Department of Health

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Monitor
Making the health sector work for patients

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Dear Colleagues

Update and Survey on IFRS 15 Revenue from Contracts with Customers

Over the summer HM Treasury established a cross departmental working group to assess the adoption issues for IFRS 15 for the public sector. The Department and Monitor have been part of this group and have been taking forward an assessment with HFMA, of the impact on the NHS and in particular the NHS standard contract. The adoption of the standard has recently been deferred by the International Accounting Standards Board (IASB) and will now be adopted from 1 January 2018, and so is expected to commence in the public sector with effect from 1 April 2018. The next stage is for the Financial Reporting Advisory Board (FRAB) to start to consider whether any interpretations or adaptations are required for the public sector.

IFRS 15 Revenue from Contracts with Customers seeks to replace IAS 18 Revenue, IAS 11 Construction Contracts and related IFRIC and SIC interpretations. IFRS 15 introduces a 5 step process for the recognition and measurement of revenue, which is more prescriptive than IAS 18.

- Step 1: Identifying a contract with a customer;
- Step 2: Identifying performance obligations;
- Step 3: Identifying the transaction price;
- Step 4: Allocating transaction prices to performance obligations; and
- Step 5: Satisfaction of performance obligations.

The core principle in IFRS 15 is that entities should recognise revenue to depict the transfer of promised goods or services to the customer at an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. It should be noted that revenue relating to leases, insurance, and financial instruments are out of scope and are subject to other accounting standards. It is expected that the bodies most affected are those that enter into complex contracts which deliver goods and services or which are delivered over a long period of time.

The standard will apply to all of the contracted income (and implied contracted income) received by NHS bodies. This will include contracts for non-patient services as well as for patient services. The majority of income for most NHS providers will come from the NHS contracts with commissioning bodies. It will not apply to payments made outside of a contract such as financial allocations and support provided by the Department of Health.

From our assessment of the NHS contract, we expect:

- Tariff procedures covering a spell of care will be separate performance obligations. There may however be some complex spell cases with distinct elements that could involve multiple performance obligations. For block contracts the obligations may need to be split to the procedures that are subject to different measurement under the contract. However this latter point may be simplified in application by the fact that the revenue is usually recognised in a single reporting period.
- Healthcare is performed, and the income recognised, over time, rather than at a point in time, and the tariff system provides a clear allocation of prices to obligations.
- The move to expected value (i.e. recognising revenue to which the entity expects to be entitled) in IFRS 15 may affect some income calculations at year-end when penalties and sanctions are considered.
- There may be a case for income under IFRS 15 that relates to re-admissions to be apportioned across the original treatment and the re-admission treatment. We welcome respondents' views on this in applying the technical requirements of the standard.
- There will be the additional disclosures required by the standard on contract income.

FRAB will be considering IFRS 15 at its November meeting to look at whether any interpretations or adaptations are required for the public sector. HM Treasury is collecting views from Departments to analyse for FRAB and we are interested in gaining insights from NHS bodies which we will feed into that. We have attached HM Treasury's consultation, which summarises the views from the working group, at Annex B for your reference. For the purposes of our engagement with you we have distilled the Treasury questions to a shorter set at Annex A. We invite you to respond to the questions we have included as Annex A to this letter and have included a pro forma document for your use.

We would appreciate your responses by Tuesday 27th October. Please submit your response by e-mail as follows:

- NHS trusts: to TDA.TFMSqueries@nhs.net with the subject line 'IFRS 15 consultation'.
- NHS foundation trusts: to FT.Accounts@monitor.gov.uk with the subject line 'IFRS 15 consultation'.

Thank you in advance for your help. We look forward to receiving your views.

Yours faithfully

Keith Morton
Head of Accounts Policy
Department of Health

Ian Ratcliffe
Head of Sector Financial Accounting
Monitor

Annex A: Department of Health and Monitor IFRS 15 Survey Questions

Organisation:

Name:

Position:

1) Do you consider that IFRS 15 may have a significant impact on your recognition of revenue from the NHS standard contract? Please give your views on how the accounting could change and approximate values and any comments on our NHS assessment bullets listed in the letter.

2) Do you have any other contract revenue that is likely to be affected by IFRS 15 and if so can you provide details and indication of the value and how that might affect your financial reporting – these may include complex multi-year contracts or where a contract contains a bundle of services. Please include details of the contract and brief information on what performance obligations you believe might exist in the contract.

3) Do you have any unusual income streams where it is unclear whether IFRS 15 will apply? An example may be if you receive some consideration for no obligations (Annex B HMT paper para 5). Please give an estimated value for each.

4) Do you perceive any issues where the application of IFRS 15 may cause difficulties with agreement of balances and group eliminations with commissioners?

5) Are there any disclosure requirements in the standard (see Annex B HMT paper para 25) that you believe are not relevant or applicable to the NHS? If so can you outline your reasons and basis of arguments for adapting the standard?

6) The working group considered the two options for transition and favoured retrospective application with no restatement (Annex B HMT paper para 30). Do you agree with this approach? And if not please can you set out your reasons.

7) Do you have any other comments on the standard?