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Capital costs in trusts and the impact of PFI

Briefing

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The briefing is based on data analysis and uses a series of charts to illustrate the key messages of the research

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Introduction and summary

This briefing has been produced by the HFMA with support from its Financial Management and Research Committee and explores the financial challenges faced by trusts due to their capital costs by using data from NHS trusts' and foundation trusts' (FTs') annual accounts.

Some trusts are facing larger financial challenges than others as they deal with the impact of past financing decisions.

Trusts are continually looking for ways to meet their efficiency savings challenges. High capital costs can make meeting savings targets more difficult and have the potential to adversely affect the quality of front-line clinical services.

The briefing is intended to generate debate around the impact of capital costs and how to ensure they do not lead to cutting operational budgets due to accounting for financing charges such as depreciation and interest costs. It is also intended to raise awareness and increase understanding of a complicated finance problem.

The briefing is based on data analysis and uses a series of charts to illustrate the key messages of the research.

In summary we found that:

- The higher the value of trusts' land, buildings and other assets, the greater the proportion of its total costs are spent on capital costs such as depreciation and financing costs, including interest payments on borrowings. The key factor driving high capital costs is depreciation but PFI costs can add to these.
- Once decisions have been made about investing in and financing new assets, the capital costs are difficult to change. Trusts with a high proportion of capital costs need to generate a higher surplus from their operating revenue (often measured as earnings before interest, tax, depreciation and amortisation, or EBITDA) than other trusts to cover their capital costs.
- Generating a high EBITDA margin requires high revenue or efficient spending (or both). It is difficult for trusts to increase revenue at the moment, as there is no growth in the national NHS budget, which means trusts must seek to become more efficient by making greater savings on their operating costs.
- A high proportion of total spending on capital costs that would be considered as fixed costs means trusts need to make a larger proportion of efficiency savings in their more flexible operational budgets, potentially affecting front-line services.
- Nationally, however, average EBITDA margins are decreasing due to financial pressure across the NHS. In some trusts, the EBITDA margin is either lower than, or only slightly in excess of, the proportion of capital costs, meaning they are struggling to cover their costs.
- There is a small number of trusts generating lower EBITDA margins than their capital costs as a proportion of total costs. Some of these trusts have required

additional financial support from the Department of Health or their local commissioner to make sure they can continue to provide healthcare services.

- Providing additional financial support to trusts struggling with capital costs is not sustainable or fair and the rationale for the support is not always clear. It is likely that more trusts will require financial support in future, if EBITDA margins continue to decrease.
- Trusts may have a high proportion of capital costs for several reasons. Our data analysis shows that those trusts with a higher proportion of PFI-funded assets also tend to have a high proportion of capital costs.
- But PFI-funded assets do not automatically lead to financial problems as some trusts are able to generate sufficient turnover, and hence EBITDA, to cover their higher capital costs.
- Our analysis also shows that high capital costs could have an adverse effect on trusts' performance on Monitor's capital servicing capacity ratio, which informs the risk assessment framework rating for foundation trusts.

This briefing highlights the main issues for trusts but more work needs to be done to understand the impact past capital financing decisions have on front-line clinical services now and in the future and how trusts with a high proportion of capital costs can be supported to enable the continued delivery of clinical services.

It also serves as a useful reminder about the future impact of financing decisions and the need for rigorous appraisal of capital options.

The first of our findings shows there is a strong link between trusts' non-current asset values and their capital costs

Several trusts can attribute their financial difficulties in part to investment in high-value PFI-funded assets. There are many other factors in addition to capital costs, such as historical underfunding that does not fully take into account the local costs of rurality or other demographics, and local costs of staff salaries, land and buildings.

This briefing does not consider the debate about the existence of alternative options available to individual trusts at the time, but seeks to highlight the ongoing impact on the NHS from such investments. Long-term investments require trusts to have long-term security of funding or the flexibility to reduce their cost base. Where neither of these is guaranteed it can lead to financial pressure.

The briefing presents several charts based on our analysis of trusts' financial accounts. A data analysis tool that accompanies this briefing is available on the HFMA website for members to explore the data for their own trusts in more detail.

Data analysis shows the link between a trust's non-current asset base and the proportion of its total costs spent on capital costs

Using data available for all NHS trusts and FTs in their financial accounts for 2012/13, we have carried out analysis to help understand the factors affecting capital costs and why this can contribute to some trusts being in financial difficulty.

The first of our findings shows that there is a strong link between trusts' non-current asset values and their capital costs. Capital costs are defined as the sum of the dividend on public dividend capital, depreciation, amortisation and net interest costs (which takes into account investment revenue and finance interest costs).

We have deliberately chosen to classify depreciation as a capital cost, rather than an operating cost, as it is linked to the value of a trust's assets.

Trusts' asset bases range in size, age and value and depend on the number of patients and services provided, as well as historical factors.

The ratio of non-current assets to turnover is one measure we can use to compare how well trusts generate revenue from their asset base. As the value of the non-current asset base will differ according to a trust's sector and location and age of the estate, we cannot be categorical about whether it is right for a trust to have a high or low value for the non-current assets to turnover ratio.

However, in the private sector, investors may use this ratio to make a judgement about the efficiency of a company.

For instance, if a company makes the same value of sales as a competitor but has a lower asset base, the non-current asset to turnover ratio is lower. This could indicate it is a company that is using its assets efficiently. A higher turnover ratio might suggest assets are not being used optimally.

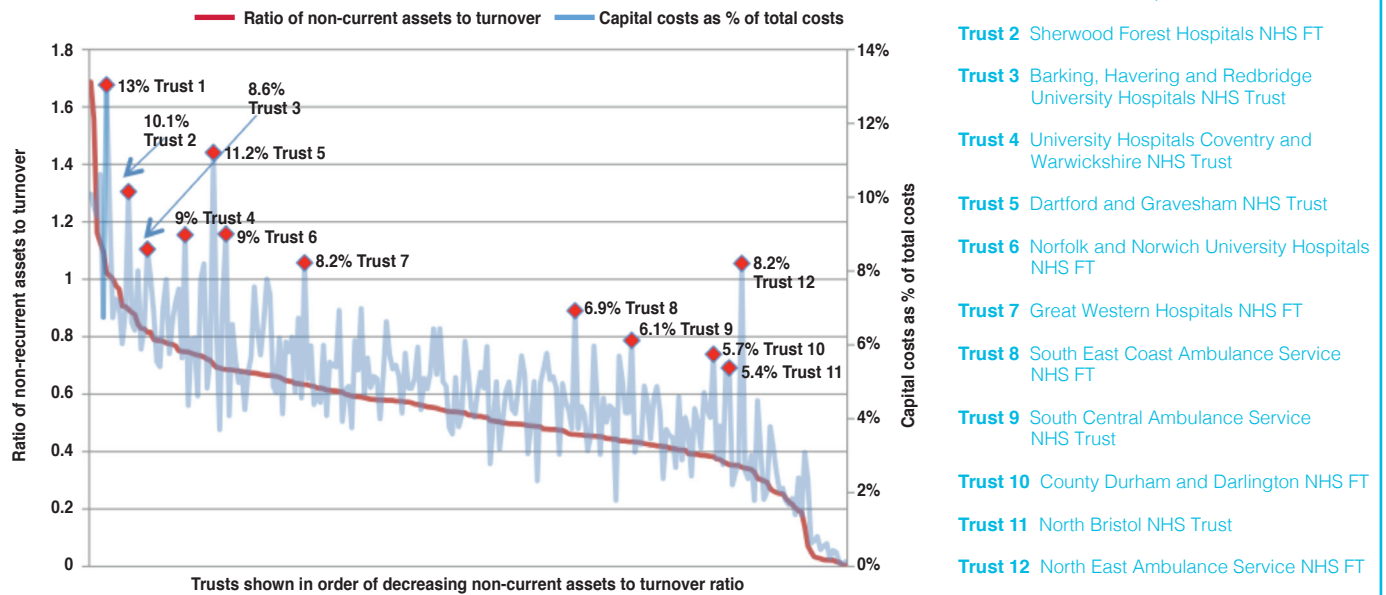
However, what is important to trusts is whether the trust can afford the capital costs associated with the asset base.

Chart 1 shows that the higher the ratio of non-current assets to turnover, the higher the proportion of capital costs. The chart shows that there are some outlier trusts that have a high proportion of capital costs relative to their total costs, when compared with trusts that have a similar ratio of non-current assets to turnover.

These trusts are identified with markers, as spikes on the blue line. Some of these organisations are considered to be financially and clinically sustainable, successful trusts while others are operating in very challenging financial environments and may not be able to provide the quality of services they would like to.

The highlighted trusts generally considered to be in financial difficulty – including Mid Essex Hospital Services

Chart 1: Trusts with high ratio of non-current assets to turnover generally have a high proportion of capital costs (2012/13 data)



Key to trust names

- Trust 1** Mid Essex Hospital Services NHS Trust
- Trust 2** Sherwood Forest Hospitals NHS FT
- Trust 3** Barking, Havering and Redbridge University Hospitals NHS Trust
- Trust 4** University Hospitals Coventry and Warwickshire NHS Trust
- Trust 5** Dartford and Gravesham NHS Trust
- Trust 6** Norfolk and Norwich University Hospitals NHS FT
- Trust 7** Great Western Hospitals NHS FT
- Trust 8** South East Coast Ambulance Service NHS FT
- Trust 9** South Central Ambulance Service NHS Trust
- Trust 10** County Durham and Darlington NHS FT
- Trust 11** North Bristol NHS Trust
- Trust 12** North East Ambulance Service NHS FT



Note: The source data for this chart is the NHS trust 'TRU' forms and FT 'FTC' forms, which do not include any explanatory notes added by trusts to their published accounts that might affect this data. The capital costs calculated for Mid Essex Hospital Services NHS Trust are based on reported depreciation of £22.6m, which includes one-off accelerated depreciation costs of £10.4m. The chart excludes eight trusts with zero values.

NHS Trust, Dartford and Gravesham NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust and Barking, Havering and Redbridge University Hospitals NHS Trust – tend to have a high proportion of capital costs and also a high ratio of assets to turnover. Those organisations that have a high proportion of capital costs but lower ratio of assets to turnover have fewer financial challenges.

Trusts in financial difficulty are often experiencing cost pressures due to a range of factors. NHS England has developed the PLACE (Patient-led assessments of the care environment) data analysis tool with ERIC (Estates Return Information Collection) data¹, which may help trusts to benchmark themselves against other trusts. Interestingly, several ambulance trusts have a high level of capital costs, relative to acute and mental health trusts with similar asset to turnover ratios.

The same link is also present in 2011/12 data as well as 2012/13 data.

What is the impact on trusts with a high proportion of capital costs?

All trusts are required to make efficiency savings due to the design of the national payment system and the spending power of commissioners. But trusts that spend a higher than average proportion of their total costs on capital costs will often then need to make higher than average savings on operational pay and non-pay budgets, with the potential to affect the quality of front-line clinical services.

By way of example, taking two trusts with the same annual expenditure and the same cost savings requirement, the trust with the higher proportion of capital costs that cannot be reduced easily will consequently need to save a greater proportion of its other operating costs to achieve the same overall saving.

Put another way, trusts with high capital costs are required to generate a higher EBITDA (earnings before interest, tax, depreciation and amortisation) to cover

¹ www.england.nhs.uk/ourwork/qual-clin-lead/place/ (accessed 8 July 2014)

Average EBITDA margins are decreasing, making the task of achieving savings targets progressively more difficult for trusts with high capital costs

those capital costs. Nationally, however, average EBITDA margins (which are a measure of trusts' profitability) are decreasing, making the task of achieving savings targets progressively more difficult for trusts with high capital costs.

While there is no strong link between EBITDA margin and high non-current asset values as a proportion of turnover, there is an observable trend between EBITDA margin and capital costs. Therefore, it is not the value of a trust's assets that is important but the cost of funding them that has an impact on EBITDA margins required.

Chart 2 shows, on the blue line, trusts' capital costs as a proportion of their total costs. The chart is ordered from left to right according to trusts with the highest to lowest EBITDA margin, as shown by the red line. Trusts with higher capital costs are at a disadvantage as they are forced to generate a higher EBITDA margin to cover capital costs, which may result in unachievable cost savings targets. According to Monitor², the average EBITDA margin for FTs fell from 5.97% in 2012/13 to a planned 5.68% in 2013/14 and notes a 'long-term deterioration in EBITDA margin'.

The chart shows at the left-hand side that there are several trusts with above average EBITDA margin but also above average capital costs. At the right-hand side, where the proportion of capital costs starts to exceed EBITDA margin, there are a handful of trusts seemingly in serious financial difficulty, with negative EBITDA margin – these are loss-making trusts.

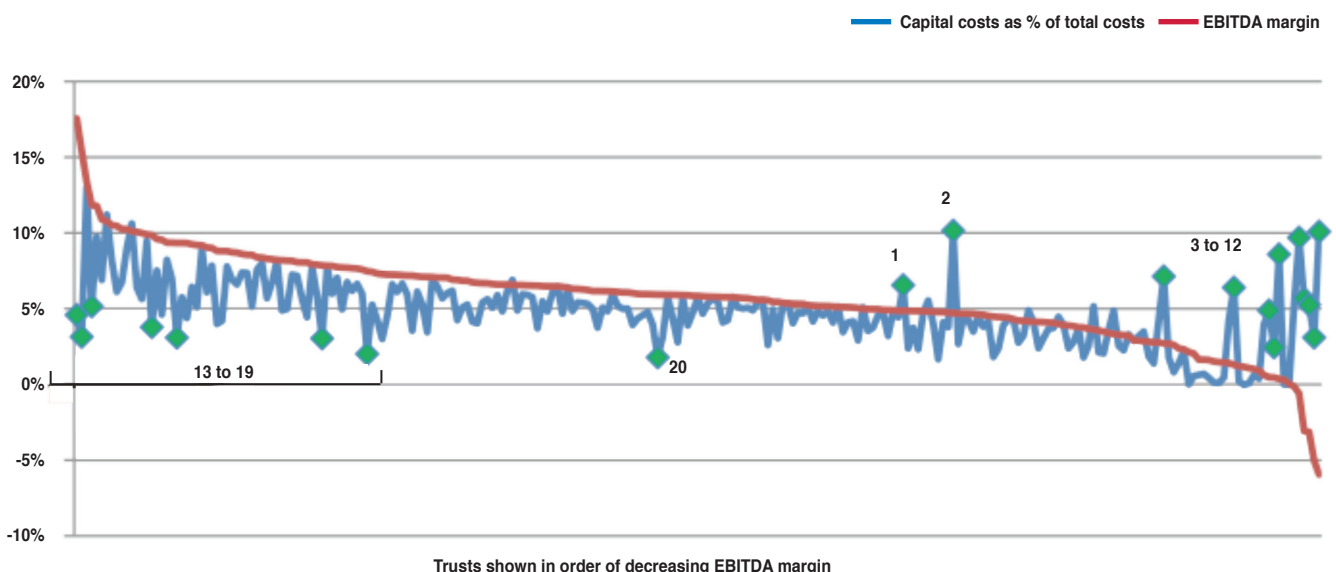
Table 1 shows the trusts that have a higher or significantly lower proportion of capital costs compared with their EBITDA margin highlighted in Chart 2. Most of the trusts represented by data points 1 to 12 in the chart have, or have had, financial difficulties. Data points 13 to 20 represent trusts that are generally financially better off (although this is based on 2012/13 data and financial health can change rapidly in the NHS).

In general, trusts that are financially better performing have greater headroom between their EBITDA margin and the proportion of total costs represented by capital costs.

Table 1 shows selected data from Chart 2 and a separate calculation of the ratio of EBITDA to capital costs, which is a measure of how much EBITDA covers a trust's capital costs.

2 www.gov.uk/government/uploads/system/uploads/attachment_data/file/284608/indeptheviewBM1386_APR_201314.pdf (accessed 10 July 2014)

Chart 2: Chart showing all trusts' capital costs as proportion of total costs in order of trusts with decreasing EBITDA margin (2012/13 data)



The trusts at the right-hand side of Chart 2 have a ratio that is negative or less than one while those at the left-hand side have an EBITDA margin that is a minimum of twice the proportion of capital costs. The trusts with a low EBITDA to capital costs cover tend to be medium to large turnover acute trusts, while those with higher EBITDA to capital costs cover are mainly specialist or mental health trusts.

How do trusts receive funding for their capital costs?

Trusts generate most of their turnover as operating revenue for healthcare activity, which they receive from clinical commissioning groups and NHS England. In acute trusts the revenue is determined by the national payment system, which specifies national prices for some activity and the remainder is determined locally but may be based on nationally defined activity.

The nationally set prices for each service are based on the average cost among trusts of providing a particular service. This average cost will include an element of capital costs. Chart 3 shows the range, for all acute trusts, of capital costs as a proportion of total turnover. The red line shows the

Table 1: List of data points in Chart 2 and EBITDA to capital costs ratio

Trust	Capital costs as proportion of total costs, 2012/13	EBITDA margin, 2012/13	EBITDA (£) cover for capital costs (£)
1 The Hillingdon Hospitals NHS FT	6.6%	4.9%	0.7
2 Sherwood Forest Hospitals NHS FT	10.1%	4.7%	0.4
3 Mid Yorkshire Hospitals NHS Trust	7.1%	2.7%	0.4
4 Milton Keynes Hospital NHS FT	6.4%	1.3%	0.2
5 Surrey And Borders Partnership NHS FT	4.9%	0.5%	0.1
6 Tavistock and Portman NHS FT	2.4%	0.5%	0.2
7 Barking, Havering and Redbridge University Hospitals NHS Trust	8.6%	0.4%	0.0
8 South London Healthcare NHS Trust	9.7%	-0.6%	-0.1
9 Mid Staffordshire NHS FT	5.7%	-3.1%	-0.5
10 University Hospitals of Morecambe Bay NHS FT	5.3%	-3.1%	-0.5
11 Bolton NHS Foundation Trust	3.1%	-5.0%	-1.5
12 Peterborough and Stamford Hospitals NHS FT	10.1%	-5.9%	-0.5
13 Walton Centre NHS FT	4.6%	17.5%	4.4
14 Royal National Hospital for Rheumatic Diseases NHS FT	3.1%	15.4%	5.6
15 Queen Victoria Hospital NHS FT	5.2%	11.8%	2.5
16 Clatterbridge Centre for Oncology NHS FT	3.8%	9.9%	2.8
17 Alder Hey Children's NHS FT	3.1%	9.3%	3.2
18 Lincolnshire Partnership NHS FT	3.0%	7.9%	2.7
19 Dorset Healthcare NHS FT	2.0%	7.5%	3.9
20 Oxleas NHS FT	1.8%	5.9%	3.5

median capital costs for acute trusts as a proportion of total turnover, at 5%. The mean value for capital costs as a

Chart 3: The median capital costs for acute trusts, as a proportion of total turnover, is 5%

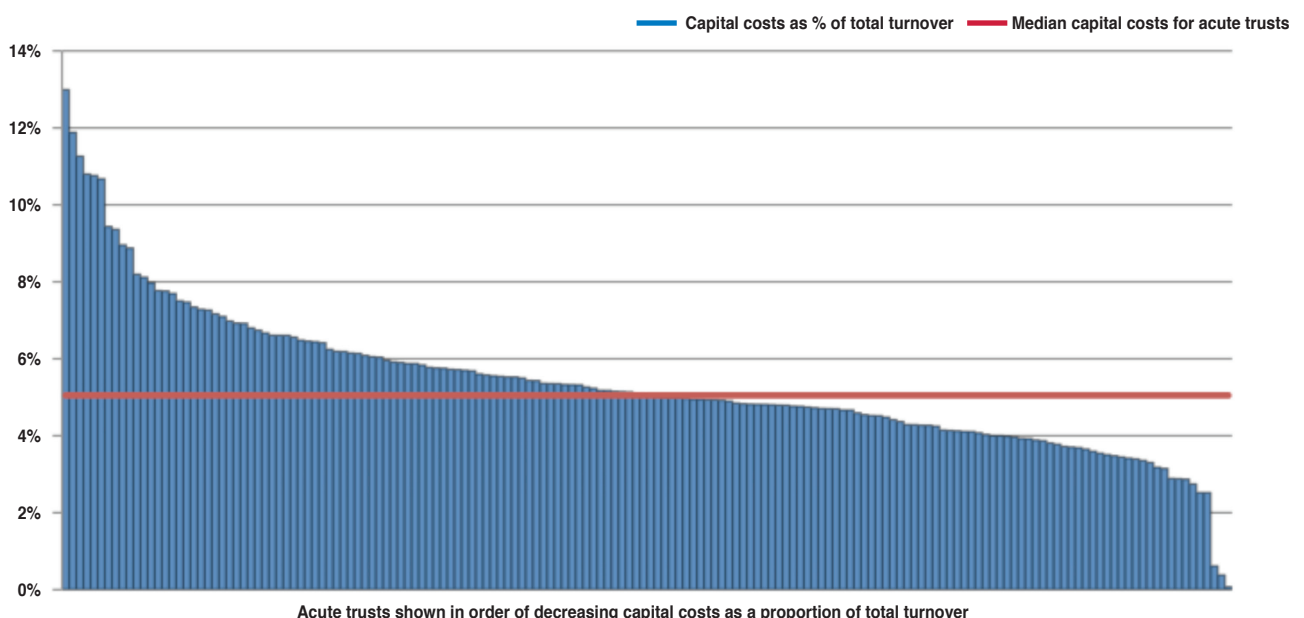
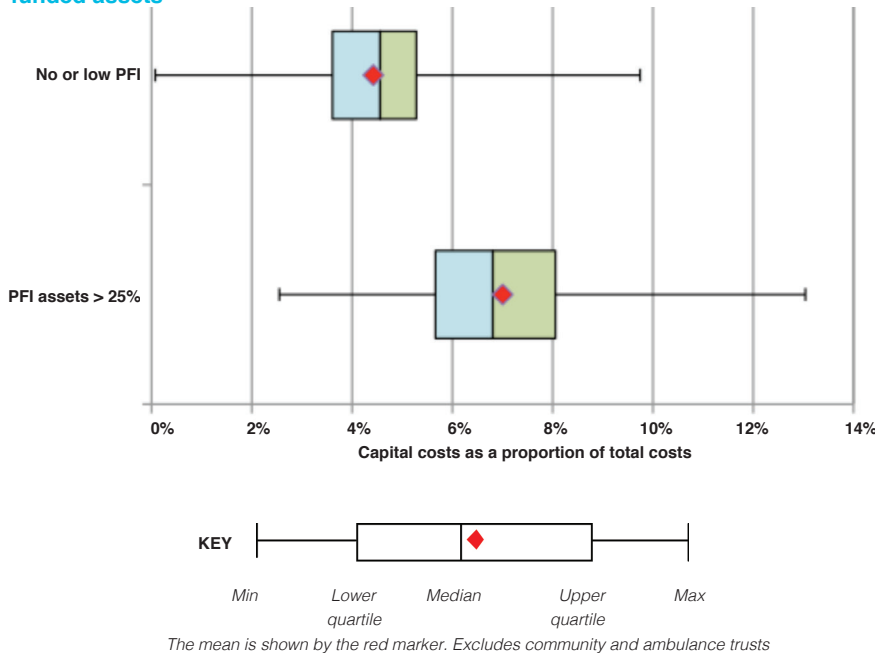


Table 2: Analysis of PFI-funded assets as a proportion of total asset net book value for acute and mental health trusts

PFI-funded assets as a proportion of total net book value of assets	Number of acute and mental health trusts	Proportion of acute and mental health trusts
0%	121	55%
>0% to < 10%	25	11%
10% to < 25%	28	13%
25% to < 50%	26	12%
50% to < 75%	14	6%
75% to 100%	8	4%
	222	100%

Chart 4: Box plot showing difference in proportion of capital costs for trusts with PFI-funded assets in excess of 25% of net book value and no, or low, PFI-funded assets



proportion of turnover for acute trusts in 2012/13 is 5.6%. The actual figure for capital funding in the national payment system is not available.

As the national payment system is based on average costs there will be trusts that have higher or lower capital costs than the element of the funding they receive is designed to cover. But some trusts will receive considerably less and need to find alternative sources of funding.

This can be done either through negotiating local payments for services that are not covered by national prices that help offset the shortfall or through specific additional revenue support, of the kind identified by the National Audit Office³.

Are higher capital costs caused by PFI-funded assets?

EBITDA margin and the proportion of resources spent on capital costs matter to trusts' financial health. Trusts with high-value PFI-funded assets and high capital costs have received much attention in recent years and there is a link between the two.

Table 2 shows the numbers and proportions of trusts according to the value of their PFI-funded assets.

Chart 4 shows the difference between the capital costs of trusts with PFI-funded assets with a value exceeding 25% of total trust net book value and those with no, or low, value PFI-funded assets. The 25% value was chosen as an indicative value for trusts with substantial PFI-funded assets to ensure an adequate sample size.

The data shows that as the proportion of PFI-funded assets in a trust increases, so does the proportion spent on capital costs. But the two do not increase at the same rate.

³ 2012-13 update on indicators of financial sustainability in the NHS, Report by the Comptroller and Auditor General HC 590 session 2013-14, National Audit Office, July 2013

Chart 5 shows, on the red line, that trusts' PFI assets range from just above zero to more than 80% of their total net book value (chart excludes trusts that do not have any PFI-funded assets). The blue line plots the proportion of capital costs for each trust, measured on the right-hand axis and varying from around 3% to 13%.

The chart shows there is a clear, increasing trend in capital costs but that as the value of PFI assets exceeds about 50%, the proportion of capital costs starts to include some trusts with outlying costs.

Table 3 identifies the outlying trusts highlighted in Chart 5. All the trusts have PFI-funded assets but the trusts in the table with the higher proportion of capital costs are those generally considered to have the more serious financial challenges.

In 2011/12, the Department of Health identified seven NHS trusts as needing additional financial support because of high capital costs (specifically, PFI payments). These were⁴:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Dartford and Gravesham NHS Trust
- Maidstone and Tunbridge Wells NHS Trust
- North Cumbria University Hospitals NHS Trust
- Peterborough and Stamford Hospitals NHS FT
- South London Healthcare NHS Trust
- St Helens and Knowsley NHS Trust.

Three trusts from this list appear in Table 3.

Chart 5: Acute trusts' capital costs as a proportion of total costs increases with the proportion of PFI-funded assets (2012/13 data)

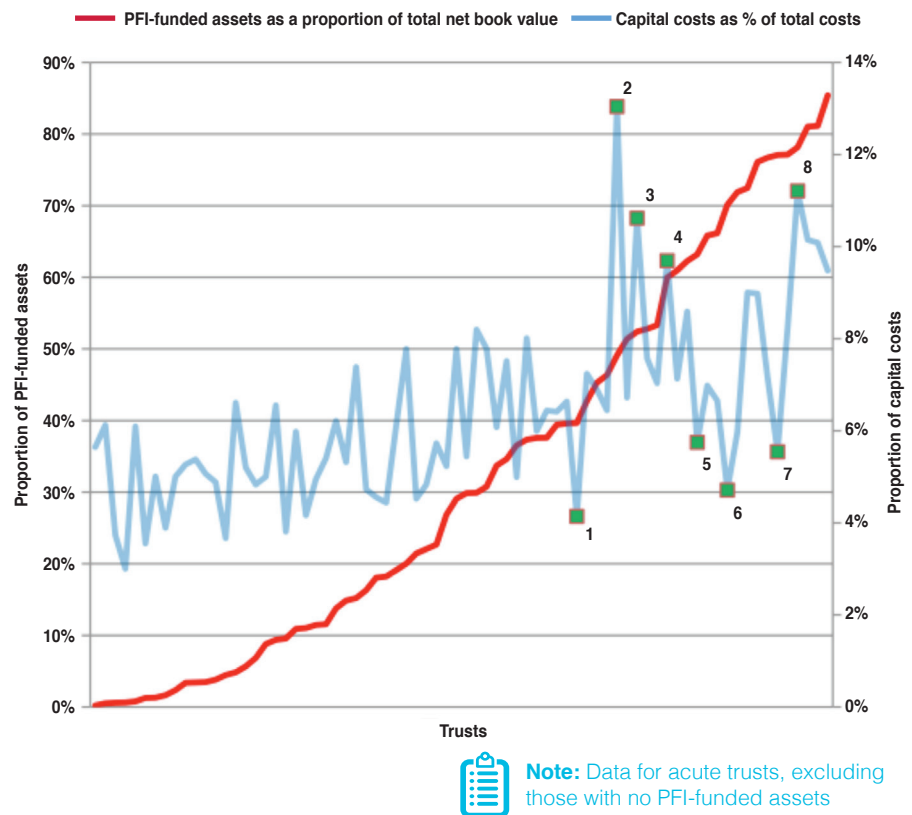


Table 3: Trusts with significant PFI-funded assets have a wide range of capital costs

Chart 5 data point	Trust	Capital costs as proportion of total costs	PFI-funded assets as a proportion of NBV
1	Salford Royal NHS Foundation Trust	4.1%	39.7%
2	Mid Essex Hospital Services NHS Trust	13.0%	49.1%
3	Maidstone and Tunbridge Wells NHS Trust	10.6%	52.4%
4	South London Healthcare NHS Trust	9.7%	60.0%
5	County Durham and Darlington NHS FT	5.7%	63.2%
6	Wye Valley NHS Trust	4.7%	70.1%
7	Derby Hospitals NHS Foundation Trust	5.5%	77.1%
8	Dartford and Gravesham NHS Trust	11.2%	78.2%



Note: Capital costs for Mid Essex Hospital Services NHS Trust are based on reported depreciation of £22.6m, which includes one-off accelerated depreciation costs of £10.4m

⁴ www.gov.uk/government/news/nhs-trusts-to-receive-funding-support (accessed 10 July 2014)

Some trusts are considered to be in better financial health than others, despite similar profiles when looking at PFI-funded assets and proportion of capital costs

What drives capital costs?

PFI is not the only factor resulting in high capital costs. In fact, the key factor determining capital costs appears to be depreciation. High PFI interest can, however, exacerbate this, leading to the outliers, some of which appear to have serious financial challenges.

Generally, capital costs rise in line with depreciation costs. In Chart 6 we show how, when trusts are placed in order of capital costs (lowest to highest, from left to right – blue columns), the red line shows that depreciation is broadly in line with the trend and increases along with the proportion of capital costs.

Depreciation is shown as the ratio of depreciation to turnover, to take into account trusts of different sizes.

Analysing the data further shows those trusts with higher capital costs (right-hand side of Chart 6) tend also to have high PFI interest costs, in addition to higher proportions of depreciation costs. We know that high capital costs arise from a combination of high depreciation and PFI costs but that not all PFI trusts are considered to be financially challenged.

Chart 7 shows the three components of trusts' capital costs – depreciation, net interest (PFI and other interest costs net of revenue from investments) and dividends payable on public dividend capital (PDC). The chart shows trusts in order of largest to smallest proportion of PFI-funded assets and the effect that PFI has on interest costs can be seen clearly in the red columns.

Previous charts show that, as the proportion of capital costs decreases, so does the EBITDA margin, the depreciation to turnover ratio and the non-current assets to turnover ratio. However, some trusts are generally considered to be in better financial health than others, despite similar profiles when looking at PFI-funded assets and proportion of capital costs.

We have calculated our best approximation, based on the data available in trusts' annual accounts, of Monitor's continuity of service ratio of capital servicing capacity, used in its risk assessment framework. The calculation is based on the methodology set out in an appendix to Monitor's *Draft Risk Assessment Framework: consultation* document⁵.

⁵ www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=18354 (accessed 28 April 2014 but no longer available on new Monitor website)

Chart 6: Trusts' proportion of capital costs increases broadly in line with depreciation charges (2012/13 data)

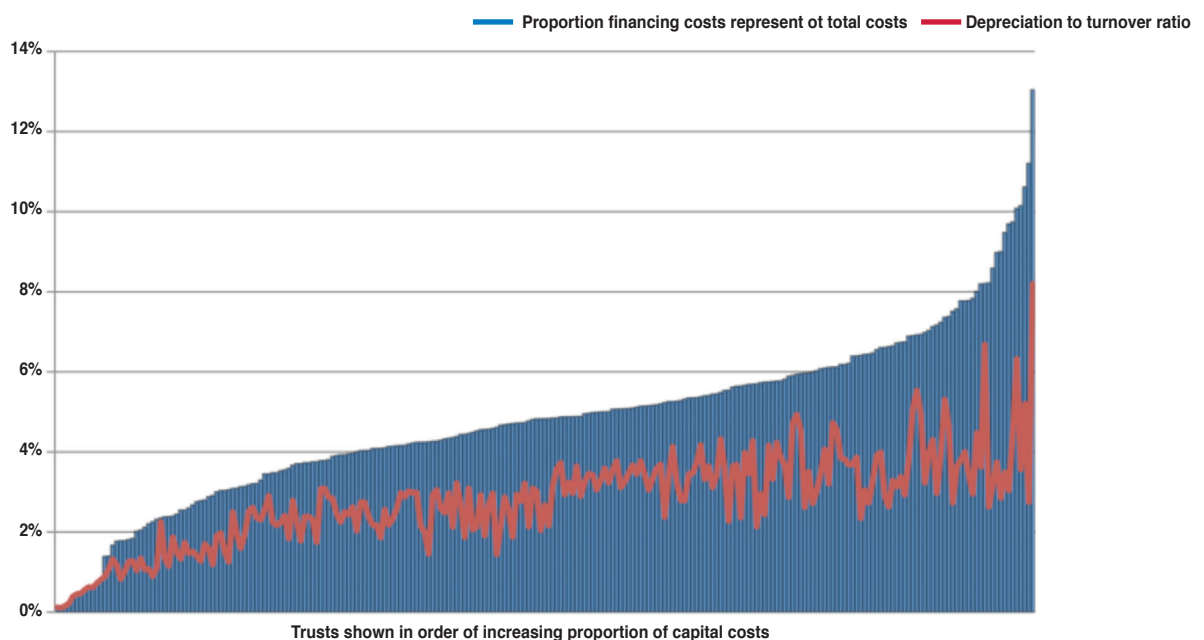
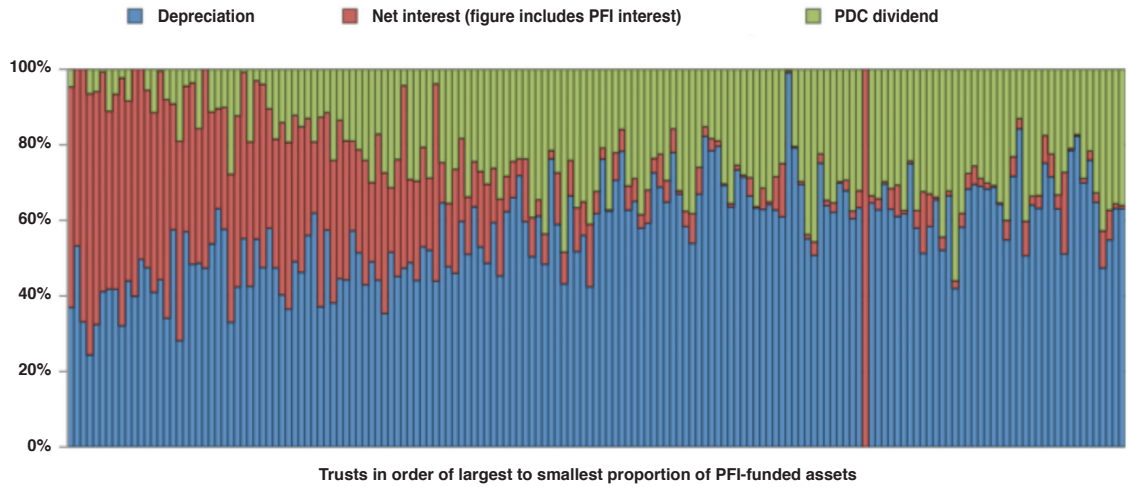


Chart 7: Composition of trusts' total capital costs showing the split between depreciation, net interest and PDC dividend (2012/13 data)

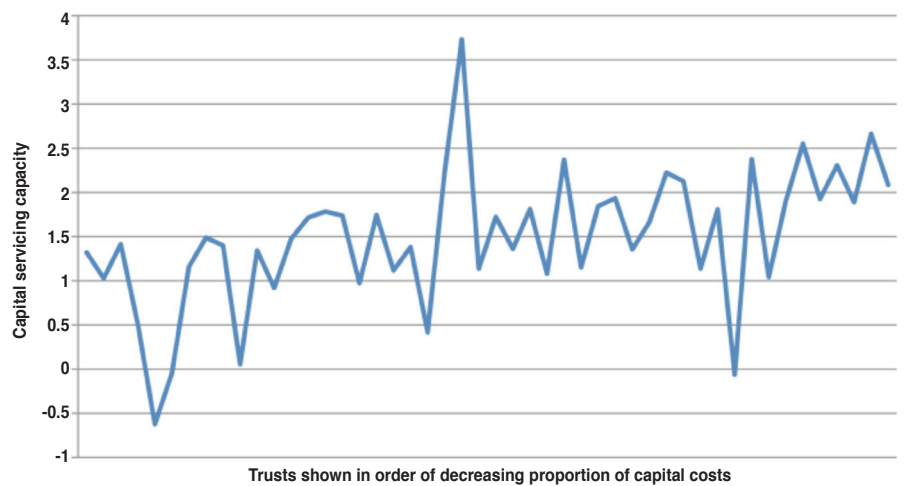


Note: This chart includes acute, specialist and mental health trusts only. Excludes trusts with negative net interest

We have excluded some figures unavailable in trusts' annual accounts from our calculation and so the capital servicing capacity figures in Chart 8 represent our best estimate of the actual figures.

Chart 8 shows trusts in order of decreasing capital costs from left to right, for those trusts with PFI-funded assets in excess of 25% of total NBV. As trusts' proportion of capital costs falls (trusts to the right-hand side of the chart), their performance in Monitor's ratio improves.

Chart 8: As trusts' capital costs decrease their estimated value for Monitor's capital servicing capacity ratio improves



Monitor continuity of service ratios

In its risk assessment framework, Monitor sets out how it will use a 'continuity of services' risk rating to assess financial risk. The framework states:

'The continuity of services risk rating incorporates two common measures of financial robustness:

- (i) liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown; and
- (ii) capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.'

The liquidity ratio results in a (negative) number of days. The greater the number, the lower the liquidity risk. Similarly, a higher capital servicing capacity is considered to be a lower financial risk.

Source: Risk Assessment Framework, Monitor, August 2013

Trusts need to balance investment decisions to ensure their proportion of capital costs can be managed within the requirement for making efficiency savings

Conclusion

High capital costs can lead to challenging savings targets, which could potentially threaten funding for front line clinical services in some trusts. Trusts have a wide range of capital costs and these often relate to past investment decisions, rather than current spending.

This briefing provides useful background data to help explain the issues. We are aware that the problem of funding capital costs is not limited to those with PFI-funded assets and also that not all PFI trusts have a problem.

PFI-funded assets generally increase trusts' proportion of interest costs and hence their overall proportion of capital costs, although some trusts are able to cope with this where they have a sufficiently high EBITDA margin to cover the higher capital costs.

It is not always possible for all trusts to do this and it depends on local circumstances affecting trusts' ability to generate revenue.

Trusts need to balance investment decisions to ensure that their proportion of capital costs can be managed within the requirement for making efficiency savings and potential changes in future revenue from commissioners.

This can be measured by calculating the ratio of capital costs to EBITDA margin – there needs to be sufficient 'cover' and those trusts that are financially challenged have low cover.

High capital costs are only affordable by those trusts that are operationally efficient, that can generate a high EBITDA margin and can expect to continue to do so.

There are some actions that trusts can take to minimise the impact of high capital costs. These include:

- Revaluations across each asset class
- Refinancing PFI schemes to reduce payments
- Making use of nationally available data, such as the PLACE data analysis tool developed by NHS England.

This briefing is intended to help highlight the key issues and quantify the scale of the challenge some trusts face. The HFMA is interested to hear from trusts that have come up with solutions for funding capital costs.

If you would like to discuss the issues raised in this briefing please contact us via policy@hfma.org.uk

CHAIR, NED & LAY MEMBER FACULTY



“Actually the FD
recommended the
Faculty to me... but
I like to pretend it
was my idea.”



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Glossary and definitions

Capital costs We refer to trusts' capital costs throughout this briefing. We define these as the sum of depreciation and amortisation, net finance costs and dividends payable on public dividend capital. These costs can be found in trusts' annual accounts.

Capital costs as a proportion of total costs This metric is calculated by dividing capital costs by total costs – in other words, the sum of pay costs, capital costs and non-pay costs. Non-pay costs are defined as other operating costs that are not pay costs (taken from trusts' accounts) less impairments and reversals of impairments and less depreciation and amortisation (included in capital costs).

Depreciation and amortisation Depreciation is a non-cash expense that recognises assets are used up during their useful life. The term relates to tangible assets such as property, plant and equipment. Amortisation follows the same underlying principle as depreciation but is the term used in relation to intangible assets such as patents, intellectual property and software licences.

Finance costs Finance costs include bank interest payable and interest on PFI obligations. It is net of finance income, such as interest received from bank accounts.

Dividend on public dividend capital Public dividend capital (PDC) is the taxpayer's equity – the taxpayer's stake in the NHS trust – arising from the government's original investments in NHS trusts when they were created. It is similar to company share capital and, as with company shares, a dividend is payable to the Department of Health. The PDC dividend is calculated at 3.5% of net relevant assets – a measure of how much the NHS trust owns.

Non-current assets Assets a trust expects to hold for more than one year. Types of non-current asset include land and buildings, property, plant and equipment, investment property or some types of financial asset.

Turnover This is the total operating revenue reported in a trust's accounts and is the funding received by an NHS organisation to meet the costs of its day-to-day activities.

Non-current assets to turnover ratio The ratio of non-current assets to turnover is a measure we use in this briefing to compare how well trusts generate revenue from their asset base. As the value of the non-current asset base will differ according to a trust's sector, location and age of the estate, we cannot be categorical about whether it is right for a trust to have a high or low value for the non-current assets to turnover ratio. But in the private sector, investors may use this ratio to make a judgement about the efficiency of a company. For instance, if a company makes the same value of sales as a competitor but has a lower

asset base the non-current asset to turnover ratio is lower. This could indicate it is a company that is using its assets efficiently. A higher turnover ratio might suggest assets are not being used optimally.

Earnings before interest, taxation, depreciation and amortisation (EBITDA) and EBITDA margin EBITDA is an expression of a trust's surplus from normal operations and a measure of profitability. It provides an indication of the organisation's ability to reinvest and meet any charges associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation. EBITDA margin is simply EBITDA divided by turnover and is expressed as a percentage.

Total costs We use this term to refer to the sum of a trust's total operating expenses and net financing costs – normally disclosed separately in trusts' annual accounts.

EBITDA to capital costs ratio A measure of by how much a trust's EBITDA covers its capital costs. The greater the number, the greater the surplus to service capital costs.

National payment system and prices Monitor and NHS England have responsibility for the system of national prices in the NHS, the methodology for price-setting and the rules for varying national prices and agreeing local prices. National prices exist for admitted patient care, outpatient attendances, accident and emergency attendances and some outpatient procedures. For admitted patient care and A&E activity, the currency – the unit of healthcare to which the nationally set price applies – is the healthcare resource group (HRG). HRGs are defined by diagnosis and procedure codes. Current estimates are that £29bn of healthcare services have national prices – a third of all NHS spending and more than 40% of secondary care spend, representing 60% of acute hospital income.

Private Finance Initiative (PFI) PFI has been the primary way of funding major capital investments in the NHS over the past two decades without immediate recourse to the public purse. Private consortia, usually involving large construction firms, were contracted to design, build and in some cases manage new projects. Contracts typically last for 30 years, during which time the NHS trust leases the building for a single annual unitary payment. The accounting entries are complex and do not just amount to the annual unitary payment. Instead, the Statement of Comprehensive Income shows separate amounts for the service charge, the finance cost (interest) of the project and depreciation of the asset. HM Treasury has recently introduced reforms to PFI and a new scheme called PF2.

Net book value An asset's net book value is the current value or cost of replacement minus the depreciation charged.



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.

Our vision & mission

The vision that inspires us is a world where we see:

Better quality healthcare through effective use of resources

In order to help deliver our vision, we are committed to our mission of:

- Representing and supporting healthcare finance professionals
- Influencing healthcare policy
- Promoting best practice, education and CPD

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How do you solve a problem like PFI?



Sign up for DWF ProjLink - your free online forum

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DWF ProjLink is a free online forum which enables you to discuss issues which have an ongoing and direct impact on PFI schemes within the NHS, enabling you to share best practice and explore solutions with experts and peers in a secure, closed group environment.

DWF ProjLink facilitates:

- effective contract management
- informed and confident engagement with your PFI partner from a position of strength wherever possible
- sweating your PFI asset.

At DWF, we have extensive experience of closing PFI schemes for the NHS and now advise clients about operational issues affecting them.

Get in touch

To register for DWF ProjLink or to find out more about our legal services, call Michael Boyd, Partner & Head of Healthcare on **0113 261 6003** or email **ProjLink@dwf.co.uk**

