Property, plant and equipment

Accounting and valuation issues

Background

The value of property, plant and equipment (PPE) is usually the largest number on the statement of financial position for NHS provider bodies. NHS bodies are required to hold them 'at valuation' which involves judgements by the NHS body, the valuation experts they engage as well as their auditors.

This briefing looks at some of the issues NHS bodies should consider around accounting for and the valuation of PPE.

Draft briefing for comment

This briefing has been issued as a draft for comment and consideration ahead of the financial year end. If you have any comments, please contact Debbie Paterson – debbie.paterson@hfma.org.uk

The briefing was intended to cover the valuation of property, plant and equipment and that is the issue covered in this draft.

In order to be useful for the year-end, this draft is being issued for comment. However, in discussing it, the accounting and standards committee have agreed that it will be expanded to include more information on:

- capitalisation of building projects
- capitalisation of subsequent expenditure
- accounting for the costs incurred during an asset disposal
- accounting for depreciation including residual values, useful life, componentisation, accelerated depreciation
- impairments & reversals of impairments – accounting treatment and budgeting treatment
- disclosures, particularly in relation to assumptions and judgements.

We would like to include some more examples – in relation to apportioning an MEA alternative site valuation to an asset and one on componentisation of assets. If any members have examples that can be used in the briefing, please contact Debbie Paterson.

The accounting and standards committee will continue to discuss the issue during their meetings in June and September 2019.

PPE and capital expenditure

Initial measurement of purchased assets

IAS 16 *Property, plant and equipment* states in paragraph 7 that:

> 'The cost of an item of property, plant and equipment shall be recognised as an asset if, and only if:
>
> - it is probable that future economic benefits associated with the item will flow to the entity; and
> - the cost of the item can be measured reliably.'

Paragraph 15 goes on to say:

> 'An item of PPE that qualifies for recognition as an asset shall be measured at its cost.'

The standard then sets out what can be included in the cost of an item of PPE and what cannot. NHS bodies do not capitalise any purchases of assets for less than £5,000 in accordance with the requirements of the DHSC *Group accounting manual*. For the purchase of a stand-alone item of equipment, determination of cost is usually straightforward – it is the amount that has been paid for that item of equipment including the cost of VAT where that is not recoverable. For items of equipment that require installation or have a service contract this is more complex and for large capital developments it is more complex still.

In essence, the amount included in cost (or capitalised) should be the costs directly attributable to getting the asset to a location and condition necessary for it to be capable of operating in the manner intended by management. It will include the purchase price plus irrecoverable taxes less discounts plus, possibly, the costs of employing staff directly involved in the construction or acquisition of the assets, delivery and installation costs, costs related to site preparation and professional fees where they directly relate to the acquisition or building of the asset.

It will not include operating costs, costs of training staff to use the new asset or costs relating to developing the initial business plan.

For some capital projects, the determination of the cost at which an asset should be initially measured will involve detailed consideration of the requirements of the standard. Any costs which do not meet the requirements of IAS 16 should be expensed as incurred.

Subsequent measurement

The standard goes on to say that after initial recognition there are two possibilities for measurement of the value of the asset:

- cost model
- revaluation model

NHS bodies are, along with all public sector entities, required to use the revaluation model – the cost model is not available to them[1]. In the commercial world, most entities elect to use the cost model.

IAS 16, paragraph 31 states

> 'After recognition as an asset, an item of PPE whose fair value can be measured reliably shall be carried at a revalued amount, being its fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses. Revaluations shall be made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period.'

For public sector bodies, IAS 16 has been adapted to reflect that assets are held for their service potential rather than to generate income – this means that fair value is used as a measurement basis as a last resort, with other measurement bases being used first. Determining the valuation of PPE usually requires the use of professional valuers and will require the application of judgements from the NHS body and the valuation experts. It is the subject of most of this briefing.

Basis of valuation

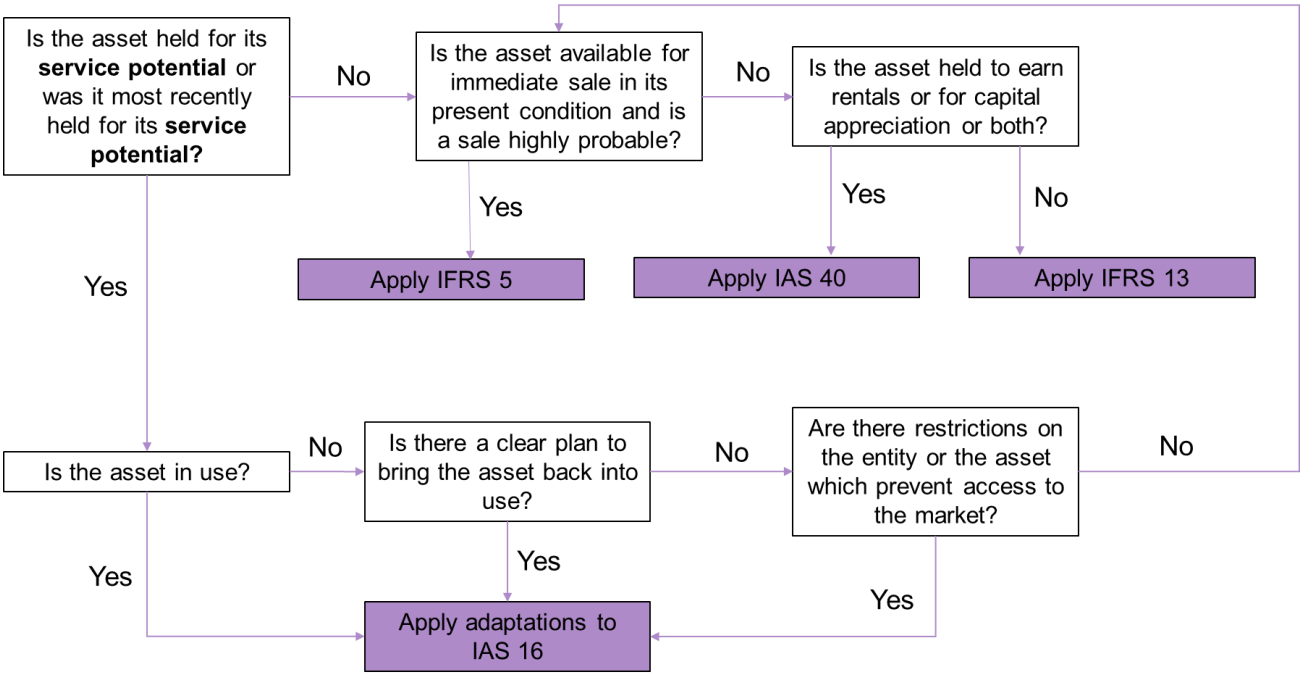
DHSC's *Group accounting manual 2018/19*[2] (GAM) sets out the basis of valuation of non-current assets in paragraphs 4.100 to 4.113 and annex 4. The valuation basis varies depending on the type of asset and the reason that it is being held by the NHS body. This briefing does not repeat that guidance, but it is summarised in the table below:

Asset	Reference to 2018/19 GAM	Valuation basis
Non-specialised asset in use held for its service potential	4.110 and 4.111	Current value in existing use (EUV)
Short-lived and/or low value assets	4.111	Depreciated historic cost as a proxy for EUV
Specialised asset in use held for its service potential	4.110 and 4.112	Depreciated replacement cost on a modern equivalent asset basis (DRC – MEA)
Assets which are held: • **to earn rentals and/ or** • **to increase in value through capital appreciation** **rather than for their service potential**	4.115	Fair value in accordance with IAS 40 and IFRS 13
Assets that meet the following criteria: • **they are available for immediate sale in their present condition** • **the sale is highly probable:** • **management is committed to the sale and it is unlikely there**	4.115	Lower of carrying amount and fair value less costs to sell in accordance with IFRS 5

[1] Page 34, HM Treasury, *Financial reporting manual 2018/19*, December 2017
[2] DHSC, *Group accounting manual 2018/19*, January 2018

Asset	Reference to 2018/19 GAM	Valuation basis
will be significant changes to the plan for selling the asset • **an active programme to find a buyer has been started** • **the asking price is reasonable** • **the sale is expected to be completed within a year**		
Surplus asset most recently used for its service potential – with restrictions on sale	4.113 and 4.114	Current value in existing use (EUV)
Surplus asset most recently used for its service potential – with no restrictions on sale	4.113 and 4.114	Fair value in accordance with IFRS 13
All other assets	4.116	Fair value in accordance with IFRS 13

The flow chart on page 95 of the GAM (replicated below) clearly sets out how the basis of valuation should be determined.



Apply IFRS 5	Measure the asset at the lower of: • its carrying amount before classification and • fair value less costs to sell
Apply IAS 40	Measure the asset at fair value

	The option for cost model is withdrawn
Apply IFRS 13	Measure the asset at fair value The option for cost model is withdrawn
Apply adaptations to IAS 16	Measure the asset at current value in existing use. For specialised assets, this will be the present value of the asset's remaining service potential on a DRC – MEA basis

Frequency of valuations

IAS 16 requires that valuations should be 'made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period'. In this context, fair value means the valuation basis which is applicable to the particular asset.

NHS bodies therefore need to consider the valuation of their assets each year to determine whether they are materially correct. The standard states that the frequency of valuation is dependent on the volatility of the valuation – annual valuations may be necessary where there is volatility but in a stable environment, valuations every three to five years are required.

The FReM suggests that appropriate approaches to valuation might include:

- a quinquennial valuation supplemented by either annual indexation or regular desktop valuation update
- a quinquennial valuation supplemented by an interim professional valuation in year 3;
- annual valuations
- a rolling programme of valuations or
- for non-property assets only, appropriate indices.

NHS bodies will have a preferred approach to valuation for example, a quinquennial valuation with interim desktop updates, but this needs to be kept under review and may need to be changed if circumstances dictate.

The method chosen and the frequency of update of the valuation will depend on the factors used in determining the valuation. For assets held at IFRS 13 fair value, changes in the property market will affect the valuation. However, for assets held at MEA valuation it may be that changes in the costs of materials to build the asset affect the valuation. It is up to the NHS body to understand these different factors when determining whether the valuation is up to date or not.

The role of management

It is management's responsibility to ensure that the accounts reflect a valuation for its PPE which is materially correct. To do this, management need to decide how they will get a valuation and assess its appropriateness.

Most NHS bodies will engage an external valuation expert – management's role in engaging the appropriate expert, agreeing the terms of the engagement and reviewing the output are discussed in the following section.

When making decisions and judgements, it is worth bearing mind the qualitative characteristics of useful financial information set out in the IASB's *Conceptual framework for financial reporting*:

- relevant – the information is capable of making a difference in decisions made by users
- faithful representation – as complete, neutral and free from error as possible
- comparable – both between financial years and between NHS bodies

- verifiable – that different independent and knowledgeable observers could reach consensus that a particular depiction is a faithful representation
- timely
- understandable.

The valuer may advise on judgements and assumptions but responsibility for those judgements and assumptions lie with management. This means that adequate disclosure of these judgements and assumptions should be disclosed in the accounts. It is not sufficient to simply say that the valuation was provided by a professional valuer.

Engaging valuation experts

IAS 16 does not give any guidance on who should undertake the valuation. It simply requires entities to disclose whether or not an independent valuer was involved.

However, the FReM and GAM require that the valuation is done in accordance with the Royal Institution of Chartered Surveyors (RICS) *Red book*[3], its UK supplement[4] and the guidance note on DRC valuation[5] which means that the valuation needs to be undertaken by a RICS qualified valuer. In practice, for NHS bodies, this will mean that an external valuer will need to be engaged as very few NHS bodies have staff members who have the appropriate qualification.

It is for the NHS body to decide which valuer to engage and the terms on which they are engaged. The NHS body will need to:

- satisfy itself that the valuer is appropriately qualified
- consider whether the valuer also has appropriate public sector experience[6]
- set the terms of reference for the valuation – this will include the basis on which the valuation is provided, for instance, the version of the Red book being used, and any supplementary guidance being used[7]
- agree the valuation basis for the PPE being valued
- provide accurate information on the PPE being valued
- agree any judgements and estimates with the valuer.

Once the valuation report has been received, the NHS body will need to critically review the valuation before accepting it and including it in their accounts.

HM Treasury guidance[8] on asset valuations says the following about working with the valuer:

> 'Early and ongoing dialogue with the valuer is vital. Neither RICS guidance nor FRS 15 are tightly prescriptive regarding aspects of asset valuation methodology, particularly at the detail

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[3] RICS, *Red book*, 2017
[4] RICS, *Supplementary UK material*, 2018 which is effective from 14 January 2019
[5] RICS, *Depreciated replacement cost method of valuation for financial reporting,* 2018 which is effective from January 2019
[6] There is a RICS committee which discusses the valuation of public sector assets and liaises with the accountancy firms. It may be worth asking if the valuer is on that committee or has access to its outputs.
[7] In November 2018, the Royal Institution of Chartered Surveyors (RICS) updated and clarified their supplementary UK material on the RICS valuation professional standards and published a guidance note on undertaking DRC valuations for financial reports. This guidance is effective from 14 January 2019, and it may affect the assessment of asset lives in the valuations that some NHS bodies use when producing their annual report and accounts. NHS bodies may have been contacted by their valuers already, if not, it is worth raising the issue with valuers as part of the 2018/19 year-end process to understand what impact, if any, there is likely to be.
[8] HM Treasury have included a paper *Guidance on asset valuation* in its application guidance for the *Financial reporting manual (FReM)*. The paper is old as it refers to RICS valuation paper 10 which has now been superseded by the Red Book and FRS 15 which has been superseded by IAS 16. However, it does contain some useful guidance on issues to consider in relation to modern equivalent asset valuations.

level of DRC. Within their confines, many subtle variations in approach or interpretation are possible and these can have a significant impact on the resulting figures produced. An instruction which simply asks for an asset valuation to be undertaken in accordance with RICS and FRS 15 will be insufficient to ensure that the entity receives a common result and consistency of approach over time, regardless of which valuer is used. Discussion between entity and valuer about the exact nature of the entity's bespoke requirements and how these can best be fulfilled is essential. Sufficient details about the exact approach employed must be captured for the benefit of future valuations, when it is likely that there will have been a change of valuer.'

Information on PPE

Each valuer will ask for the information they need for the work they have been commissioned to undertake. This may include:

- a detailed list of the assets subject to the valuation
- the types of asset to be valued and how they are used and classified by the NHS body
- a comprehensive asset register listing all assets owned, leased or rented by the NHS body
- reference to where deeds or other documentation relating to the assets are held
- a list of recent asset disposals and additions
- an assessment of any incidents which may result in an impairment
- the capital programme and a schedule of recent capital expenditure
- the maintenance schedule/ log.

The valuer should also speak to both the estates team and the finance team.

The information that they will use, and the extent of their investigations should be set out in the terms of engagement,

Decisions to be made

NHS bodies, along with their valuers, need to make a number of decisions in relation to the valuation of their assets:

- is the asset being held for its service potential?
- is the asset specialised or not? What is the reason the asset is considered specialised? It may be due to its size or location but it is not enough simply to say the whole estate is specialised because it is a hospital or NHS owned building, the HM Treasury guidance indicates that the following questions need to be considered:
  - does it have specialised features?
  - does it include specialised adaptations?
  - does it have to be in that particular location?
  - can part of the estate be elsewhere?
  - which parts of the estate are needed to serve a particular population? Could part of the site (say, the administration block) be valued on an alternative or non-specialised basis?
  - is there any useful/ relevant evidence of recent market transactions in relation to similar types of asset (if there is then this is an indication that it is not specialised)?
- is the asset surplus to requirements? What is the evidence that it is surplus?
- if so, are there any restrictions on its disposal? What are they?
- if the asset is being valued on a modern equivalent asset basis:
  - what assumptions can be made about the size/ footprint of the modern equivalent?
  - should the valuation be based on the current site or an alternative site?
  - if any alternative site valuation is used, where should that alterative be?

- what build costs should be included in the valuation?
- how should VAT be treated in the valuation? Where an NHS body builds an asset, the VAT is generally irrecoverable and should therefore be included in the valuation. However, if an asset is built by a non-NHS partner (for example a PFI partner or a subsidiary[9]) then the VAT may be recoverable and can be excluded from the valuation. This one assumption can make a 20% difference in the valuation.
- what allowances should be made for professional fees and contingencies in the valuation?

- what is the remaining useful life of the asset?

It is important to remember that these are decisions for the management of the NHS body to make – they can take the advice of the expert but the final decision rests with management. The objective of the valuation is to get a materially correct valuation rather than to necessarily achieve a particular financial outcome.

The RICS guidance states that the appropriate valuation basis and the assumptions that may impact on reported values should be agreed at the outset and set out in the terms of engagement between the valuer and the NHS body, as the client. Ideally, the guidance says, they should also be agreed with the auditors at the same time.

The NHS body will need to be able to justify their assumptions as being reasonable. This will especially be the case where assumptions have been changed from year to year. For example:

- where an alternative site valuation is used, does the alternative make sense from a patient's perspective? Proposing an alternative site many miles away from the existing site or with limited transport links does not seem to be reasonable
- where the current site was used for previous valuations, what is the rationale for changing to an alternative site valuation?

The role of the auditor

PPE will usually be material to an NHS body's accounts – it is often the largest number on the statement of financial position. Therefore, it will be an area that auditors will want to look at.

In many cases, PPE will be identified as a key risk by the auditors. Auditors of foundation trusts are required to list the key risks that they have identified in the year and a summary of the audit approach they have taken in relation to those risks. This work could include:

- assessment of the qualifications, competence, objectivity and experience of the valuer
- inspection of the terms of engagement and instructions sent to the valuers
- review of the scope of the engagement with the valuer
- review of the accuracy and completeness of data provided to the valuer
- consideration of whether the methodology used to determine the valuation is appropriate and in line with industry practice
- evaluation of management's process for making assumptions and reaching a valuation
- assessment and challenge of the assumptions used by management and the valuer
- review of valuations against benchmarks
- testing of the accuracy of the data provided to the valuer
- reconciliation of the data provided to the valuer to accounting records
- re-performance of measurements of a sample of assets

[9] The assumption here is that PFI assets will be replaced on a similar basis. Given the announcement by the Chancellor in the 2018 Budget that there will be no new PFI deals, it cannot be assumed that PFI would be used to replace any other type of asset. Similarly, if an NHS body has a subsidiary company which manages its estate, it is reasonable to assume the subsidiary would be used to replace those assets. The future establishment of a subsidiary company cannot be assumed.

- review of significant changes since the previous year or obtaining conformation that no changes have occurred since the previous year
- testing additions to ensure that an appropriate valuation basis had been adopted when they became operational
- testing the assumption that the NHS body will receive future benefits from the assets
- confirmation that the accounting for valuation changes is correct and in accordance with the requirements of the GAM
- using their own valuation experts to review the valuation.

The auditor will need to meet the audit requirements set out in:

- International standard of auditing (ISA) (UK) 500 *Audit evidence* in relation to information which has been prepared by an expert engaged by management and
- ISA(UK) 260 *Using the work of an auditor's expert.*

Modern equivalent asset valuation

A modern equivalent asset valuation, especially one based on an alternative site, is not a valuation of the actual bricks and mortar but a hypothetical site which is able to deliver the same level of services. The valuation is of the service potential of a site rather than the actual site.

This can cause difficulties, particularly when parts of the site are disposed of as this requires book value of the actual land and buildings rather than the hypothetical one with the same service capacity. This, plus the various different valuation bases for assets meeting different criteria can lead to variations in the impact of disposals on the accounts.

These differences may be better explained by some examples.

Example 1

An NHS trust is building a hospital on a new site. On completion of this hospital in approximately 12 months, the trust plans to move the majority of its services to that site and decommission several of the separate sites currently in use.

The MEA valuation of the existing separate sites at the end of the previous financial year was based on an alternative single site valuation – this was considered reasonable as the new hospital will move services to a single site. The alternative site has a footprint 4/5 of the existing multiple sites.

One of the existing sites consists of an area of land with a clinic on one half. The remaining land is not utilised but not marketed for sale at that time. The site makes up 1/8 of the trust's current footprint. For the prior year valuation the site was split in two:

- the excess land was classified as surplus and valued at fair value
- the portion of the site containing the clinic is still in use as a service potential asset and was included in the alternative site valuation.

In the current year, the trust begins to actively market the surplus land. A developer offers to buy not only the surplus land but the whole site. The developer would like to acquire the whole site now and offers to lease back the operational portion to the trust until the new hospital site is complete. (The rest of this example ignores the leaseback arrangement and considers the valuation issues for the disposal only.)

For the operational portion of the disposed asset, the trust needs to apportion its MEA valuation for the alternative site to the existing sites to be able to determine the book value for the disposal. This is an accounting judgement and the trust needs to consider the most appropriate basis of apportionment. The trust does this separately for the land and building elements of the site. The rest of this example deals with the land element of the site.

The trust considers some alternative approaches for apportioning the MEA valuation of the land:

1. After the disposal, the trust will hold 7/8 of its existing land holdings which still exceeds the assumed footprint of the alternative site. One view could therefore be that as the disposal of the land has no impact on the value of the alternative site land, that the carrying value of the land being disposed is nil.
2. The trust could apportion the alternative site land value to the existing sites solely on the basis of area.
3. A more nuanced version of option 2 is to consider whether the market values of land in the areas that the different current sites are located differ significantly. If this is the case, the apportionment of land value per square foot could be weighted more towards the high cost area.
4. Finally the trust considers allocating the book value according to the relative cost bases or income generated from the differing services at each site, reflecting the different levels of current service potential.

The trust dismisses option 1 as although this would maximise profit on disposal it would be hard to justify that this was a 'fair' reflection of the value of the service potential in the disposed land. The trust considers whether options 2, 3 and 4 would give materially different results. They do not and therefore the trust concludes to use the simpler option 2. The trust prepares a detailed paper setting out the decision and the considered approaches.

The approaches considered are not exhaustive and other estimation methods may exist. The possibility of at least three reasonable approaches illustrates the level of judgement required.

Example 2

An NHS foundation trust has a single site on which its hospital is based – the site is on the edge of the town that the hospital services with excellent transport links. It has been agreed with the valuers that an alternative site valuation is not appropriate.

Like many hospitals, the site has expanded over the years. The main hospital is a three-storey building but there are various single storey extensions. The site includes some pleasant landscaping which is not necessary for service delivery (or car parking) but is used by patients and staff when the weather allows.

In developing the valuation, it is agreed that:

- the hospital is a specialised asset
- a modern equivalent asset providing the same level of service would be a five-storey building with no extensions on a footprint of 2/3 of the current site
- the landscaping is not a specialised asset but is held for its service potential, as recreational space.

The trust considers the basis on which it will allocate the modern equivalent asset valuation to its actual site. The MEA valuation of the hypothetical hospital is apportioned based on floor area.

Using the flowchart, the landscaping is valued at current value in existing use (EUV). Using the flowchart in the GAM the trust considers the appropriate valuation basis:

- Is the asset held for its service potential or was it most recently held for its service potential?
  Yes
- Is the asset in use?
  Yes
- Apply adaptations to IAS 16 which is EUV

The trust decides that it will sell a corner of the existing site – which is currently part of the landscaped garden and is not used to provide patient care although it is used by both patients and staff. The site is not declared surplus to requirements because it is still being used although it can be vacated with no notice.

The trust seeks, and receives, planning permission to build a number of houses on the land and puts the land on the open market.

Using the flowchart in the GAM the trust considers the appropriate valuation basis now:

- Is the asset held for its service potential or was it most recently held for its service potential?
  Yes
- Is the asset in use?
  No
- Is there a clear plan to bring the asset back into use?
  No
- Are there restrictions on the entity or the asset which prevent access to the market?
  No
- Is the asset available for immediate sale in its present condition and is a sale highly probable?
  No
- Apply IFRS 5 – measure at lower of carrying amount before classification and fair value less costs to sell

The site is ready to sell in its current state, the trust knows that there are a number of property developers interested in the site and has engaged agents to sell it for them. The agents are confident that the site will be sold within a matter of months.

In accordance with IFRS 5 the land is not revalued as a result of the decision to sell and is continued to be held at EUV as this is its carrying amount before classification as an asset held for sale.

The land is sold within a year to a property developer for £500,000. The difference between the value and the sale price is taken as a profit on disposal to the statement of comprehensive income.

Impact on financial position

The whole of the profit on disposal improves the trust's surplus/deficit position. The cash can be used to finance additional capital expenditure or on the trust's running costs.

- The trust needs to engage with NHS Improvement and the DHSC to determine the impact of the disposal on departmental expenditure limits – both revenue and capital. There is a limit on the amount of profit on disposal which can be counted against the revenue resource limit without HM Treasury approval.