taxpayers' equity (%)	19.9	63.7	5.1	207.1	22.1	3.7
Gearing ratio (%)	20.9	66.9	5.2	213.2	23.4	3.9
Return on capital employed (%)	13.4	4.9	4.4	22.6	13.6	10.2
Prudential code tests (%)	Met	Not met	Met	Not met	Met	Met
Asset sustainability ratio (%)	36.8	23.5	16.6	114.7	92.0	46.7

in the form of inflows or enhancements of assets or decreases of liabilities that result in increases in equity, other than those relating to contributions from equity participants.'

The framework also states: 'Expenses are decreases in economic benefits during the accounting period in the form of outflows or depletions of assets or incurrences of liabilities that result in decreases in equity, other than those relating to distributions to equity participants.'

Before the recent announcement that control totals will not be used beyond 2018/19, our members expressed concern that the focus on a single metric, the performance against the control total, which is an income and expenditure metric, has, in the worst cases, resulted in:

- Judgements and estimates being made to improve the reported position against the control total, which have resulted in reduced levels of internally generated cash available to finance replacement capital expenditure
- Working capital management practices being established to manage the cash position in a way that has resulted in real cashflow problems for businesses supplying the NHS
- Seemingly sudden and unexpected deterioration in financial position (for example, Barking, Havering and Redbridge University Hospitals NHS Trust), where, on closer inspection, the assumptions and judgements made in reporting the financial position were untenable and the organisations were about to run out of cash.

The control total is an absolute target each year that must be achieved or exceeded each year. It therefore reduces

providers' ability to enter into invest to save schemes. The rolling break-even duty allows providers to make a deficit in one year, which will be recovered in subsequent years.

The generation of surpluses means that trusts will be building up internally generated resources and cash balances, which they could use to finance capital expenditure. However, this capital expenditure will impact on the DHSC's performance against CDEL. The system of control totals may have unintended consequences on capital spending.

Control totals vs balance sheet metrics

We took six foundation trusts that performed well against the STF criteria³⁰ of meeting A&E waiting times and achieving their control totals in year and looked at their balance sheet metrics to see if there were any common results (**Table 2**).

This identified that the use of different metrics results in different conclusions in relation to financial performance. For example, trust 4 has a gearing ratio³¹ of more than 100%, which may be a concern as it means that it is heavily reliant on borrowing. However, its asset sustainability ratio of more than 100% means that it is replacing its assets as they reach the end of their useful lives. Its relatively high return on capital employed indicates that it is using its capital efficiently to generate a surplus.

On the other hand, trust 3 seems to be performing well and has a relatively low level of debt. However, the low asset sustainability ratio indicates that it is not replacing its assets as they reach the end of their useful economic lives.

³⁰ The sustainability and transformation fund (STF) of £1.8bn was introduced in 2016/17. The fund was allocated to trusts as non-recurrent income by NHS Improvement. To receive that income, trusts had to agree and meet their control total as well as meet operational access criteria (the four-hour A&E waiting time target)

³¹ The gearing ratio is borrowing divided by taxpayers' equity

What does a healthy balance sheet look like?

NHS bodies are not homogeneous entities and they all have:

- Different ways of working
- Entered into different transactions
- Varied estates portfolios
- Made different decisions and
- Very different challenges.

This means that when looking at the population of foundation trusts as a whole, it has been difficult to draw out any common features of 'good'.

As we have indicated earlier, the accounts of any entity are complex and need to be considered in the round, so it has been difficult to determine any single balance sheet metric that will answer this question.

In developing this briefing, we used a number of common ratio analysis techniques to see if we could identify the characteristics of a healthy balance sheet. These included:

- The current ratio
- Debt to equity ratios
- Return on capital employed
- Asset sustainability ratio.

The results of this analysis did not identify any simple common themes. Having said that, we have identified a few

qualities that an organisation with a 'good' balance sheet will have. They are:

- Sufficient cash balances to finance short-term working capital needs³²
- Historic and in-year surpluses that have allowed the build-up of cash balances to finance the capital programme
- If the organisation has debt, it is being used to finance capital investment rather than servicing working capital needs
- An unqualified value-for-money conclusion from the auditors with no emphasis of matter in the audit report.

In addition, the organisation will not have reviewed balance sheet judgements and estimates solely to improve the income and expenditure position.

Examples of such actions might include increasing estimated asset lives to reduce depreciation charges, reviewing valuation assumptions to reduce depreciation charges or reviewing provisions to see whether any can be released.

While all estimates and judgements must be kept under review to ensure that they are still appropriate, especially as circumstances change, it is the rationale behind the review and the final decisions that are important.

When looking at the population of foundation trusts as a whole, it has been difficult to draw out any common features of 'good'. The accounts of any entity are complex and need to be considered in the round, so it has been difficult to determine any single balance sheet metric that will answer this question

³² NHS Improvement's *Single oversight framework*, 2017, includes liquidity days as one of the financial metrics. NHS bodies with liquidity days of more than zero are given the best score available. In this context, liquidity is measured as 'days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown

What might a new capital regime look like?

We have given some thought to what a new capital regime might look like and, while we do not presume to have all of the answers, we have identified some characteristics any new system should have.

Issues to be resolved

This briefing is focused on access to capital financing and the impact of the focus on control totals. Any new system needs to be designed to tackle the following problems:

- The need to replace the worn-out NHS estate in a planned and effective way
 - Recognising that there is a difference between capital expenditure that is replacing/renovating existing assets (backlog maintenance) and capital investment in new assets/developments.
- The need for future proofing – to allow NHS bodies to take advantage of technology to improve efficiency.
- To allow for partnership working with local authorities, which work under a completely different capital system³³.
- The perception that it may be possible for NHS bodies to get a better deal (lower interest) from commercial organisations, pension schemes or even local authorities, than they currently can from the DHSC. This is an issue for two reasons:
 - A lower interest rate, and consequently lower interest charges, would have a positive effect on the financial position of the NHS body, borrowing from outside of the NHS but would mean that the interest payment would be made outside of the NHS and it would therefore count against the RDEL at a consolidated level. Interest payments on loans to NHS bodies by the DHSC are kept within the DHSC group and are therefore reallocated elsewhere in the system
 - It makes it more difficult for the DHSC to manage the expenditure that counts towards its CDEL – with the consequent risk that it will fail to meet this statutory duty.
- The current system of interest payments and PDC dividends is intended to add a financial consequence to decisions around the management of the estate. This system has

unintended consequences and can penalise the patient rather than encourage good management. Nevertheless, any new arrangements must encourage the good management of estates.

- The complexity of the current system means provider bodies focus on simply working through the process, any new system should incentivise better value procurement and financing.
- To move the financial management focus towards consideration of the financial position as a whole.

Suggested characteristics for a new capital regime

Before considering solutions to the current financial difficulties in the NHS, we have considered what characteristics we would want to see in a new capital regime. It may seem obvious but some of the current difficulties and frustrations are down to complexity of the system and the sometimes, seemingly, arbitrary decisions that are made.

If a new NHS capital regime is developed it needs to be:

- **Open and transparent.** To do this, the system needs to be supported by clear guidance which is available to all. The current guidance on accessing loans from the DHSC³⁴ was published in October 2014 and does not describe the system that is currently in operation.

As set out above, the funding system for the NHS is complicated and different entities all have different responsibilities and duties. To improve the system, all parts of the system need to understand the pressures that their colleagues are working under so that they can work together. This is the current direction of travel with the STP capital allocation process.

- **Fair and equitable.** There will always be NHS bodies that are less financially stable than others. The reasons for this may be down to poor financial management (current or historic) but may also be due to circumstances beyond anyone's control – for example, due to location, estate, or demographic/population needs. Whatever the reason, access to scarce resource must be fair and equitable and based on need,

³³ HFMA, *Capital collaborations between the NHS and local authorities*, 2017

³⁴ Department of Health, *Secretary of State's guidance under section 42A of the National Health Service Act 2006*, 2014

rather than penalising those that are already struggling financially.

As discussed earlier, most foundation trusts and NHS Property Services Ltd can keep (and use) proceeds from the sale of assets – this increases their spending power in the year of disposal or in future years. However, foundation trusts in financial distress and NHS trusts are not entitled to automatically keep the proceeds of sales – there is a business case process for them to go through when sales are above £15m.

While difficult to solve, an equitable system will acknowledge that some entities are able to benefit from selling surplus assets simply because their estate has assets that are commercially valuable either due to their location or due to the fact that there are assets that can be sold without affecting patient care. Any allocation process should take into account the fact that some organisations can generate additional resource while others cannot.

- **Based on clear criteria.** Unless resources are unlimited, there needs to be clear criteria for eligibility. This will not be straightforward as each business case will have its own merits and there are risks that any nationally developed criteria will not align to local needs and strategies. Equally, locally developed criteria may not take account of the wider, national strategy. The system needs to be robust enough not to be impacted by vocal local interest groups and/or politicians.

- **Cooperative rather than combative.** Anecdotally, the system for applying for, approving and authorising the fixed envelope of capital funding is not one of mutual support and understanding. As the NHS in England moves towards system working, any new arrangements need to be based on cooperation and a movement towards common goals and away from the current ‘us and them’ mentality.

- **Timely.** Capital programmes take time to implement so it is important that decisions about capital allocations are made on a timely basis. NHS bodies report delays in decisions on capital plans and funding, which results in them having to enter into contracts late in the financial year in order to use the funds. This increases the risk of both poor and short-sighted decisions being made to ensure that the financing is not lost. On the other hand, as quoted above, in its quarter 4 performance report for 2017/18, NHS Improvement reported that NHS providers had not accurately forecast the year-end capital expenditure resulting in a loss of £256m of funding. For the national bodies to manage their financial position, NHS bodies need to ensure that their in-year and year-end financial reports and forecasts are accurate.

- **Provide some long-term certainty.** While any public sector system is subject to change, as far as possible, any

system must be established so that organisations can put in place plans for the medium- to long-term based on their understanding of how they can access capital.

- **Streamlined.** Finance colleagues in the NHS report that filling in the documentation to access financial support is resource intensive. Any system for allocating resources needs to ensure that those making the decisions have the necessary high-quality information to allow them to make appropriate decisions on a timely basis without having to go back and forth for more information. The system needs to be as un-bureaucratic as possible while ensuring that the right information is provided only once. The digital investment strategy is aligned with hypothecated funding levels and has therefore been much more straightforward to develop than STP capital plans.

Ideally, the information needed for decisions to be made by regulators would be the same information that local management teams need to run NHS bodies. Some work to streamline the information flow and focus it on the decision-making needs of all parties is something the HFMA will be working on in the next year.

Possible solutions

We do not offer a single solution but instead highlight some changes that may go some way to solving the issues identified.

The cumulative financial position is untenable for some NHS provider bodies

At the moment, there is an assumption that income earned through the national contract and tariff will be sufficient to allow NHS bodies to cover their operating expenditure and, through depreciation, build up internal resources to fund replacement capital expenditure. As more and more providers are in deficit, there are other priorities for these resources.

The use of internally generated resources to fund capital

One HFMA member reported that their foundation trust was providing bariatric services. The tariff did not adequately cover the capital cost of the specialist equipment needed so the decision was taken to withdraw the service.

However, other local bodies had also withdrawn their services for the same reason. In order to ensure that the service was continued in the locality, additional funding was found to replace the equipment. When resources are scarce, there needs to be clear criteria for approval which means that all needs are considered relative to other demands.

expenditure also causes the DHSC problems with managing the CDEL as it means that bodies can incur capital expenditure without recourse to the DHSC, therefore incurring expenditure that they are not sighted on.

A solution would be to set the tariff to cover the revenue costs of service provision, taking all costs relating to capital outside of tariff. This would have the advantage that the system of reimbursement would recognise that for public sector bodies revenue and capital allocations are separate and different. However, it would require a complete revision of the tariff arrangements, which would be a long-term project and not without difficulty.

Even if the funding arrangements were revised for future years, this does not address the fact that some NHS bodies are in such financial difficulty that, if they were a commercial organisation, they would be insolvent.

To resolve this issue, a financial reset would be required that clears the debt NHS bodies have and that is never going to be repaid. This has never happened before – ‘No loans to NHS trusts or NHS foundation trusts have been written off since the re-introduction of loan financing for NHS providers in 2004.’³⁵ However, many loans are simply rolled forward year on year and it is apparent that they will never be repaid. It is not clear what impact this would have on the performance of the DHSC as a whole.

More radically, the cumulative deficits of affected NHS bodies could be written off. Equally, the impact of this on the performance of the whole group is not clear. A write-off of historic debt or cumulative deficits would need to avoid penalising bodies that have managed to stay in good

financial shape. These options may not have the impact that they are expected to have as, currently, NHS bodies make payments to the DHSC no matter what their balance sheet looks like:

- Those with more liabilities than assets are likely to be indebted to the DHSC, either in the form of working capital loans or capital loans, and therefore pay interest (at varying rates) on those liabilities to the DHSC
- Those with more assets than liabilities pay 3.5% of net relevant assets in PDC dividends to the DHSC.

Detailed modelling would need to be undertaken to understand the impact of these solutions.

The investment needed by the NHS estate is greater than the available resource

An analysis of the estates returns collections (ERIC)³⁶ shows that the amount invested in the estate to keep it to expected levels declined year on year from 2013/14 to 2016/17 but increased in the last financial year. The cost to bring the assets up to expected levels³⁷ is increasing year on year. This is shown in **Table 3**.

Backlog maintenance is used as an indicator of this cost – it is not perfect as it does not include any amounts relating to PFI-funded estates, as usual contract terms require buildings to be maintained to an agreed condition, so will be included in the unitary charge and neither does it include the cost of replacing medical and IT equipment.

Backlog maintenance is just one call on the limited CDEL³⁸ available for the whole of the NHS. For instance, backlog

Table 3: backlog maintenance

Year	Cost to eradicate total backlog maintenance		Cost to eradicate total backlog maintenance	
	£m	% change	£m	% change
2011/12	397.8	–	4,023.8	–
2012/13	445.4	12.0%	4,035.9	0.3%
2013/14	393.4	- 11.7%	4,041.7	0.1%
2014/15	369.8	- 6.0%	4,337.9	7.3%
2015/16	352.4	- 4.7%	4,974.7	14.7%
2016/17	324.0	- 8.1%	5,545.5	11.5%
2017/18	404.5	24.8%	5,959.3	7.5%

³⁵ Source: page 171 of the *DHSC annual report and accounts 2017/18*

³⁶ Source: HFMA analysis of *Estates returns collection (ERIC) - England 2015/6 and 2016/17*

³⁷ Backlog maintenance is the amount it is expected to cost to bring an asset up to a suitable condition (known as Condition B) which is in accordance with mandatory fire safety requirements and statutory safety legislation. See NHS Estates, *A risk-based methodology for establishing and managing backlog*, 2004

³⁸ According to the 2017 Autumn budget, the health CDEL is £5.6bn for 2017/18, £6.4bn for 2018/19, £6.7bn for 2019/20 and £6.8bn for 2020/21

maintenance is reported by NHS provider bodies only – the CDEL has to cover all capital expenditure incurred by the DHSC group. Therefore, there will need to be a method of prioritisation and allocation. This could be done at a national level or at a STP level. As system working comes into force then there could be peer to peer review of capital programmes against a system level strategy.

This would have the advantage that local decision-making should mean that the spend is aligned with the strategy. However, it would only work where that strategy was clear and agreed by all parties.

The new system would also have to take account of capital receipts and the fact that some NHS bodies have surplus assets while others do not. Asset sales and estate rationalisation should be incentivised for the good of the system rather than for the good of the organisation. Again, resources and performance metrics need to be aligned to ensure that best value for money is achieved.

The current system requires business cases to be submitted to access capital funding and this would continue to be the case. High-quality business cases and forecasts would need to be assessed against clear criteria to ensure that limited capital resource is used in the most appropriate way.

The current arrangements for accessing capital is too complex

A simple solution would be to give each NHS body (or STP footprint) a capital allocation before the start of the year to which it relates, which is cash backed and for them to spend as they wish. This would avoid the timeliness issue and would

be very transparent. As described above, there will be issues coming up with an allocation process as capital resource is currently scarce. We note that the development of STP wide capital programmes is a move in this direction.

A more refined version of this solution would be to give an allocation at an NHS body level for backlog maintenance type capital expenditure while holding an allocation at an STP or national level for new investment. The second allocation would be accessed based on business cases - in a timely manner based on clear criteria.

Both of these arrangements would require the establishment of a single system for accessing capital funding, which all NHS bodies use regardless of their financial position or statutory basis. This would allow the DHSC/NHS Improvement to have control over where funding is spent, as applications for funding would have to be supported by a high-quality business case. It would not, however, resolve the historic deficit position of some NHS providers as set out earlier.

This process of allocations would remove the current arrangement of 'repayable' loans as the mechanism for funding capital expenditure. For more and more NHS bodies, capital loans in addition to working capital loans mean that their interest payments are having an adverse effect on their financial position and they will never be in a position to repay them.

A system of allocations from the DHSC to provider bodies would mirror the arrangement at a national level. Provided that NHS bodies did not exceed their allocation, this would have the advantage of making managing the position against the CDEL much more straightforward.

If a new NHS capital regime is developed it needs to be:

- Open and transparent
- Fair and equitable
- Based on clear criteria
- Cooperative rather than combative
- Timely
- Provide some long-term certainty
- Streamlined

Conclusions and future work

This is not a simple subject and we do not presume to have the solution. However, we hope that this work will contribute positively to the current discussions around the 10-year plan, in particular, the prime minister's requirement that 'it must be a plan that makes better use of capital investment to modernise its buildings and invest in technology to drive productivity improvements.'³⁹

In terms of the HFMA's contribution going forward, we will focus on two areas:

- Education and training to improve senior manager and non-executives' understanding of financial reports and balance sheets in particular
- Best practice in board reporting.

³⁹ Source: Prime Ministers speech on the future of the NHS on 18 June 2108

Appendix 1:

Acknowledgements

The HFMA would like to thank everyone involved in preparation of this briefing, in particular:

- Caroline Clarke, group CFO and deputy chief executive, Royal Free London NHS Foundation Trust
- Phil Bradley, finance director, Northampton General Hospital NHS Trust
- Martin Chamberlain, deputy director of finance, Dartford and Gravesham NHS Trust
- Kendre Chiles, head of financial services, University Hospitals of Derby and Burton NHS Foundation Trust
- Catherine Eyre, acting associate director of finance, Guys and St Thomas' NHS Foundation Trust
- Phil Foster, director of operational finance, Birmingham Women's and Children's NHS Foundation Trust
- Scott Jarvis, director of operational finance, University Hospitals of Derby and Burton NHS Foundation Trust
- Ian Moston, finance director, Salford Royal NHS Foundation Trust
- Lee Outhwaite, director of finance and contracting, Chesterfield Royal NHS Foundation Trust
- Andy Ray, director of financial operations, Barking, Havering and Redbridge University NHS Trust
- Karl Simpkins, finance director, Royal Cornwall Hospital NHS Trust
- Alison Thornley, finance business partner, Southern Health NHS Foundation Trust
- Zephan Trent, assistant director of strategic finance, NHS Improvement
- Robert White, director of health VFM audit, National Audit Office
- Christopher Young, finance director, Department of Health and Social Care
- Emma Knowles, head of policy and research, HFMA
- Emma Legg, committee executive, HFMA
- Debbie Paterson, policy and technical manager, HFMA

Appendix 2: Performance metrics for NHS provider bodies

The original prudential borrowing code

The *Prudential borrowing code* ('the Code') was written to reflect 'generally accepted principles used by financial institutions' to allow foundation trusts 'to access capital within a framework of safeguards designed to mitigate institutional or systemic failure'. It was based on the following proposed metrics determined by the, then, Department of Health⁴⁰:

- Debt service cover ratio: 1.5 times
- Debt service to revenue: 4%
- Interest cover ratio: 1.8 times.

Applying these tests to foundation trusts today

We applied these tests to the current foundation trusts using the information in their 2017/18 accounts .

Of those foundation trusts which had borrowings, only 41 (29%) met these tests in 2017/18 and 2016/17. These were then analysed by the segment that they are in under the current *Single oversight framework*.

The revised Prudential borrowing code

By 1 April 2009, the Code⁴² was revised to include the following ratios and the metrics were revised:

- Dividend cover: >1 times
- Minimum interest cover: >3 times
- Minimum debt service cover ratio: >2 times
- Maximum debt service to revenue: <2.5%.

The system was divided into two tiers – the second tier was added to reflect the fact that PFI schemes were more often on-balance sheet after the introduction of IFRS.

Applying these tests to foundation trusts today

We applied these tests to current foundation trusts using the information in their 2017/18 accounts⁴³.

Of those foundation trusts which had borrowings, only eighteen (14%) met these tests in 2017/18 and eleven (8%) in 2016/17.

	Number of bodies meeting the criteria in 2017/18	Number of bodies meeting the criteria in 2016/17	Number of bodies meeting the criteria in both years	Percentage of bodies with borrowing
Segment 1	22	19	15	10%
Segment 2	36	36	25	18%
Segment 3	1	5	1	1%
Segment 4	2	0	0	0%
Total	61	60	41	29%

⁴⁰ Department of Health, *Finance prudential borrowing code*, 2005

⁴¹ NHS Improvement, *NHS provider accounts consolidation (TAC) data for 2017/18, 2018*

⁴² Monitor, *Prudential borrowing code for NHS foundation trusts*, 2009

⁴³ NHS Improvement, *NHS provider accounts consolidation (TAC) data for 2017/18, 2018*

The Compliance framework

The 2013/14 version of the *Compliance framework*⁴⁴ did not include balance sheet metrics but, instead, included a financial risk rating and indicators of financial risk (see diagram below). These focused on working capital management and cash flow.

The financial criteria in the risk rating were:

- Achievement of plan – EBITDA achieved (% of plan)
- Underlying performance – EBITDA margin (%)
- Financial efficiency:
- Net return after financing (%)
- I&E surplus margin net of dividend
- Liquidity – liquidity ratio.

Indicators of forward financial risk

- Unplanned decrease in EBITDA margin on two consecutive quarters
- Quarterly certification by trust that financial risk rating may be less than 3 in the next 12 months
- Working capital facility used in previous quarter
- Debtors > 90 days past due account for more than 5% of total debtor balances
- Creditors > 90 days past due to account for more than 5% of total creditor balances
- Two or more changes in finance director in a twelve-month period
- Interim finance director in place over more than one quarter-end
- Quarter-end cash balances < 10 days of operating expenses
- Capital variance of +/- 15% of the plan for the year to date.

Applying these tests to foundation trusts today

The metrics set out above cannot easily be measured from the published accounts data. As a proxy for these measurements, we looked at each foundation trust's cash conversion cycle (in days), as well as whether its cash balance is more than 10 days' worth of operating expenses at the year-end.

Only fifty-one foundation trusts (57 in 2016/17) had a positive cash conversion cycle – this means that its creditor days are greater than its debtor days.

Only twenty-four foundation trusts (30 in 2016/17) had creditor days of less than 30 days. As all NHS bodies are expected to pay their trade creditors within 30 days this is a concern.

Only forty-one foundation trusts (45 in 2016/17) had a year end cash balance which was greater than 10 days of operating expenses.

Taking these metrics together, only twenty-five (31 in 2016/17) had both positive cash conversion cycle and ten days' worth of operating expenditure in cash at the year-end.

⁴⁴ Monitor, *Compliance framework 2013/14*, 2013



About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

© Healthcare Financial Management Association 2018. All rights reserved.

HFMA

1 Temple Way, Bristol BS2 0BU

T 0117 929 4789

F 0117 929 4844

E info@hfma.org.uk

Healthcare Financial Management Association (HFMA) is a registered charity in England and Wales, no 1114463 and Scotland, no SCO41994. HFMA is also a limited company registered in England and Wales, no 5787972. Registered office: 110 Rochester Row, Victoria, London SW1P 1JP

HEA.FIN.067 03/17

www.hfma.org.uk