Written evidence submitted by Healthcare Financial Management Association (DTN0013)

About the HFMA

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

Demand for healthcare services is always increasing, with the available resources not keeping pace. As the Covid-19 pandemic moves to an endemic phase, the NHS is dealing with a backlog of elective cases, increasing emergency demand and workforce pressures. There is no simple solution to any of these problems, but digital solutions are clearly part of the answer.

Our members are concerned that there is a barrier to implementing any digital solution, let alone the type of innovative solutions this inquiry is considering. The barrier is how these solutions are funded and accounted for.

As this inquiry has identified, there are many issues to overcome before the NHS can be fully digital enabled - interoperability of NHS systems, public distrust of government use of personal data and other information governance issues. These issues are complex and cannot be solved by any single organisation. However, the mechanism for funding these developments is relatively simple and within the government's power to solve. Unless the basic funding mechanisms are right, the digital transformation that NHS staff and patients are waiting for will never come to fruition.

There are two issues that we would like to bring to the attention of the Health and Social Care Committee.

Capital and revenue inconsistency

Our briefing *Accounting for revenue and capital - implications for the digital age* sets out in some detail the financial issues facing NHS bodies wanting to implement digital innovations. The briefing was produced following many discussions with NHS finance directors and chief information officers who are currently struggling to make the finances work for digital technology.

Put simply, NHS organisations usually receive capital funding to support their digital programmes, but most of the expenditure has to be accounted for as revenue. This mismatch between the funding and the accounting causes real problems and can result in NHS organisations either being reluctant to embrace digital schemes or can cause an overspend. This is explained in more detail below.

NHS organisations receive two types of governmental funding – capital and revenue. Capital funding is spent on assets that the NHS body will use for more than a year, for example a new building or equipment. Revenue funding is spent on day-to-day costs, for example salaries. Funding for most digital innovations is currently capital – usually provided in the form of public dividend capital (PDC) for NHS trusts and NHS foundation

trusts. PDC is the NHS equivalent of an injection of equity into the organisation. The 2022/23 capital departmental expenditure limit for the Department of Health and Social Care, as set out in the Spring Budget 2022 is £10.6bn, compared to the revenue departmental expenditure limit of £167.9bn.

Capital funding can only be used to finance capital expenditure. NHS bodies are required to prepare their accounts in accordance with international financial reporting standards (IFRS) as interpreted and adapted by HM Treasury set out in the DHSC's group accounting manual. The accounting treatment for transactions is based on the substance of the transaction itself without any regard for how the transaction is funded.

To meet the definition of capital expenditure, the NHS body needs to acquire an asset, or the right of use of an asset, that the NHS body will use to provide healthcare services for more than a year. Determination of whether a digital solution results in the creation of an asset for the NHS body is often complex and will be based on a detailed understanding of the terms and conditions of the transaction. It would be unusual if a project was solely capital in nature – there are usually revenue elements in all digital projects.

Determining the accounting treatment of digital projects can be complicated, but something that the well qualified and experienced NHS finance teams are very capable of doing. The problem is that because the funding stream is capital, finance teams are under pressure for the answer to the question 'how should this be accounted for' to also be capital. This is because one of the conditions of receiving PDC is that it can only be used to finance capital expenditure.

The movement towards cloud-based solutions and software as a service mean that often digital projects are revenue in nature. As most digital funding is capital, this means that finance directors are turning down capital funding for digital projects because they know that they will be unable to align the accounting with the funding stream. They are faced with impossible choices:

- turn down the capital funding and stop the digital project. As this inquiry acknowledges, digital is one of the ways that the NHS can meet the operational challenges it now faces so this option will impact on patient care
- continue with the project and fund it from revenue resources. This also impacts on patient care as finding additional revenue resource would require budget cuts elsewhere
- breach their own professional standards by accounting for the expenditure as capital and accepting that there is an error in their accounts which, if it is material, could lead to the qualification of those accounts by the auditor. Qualification of the accounts is a serious matter and would have repercussions for the NHS organisation and the finance director and potentially implications for NHS England and NHS Improvement as well as the DHSC's consolidated accounts.

Ideally, NHS bodies would be allowed to identify the best solution for their problem, then determine the accounting treatment for that solution. At this stage the funding would be provided to match the accounting treatment.

We are working with our members, NHS England and NHS Improvement, and the DHSC to identify a solution to this mismatch. One possible solution is a capital to revenue transfer. There is a mechanism for doing this in the government budgeting rules but the practice was stopped in 2019/20[1] because the capital funding was used to prevent an overspend against the revenue budget. However, for a specific digital project that has been reviewed and approved as being value for money and achieving the vision for a digital NHS, a capital to revenue transfer to match the funding with the accounting may be a possible solution.

Potential system barriers

The NHS is not one single organisation but is made up of the over 400 organisations that are part of the Department of Health and Social Care group, as well as primary care practitioners and other third and private sector healthcare providers that sit outside of the group.

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[1] Public Accounts Committee, *NHS capital expenditure and financial management*, May 2020

Patient flow and digital solutions are no respecters of organisational boundaries and, often, the best solution will be one that follows the patient journey. This means that one body will host a digital solution which is then used by other organisations that provide healthcare along a patient pathway. The host organisation will be given the funding for the digital solution and will deal with the capital/ revenue accounting issues discussed above.

A series of memorandum of understanding (MoU) or service level agreements (SLA) will need to be put in place between the NHS bodies involved in the patient journey to ensure that the arrangements for using the system are clearly set out as well as the funding arrangements. These arrangements will also cover information governance and wider management issues.

In financial terms there is a risk to acting as the host for these arrangements. The delivery of any digital solution will involve third party suppliers. Contracts between those suppliers and the host NHS body will be legally binding and will commit the host NHS body to a specific arrangement over a period of time, early termination would usually come at a cost. The MoUs/ SLAs between the NHS bodies are not legally binding. Therefore, it is possible for NHS partners to pull out of arrangements leaving the host organisation responsible for the contract with the third party.

The funding, whether it is capital or revenue, will come with conditions that apply to the host organisation but not to the other organisations using the digital solution. As well as these financial and legal risks from acting as host for digital solutions, there is also the additional administrative burden for the host of managing the arrangement with partner NHS bodies.

Once the Health and Care Act 2022 is implemented, it may be that integrated care boards (ICBs) could take the role of host. Currently, capital funding for digital solutions is provided to NHS trusts and foundation trusts in the form of PDC. As ICBs are not able to accept PDC, capital funding would have to come in the form of a capital limit and the associated ability to draw down cash. In order for ICBs to act as hosts, the funding mechanism would need to move from PDC to capital limits. We are not sure whether this is a policy decision that has yet to be made or whether there are other barriers to the DHSC moving away from the use of PDC to fund digital projects.

ICBs would be better placed to act as host for system-wide solutions as they have population-wide responsibilities. The risks associated with the project would be mitigated by the ICB's overarching role across the system. Administratively, as the main commissioner for the system, acting as host would be less burdensome as using the digital system could be part of the contract for the provision of healthcare.

Conclusion

In order to achieve a digitally-enabled health system across the NHS, the committee needs to consider the basic financial, organisational and governance barriers that are in the way of progress, as well as the more complex barriers identified in the call for evidence.

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