The HFMA's response to the Public Accounts Committee's inquiry into capital expenditure in the NHS

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 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 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.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

Summary

This submission is based on the views of our members and draws on HFMA publications and research. Our key points are:

- our members have consistently identified capital as an area of concern
- the recent changes made to the capital regime mean that the NAO's findings should be considered only to the extent that they allow for the lessons learned from the previous arrangements to be implemented
- the challenge of dealing with the Covid-19 pandemic and the changes that have been made at pace should be used to allow the NHS to consider how funding, both revenue and capital, should be best spent to deliver integrated health and social care in the right place at the right time

- the delivery of system wide capital schemes will need the legislative change set out in the proposed NHS Bill as well as good financial management on a system wide basis
- without a longer-term financial settlement, it is difficult to make any plans. The deferral of the Spending Review, while understandable, is frustrating
- we remain concerned about the affordability of capital programmes as well as the process of approval and management. The agility of the arrangements put in place to address the Covid-19 crisis should be retained where possible
- nationally announced, large scale capital projects should be tracked from the initial announcement to the opening of the facility to ensure complete transparency.

Detailed response

Introduction

Our members have been concerned about capital for some time. Many of the points highlighted in the NAO's report are not new and were set out in our evidence to the Health and Social Care Committee's inquiry on implementing the *NHS long term plan*[1], the HFMA and PwC report *Making the money work in the health and care system*[2] and the HFMA report *NHS capital – a system in distress*[3]. These documents highlighted that the NHS capital regime needed to change. The main issues were that:

- providers reporting deficits did not generate surplus cash which limited the funds that they had available to invest in capital
- the system for funding capital was complex and felt combative
- the system of allocating and managing capital funding was not clear and was perceived as a barrier to investment
- the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSE&I) were concerned that capital money was often unspent at the year-end, which could have been allocated and used. However, NHS bodies were frustrated that the flow of capital funding from the DHSC was slow and unpredictable, so it did not meet providers' needs and made capital forecasting very difficult
- the system was illogical, for example, some providers that did have cash to spend on capital had to make a business case to be able to spend it, others did not have to make a business case but had no available cash
- the focus of financial regulation was not on balance sheets, but on control totals. This increased the risk that underlying financial issues may not be identified at an early stage.

However, in early April 2020, NHSE&I published a new approach to the capital regime in the NHS for 2020/21. There is therefore little to be gained from discussing the problems of previous arrangements, unless it is to learn the lessons from the past so they are not repeated.

Our submission focuses on the capital regime for secondary care providers in the NHS – including mental health, community, and acute providers. The primary care estate and arrangements for funding capital projects are equally important and need to be considered alongside the secondary care system in order to meet the objectives of the *NHS long term plan*[4].

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[1] HFMA, *Evidence to the Health and Social Care Committee's implementing the NHS long term plan inquiry (IBH0044),* August 2019
[2] PwC and HFMA, *Making the money work in the health and care system,* June 2018
[3] HFMA, *NHS capital – a system in distress?*, October 2018
[4] NHSE&I, *NHS long term plan*, January 2019

The new approach for 2020/21

The changes to the capital regime introduced from 1 April 2020 were:

- the division of the NHS provider capital allocation into three categories – system level allocations, nationally allocated funds and other national investment
- the allocation of commissioner capital for primary care and learning disability to system level
- a clear statement that capital allocation is not the same as capital funding – NHS providers are expected to self-finance their capital programmes, although applications for public dividend capital (PDC) can be made if necessary
- the proceeds from the sale of capital assets will be made available to the system to invest in the year of disposal and the two subsequent years
- central support will be provided to assist with the delivery of national projects, particularly those named in the *Health infrastructure plan*[5].

New arrangements for monitoring spending within the system level allocation will be put in place once the immediate Covid-19 crisis has passed.

As well as changes to the capital regime, changes to the cash regime were also made – with the transfer of interim loans (both capital and revenue) to PDC. For those providers affected, this removes the need to constantly manage the loans which is welcome, but it does not improve their cash position or remove the revenue impact as the interest paid is replaced by a PDC dividend.

These changes were announced by NHSE&I alongside a package of measures to support NHS organisations with their response to Covid-19. Together these measures have ensured that the NHS has had the resources needed to deal with the pandemic. The speed of these changes and continued support and communication from NHSE&I national and regional teams has been appreciated by the NHS finance function.

Challenges ahead

Our response focuses on our concerns about the arrangements moving forward and the lessons that can be learned from the changes that have been made at pace to meet the challenge presented by the Covid-19 pandemic.

The immediate costs of dealing with Covid-19 have been met and it seems, in mid-May 2020, that the NHS has not been overwhelmed although the impact of a potential further waves of infections is unknown. As the NHS is turning its attention to how healthcare services will be delivered in a post Covid-19 world, it is important that the additional costs continue to be funded appropriately. This will be a mixture of capital and revenue – for example, the costs of providing remote consultations and enabling staff to work from home will involve the capital costs of purchasing IT equipment, but will also incur an additional revenue cost of cloud-based IT systems and storage. The same is true for adaptations to sites to allow for appropriate social distancing – some costs may be capital but other costs, for example, additional staff to manage queues and flows of patients will be revenue.

The role of the system in transforming healthcare

Prior to the Covid-19 pandemic, the *NHS long term plan*[6] already set out proposals to transform the way that health and social care is provided:

> '... the NHS and our partners will be moving to create integrated care systems (ICSs) everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with local authorities at 'place' level, and through ICSs, commissioners

[5] DHSC, *Health infrastructure plan*, September 2019
[6] NHS, *NHS long term plan* (page 10), January 2019

will make shared decisions with providers on population health, service redesign and *Long term plan* implementation.'

Progress has been hampered by the need to resolve the more immediate financial difficulties faced by NHS bodies. However, some changes have been made at pace as a result of the Covid-19 pandemic and that momentum should not be lost. NHS bodies need time to understand what changes should be made to ensure that capital funds spent now are going to deliver the best value health and social care system over the next ten to twenty years. To understand what this means, a full and frank discussion between government, government departments and regulators, NHS bodies and the public is required to determine what the health and social care system can and cannot provide going forward.

For this to happen, the NHS Bill proposed by the NHS[7] to enable the implementation of the *NHS long term plan* will need to be put before Parliament as soon as possible.

On a more practical level, robust financial management and governance at a system level will need to put in place to ensure that the sustainability and transformation partnership (STP)/ ICS capital allocations are appropriately spent. It will be important that a single balance sheet for that STP/ ICS is produced and used as one of the financial management tools when decisions are being made about how the STP/ ICS allocation will be used. This will ensure that allocations reflect system level strategic plans and will ensure that the bodies that make up the system are all working to the same goal. The production of single, consolidated financial reports for STPs/ ICSs will be an important part of the governance and financial management of the new systems.

Longer-term certainty

Capital expenditure and plans cannot be looked at in isolation – all non-current assets have a revenue cost associated with them in the form of depreciation, financing costs (whether that is interest or PDC dividend) and running costs including repairs and maintenance. It is important that the Government provides clarity to the NHS, and the wider public sector, by setting out clear revenue and capital allocations at the same time and covering at least five years. We understand why the five-year Spending Review that was due last year has been postponed to later this year, but it is difficult to make plans – particularly capital plans that span a number of years – without clarity on the resources envelope that they will be constrained by.

The provision of revenue and capital allocations to fund specific projects also needs to be reviewed as the way that goods and services are provided changes. For example, large scale IT projects have traditionally been included in capital allocations and some of £0.8bn in the 2020/21 allocation for 'other national investment' will include technology provided by NHSX. However, our members are finding that many technological solutions are now being provided as a service that is revenue in nature – for example, whereas once a multi-year licence would have been purchased from Microsoft for the office suite of programmes, this is now purchased on a subscription basis. What was once a capital cost is now a revenue cost, so the allocations need to reflect the new ways of working.

Affordability

The recent changes to the capital and cash regimes are to be welcomed but there is still some uncertainty about how they will work in practice. In order to ensure that limited resource is spent in the right place, the decision making needs to be as close to the patient as possible so the allocation of a capital envelope to each STP/ ICS is welcomed. However, we are concerned about the expectation that the majority of projects within this allocation will be self-financed by providers. As the NAO's report makes clear in paragraph 12 of the summary (and paragraph 3.3 of the report), the availability of cash to fund capital expenditure does not always match the need for capital investment.

[7] NHS, *The NHS's recommendations to Government and Parliament for an NHS Bill*, September 2019

As we have already said, capital projects cannot be looked at in isolation. Our members have expressed concern that the recent focus on performance against control totals has meant that the balance sheet is not being appropriately used as a financial management tool[8]. Both the NHS body and the STP/ ICS balance sheet and associated metrics will have to be used as part of the assessment of affordability of capital projects and that should result in a more rounded assessment of financial performance where all of the consequences of decisions are considered.

Speed of approval process

Clarity is required on how projects will be financed for those NHS bodies without the necessary cash balances. One of the frustrations frequently expressed by our members is the speed at which applications for financing for capital projects were dealt with under the old regime. We understand that delays were, in part, to allow the DHSC to manage expenditure within their capital departmental expenditure limit (CDEL) in the absence of any other control mechanism available to them. We expect that, as long as the project is approved by the appropriate STP/ICS and is within that system's allocation, the approval of funding applications will be speeded up or, at least, be processed within a known and understood timetable. Lack of clarity on when funding will be available makes planning capital projects almost impossible and impacts on the ability of NHS bodies to provide accurate capital forecasts.

We welcome the reforms to the approval arrangements set out in the new guidance. The Covid-19 pandemic has shown that the central decision-making process can be fast and agile, albeit when not constrained by resource limits. As part of the lessons learned from managing the NHS's response to the pandemic, we hope that this agility is not lost although we do understand that it will have to be changed as resource envelopes tighten. Whatever arrangements are put in place to review and approve funding applications, they need to be focused on adding value to ensure that value for money is obtained for every pound spent.

Capital forecasting

It has long been a concern that NHS bodies, particularly providers, do not provide accurate capital expenditure forecasts. This has made managing performance by the DHSC against the annual CDEL very difficult. Providing certainty early in the financial year on the availability of capital allocations and, funding if required, should make the forecasting process easier. There will also be less of a perceived risk by providers that funding will not be made available for programmes that slip, which also should improve reporting.

It is not practically possible for NHS bodies to spend capital allocations given to them in the last quarter of the year unless they have already got a specification in place and have put the contract out to tender. Some have taken the risk of doing this without certainty about the capital allocation or funding, but this does risk wasting resources invested by both the NHS body and potential contractors.

Health infrastructure plan

The announcement by the Prime Minister of the national schemes set out in the *Health infrastructure plan* was welcomed, as were previous high-profile announcements in relation to STP capital funding. The schemes are very large and, by their very nature, will take many years from the announcement to the opening of the new/ refurbished building. We are aware, for instance, that the STP wave 1 schemes announced in 2017 have yet to reach the full business case approval stage and are still a way away from starting to be built.

Over all of this time, the costs of the schemes increases with inflation and as the project moves from initial vision to reality – these additional costs are not included in the funding announced at the start and therefore need to be funded by the bodies themselves which usually means making

[8] HFMA, *How it works – understanding the financial position,* March 2018

compromises to their plans or spending less elsewhere. Such high profile projects should be tracked from the initial announcement to the opening of the facility (as recommended by the Public Administration and Constitutional Affairs Committee in their report *Accounting for democracy revisited*[9]) so that there is complete transparency about the delivery of these high profile projects as well as an understanding of how the cost of such projects changes over time. This will allow vital lessons to be learned by NHS bodies as they develop business cases for future projects.

Conclusion

The NAO's findings are still relevant but the recent changes made to the capital system along with rapid response to the Covid-19 pandemic has provided the NHS with a unique opportunity to change the way that capital projects are planned and funded going forward. The new arrangements need to be transparent, based on clear criteria with timely announcements of allocations to enable appropriate plans to be put in place.

This response should be read in conjunction with our response to the Public Accounts Committee's call for evidence on NHS financial management and sustainability[10].

[9] Public administration select committee, *Accounting for democracy revisited: the government response and proposed review* (paragraph 29), June 2018
[10] PAC, *NHS financial management and sustainability*, May 2020