HFMA introductory guide to NHS finance

Chapter 15: Capital funding, planning and accounting

Chapter 15: Capital funding, planning and accounting

Overview

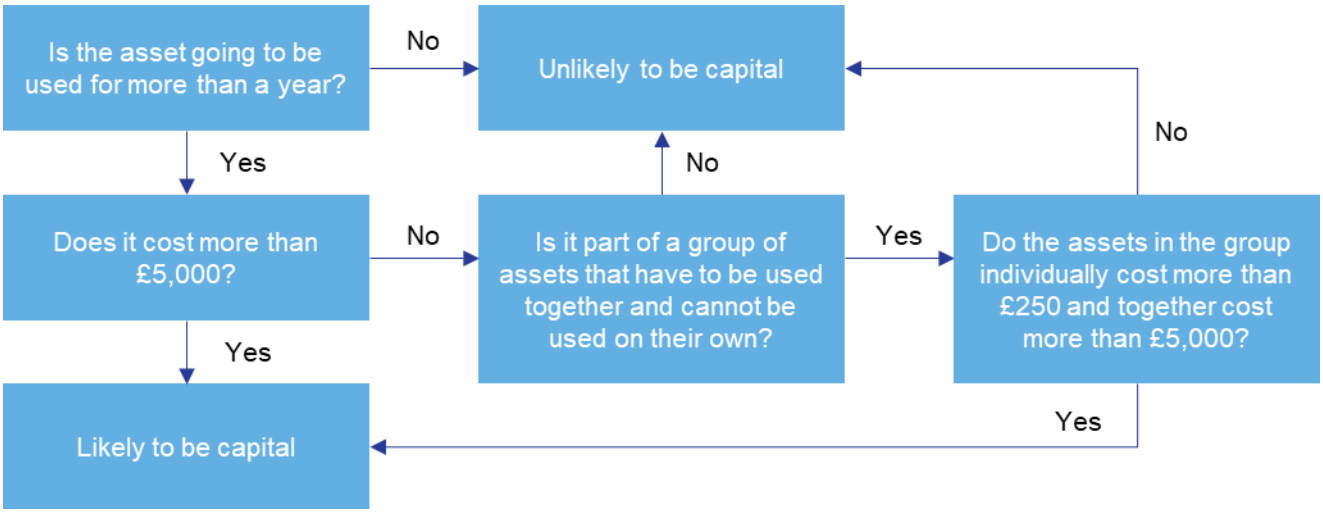
This chapter looks at what capital is and how it is controlled and funded in the NHS. It also runs through the various sources of capital funding and explains how to account for non-current assets and changes in their values.

15.1 What is capital in the NHS?

In the public sector, expenditure is classified as either revenue (spending on day-to-day operations) or capital (spending on assets that will be used for more than a year). Capital spending is incurred when an asset intended for use on a long-term basis is acquired – this is also described as capital investment.

Deciding whether expenditure meets the definition of capital or not can be difficult, but the flow diagram identifies the first questions that need to be asked. The de minimis level of £5,000 is intended to reduce the administrative burden on NHS bodies of managing their capital assets (for more information see the section below on asset registers). Likewise, the grouped asset concept is intended to align the management of assets to the accounting regime.

Figure 6: Definition of a capital asset



The assets are referred to as non-current assets or property, plant and equipment and intangible assets (formerly known as fixed assets). They are defined as:

- being held for delivering services or for administrative purposes
- having a useful life greater than one year
- having a cost which can be measured reliably
- generating future economic benefits or service potential for the organisation.

Non-current assets can be both tangible (things that physically exist) and intangible (assets that do not exist as physical entities) – examples are shown below[207]:

Table 7: Types of asset

Tangible assets	Intangible assets
Land	Software licences
Buildings	Development costs for software and systems
Dwellings	Licences and trademarks
Assets in the course of construction	Patents
Plant and machinery	Other development costs which may result in an asset
Transport equipment	
Information technology equipment (including integral software)	
Fixtures and fittings	

15.2 The capital regime – allocations, limits and controls

Allocations

The amount that can be spent on capital by the Department of Health and Social Care (DHSC) group is set by the government, usually as part of the spending review process. The amount that can be spent in any one year is called the capital departmental expenditure limit (CDEL)

Overall responsibility for ensuring that the allocation is not overspent rests with the DHSC. The limit is set for each year and any unspent allocation is lost at the end of the year – it is therefore important that the limit is reached but not overspent.

In the spring statement 2022[208], the core CDEL for the DHSC was announced to 2024/25:

Table 8: CDEL to 2024/25

	Plans 2021/22 £bn	Plans 2022/23 £bn	Plans 2023/24 £bn	Plans 2024/25 £bn
Core CDEL	9.2	10.6	10.5	11.3
Covid-19 CDEL	1.2			

[207] These are the classifications typically disclosed in NHS bodies' annual reports and accounts. From 2020/21 when reporting to NHS England and NHS Improvement, capital expenditure is classified over 27 categories
[208] HM Treasury, *Spring Statement 2022*, March 2022

In the spending review 2020[209], the government announced multi-year capital health programmes focussed on new hospitals:

Table 9: Multi-year new hospital programme

	2021/22 £bn	2022/23 £bn	2023/24 £bn	2024/25 £bn	Total £bn
Hospital building programme	0.6	0.6	0.9	1.7	**3.7**
Hospital upgrade programme	0.7	0.5	0.3	0.2	**1.7**

The majority of capital expenditure is incurred by the provider sector. In 2019/20, 77% of the DHSC's capital spend was incurred by providers[210], in 2020/21 this reduced to 56% due to Covid-19 because the DHSC purchased ventilators and other Covid-19 assets centrally[211]. Providers' spending is controlled by the use of restrictions on the amount of finance that they can access. These controls are explained below.

The rest of the CDEL is spent on NHS England and DHSC led investment in primary care, community care and social care and central research and development.

System capital allocations

In 2022/23, the NHS capital allocation for providers is £7.9bn[212]:

- £4.1bn system allocation – this includes funding for critical infrastructure risks, diagnostic equipment, and Covid-19 responses and also has to cover day to day operational investments
- £1.1bn nationally allocated funds to cover strategic projects already announced and hospital upgrades/ new builds
- £2.7bn other national capital investment such as community diagnostic hubs, national technology funding and the mental health dormitory replacement programme.

It is for the systems to determine which capital projects at which NHS bodies get priority. The bodies that make up the system are responsible for ensuring that capital spend is contained within the system envelope. The allocation at a system level was set out in the health infrastructure plan (HIP)[213] that was intended to devolve responsibility for managing capital spend to a system level on a transparent basis.

NHS providers are required to report monthly on capital expenditure to date and capital expenditure forecasts to NHS England and NHS Improvement, and the DHSC. Each system is required to manage overspends at organisational or project level to ensure that the system envelopes are not overspent.

[209] HM Treasury, *Spending Review 2020*, December 2020
[210] DHSC, *Annual report and accounts 2019/20*, January 2021
[211] DHSC, *DHSC annual report and accounts: 2020 to 2021*, January 2022
[212] NHS, *Capital guidance 2022 to 2025*, April 2022
[213] DHSC, *Health infrastructure plan*, updated October 2019

Capital resource limit

NHS trusts and CCGs are given a 'capital resource limit' (CRL) each year. For CCGs, remaining within this limit is a statutory duty – they should not exceed it and it is monitored throughout the year. The DHSC (rather than statute) requires NHS trusts to remain within their CRL.

Very few CCGs incur capital expenditure as the assets that they use are generally owned and managed by NHS Property Services Ltd. Similarly, leases of properties developed under NHS LIFT arrangements are held and managed by Community Health Partnerships Ltd (see later in this chapter). CCGs can generate their own funds internally to spend on capital investments but, in practice, this is rare.

Performance against the CRL must be reported in the annual report and accounts. The organisations should not spend more than its CRL after adjusting for asset disposals and grants and/or donations towards the purchase of non-current assets. Underspends against the CRL cannot be carried forward to the following financial year unless they are known in advance and built into submitted plans.

For CCGs, the CRL represents the amount of finance given to them for capital expenditure. For NHS trusts, the CRL does not represent the amount of finance given to the trust – they are expected to fund capital expenditure from internally generated resources or borrowing.

NHS foundation trusts do not have a CRL. In theory, they can therefore incur any amount of capital expenditure, as long as they can afford it, either through retained surpluses or public dividend capital. In practice, the DHSC will limit access to borrowing in order to ensure that the overall departmental CDEL is not overspent. The devolution of capital allocations to system level is intended to ensure that cash rich NHS foundation trusts do not spend more than their fair share of the CDEL. The *Health and Care Act 2022* includes a clause that will enable the DHSC to impose capital spending limits on NHS foundation trusts where they are not working effectively to prioritise capital expenditure within their system and risk breaching either the system allocation or national CDEL.

External financing limit

NHS trusts are also required to remain within their 'external financing limit' (EFL). This was established to control the amount of cash that could be spent on capital in a year. However, since 2008/09, it has been set to include all sources of capital finance, including from:

- the Department of Health and Social Care in the form of public dividend capital (PDC)[214] and/or loans
- internal sources by building up cash balances
- external sources (including finance leases).

This means that the EFL is a 'financing limit' – i.e. the maximum amount of cash that can be accessed through external borrowing. Achievement of the EFL is an absolute financial duty. There is no tolerance above the EFL target as it is designed to control the cash expenditure of the NHS as a whole to the level agreed by Parliament. By controlling net cash flows, the EFL sets a limit on the level of cash that an NHS trust may:

- draw from either external sources or its own cash reserves (a positive EFL) or
- repay to external sources for capital borrowing (a negative EFL).

Commissioners and NHS foundation trusts do not have an EFL.

[214] PDC is a type of government finance – it is discussed later in the chapter.

Capital to revenue transfers

The DHSC is responsible for ensuring that the NHS does not spend more than the amount allocated to it on capital. The DHSC also manages the revenue allocation – see chapters 10 and 14 for more details.

If the DHSC expects that the NHS will underspend on its capital allocation but is in danger of overspending against the revenue allocation it can apply to HM Treasury to transfer some of the allocation from capital to revenue. This means that the NHS can spend more on day to day expenditure but less than planned on longer term investment in assets.

This practice has been discontinued in recent years.

15.3 Planning the capital programme

There is an absolute requirement when spending public money to demonstrate that it has been used wisely and for its intended purpose. As a result, NHS organisations need to plan, monitor, and manage their capital investments.

Affordability

The overriding constraint when planning for capital is that organisations must not spend more than they have available and can afford, both in relation to the initial cost of the non-current assets and the associated on-going revenue costs. This means thinking through a number of factors including:

- the need for new infrastructure and strategic developments
- the need to replace medical, IT and other equipment
- maintenance costs
- depreciation costs – non-current assets wear out and over their ‘useful life’ an annual (non-cash) charge is made to the revenue account to reflect this (see later for more about depreciation)
- impact on PDC dividend – this is a cash charge paid to the DHSC which is based on the average net assets of the organisation. An increase in non-current assets results in an increase in the dividend charged (see later in this chapter for more about PDC).

Business cases

Most NHS organisations will have a rolling programme of capital investment to ensure that its asset base is fit for purpose. When additional capital investment is needed, the first stage is usually to develop a business case[215] to consider the options available, their impact and affordability. In the context of capital spending, a business case is usually a written statement of the need for investment in capital. The business case process is designed to lead to a consideration of changing circumstances, future requirements and opportunities and an agreed corporate view of the best way forward backed up by sound and reasoned assumptions and projections. It is helpful to use a standard format so that key issues are covered.

What a business case includes

- the strategic 'fit' of the proposed investment within the local health economy, including a clear and concise statement of need

[215] NHS England and NHS Improvement, *Capital regime, investment and property business case approvals guidance for NHS providers*, updated 2020

- effective project management arrangements, clear lines of communication and details of those key individuals who will be personally accountable
- an indication that the proposal has the support and approval of key stakeholders including commissioners, staff and patients
- quantified analyses of the investment and its lifetime costs, benefits and cash flows
- quantified analyses of the costs/benefits of any alternative methods of financing the investment
- evidence-based information to support the proposal in terms of priority, cost-effectiveness, clinical service management and the best use of scarce resources
- if a major investment is being considered, the business case should also bring together the arguments for the preferred option (including current and future service requirements), affordability, the organisation's competitive service position and the ability to complete the project within the specified budget and in line with agreed timescales.

Delegated limits

Business cases for NHS trusts and NHS foundation trusts that are deemed to be in financial distress are subject to a system of 'delegated limits'. This means that the capital value of a project determines what approvals are required. Business cases with a financial value of less than £15m can be approved by the provider body's board. Above this level, external approval is required as shown below.

Table 10: Delegated limits for non-foundation NHS trusts

Financial value of the capital investment	Approving person or group
£15m to £30m	NHS England and NHS Improvement and DHSC
£30m to £50m	NHS England and NHS Improvement Resources Committee and DHSC
Over £50m	NHS England and NHS Improvement Board approval, DHSC and HM Treasury

Source: NHS England and NHS Improvement, *Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts*, 2016

NHS foundation trusts that are not deemed to be in financial distress are not subject to strict limits. However, significant or material transactions are to be reported to NHS England and NHS Improvement and some will require detailed review and approval. Whether a project or transaction is significant depends on the risks associated with it.

15.4 Sources of capital

The potential sources of funding for capital investments vary by type of NHS organisation.

As mentioned earlier, it is unlikely that CCGs will have significant levels of non-current assets. However, if a CCG does enter into a capital programme, the only source of funding available to them is internally generated funds, leases or any capital allocation given to them by NHS England and NHS Improvement.

NHS trusts and NHS foundation trusts have access to several funding sources:

- internally generated resources (via retained surpluses, depreciation and proceeds from the sale of non-current assets)
- borrowing (including PDC)
- leases
- donations and grants.

Until 2018, public private partnerships or private finance initiatives (PFI) were also options to fund capital project. However, in the October 2018 budget the Chancellor announced that PFI schemes would no longer be used.

Internally generated resources

The main source of capital funding is from internally generated resources – the cash balances built up through retained surpluses, depreciation, and proceeds from the sale of non-current assets.

All NHS bodies must make a charge to expenditure to reflect the cost of using an asset over its useful life – this is known as depreciation. This charge does not involve actual cash being paid out (it is 'non-cash') and so an organisation that breaks even or achieves a surplus on its revenue account will generate a cash surplus equivalent to the value of the depreciation charge (all other things being equal).

That cash balance and/ or any surplus is available to invest in capital projects, such as replacing equipment, enhancing existing assets or building new ones subject to the organisation meeting the capital controls set out earlier in the chapter. It can also be used for revenue purposes – maintenance or sustaining the 'working capital'[216] position.

Another source of finance is the sale of existing assets. While a NHS foundation trust is able to retain the total proceeds from the sale of an asset, the amount of money that a NHS trust can retain is capped to match its delegated limit and is also reflected in its CRL.

Borrowing and public dividend capital

The way in which money can be borrowed depends on the type of organisation considering the loan.

Under the *National Health Service Act 2006*[217], the DHSC is required to produce guidance in relation to the powers that it has to provide financial assistance to NHS providers[218]. In this context, financial assistance includes the provision of loans, issue of PDC, giving of grants and other payments.

From 2020/21 onwards, the way that financial assistance is provided has changed. The DHSC will no longer issue loans, other than in exceptional circumstances. Instead, public dividend capital (PDC) will be issued to support capital investment where the NHS provider does not have sufficient internally generated resource.

NHS provider bodies can borrow from the open market, including commercial loans from banks and other private lending organisations. NHS trusts and foundation trusts in financial distress need to be able to demonstrate that this is better value for money than financing through the DHSC – and need the approval of the DHSC to borrow from outside of the group. NHS foundation trusts that are not in

---

[216] Working capital is the money and assets that an organisation can call upon to finance its day-to-day operations (it is the difference between current assets and liabilities and is reported in the statement of financial position as net current assets/ liabilities). If working capital dips too low, organisations risk running out of cash and may need a loan to smooth out cash flows.
[217] Section 42A of the NHS Act 2006 which was inserted by section 163 of the Health and Social Care Act 2012
[218] DHSC, *Secretary of State's guidance under section 42A of the NHS Act 2006*, July 2020

financial distress can borrow externally as long as they can demonstrate the affordability of the loan. However, in reality NHS bodies access finance through the DHSC.

The Secretary of State determines the terms on which PDC is provided, such as whether it is repayable. Usually, PDC does not have to be repaid. Interest is not payable on PDC, instead, a PDC dividend is paid to the DHSC based on the average net assets of the NHS provider body. The calculation of the dividend is discussed later in this chapter.

Public private partnerships

New schemes will not be entered into since the Chancellor's announcement in 2018.

Private finance initiative (PFI)

PFI schemes were used for a number of years to finance capital investment. The schemes involved the creation of partnerships between the public and private sectors. The financing of the construction of the asset was the responsibility of the PFI provider so the capital investment was funded without recourse to public money.

Private companies were contracted to design and build the assets which were then 'leased back' to the public sector, usually over a period of around 30 years.

The contract set out in detail the obligations of each party over the agreed period. The contract usually contained a service element relating to the building – for example, cleaning, catering, security and maintenance.

Private finance

Following a review of public private partnerships by the Treasury in 2012, a new approach to private sector involvement in public sector infrastructure projects was developed to replace traditional PFI schemes. Under this approach, the Government acted as a minority equity co-investor with investments managed by a commercially focused central unit located within HM Treasury.

Local improvement finance trusts (LIFT)

Local improvement finance trusts (LIFTs) were used to develop and improve primary care and community-based facilities. These were delivered by Community Health Partnerships (CHP) – a limited company wholly owned by the Department of Health and Social Care. A partnership was established with the local health economy through a LIFT company. This is a limited company with the NHS, CHP, and the private sector partner as shareholders. The company owns and maintains the building and leases the premises back to the NHS.

There are a small number of LIFT schemes where a NHS provider body is the lead lessor and their interests are not held by CHP.

Leases

A lease is often considered a suitable alternative to the outright purchase of a non-current asset.

A lease is defined as a 'contract, or part of a contract, that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration'.

From 1 April 2022, the accounting treatment for leases has changed. The change will have an impact on what is charged against CDEL as well as the profile of revenue expenditure over the life of the

lease. It is more than simply an accounting change and will affect financial reporting and financial management throughout the NHS body.

Under IFRS 16, lessees will account for all leases as a right of use asset and a liability to pay for that right[219]. All new leases as well as some changes to lease terms will count as a capital investment and will impact on CDEL. HM Treasury will adjust CDEL from 2022/23 to ensure that the change to the accounting standard does not affect the resources available to public sector bodies. NHS bodies were asked to submit information to the DHSC in January 2022 about the leases that they plan to enter into from 2022/23 that would not have been capital under the previous accounting arrangements.

Under the previous accounting arrangements, IAS 17, leases were categorised as either operating leases or finance leases. Only finance leases, where the lessee took substantially all the economic benefits and risks of asset ownership, counted as capital investment.

Lessors will continue to distinguish between operating and finance leases. This means that were two NHS bodies enter into a lease arrangement, they might both reflect the asset in their accounts. The lessee as a right to use the asset and the lessor as the owner of that asset.

Donations and grants

Charitable donations can be an important source of funds to support capital investment, but the trustees (usually the NHS corporate body) must ensure that the expenditure is in line with the charitable fund's purpose as set out in its governing documents.

Some NHS bodies also receive grants from bodies such as the Lottery Fund to finance the purchase of non-current assets.

Charitable donations and grants are recognised as income by the NHS body in the year that any conditions attached to the donation are met. When a donation or grant is used to buy a non-current asset, this means that the income is recognised in the year that the asset is purchased. However, the cost of the asset is spread over the life of that asset in the form of depreciation charges which results in a timing difference between the recognition of the income and expenditure. This timing difference is adjusted for when determining whether or not the NHS body has met its financial duties.

For more about NHS charitable funds, see chapter 19.

[219] Leases with a term of less than 12 months and leases for assets with a value of less than £5,000 are accounted for as a cost when payment is made to the lessor.

15.5 The cost of capital

In terms of the cost of capital, there are three elements – PDC; depreciation; and interest. Each is discussed in turn below.

PDC dividend

The PDC dividend is derived by applying a percentage 'rate of return' to an organisation's 'average relevant net assets', calculated as follows:

> **Average relevant net assets calculation**
>
> The average of the organisation's relevant net assets (i.e. the opening balance at 1 April added to the closing balance at 31 March divided by 2) :
>
> Total public dividend capital and reserves (●)
>
> | | |
> |---|---|
> | Less | the net book value of donated assets and grant funded assets |
> | Less | charitable funds |
> | Less | net cash balances in government banking service (GBS) accounts |
> | Less | outstanding PDC dividend prepayments |
> | Plus | outstanding PDC dividend payables |
> | Less | approved expenditure on Covid-19 capital assets |
> | Less | assets under construction for nationally directed schemes |
> | Plus | cash support for revenue requirements PDC drawn down in-year |

The percentage used is currently 3.5%, the dividend is payable to the DHSC in two instalments during the year.

Depreciation

Depreciation is calculated annually to reflect the cost of 'using up' the asset during its useful life – a number of assumptions are used:

- land is considered to have an infinite life and is not depreciated
- buildings, installations and fittings are depreciated over their assessed useful lives, with both the value and life expectancy determined periodically by a qualified valuer
- assets in the course of construction are not depreciated until they are brought into use
- equipment is depreciated over its useful economic life
- leased assets are depreciated over the shorter of the lease term remaining or the asset's remaining economic life.

Depreciation is usually calculated on a 'straight line basis' which means it is assumed that the asset will be 'used up' evenly over its life. As depreciation is calculated on asset values which are subject to revaluation, the depreciation charge and total value of the assets held will vary each year.

Interest

Where an NHS body has borrowed to fund capital expenditure, interest will be payable. Interest is also payable on lease arrangements.

15.6 Accounting for capital

Accounting for capital can be complicated and is often an area of the accounts subject to additional audit scrutiny. This is because, by its very nature, the amounts involved are usually material[220] but also because there is a level of judgement and estimation required to reach a true and fair view.

Accounting standards

HM Treasury has developed a *Financial reporting manual*[221] that sets out how accounting standards should be implemented in the public sector. The DHSC's *Group accounting manual* also includes guidance on accounting for non-current assets. The following accounting standards[222] are of particular relevance when accounting for capital:

- IAS 16 Property, plant and equipment
- IAS 20 Accounting for government grants and disclosure of government assistance
- IFRS 5 Non-current assets held for sale
- IAS 36 Impairment of assets
- IAS 38 Intangible assets
- IAS 40 Investment property
- IFRIC 12 Service concession arrangements
- IFRS 16 Leases.

Valuation

One of the reasons that accounting for capital can be complicated is that, in the public sector, non-current assets are not recorded in the accounts at the amount that they cost to buy. Instead, they are held at 'fair value'. In accounting terms, fair value has a specific meaning, but it is essentially the amount that the asset could be bought for on the open market.

On acquisition, non-current assets are recorded at their cost, but they are subsequently revalued to their fair value. The timing of that revaluation is dependent on a number of factors which are discussed below.

For NHS organisations, identifying the fair value for non-current assets is difficult as they are held to provide services and there is a limited open market for NHS assets. Specialised property, such as hospitals for which a market value cannot be determined easily, is valued at the cost of replacing it with an equivalent, modern one, not an exact replica of what currently exists. This is the 'depreciated replacement cost' approach, also known as the 'modern equivalent asset basis'. Determining the modern equivalent asset valuation for a hospital can only be done by a professional valuer and will be done in conjunction with the NHS body's finance and estates teams[223].

---

[220] Materiality is an accounting concept that allows the preparers and auditors of accounts to make a judgement about whether an item or transaction will influence the reader/user of the accounts. If it is decided that it would influence the reader/user of the accounts, then the item is material and should be included and explained in the accounts. Immaterial items do not need to be explained.
[221] HM Treasury, *Guidance on annual reports and accounts,* December 2021
[222] IFRS, *Issued standards,* accessed March 2022
[223] HFMA, *Property, plant and equipment: accounting and valuation issues*, December 2019

Assets which are not specialised, such as offices and some clinics, are valued based on what they could be sold for.

The timing of the valuation is a matter of judgment. Under IAS 16, organisations must consider whether the recorded value of their assets continues to reflect fair value taking into account market volatility. For example, if the local property market is particularly volatile or the organisation embarks upon a significant capital expenditure project, annual revaluations may be needed to keep the recorded value up to date.

Equipment is usually valued at depreciated historic cost where they have short useful economic lives or low value.

When an individual asset (for example, a piece of medical equipment) is revalued, all assets of its type must also be revalued. In the absence of a significant change, revaluation may be needed less frequently.

Each year, an assessment must be made of whether the valuations are materially correct or not. This will involve consideration of the volatility of the property market and usually requires discussion with a professional valuer. In years where a professional valuation has not been undertaken, the value given to land and buildings will need to be reviewed and any changes appropriately evidenced to support the preparation of the accounts. Valuation may also be required when:

- there is a major change in use
- an asset formerly under construction is brought into use.

Most intangible assets (i.e. assets that have a financial value even though they are not visible – for example, software licences that run for more than a year) are recorded at cost less 'amortisation' (equivalent to depreciation but for intangible assets) as a proxy for fair value. However, where a market value is readily available then this should be used.

Gains

Gains (or increases) in asset value may occur following a revaluation by an external reviewer or, for equipment assets, by a review undertaken by the finance and/or estates departments to provide a new fair value.

The gain is not treated in the same way as revenue or income. Instead, it is reflected in the revaluation reserve.

Losses (including impairments)

Impairments occur where there is a loss (or reduction) in the value of a non-current asset compared to its recorded value. This can be due to:

- a loss of economic benefit to an asset itself – for example, it is physically damaged
- a change in the asset or its environment which has permanently reduced its capacity to provide services.

IAS 36 is relevant here. However, HM Treasury guidance diverges from IAS 36 and requires organisations to identify the cause of impairment as the result of either:

- the consumption of economic benefits or service potential or

- a loss following revaluation.

In the first scenario, the resulting loss is charged to operating expenses in the year that the impairment occurs.

However, where there has been a previous upward revaluation for the asset and a revaluation reserve balance exists, a transfer is made from the revaluation reserve to the general fund/retained earnings.

In the second scenario, a revaluation loss, the reduction should initially be charged to the revaluation reserve to the extent that a balance exists for the asset. Any remaining amount is charged to operating expenses.

If impaired assets then have an upward valuation, the charge made to expenditure can be reversed to the extent that the upward revaluation reverses the original impairment. It is therefore important to record all impairment charges by individual asset to enable entries to be reversed if needed.

Asset sale or disposal

When assets are sold or scrapped, the difference between the value at which they are held and the amount of income received is the profit or loss on disposal. In the case of assets which are scrapped the income will be nil so there is likely to be a loss on disposal.

Profits on sale are reflected in other operating income. Losses are an operating expense in the year of disposal.

Leases

As mentioned earlier, from 1 April 2022, the accounting arrangements for leases changed.

When a lease is entered into, the right of use asset is recorded in the asset register with a corresponding, matching lease liability. The asset is treated as if it had been bought outright as soon as it becomes operational. It forms part of average relevant net assets for PDC dividend calculations, is subject to depreciation and is revalued in the same way as any owned asset. The lease liability is written down as the capital element is repaid. The interest payments on the lease are treated as an expense each year.

The profile of the expenditure on leases that would have been operating leases under the old accounting arrangements will change. Interest payments will be higher at the start of the lease and lower at the end, depreciation charges will be on a straight line over the length of the lease. Under the old arrangements, operating lease rentals were charged to revenue as they were incurred – this was usually on a straight line basis. NHS bodies will need to budget for the higher interest costs at the start of the lease.

Leases are a complex area in accounting terms.

PFI and LIFT schemes

PFI and LIFT schemes are also complicated arrangements to account for. Relevant accounting standards are *IFRIC 12 Service Concession Arrangements* and *SIC 29 Service Concession Arrangements: Disclosures*.

Key components in accounting for PFI and LIFT schemes

Organisations consider whether the scheme represents a service concession under IFRIC 12 for which a number of specific 'tests' exist, and if not, whether the scheme is a lease arrangement.

Where the scheme is a service concession under IFRIC 12, the asset is recognised in the organisation's accounts at 'fair value' – the capital cost of the asset at the inception of the scheme which is determined using the contractor's financial model.

The accounting arrangements for the liability to make unitary payments over the life of the contract will change as a result of IFRS 16. Where the unitary payments vary in accordance with changes to the retail price index (RPI) or another index, the liability will have to be remeasured when the index changes. Detailed guidance is being developed as this will be a complex exercise.

The unitary payment (i.e. the payment made by the public sector organisation to its private sector partner) is allocated between:

- payment for services
- payment for the property:
    - repayment of the liability
    - interest charge relating to the lease
- life cycle costs relating to future capital expenditure.

Depreciation and other changes in value must be accounted for as with any other asset owned by the organisation.

Donated assets

Assets funded by donation require specific identification in the asset register. The most common method of receiving a donated asset is for it to be purchased by the NHS organisation and for an invoice to be raised to the charitable body funding the asset; this can help with identification. It is worth noting that donated assets do not form part of the PDC dividend calculation.

Income will fluctuate in line with the receipt of new donated assets, either improving or worsening the revenue position of the NHS body according to whether more or less donated income is received as compared to the depreciation charge on the overall value of donated assets.

15.7 Asset registers

Every NHS organisation maintains a register of its non-current assets (tangible and intangible) so that they can be managed effectively and to demonstrate accountability. The register records a range of information about each asset and is used to help in the preparation of the organisation's financial accounts and helps enable replacement programmes.

Asset registers – what they record for each asset

- identification, description and location of the asset – assets should be tagged with a unique identifier
- date, method of acquisition and initial capital outlay

- how the asset has been financed (for example, is it owned, leased, donated or covered by a PFI agreement?) From 2020/21, whether the asset was purchased using Covid-19 funds will also need to be documented
- opening value on the 1 April of each financial year
- any additions to the asset and the year that they were made
- the value if reclassified for sale
- gains from revaluation (so that there is a clear link to the revaluation reserve – see later in this chapter)
- impairments (i.e. a loss in value – see later in this chapter) including any reversals
- cumulative depreciation charges and estimated life
- closing value at 31 March of each financial year.

Theoretically, each non-current asset should be recorded in the asset register. However, to include all very low value items would be a costly administrative burden. As a result, NHS organisations use a minimum level of expenditure or de minimis below which property, plant or equipment is not considered to be a non-current asset.

Items that fall below this threshold are charged as a revenue cost in the year of purchase and are not recorded in the asset register. The de minimis level is £5,000[224].

Where assets are interdependent (they only work together, they were bought together and are expected to be disposed of together) and cost more than £250 individually, then the de minimis level applies to the cost of the group of assets[225]. An example of grouped assets is IT hardware attached to a network – however, the application of the definition of a group of assets varies between NHS bodies. Groups of similar assets (for example, hospital beds) cannot be grouped together or classed as interdependent as each can be used independently.

[224] The £5,000 'threshold' includes VAT where this is not recoverable, installation costs and external fees such as architect, surveyor or installation fees.
[225] This may be different for the devolved nations. For example, in Scotland, in addition to the individual asset value of £5,000, the group value must be more than £20,000.

Key learning points

- Non-current assets deliver a benefit to an organisation over a period of time
- Non-current assets can be tangible or intangible
- In order to account appropriately for non-current assets, a detailed asset register must be maintained and kept up to date
- Organisations work within a system of controls and financial limits to ensure that capital expenditure does not exceed the DHSC's capital departmental expenditure limit (CDEL)
- It is important to consider capital needs and plan to meet them; organisations must consider the affordability of financing capital investment as well as the on-going revenue costs within the context of the capital controls
- A well-structured, logical and concise business case can help explain the case for capital investment. It may be subject to external approval depending on its value
- The potential sources of funding for capital investments vary by type of NHS organisation – not every option is available to every type of organisation
- Most of the capital expenditure incurred in the NHS is incurred by provider bodies
- Commissioners do not hold many non-current assets
- NHS Property Services Ltd holds most of the assets used by CCGs
- LIFT schemes are held by Community Health Partnerships Ltd
- Commissioners have limited access to sources of capital funding
- Capital expenditure is funded from a number of sources: internally generated resources; leases, grants and donations. NHS organisations also have access to public dividend capital (PDC)
- Accounting for capital can be complicated and requires management to make many judgements.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects, including a section dedicated to capital. It also highlights e-learning courses that are available. The directory of resources can be found here.