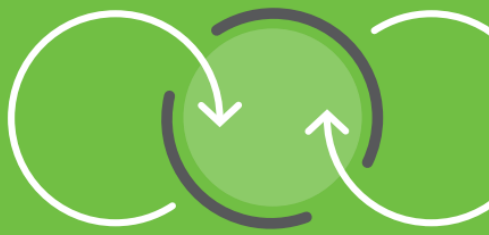
CIPFA The Chartered Institute of Public Finance & Accountancy

hfma

Integration Finance Network
The HFMA & CIPFA Health & Social Care Partnership

Capital collaborations between the NHS and local authorities



June 2017

Introduction

Health and social care services are delivered by different organisations working under different regulatory and statutory regimes but increasingly those organisations are working together to provide an integrated service to all delivering the best possible value to the patient and/ or service user. However, both health and social care face well-documented resource challenges.

Analysis undertaken by the British Medical Association[1] identified that the NHS will need £9.5bn of capital funding to deliver the sustainability and transformation plans (STPs) – local health economy plans being developed alongside local authority colleagues. The level of funding available to the NHS is not expected to rise above £5bn before 2020 at the earliest. This gap and the wider integration agenda has prompted renewed interest in joint working between the NHS and local authorities in the areas of capital investment and cash management.

Although much discussion has taken place regarding how the NHS and local authorities can work together on capital schemes, this has often been between colleagues who hold individual pieces of the jigsaw. CIPFA and the HFMA brought together representatives from local authorities and the NHS in a workshop on capital that aimed to help complete this puzzle and in doing so, set out what might be possible and how local areas could take forward their initiatives.

At a national level, the Naylor review[2] has also looked in detail at the NHS estate and how it can be best used for patients. It considers the capital funding challenge faced by STPs and identifies some ways that the estate can be rationalised to provide capital receipts which can be used to fund capital

[1] www.bma.org.uk/news/media-centre/press-releases/2017/february/capital-funding-needed-to-deliver-stps
[2] Sir Robert Naylor was commissioned by the Secretary of State to develop a new NHS estate strategy which supports particular Department of Health targets as well as the capital funding gap identified by STPs. The report *NHS property and estates: why the estate matters for patients* was published in March 2017 www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

expenditure. This paper focuses particularly on what can be done at a local level with local authorities and NHS bodies working together.

While every care has been taken in the preparation of this briefing, the HFMA and CIPFA cannot in any circumstances accept responsibility for errors or omissions, and are not responsible for any loss occasioned to any person or organisation acting or refraining from action as a result of any material in it.

Background

Joint working on capital projects has a long history, and whilst there are existing examples it is important to concentrate on what's needed and agreed locally. Local authorities have the capability to undertake investment but any proposals need to be prioritised against their long list of other commitments, therefore the strength of local relationships and the political acceptability of the projects being considered will be key to delivery.

Whilst the introduction of the better care fund and STPs has led to close working between local authorities and the NHS in some areas, this is not universally the case[3] and discussions around capital investment may need to be held outside of these nationally mandated initiatives. Local systems should identify the local pressures and risks as well as the benefits of joint projects for the local population.

Widening thinking about joint working beyond health and social care integration to encompass the wider determinants of health or economic regeneration may provide a broader range of joint working opportunities[4].

The joint NHS/ local authority workshop

The joint workshop on capital provided a timely opportunity for NHS and local authority colleagues to understand each other's capital funding regimes.

The workshop concluded there are opportunities available to promote joint working opportunities but these must be viewed on a case by case basis at local level.

Our workshop revealed it is only in discussion with members of staff who work in all of the different bodies within the health and local government sectors that the real issues can be teased out. For example – going into the workshop there was an expectation that the outcome would be a scheme that would allow NHS bodies to borrow from local authorities, this would allow NHS bodies to fund capital expenditure and would provide local authorities with a return on their cash balances. By the end of the session it was clear that the constraining factor in the NHS is the departmental limit on capital expenditure that is set by HM Treasury than access to cash.

The workshop then started to explore other possibilities which would solve problems being faced in both sectors. The conclusion of the workshop was that there are a number of myths regarding the availability of cash and capital in the NHS.

This paper, along with various presentations in both sectors, is a first step to clarifying the frameworks which both sectors work in to allow local conversations to take place. Appendix 1 to this briefing summarises some of the questions asked, and answered, at the workshop.

CIPFA and HFMA will continue to work with their members to identify joint working opportunities and will continue to share real life examples as they are developed. If you are currently working on, or are planning, a joint capital investment arrangement or have any successful past examples to share please contact Jane Payling, Head of Health & Integration at CIPFA (jane.payling@cipfa.org or 020

[3] See the Public Accounts Committee report on integrating health and social care www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/959/95902.htm

[4] See the latest guidance from NHS England on integration and the better care fund www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

7543 5600) or Debbie Paterson, technical editor at HFMA (debbie.paterson@hfma.org.uk or 07500 859503).

Sector background and context

NHS bodies and local authorities have different legislative basis, governance arrangements and financial frameworks. This section of the briefing sets out, at a high level, how the different systems work in relation to capital funding and expenditure.

CIPFA and the HFMA have produced a *Glossary for NHS and local government and finance*[5] which may be useful when starting these conversations.

Local authorities

Local authorities have to 'have regard' to CIPFA's *Prudential code for capital finance in local authorities*[6] ('the Code') when developing their capital investment plans. Effectively, the Code allows local authorities to borrow for capital investment over the medium term.

The Code was developed to support local authorities as they develop their capital investment plans with:

- local strategic planning
- asset management planning
- proper option appraisal.

Its objectives are to ensure, within a clear framework, that capital investment plans of local authorities are affordable, prudent and sustainable, and that treasury management decisions are taken in accordance with good professional practice. The Code sets out prudential indicators which are designed to demonstrate compliance with these objectives and provide assurance to Government that local authorities are acting responsibly. This assurance means that there is no national expenditure limit for local government capital expenditure, as the Code is designed to allow capital to be managed at local level.

Local authorities have flexibility to invest in capital schemes providing they can be afforded and then that they meet an avowed policy and/ or generate a financial return for the authority. Each local authority works autonomously and independently so any arrangements with NHS bodies will have to be negotiated on a case by case basis between the parties involved.

Local authorities generally borrow from the Public Works Loans Board (PWLB) at interest rates determined by HM Treasury in accordance with section 5 of the National Loans Act 1968[7].

The broad span of services provided by local authorities means that any investments have to be prioritised against their wider plans. Support for joint investments with NHS partners will need the support of local politicians to make it a priority.

NHS bodies

NHS bodies' powers to incur capital expenditure

The powers and financial frameworks in the NHS are different for each type of NHS body. At the highest level, all capital expenditure incurred by all NHS bodies in England has to be contained within

[5] www.hfma.org.uk/publications/details/glossary-for-nhs-and-local-government-finance-and-governance
[6] www.cipfa.org/policy-and-guidance/publications/t/the-prudential-code-for-capital-finance-in-local-authorities-2011-edition-pdf
[7] www.dmo.gov.uk/index.aspx?page=PWLB/PWLB_Interest_Rates

the Department of Health (DH) capital departmental expenditure limit (CDEL)[8]. The expenditure incurred in relation to finance leases is included as capital expenditure against the CDEL.

Foundation trusts (except those deemed to be in financial distress) have the most flexibility as they can incur capital expenditure using internally generated resources to the limit of those resources. They also have powers to borrow and can use this to fund capital expenditure. This is not an unlimited power as they are required to report significant and/ or material transactions to NHS Improvement.

NHS trusts and foundation trusts in financial distress have to work to the following delegated limited for capital investments:

Table 1: Delegated limits for foundation trusts in financial distress and all NHS trusts

Financial value of the capital investment or property transaction	Approving person/ committee/ board
Up to £15 million[9]	Trusts approve under their own governance arrangements
£15 million to £30 million	NHS Improvement executive director of resources/ deputy CEO or NHS Improvement director of finance and DH
£30 million to £50 million	NHS Improvement Resources Committee and DH
Over £50 million	NHS Improvement Resources Committee, NHS Improvement Board, DH and HM Treasury

Source: NHS Improvement *Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts*[10]

A foundation trust is deemed to be in financial distress if they are in:

- financial special measures
- breach of their licence
- receipt (or planned receipt) of interim financing.

NHS trusts are also given a CDEL which their capital expenditure cannot exceed.

CCGs are less likely to incur capital expenditure but they are funded from the DH's capital allocation and are also given an entity level CDEL which they have a statutory duty to remain within.

The DH itself and its arm's length bodies are required to stay within their entity level CDEL.

The perceived problem for NHS bodies

Currently, NHS bodies are struggling to access cash to finance their capital programmes. The main reason for this is to enable the DH to manage the total capital expenditure incurred in the NHS in England against the CDEL.

In 2015/16, the Department of Health reported an underspend of £58m against the CDEL which is, in itself, a large number, but is only 1.57% of the budgeted CDEL. In 2016/17, it is expected that the

[8] For information on how allocations work in the NHS see www.hfma.org.uk/publications/details/how-it-works-the-department-of-health-and-nhs-england-allocation-process

[9] NHS Improvement can lower this limit if business cases are considered novel, contentious or repercussive, trusts are in the highest risk categories of distress based on their segmentation under the *Single oversight framework* or trusts have an excessive number of business cases below £15m.

[10] https://improvement.nhs.uk/uploads/documents/NHSI_Capital_Regime_Investment_Property_Business_Case_Main_Comms_V9.0_final_v2.pdf

outturn position will be as close, if not closer to the limit. This is a relatively new phenomenon, prior to 2013/14, the underspend against CDEL was comfortably above 10% of budget.

Table 2: Performance against CDEL 2010 - 2016

	2010/11 £bn	2011/12 restated £bn	2012/13 £bn	2013/14 £bn	2014/15 £bn	2015/16 £bn
CDEL	4.9	4.4	4.5	4.4	4.0	3.7
Outturn	4.2	3.8	3.8	4.3	4.0	3.6
Under/ (over) spend	0.7	0.6	0.7	0.1	0.1	0.1
Under/ (over) spend %	15.1%	13.4%	15.8%	2.1%	1.6%	1.6%

Source: Department of Health, *Annual report and accounts 2015/16*[11]

The 2015 spending review set the CDEL flat until 2020/21, whilst the most recent budget announced some more capital funds it is not expected that the amount of capital expenditure that can be incurred in the NHS will increase until the end of this period at the earliest. It is also expected that the Department of Health will transfer some capital funding to revenue each year until the end of this period.

Table 3: Capital funding for the Department of Health

	2016/17 £bn	2017/18 £bn	2018/19 £bn	2019/20 £bn	2020/21 £bn
CDEL announced in the 2015 spending review	4.8	4.8	4.8	4.8	4.8
CDEL announced in the 2017 budget	4.6	6.1	6.0	6.0	5.9
Difference	-0.2	1.5	1.4	1.4	1.3
Due to:					
Additional resource for A&E		0.1			
Additional resource for STPs		0.1	0.1	0.1	
Transfer of research budgets from RDEL to CDEL[12]		1.0	1.0	1.0	1.0

Source: HM Treasury *2015 spending review,* HM Treasury *2017 budget,* Department of Health *2016/17 estimates memorandum*[13]

[11] www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2015-to-2016

[12] It looks as if the capital funding for NHS bodies has increased but the majority of this increase is due to a change in accounting for research and developments in the national accounts. It is therefore a transfer of funds between capital and revenue rather than additional resources. The budget did include an additional £100m for capital schemes in relation to A&E and £325m to support STPs over three years.

[13] Table 2.2 www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf, table 1.7

Therefore, borrowing money from local authorities to spend on NHS assets is not a solution to the problem if it means that the NHS incurs capital expenditure over and above the national CDEL. The 2017/18 CDEL is almost entirely consumed by expenditure that NHS bodies can fund from their own internally generated resources - for example, depreciation and existing commitments. The control systems summarised above are in place to allow the DH to manage capital expenditure nationally against its CDEL. The flexibilities afforded to non-distressed foundation trusts makes capital management more complex, requiring contingency plans to be in place and restriction of cash into the system.

From the DH's perspective, any joint working between the NHS and local authorities must result in investments which do not count against the DH CDEL. This means that the arrangement must not result in assets on the NHS body's balance sheet.

NHS bodies are therefore looking for ways to finance capital projects without incurring capital expenditure. Some are looking outside of the public sector by entering into strategic estates partnerships with private sector bodies or managed service contracts but many are looking to work with local authority partners on integrated schemes which meet all partners' objectives.

Alternatively, some NHS bodies are looking to sell existing properties to generate capital receipts which can be used to reinvest in capital schemes. The Naylor report identifies this as an opportunity and local arrangements are being entered into.

Possible joint investment schemes

One asset providing health and social care services

Prior to 2013, it was reasonably common for primary care trusts[14] (PCTs) and local authorities to come together to invest in joint administrative buildings and 'one stop shops' serving the public. The building would therefore be home to a GP practice, community healthcare services such as district nursing as well as community social services.

Given their freedom to borrow, it was often the local authority which invested in and controlled the asset with the PCT contributing through rental income and sharing running costs. Sometimes, the asset and/ or the site was originally owned by the NHS but was usually in need of complete renovation to make it fit for purpose or to make it usable as a 'one stop shop'.

Such schemes were often associated with provision of shared services, sharing of administrative functions or based around contact with the public. The reorganisation of the NHS in 2013, moved responsibility for managing the estate previously owned by PCTs to the NHS Property Services Ltd. The reorganisation resulted in a lull in such schemes but once again local authorities are beginning to work with CCGs and NHS trusts to deliver joint estates solutions. The better care fund and other health and social care integration schemes provide scope for such further investments.

CIPFA's white paper on managing public sector property to support aligned local public services, *Place based asset management*[15] provides further context for this debate.

Issues to consider include:

- the potential to deliver efficiency savings or improved services by co-locating NHS and local authority bodies provides the greatest scope for joint investment
- joint investment should reduce the capital and revenue resource impact on both NHS and local authority bodies

www.gov.uk/government/uploads/system/uploads/attachment_data/file/597467/spring_budget_2017_web.pdf and www.parliament.uk/documents/commons-committees/Health/Department-of-Health-Estimates-Memorandum-2016-17-with-Appendix.pdf

[14] Primary care trusts were the predecessor bodies to commissioning care groups (CCGs). They commissioned primary and secondary healthcare but also, in many cases, provided community healthcare services. They were abolished on 1 April 2013.

[15] www.cipfa.org/cipfa-thinks/aligning-local-public-services

- the risk to local authorities is to some extent offset by their retention of the underlying assets. This benefits the NHS body as it does not impact on the CDEL
- under minimum revenue provision rules, local authorities are required to provide for the repayment of borrowing associated with any assets over the life of that asset.

Local authority investment

Local authorities have the scope to invest in NHS assets on a commercial basis with the aim of making a return on their investment. Examples include investment in car parking, shops or facilities generating rental income.

However, most local authorities will want to see clear benefits for their local area in addition to a rental return. Strategic investment would need to be justifiable to the local taxpayer, and demonstrate that the proposal is a win-win for both the local authority and NHS body; each case will need to be considered on its merits looking at the commercial, economic and local taxpayer impact.

The asset would have to remain on the local authority's balance sheet for it to avoid hitting the NHS CDEL. Investment options might include the use of operating leases where the local authority buys an asset then leases it to the NHS body. The lease would need to be a relatively short term arrangement and be a landlord repairing lease to avoid it being a finance lease. Clearly, the changes coming in with the adoption of IFRS 16 *Leases* from 2019/20 would need to be considered. It may be that service related contracts falling outside of IFRS 16 would be more favourable.

Sale of surplus or semi-surplus NHS property to a local authority may be an option, possibly for leasing back to the NHS body. The sale would generate a capital receipt for the NHS body which should be available to fund capital expenditure. There may also be opportunities to assemble land/ property packages from across partners to create an overall package which is more viable for joint use or attractive for sale.

It is worth noting that NHS organisations do not represent a credit risk to local authorities as they are effectively backed by the DH which has a duty to ensure that healthcare services continue to be provided (see appendix 2 to this briefing).

Practical action and case studies

This is the first briefing to support the work that CIPFA and the HFMA are doing with the Department of Health on this issue.

We would welcome feedback from local authorities and NHS bodies on the support that they need to turn the theory into reality, real life examples they might have and any additional guidance we should develop. We have two examples of integrated capital schemes which are at an early stage which are summarised below. We will update these examples as they develop.

Please contact Jane Payling, Head of Health & Integration at CIPFA (jane.payling@cipfa.org or 020 7543 5600) or Debbie Paterson, technical editor at HFMA (debbie.paterson@hfma.org.uk or 07500 859503).

Case study: Cylch Caron integrated resource centre

The Cylch Caron project[16] is a joint project between Hywel Dda University Health Board and Ceredigion County Council to bring together primary and community healthcare services, social care and housing services.

The plan is to build a purpose-built centre which will house a GP surgery, community pharmacy, out-patient clinic, community nursing services, long-term and day care. There will also be 34 flats

[16] See www.mid-walesha.co.uk/en/plans-view-cylch-caron-integrated-resource-centre and www.ceredigion.gov.uk/English/CeredigionForAll/cylchcaron/Pages/default.aspx

on site for people who need extra care and support to live independently and 6 integrated health and social care places to provide support for people in their move from hospital back home.

This new site will replace an existing community hospital, residential care home and GP surgery; none of which are fit for purpose any longer.

The project is currently at the planning stage and the Mid-Wales Housing Association has been appointed as delivery partner. The project is expected to be funded partly by Welsh Government NHS capital and also from social housing. For example, the land has been purchased by the local authority using funding from the Welsh Government NHS capital[17]. It is expected that the housing association will enter into lease arrangements with the other parties once the centre has been built.

A full business case for submission to the Welsh Government is being developed[18].

Case study: Essex County Hospital site

Colchester Hospital University NHS Foundation Trust (CHUFT) is planning to transfer services off the original Essex County Hospital site[19].

CHUFT has reached an agreement with Essex Housing, part of Essex County Council, to commission a piece of work to assess this key site's suitability for future redevelopment.

The council will work in partnership with CHUFT to undertake investigations at the site in Lexden Road.

Some of the buildings at the 4.5 acre Lexden Road site are currently in use but are surplus to CHUFT's requirements and are scheduled to become vacant when CHUFT finally transfers the hospital's services off of the site in 2018.

This is the first stage of bigger plans for the site and demonstrates the importance of both strong local relationships between health and local government and the need to plans to be politically acceptable locally.

[17] http://gov.wales/newsroom/health-and-social-services/2016/land/?lang=en
[18] See page 7 of the health board's capital infrastructure plan, March 2017 www.wales.nhs.uk/sitesplus/documents/862/Item19iv.HywelDdaAnnualPlan2017-18CapitalInfrasturcturePlan9-3-17v3%20Final.pdf
[19] www.colchesterhospital.nhs.uk/essexcountytransfer.shtml

Acknowledgements

CIPFA and the HFMA would like to thank everyone who attended the joint workshop and added to the discussion which resulted in this paper:

Andrew Baigent, Department of Health

Stuart Baron, Calderdale and Huddersfield NHS Foundation Trust

David Carter, Warwickshire County Council

Simone Hines, Nuneaton and Bedworth District Council

Shahana Khan, George Eliot Hospital NHS Trust

Jay Mistry, NHS Improvement

Sean Nolan, CIPFA/ALATs

Lee Outhwaite, NHS Improvement

Sonita Osbourne, George Eliot Hospital NHS Trust

Debbie Paterson, HFMA

Jane Payling, CIPFA

Virginia Rennie, Warwickshire County Council

Alison Scott, CIPFA

Chris Tidman, NHS Improvement

We would also like to thank those who contributed to the case studies:

Stephen Forster, Hywel Dda University Health Board

Chris Howlett, Colchester Hospital University Foundation Trust

Dawn Scrafield, Colchester Hospital University Foundation Trust

Eldeg Wyn Rosser, Hywel Dda University Health Board

Further reading

CIPFA/ HFMA *Glossary for NHS and local government and finance*

www.hfma.org.uk/publications/details/glossary-for-nhs-and-local-government-finance-and-governance

CIPFA *Prudential code for capital finance in local authorities*

www.cipfa.org/policy-and-guidance/publications/t/the-prudential-code-for-capital-finance-in-local-authorities-2011-edition-pdf

HFMA *How allocations work in the NHS*

www.hfma.org.uk/publications/details/how-it-works-the-department-of-health-and-nhs-england-allocation-process

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

https://improvement.nhs.uk/uploads/documents/NHSI_Capital_Regime_Investment_Property_Business_Case_Main_Comms_V9.0_final_v2.pdf

CIPFA *Place based asset management*

www.cipfa.org/cipfa-thinks/aligning-local-public-services

NHS property and estates: Naylor review

www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

Letter from Philip Dunne MP, Minister of State for Health on capital to revenue transfers in the NHS

www.parliament.uk/documents/commons-committees/Health/Correspondence-with-DoH-re-Supplementary-Estimates-2016-17.pdf

Community Health Partnerships and NHS Property Services Ltd *Making the most of NHS buildings and land*

www.property.nhs.uk/what-we-do/sep/

Appendix 1: Questions asked, and answered at the workshop

During the workshop, participants found that their preconceptions were challenged. This appendix provides some of the details of the myths that were busted simply by representatives from different public bodies sitting around the same table.

The problem in the NHS is access to cash, isn't it?

No, at least not in terms of capital expenditure. There is a limit (called CDEL) to the amount of capital expenditure all NHS bodies in England can incur.

Different NHS bodies have to adhere to different rules and some NHS bodies do not have limits on their capital expenditure other than the amount that they can finance. Therefore, to manage the situation at a national level, the Department of Health restricts the amount of funding available to finance capital expenditure.

Local authorities tend to be cash rich and have treasury management powers to lend that cash. NHS bodies have powers to borrow. Isn't the solution to this problem therefore for NHS bodies to borrow from local authorities?

This paper is looking for solutions to the problem of funding capital expenditure in the NHS and therefore focuses on local authorities' powers to invest under the Code.

Local authorities manage a significant cash portfolio and may borrow and invest money for treasury management purposes. As at 31 March 2016, UK local authorities had outstanding borrowing of £88bn and investments of £32bn.

Local authorities in England, Scotland and Wales are required to 'have regard' to the *Treasury management code* which defines treasury management as follows:

> 'The management of the organisation's investments and cash flows, its banking, money market and capital market transactions; the effective control of the risks associated with those activities; and the pursuit of optimum performance consistent with those risks.'

It is therefore possible for local authorities to lend money to NHS bodies to finance capital programmes as long as the loan generates a commercial rate of return. However, that does not solve the NHS problem of staying within the CDEL.

This option was therefore discounted at an early stage at the workshop and is not covered further in this paper.

Local authorities can only lend to entities with a good credit rating. NHS bodies don't have the necessary credit rating, do they?

NHS bodies do not represent a credit risk to local authorities as they are effectively backed by the DH which has a duty to ensure that healthcare services continue to be provided (see appendix 2 to this briefing).

Why is it necessary for NHS bodies to find off-balance sheet solutions?

Again, this is so that capital expenditure remains within the CDEL. Any capital expenditure counts against the CDEL as well as any finance leases or on-balance sheet PFI arrangements.

The book value of any surplus property that is sold counts as negative expenditure against CDEL, which means that a greater amount of capital expenditure can be incurred without breaching the CDEL.

Appendix 2: Credit worthiness of NHS bodies

Clearly, local authorities cannot enter into financing arrangements without assessing the credit worthiness of the other party.

Unlike commercial entities, NHS bodies do not have an easily determined credit rating. This is because the Department of Health has a duty to ensure the continuation of healthcare services.

The statutory basis for this is different for the different types of NHS body.

NHS trusts

Section 70 of the NHS Act 2006 states:

(1) If an NHS trust or a Special Health Authority ceases to exist, the Secretary of State must exercise his functions so as to secure that all of the body's liabilities (other than any criminal liabilities) are dealt with.

(2) A liability is dealt with by being transferred to an NHS body, the Secretary of State or the Welsh Ministers.

Paragraph 29 of Schedule 4 of the NHS Act 2006 states:

(1) If an NHS trust is dissolved under paragraph 28, the Secretary of State may by order transfer, or provide for the transfer, to himself or an NHS body of such of the property and liabilities of the NHS trust which is dissolved as in his opinion is appropriate; and any such order may include provisions corresponding to those of paragraph 9.

Paragraph 23 of Schedule 4 of the NHS Act 2006 states:

23(1) The powers of an NHS trust include power to enter into externally financed development agreements

(2) For the purposes of this paragraph, an agreement is an externally financed development agreement if it is certified as such in writing by the Secretary of State.

(3) The Secretary of State may give a certificate under this paragraph if—

(a) in his opinion the purpose or main purpose of the agreement is the provision of facilities or services in connection with the discharge by the NHS trust of any of its functions, and

(b) a person proposes to make a loan to, or provide any other form of finance for, another party in connection with the agreement.

(4) If an NHS trust enters into an externally financed development agreement it may also, in connection with that agreement, enter into an agreement with a person who falls within sub-paragraph (3)(b) in relation to the externally financed development agreement.

(5) “Another party” means any party to the agreement other than the NHS trust.

(6) The fact that an agreement made by an NHS trust has not been certified under this paragraph does not affect its validity.

NHS foundation trusts

Sections 128 to 133 of the *Health and Social Care Act 2012* make provision for the special administration of NHS foundation trusts. This includes provision for the transfer of liabilities. Section 65LA of the *National Health Service Act 2006* requires the regulator to transfer the liabilities of a dissolving NHS foundation trust to another NHS foundation trust or the Secretary of State.

Section 40 of the NHS Act 2006 states:

(3) The Secretary of State may guarantee the payment of any amount payable by an NHS foundation trust under an externally financed development agreement

(4) For the purposes of subsection (3), an agreement is an externally financed development agreement if it is certified as such by the Secretary of State.

(4A) The Secretary of State may give a certificate under subsection (4) if—

(a) in the opinion of the Secretary of State, the purpose or main purpose of the agreement is the provision of facilities or services in connection with the discharge by the NHS foundation trust of any of its functions, and

(b) a person proposes to make a loan to, or provide any other form of finance for, another party in connection with the agreement.

(4B) In subsection (4A) (b), “another party” means any party to the agreement other than the NHS foundation trust.

About CIPFA

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our 14,000 members work throughout the public services, in national audit agencies and major accountancy firms, anywhere where public money needs to be effectively and efficiently managed. As the world's only professional accountancy body to specialise in public services, CIPFA's qualifications are the foundation for a career in public finance. We also champion high performance in public services, translating our experience and insight into clear advice and practical services. Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance.

CIPFA

77 Mansell Street, London, E1 8AN
T 020 7543 5600
W cipfa.org

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.

HFMA

1 Temple Way, Bristol, BS2 0BU
T 0117 929 4789
E info@hfma.org.uk
W hfma.org.uk