HFMA Response
February 2024

Response to HM Treasury's exposure draft on non-investment asset valuation for financial reporting purposes

Introduction

In 2022, HM Treasury undertook a thematic review of non-investment asset valuations. The review found that there was a case for changing the way that property, plant and equipment, and intangible assets are valued. The aim is to reduce the time that preparers spend on valuation of non-investment assets, the cost of engaging external valuers and the amount of audit focus on property, plant and equipment. HM Treasury have concluded that the quality of financial reporting can be maintained or improved through reducing areas of judgment and streamlining the valuation process.

In March 2023, HM Treasury published their consultation paper on proposed changes that would affect the adaptations and interpretations for the public sector of *International accounting standard* (IAS) 16 *Property, plant and equipment* and IAS 38 *Intangibles* (IAS 38). The HFMA responded to this consultation.

Following the responses to this consultation, HM Treasury established a technical working group to further consider the practical implementation of the proposed changes. HM Treasury also consulted with members of the Financial Reporting Advisory Board, including the National Audit Office.

As a result, *Non-investment asset valuation – exposure draft 23(01)* was published in December 2023[1]. In summary, the proposed changes are:

- The introduction of a classification of assets held for their operational capacity – assets currently classified as networks, specialised and non-specialised will fall into this new classification. Donated assets and investment assets, surplus assets and assets not held for their service potential will continue to be separately classified with no change.
- Assets will still be held on an existing use valuation basis and the depreciated replacement cost method will continue to be used. However, the option to use an alternative site when calculating an asset's depreciated replacement cost will be removed.
- There will only be three processes that can be followed when revaluing assets – this is intended to remove the need for desk top or interim valuations between full valuations:
    - a quinquennial valuation with annual indexation

[1] HM Treasury, *Non-investment asset valuation - exposure draft 23(01)*, December 2023

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    - a rolling programme of revaluations over a 5-year cycle with indexation in the intervening years
    - for non-property assets only, appropriate indices.
- The requirement to hold intangible assets at valuation will be removed – intangible assets will be held at historical (deemed) cost.

It is proposed that the effective date will be 2025/26 on a prospective basis. HM Treasury is proposing that the changes will be implemented on a phased approach at the point of the next full valuation for each individual entity.

These proposals will affect HM Treasury's *Financial reporting manual (FReM).* NHS bodies follow the DHSC's *Group accounting manual (GAM)* that has to be consistent with the FReM's requirements. The GAM will therefore reflect the changes to the FReM but may impose further restrictions to ensure that NHS bodies take a consistent approach for practical reasons.

Consultation response

Question 1: Do you agree that HM Treasury should introduce a new asset class – assets held for their operational capacity – to replace the existing asset classes 'networked assets', 'specialised assets' and 'non-specialised assets' for valuation purposes. If so, why? If not, why not, and what alternatives do you propose?

Yes, we agree. However, NHS bodies do not hold networked assets, so we have no view on the impact of this new asset class on such assets.

NHS bodies hold both specialised and non-specialised assets and there has always been an element of judgement required when applying these classifications. Hospitals are generally considered to be specialised assets, but hospitals are rarely a single building. Instead, they are a site or several sites that consist of multiple buildings that have different uses. So, in some cases, office buildings are in the middle of a hospital building or site and cannot be separated from the specialised, clinical parts of the building. In other cases, office buildings are on the edge of the site or separate from the clinical buildings so they could be separately valued but, in practice, are managed as part of a single estate. This new classification would remove these differences and judgments.

Some NHS bodies, usually commissioning bodies such as integrated care boards, own office buildings that are clearly not specialised as they could be used by any business in the private or public sector.

There are other assets, such as community clinics that are not clearly specialised as they could be used for other purposes but are being used for specialised purposes. This is an area where judgements have had to be made and where the new classification will be helpful.

Our members will therefore welcome this change as it should remove judgements and therefore audit queries. We have not discussed this response with valuation experts, therefore, our response is purely from the finance perspective – it may be that application of this new classification will be difficult for valuers. However, it is likely that introduction of this new asset class will impact on the valuation of assets in NHS bodies' accounts so it will be important for entities to be able to assess this impact ahead of 2025/26.

Question 2: Do you agree that the introduction of a new asset class - assets held for their financial capacity - is not required and should not be incorporated into the FReM? If so, why? And if not, why not?

We agree that a new class for assets held for their financial capacity is not required. NHS bodies hold assets for operational use and, if they are not in operational use, assets are usually considered to be surplus or held for sale.

It would be helpful if some guidance or consideration could be given to the process of disposing of an asset. Sometimes the classification of an asset as surplus is not clear cut and requires judgement.

Some assets will remain in use until they are disposed of and, sometimes, assets are disposed of and continue to be used by the NHS body in a sale and lease back type of arrangement. There is not

always a clear difference between an asset that is in operational use and one that is surplus, and this can therefore be an area for management and audit review and discussion.

It would be helpful if the FReM could make it clear that not all assets will be declared surplus prior to disposal and, therefore, whether a revaluation is necessary at the point of disposal. We note that the flowchart in chapter 10 of the FReM (page 86 of the 2023/24 FReM) does not use the term surplus – instead it asks whether the asset is in use. This is a clearer description, and we suggest it should be used instead of surplus in paragraph 10.1.5. Paragraph 10.1.6 should then make it clear if an asset is not in use but where there is a clear plan to bring it back into use the asset is valued as if it was in use which is what the flowchart indicates.

Question 3: Do you agree that the EUV measurement basis should be maintained? If so, why? If not, why not? Would you support the introduction of COV as an alternative?

We agree that the EUV measurement basis should be maintained. However, this is something that we expect professional valuers will have a view on.

From an accounting perspective, it is important for an entity's management to understand the judgements that need to be made to reach an appropriate valuation and the impact of these changes on managing the valuation process and responding to audit queries.

Question 4: Do you agree that this Exposure Draft provides sufficient guidance and context regarding the valuation approach for Right-of-Use assets, and that no changes are required to Section 10.2 of the FReM in light of the other changes to the valuation of non-investment assets being proposed? If so, why? If not, why not?

The adoption of IFRS 16 was difficult and NHS bodies are still embedding it into business-as-usual working practices. Therefore, it is important to minimise changes to accounting for leases to allow time for IFRS 16 to be embedded into business-as-usual.

However, our members are now struggling with the impact of IFRS 16 on budgeting, in particular, on managing and forecasting the impact on the capital departmental expenditure limit (CDEL) and the impact of any revision of any lease terms or value of right of use assets. Prior to implementation it was expected that the change to an accounting standard would not have an impact on budgets, but this is not proving to be the case. Our members are reporting that they are making sub-optimal decisions so they can keep within CDEL, such as entering into shorter leases or not renewing leases at all. In order that this does not happen again, it is important that the budgetary impact of this proposed change is fully explored and understood so that unintended consequences like this do not occur again.

Our members report that the valuation of right of use assets has been raised by auditors during 2022/23 with some firms insisting that a valuation is required as lease contracts do not reflect market price. Similarly, auditors have noted that some organisations are also considering revaluing right of use assets. It was expected that it would be rare that an external valuation for a right of use asset would be required. This would be a good opportunity to review the existing guidance in section 10.2 of the FReM relating to the valuation of right of use assets to ensure that this is the case.

In terms of cost of valuations and management and audit time, this is particularly an issue in the case of intra-NHS leases, for example where is Trust A runs the regional renal service and has renal dialysis units at Trusts B and C. Trust A has to get a valuation of their right of use asset and deal with the associated audit queries, while Trusts B and C are also getting separate valuations as part of their normal estate valuations. Some clear guidance that could be applied consistently by all three organisations would be helpful and would reduce the burden on finance teams, valuers and auditors.

Question 5: Do you agree that the requirement to consider alternative locations when valuing an asset using DRC should be removed from the FReM? If so, why? If not, why not?

We accept that removing the option to consider alternative locations when valuing an asset takes away a significant area of judgement which is one of the aims of this proposal. However, our members are divided on whether they agree with this proposal or not.

Some feel strongly that an alternative site valuation should only be considered where there are plans to move the site. They feel that the alternative site basis is too far removed from the actual assets to be useful to the reader of the accounts. Others argue the exact opposite.

Those NHS bodies that use an alternative site basis for their valuation usually do this because any modern equivalent asset would never be in its existing location, so the use of an alternative site is more appropriate to a modern equivalent asset valuation. This is more often the case for mental health and community providers that have multiple sites, although it can be an issue for acute sites that are situated in places where access is difficult. For example, a mental health trust currently operates from eight hospital sites and other community centres as that is how the services has grown over the years. Their current modern equivalent asset valuation is based on an alternative site provision of two hospital sites with community hubs which reflects their plans to establish smaller centres of excellence. Removing the option to use an alternative site valuation in this case would result in a very different valuation that would not be a true modern equivalent.

Where an NHS body has multiple sites, the cost of the valuation may increase if the alternative site option is removed as some valuation firms base their charges on the number of sites they value. In the example we have given, a valuation for more than eight sites would be required rather than the two that are currently provided resulting in a cash cost pressure in quinquennial years.

As we noted in question 4, it is important that the impact of this change on the financial position of NHS bodies is fully assessed so there are no unexpected consequences. The financial assessment should consider the impact of the changes but also the consequences of the current regime.

Historically, NHS bodies have generally been encouraged to use an alternative site valuation so this change will have a major impact on the sector. It is expected that changing from an alternative site valuation to an actual site valuation will increase the valuation of an NHS body's non-current assets. It will therefore result in increased depreciation charges and public dividend capital (PDC) dividend payments.

This will impact on the revenue performance of NHS provider bodies – particularly in the year of implementation. The payments received by NHS provider bodies for the provision of healthcare services are based, in part, on historical costs including depreciation and PDC dividend. If there is a material change in either, it will not be reflected in prices until at least the year after the year of implementation. As we have set out in our response to question 12, work will need to be done prior to 2025/26 in relation to forecasts and plans to ensure that the impact on the financial position of NHS bodies can be managed.

For some years now, the sum of the capital programmes of NHS bodies has outstripped the DHSC's capital departmental expenditure limit (CDEL) by some margin. The ability to incur capital is therefore a major constraint in NHS bodies' plans. NHS England use a methodology[2] that includes the net book value of each bodies' property, plant and equipment as well as their depreciation charge for the year. As some NHS bodies will be affected more than others by this proposed change, it will affect the relative proportions of the CDEL that each entity is allocated. For some bodies it may increase the amount of CDEL that is made available to them. Increasing asset valuations may also result in increased CDEL for the DHSC group, without that the amount of capital available for national projects would be reduced if more is made available to provider bodies.

[2] NHS England, *Capital guidance 2022 to 2025*, April 2022

Question 6: Do you agree with HM Treasury's proposed three processes for asset valuations? If so, why? If not, why not and what alternatives do you propose?

We agree with this proposal. Our members tell us that, currently in England, NHS bodies tend to have regular full valuations, usually every five years, with desk top/ interim valuations in the years in between.

The work involved in a desk top/ interim valuation, and therefore its cost, varies between organisations, valuers and year by year depending on each entity's estate and capital programme. However, it is expected that moving to the use of indexation between quinquennial valuations (whether on a whole site or rolling basis) will be cheaper and reduce the time and effort required to prepare and audit the accounts. This is assuming that the indices are accepted by auditors as appropriate. As we have said in our response to question 8, if NHS bodies have to find their own indices and demonstrate that they are the most appropriate then the benefits of this change will not be realised.

We note that NHS bodies in the devolved nations already undertake quinquennial valuations with annual indexation. We expect that English NHS bodies are likely to move to this approach under the proposed arrangements rather than a rolling valuation.

Having said that we agree with the proposals, there needs to be clear guidance about how new builds or other capital projects, including those intended to extend the life of an existing asset, are valued when they fall between quinquennial valuations. Currently, we know that when new builds are valued, there is usually a large impairment due, in part, to the valuation being based on modern methods of construction. If a new building comes into use or a capital project is completed in the year after a quinquennial valuation then, if it is not revalued for four years, it is likely to be held at a higher value relative to other similar assets. This will have an impact on the financial position of the NHS body that will be unfunded. The updated FReM needs to include guidance on treatment of capital expenditure.

Question 7: Do you agree with HM Treasury's proposal for indexation to be applied to property assets each year in-between full revaluations? If so, why? If not, why not and what alternatives do you propose?

See our answer to question 6.

Question 8: Do you agree that it is not appropriate for HM Treasury to prescribe indices but that it should provide guidance on what indexation is and common indices to help entities implement changes? If so, why? If not, why not and what alternatives do you propose?

We do not agree with this proposal. We think that HM Treasury, or the DHSC, should prescribe indices for NHS bodies to use. The exposure draft provides one example of an index for buildings valued at depreciated replacement cost (DRC) and another for vehicles, plant and equipment. If these are included in the FReM, we would expect that these would be the indices most commonly used – entities would be unlikely to seek other indices. Given that there is only one example for each type of asset, we suggest that it would be appropriate for the FReM to say that these should be used, except in the unusual situation that a more appropriate index is available. That way, only using alternative metrics would involve convincing auditors that they are more appropriate for the body in question than the example indices.

While we understand that the whole of the public sector has a very diverse asset base, we do not think that this is the case for the NHS. The assets needed to provide healthcare services vary by the type of service being provided but do not vary very much across the country and within broad classifications of healthcare services – acute, community, mental health and primary care. There are likely to be geographical differences based on the differences in the property market across the UK but, we understand, that these are reflected in the BCIS all-in tender price index.

We are concerned that by not prescribing indices, individual bodies will need to make judgements as to which indices to apply which will be contrary to the aim of these proposals.

Any example, or actual, indices referred to in the FReM should be free for public sector entities to access.

Question 9: Do you agree with HM Treasury's conclusion that the valuation cycle should be 5 years (with the exception of non-property assets where appropriate indices are applied)? If so, why? If not, why not and what alternatives do you propose?

We agree that the valuation cycle should remain five years – this reflects the upper limit suggested in IAS 16 and reflects current practice. It strikes a balance between keeping valuations up to date and managing the cost and effort involved in a formal valuation. The benefits of the proposed changes will be felt without any reduction in the quality of the financial reports.

Question 10: Do you agree with the change in wording to the FReM adaptation for IAS 38 *Intangibles*, where HM Treasury will be mandating a historical cost model (and withdrawing the revaluation option)? If so, why? If not, why not and what alternatives do you propose?

We agree. In our members' experience, finding a suitable valuation for intangible assets has always been difficult due to the lack of an observable market. Often intangible assets are held at cost as a reasonable proxy for market value in existing use. The exception to this is electronic patient record systems that have been impaired as they have been brought into use.

This means that the cost of intangible assets is usually known so moving to a historical (deemed) cost measurement basis is unlikely to have big practical impact. It also reduces the need for judgements to be made in the accounts which is to be welcomed.

Question 11: Do you agree that intangible assets should be measured at historical (deemed) cost, with the value of intangible assets at the date of transition being taken as historical (deemed) cost, and historical cost accounting applied thereafter? If so, why? If not, why not and what alternatives do you propose?

We agree. As we said in our answer to the previous question, often cost has been used as a proxy for current valuation so this would not make a huge practical difference.

Question 12: Do you agree with the proposed effective date of financial year 2025-26 for the changes? If so, why? If not, do you think the proposed effective date should be financial year 2026-27? If so, why? Are there any significant operational challenges you consider might be encountered during the implementation of this proposed approach to the valuation of non-investment assets?

For NHS bodies, an implementation date of 1 April 2025 is the earliest that these changes can be made. As we will set out in our answers below, we think that these changes will need to be made by all NHS bodies at the same date so all the necessary guidance, training and information will need to be issued by the end of 2024 at the latest.

The proposed changes will need to be adopted within the DHSC's *Group accounting manual* that will have to be issued for consultation. Depending on how the changes are implemented, sector wide indices will need to be available for NHS bodies to apply. The expected impact on depreciation and PDC dividends will need to be calculated for accurate planning and forecasts.

Some NHS bodies will be considering moving to an alternative site valuation in 2023/24 or 2024/25. It is important that these changes are communicated as soon as possible. Plans to change the valuation basis may be revised if these proposals are implemented from 1 April 2025. Disclosures may be required in the 2024/25 accounts as a change akin to an accounting standard not yet effective.

A detailed financial assessment (as set out in our response to question 5) must be completed as soon as possible in order that the impact on the financial position of individual NHS bodies and the sector as a whole, both in terms of revenue and capital budgets can be assessed and managed. This

work could be completed during 2025/26 but that would mean that there would be little time to manage any impact.

Given the work that needs to be done, it may be better to move the implementation date to 1 April 2026 in the NHS. However, our experience is that, sometimes, deferring changes to financial reporting requirements does not necessarily make implementation easier. However, unlike the implementation of IFRS 16 *Leases* this change is unlikely to have an impact beyond the finance and estates departments once the financial implications are understood.

Question 13: Do you agree with HM Treasury's proposals for transition described above? If so, why? If not, why not and what alternatives do you propose?

We agree with the prospective implementation of accounting for intangible assets at historical (deemed) cost. As we indicated above, we do not expect that the change in valuation basis will change the actual valuations.

In our view, the proposed change to the frequency of valuations cannot be applied retrospectively – particularly as NHS bodies undertake a valuation of some kind, whether full or a desk review, every year.

Equally, it would be difficult to change the valuation basis to a same site valuation on a retrospective basis. This change seems more akin to a change in estimation rather than a change to accounting policy as the policy is still to hold assets at valuation. The benefit of retrospective restatement is unclear so we agree that this should also be adopted prospectively. As we indicated in our response to question 5, we do have concerns about the effect this change will have on the financial position of NHS bodies.

In terms of the transition, we think that all NHS bodies should move to the new valuation basis on the same date. NHS bodies work within a single financial framework and financial performance of individual bodies is assessed on a system and then national level. It is therefore important that all bodies are following the same approach.

As previously explained in our response to question 5, changing the valuation basis will affect annual depreciation charges and the public dividend capital (PDC) dividend payment made annually to the DHSC. The PDC dividend is based on the net assets held by each NHS body, adjusted for cash balances and donated assets, so changes to asset valuation will directly impact dividend payments.

The reason for these proposed changes is to simplify the accounts preparation process by reducing the level of judgements required to value non-current assets. As we said in our response to question 8, we are concerned that if indices are not mandated then there will be prolonged and difficult discussions about the indices selected and whether they are appropriate.

Question 14: Do you agree with HM Treasury’s conclusions on disclosure guidance? If so, why? If not, why not and what alternatives do you propose?

The suggested narrative does not include any reference to the change in valuation of intangible assets from the revaluation to the cost model. While it is not expected that this will make a material difference, this is a change in accounting policy that should be disclosed.

The first paragraph of the suggested narrative includes too many negatives which makes it difficult to understand. It does not refer to the change to classification of assets held for their operational capacity. We suggest that something along these lines:

> From 1 April 2025 HM Treasury changed the requirements in the Government Financial Reporting Manual (FReM) in respect of revaluations of property, plant and equipment.
>
> Under the new requirements, assets previously classified as networked, specialised and non-specialised assets will be classified as assets held for their operational capacity. The valuation basis for these assets continues to be existing use value.
>
> Non-property assets will continue to be valued using appropriate indices.

For all other assets held for their operational capacity, there are now only two processes that can be used for revaluation:

- a quinquennial revaluation supplemented by annual indexation in intervening years
- a rolling programme of revaluations over a 5-year cycle, with annual indexation applied to assets during the four intervening years.

This means that from 1 April 2025, those assets will be valued using [insert process here], rather than [insert old process here]. [if possible, insert detail of what this will mean for the entity].

Question 15: Do you agree with HM Treasury's proposed update to Chapter 10 of the FReM to introduce the concept of assets held for their operational capacity, remove the specialised/ non-specialised asset split from the FReM, and add additional guidance from IPSAS 45 on how to identify as asset held for its operational capacity? If so, why? If not, why not and what alternatives do you propose?

The third paragraph in the box on page 20 is not clear. While we understand that this is an extract from IPSAS 45, it does not provide helpful guidance to the preparers of accounts.

The final sentence of that paragraph states entities should presume that an asset is held for operational capacity where the primary objective of holding an asset cannot be determined, we think it is likely that entities will rely on this presumption rather than develop their own criteria to exercise judgement on the objective of holding an asset. The first bullet point in the box below paragraph 5.8 indicates that assets held for financial gain will only be surplus assets or assets held for sale and all other assets will be held for operational use. We therefore suggest that the first two sentences of in the final paragraph in the box on page 20 are not needed.

If necessary, a sentence could be added that where it is not clear that an asset is surplus, held for sale or held for operational capacity then the entity will need to use judgement to determine the most appropriate classification.

We suggest that in the first sentence, the word operational is not used to explain what held for operational capacity means. Instead, we suggest that the description should be assets that are being used primarily to deliver front line services or back-office functions. This reflects an assumption that operational assets are assets in use.

Question 16: Do you agree with HM Treasury's proposed update to the existing adaptation of IAS 16 covering measurement bases to introduce the concept of assets held for their operational capacity and remove the specialised/ non-specialised asset split from the FReM? If so, why? If not, why not and what alternatives do you propose?

We agree that the proposed update reflects the proposed changes that we have commented on in our response to question 1. It may be that answering the questions raised above will mean that the wording to the FReM will need further amendment.

Also, it may be that once the whole chapter is revised, further amendments will need to be made to ensure that it is clear and internally consistent.

We suggest that in the first bullet point in the box below paragraph 5.8, '(i.e., operational assets)' is deleted as it does not add to the understanding of what an asset held for its operational capacity is.

Question 17: Do you agree with HM Treasury's proposed adaptation of IAS 38 to mandate measuring intangible assets using the cost model after initial recognition? If so, why? If not, why not and what alternatives do you propose?

We agree with this interpretation.

Question 18: Do you agree with HM Treasury's proposed adaptation of IAS 16 paragraph 34 and the changes to FReM paragraphs 10.1.1 and 10.1.2? If so, why? If not, why not and what alternatives do you propose? Do you agree that, under the adaptation to IAS 16.34, full revaluation will only be required where there are indicators of impairment under IAS 36, or where no appropriate indices are available?

We are concerned that the final part of the final sentence in the box below paragraph 5.14 will mean that the time and effort currently spent on agreeing valuations will simply shift to discussing whether there are any indications of impairment of assets. As indicated above, NHS bodies tend to have a valuation of some kind annually – this effectively identifies indications of impairment making the application of IAS 36 *Impairment of assets* relatively straightforward.

We welcome the new paragraph suggested in the box beneath paragraph 5.28 as that makes it clear that a full valuation is not required to demonstrate that there has not been a material impairment. However, we think that the IAS 36 will need further adaptation or interpretation.

As with all accounting standards, IAS 36 is written with profit making entities in mind. Therefore, it assumes that assets are only held to generate cash flows whether that is by making goods to be sold, to provide services that are delivered or from selling the asset itself. The adaptation of IAS 36 relates to accounting for impairment losses and the impact on national budgets. The interpretation does indicate that where assets are not held for the purposes of generating cash flows the value in use is assumed to be the cost of replacing the service potential. However, we are concerned that this means that entities will be required to demonstrate that there are no indications that assets have been impaired.

Some of the indications of impairment set out in paragraph 12 of IAS 36 are applicable to public sector bodies such as evidence of obsolescence or physical damage. However, other indications, such as, market interest rates market capitalisation and indications that an asset's value has declined are difficult to apply in the public sector. There is little market for those assets that are held for their operational capacity, particularly assets held by NHS bodies. It is therefore difficult to demonstrate that none of these indications exist.

Equally, the definitions in IAS 36 are difficult to apply to public sector bodies. The recoverable amount of an asset is defined as the higher of its fair value less costs of disposal and its value in use. The FReM already indicates that assets held for their operational capacity should not be measured at their value in use rather than their fair value, so this definition is difficult to apply to the public sector.

In our response to question 6, we raised questions about how additions will be managed under the new proposals. It may be that answering the questions raised above will mean that the wording to the FReM will need further amendment.

As we indicated in our answer to question 4, the impact of impairments on budgets (DEL or AME) is a concern to our members. This needs to be considered as part of the assessment of the impact of these proposals.

Question 19: Do you agree that it is appropriate for accounts preparers (where necessary, in consultation with their valuers and using the RICs Red Book) to determine the most appropriate revaluation methodology for an asset given the methodologies being proposed by HM Treasury in this Exposure Draft? If so, why? If not, why not, and what alternatives do you propose?

It makes sense for accounts preparers and their valuers to decide together which of the two options for the valuation of assets that are not non-property assets to apply. It is for valuers to provide guidance from the *RICS red book*, assuming that it includes appropriate guidance.

If the red book does contain such guidance, it would be helpful for that guidance to be included in the FReM or, at least, specific reference is made to the appropriate section.

Question 20: Do you agree with HM Treasury's proposed changes to FReM paragraphs 10.1.10? It is HM Treasury's intention that a phased transition approach, supported by disclosure, will be permissible even where the impact is materially different to full transition on implementation. Do you agree that the revisions to FReM 10.1.10 achieve this intent?

Yes, we agree with the proposed change to paragraph 10.1.10 subject to our comments above. However, this paragraph does not make reference to the timing of the transition to the new approach – we think that specific mention will need to be made to the proposed approach.

Question 21: Do you agree with the index examples HM Treasury has provided? If so, why? If not, why not and what alternatives do you propose? Are there any areas in respect of indexation where you think additional guidance might be required?

As we said in our response to questions 8 and 13, we think that indices should be specified for NHS bodies. Otherwise, we are concerned that time, money and effort will be spent demonstrating that the indices selected by NHS bodies are the most appropriate. Given that the FReM only includes one example, it seems unlikely that there are other suitable measurements.

Our members are concerned that indices used should reflect geographic differences.

Question 22: Do you agree with HM Treasury's proposed guidance to add to chapter 10 of the FReM in respect of impairment reviews? If so, why? If not, why not and what alternatives do you propose?

Please see our response to question 18.

Question 23: Do you agree that the proposed FReM amendments reflect the HM Treasury position on non-investment asset valuation as set out in this Exposure Draft? If not, why not? Are there specific areas amendments that you feel require greater explanation or clarification?

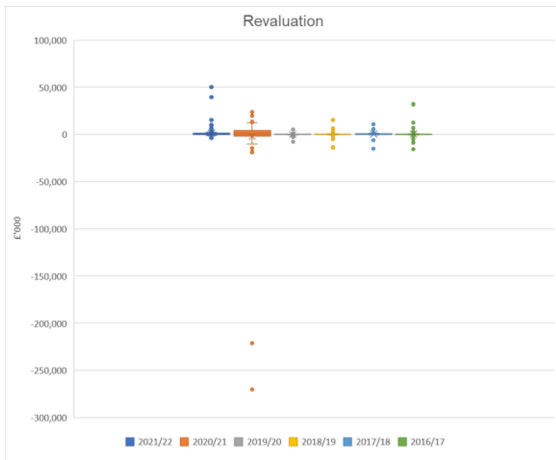
Subject to our comments above, we think that the proposals will achieve the aim of reducing the time and money currently spent on valuation of non-current assets.

However, as set out in our response to question 5, our members are very concerned about the wider impact of these proposals beyond financial reporting. We think that additional work needs to be undertaken to understand the full financial impact of these proposals – both negative and positive.

We have started some work to look at current levels of revaluations and impairments of buildings excluding dwellings (main code A14CY03 on the TAC forms). This analysis looks only at NHS foundation trusts that have been operational for the past six years.

In the four years prior to 2020/21 (Covid-19) between 40 and 50% of NHS foundation trusts had no revaluation movement recorded for the valuation/ gross cost of that category of asset. In 2020/21 only 6% had no revaluation of these assets and in 2021/22, it was 28%.

The range of values was also relatively small for revaluation and impairments as well as reversals of both (see below for box and whisker charts). This simple analysis is not enough to reach any conclusions but simply demonstrates that more work needs to be done to understand the financial impact across the sector, both in terms of the short-term impact on the surplus/ deficit reported each year but also on the longer-term impact on capital allocations and the ability of NHS bodies to invest in their estate.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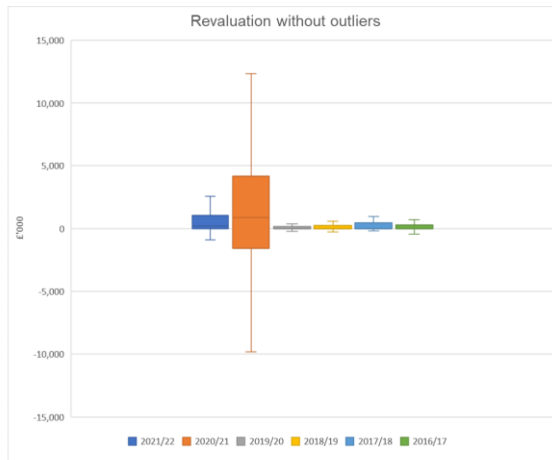
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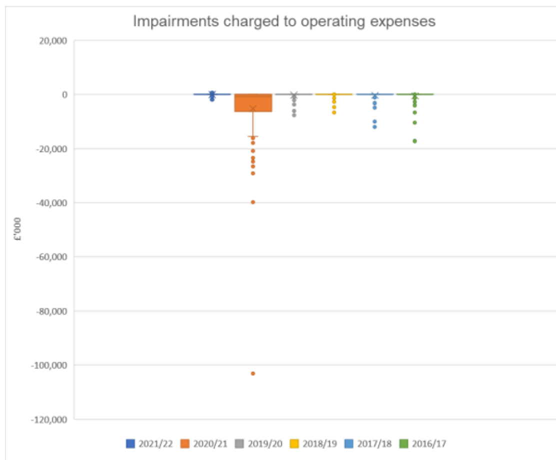
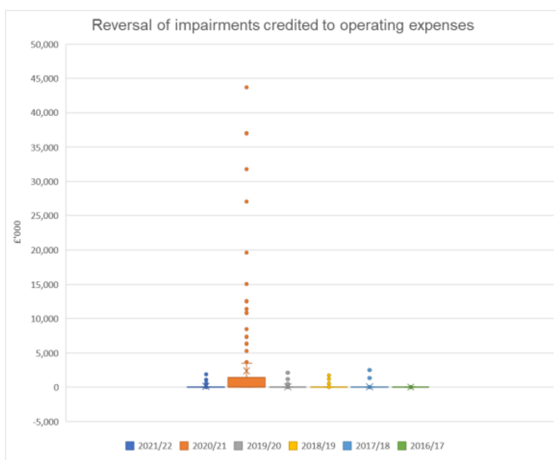
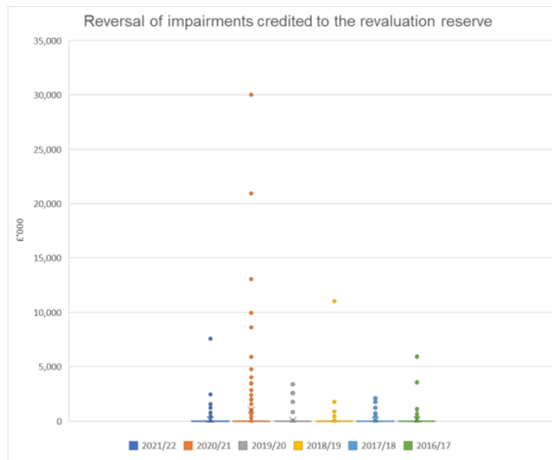
£'000
2021/22 2020/21 2019/20 2018/19 2017/18 2016/17


Impairments charged to operating expenses
20,000
0
-20,000
-40,000
-60,000
-80,000
-100,000
-120,000
£'000
2021/22 2020/21 2019/20 2018/19 2017/18 2016/17

Impairments charged to the revaluation reserve
20,000
10,000
0
-10,000
-20,000
-30,000
-40,000
-50,000
£'000
2021/22 2020/21 2019/20 2018/19 2017/18 2016/17


Reversal of impairments credited to operating expenses
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
-5,000
£'000
2021/22 2020/21 2019/20 2018/19 2017/18 2016/17


Reversal of impairments credited to the revaluation reserve
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
£'000
2021/22 2020/21 2019/20 2018/19 2017/18 2016/17

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.

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HFMA
HFMA House, 4 Broad Plain, Bristol, BS2 0JP
T 0117 929 4789
E info@hfma.org.uk

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