HFMA introductory guide to NHS finance

Chapter 14: Capital funding, planning and accounting

Chapter 14. Capital funding, planning and accounting

Overview

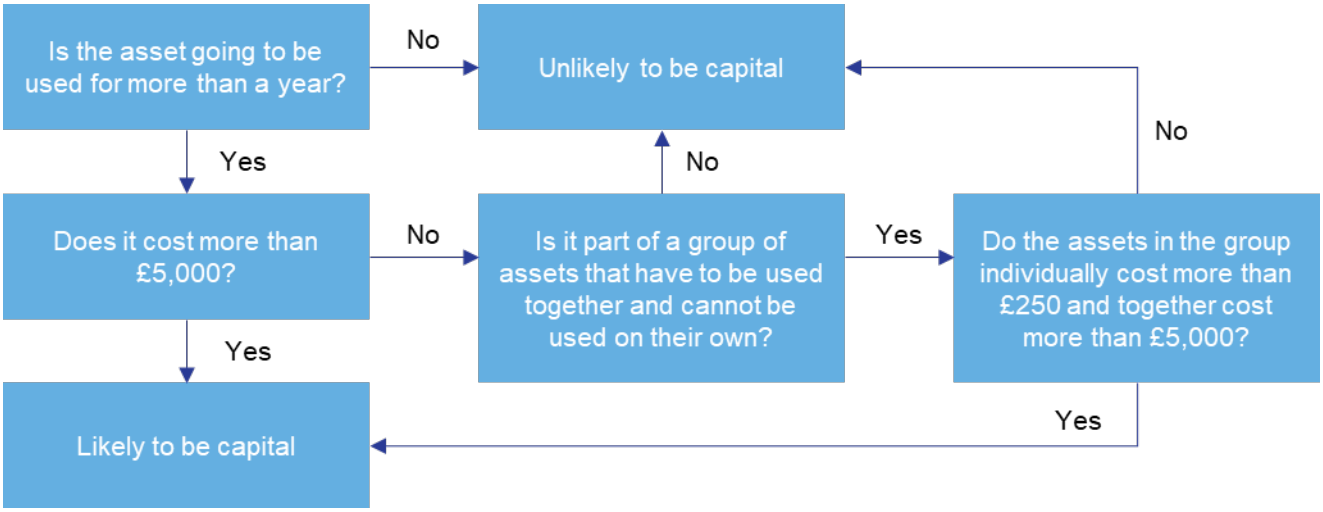
This chapter looks at what capital is and how it is controlled and funded in the NHS. It also runs through the various sources of capital funding and explains how to account for non-current assets and changes in their values.

14.1 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[256] 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). The grouped assets concepts ensures that it is the overall value of an asset that is recognised, rather than treating dependent component parts as separate items.

Definition of a capital asset



The assets are referred to as non-current assets or property, plant and equipment and intangible 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 that can be measured reliably
- generating future economic benefits or service potential for the organisation.

[256] Department of Health and Social Care, *Group accounting manual 2023-24*, June 2023

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.

Tangible assets

- Land
- Buildings
- Dwellings
- Assets in the course of construction
- Plant and machinery
- Transport equipment
- Information technology equipment (including integral software)
- Fixtures and fittings

Intangible assets

- Software licences
- Development costs for software and systems
- Licences and trademarks
- Patents

14.2 The capital regime – allocations, limits and controls

Allocations

The amount that can be spent on capital across 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 annually, and any unspent allocation is lost at the end of the year. It is therefore important that the funds are fully utilised (but not overspent). However, costs should not be incurred solely to ensure the limit is reached; all investments must be appropriate and provide value for money.

The *Autumn budget and spending review 2021*[257] set out the resource limits for the DHSC to 2024/25. The allocations have been updated at subsequent budget statements, most recently in the *Autumn statement 2023*[258].

Most capital expenditure is incurred by the provider sector. In 2021/22, 75% of the DHSC's capital spend was incurred by providers (£6.8bn)[259]. Providers' spending is controlled by restricting 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, Covid-19 and central research and development.

[257] HM Treasury, *Autumn budget and spending review 2021*, updated December 2021
[258] HM Treasury, *Autumn statement 2023*, November 2023
[259] Department of Health and Social Care, *Annual report and accounts 2021-22*, January 2023

Departmental Capital Budgets - Capital DEL (CDEL)

	Outturn 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Health and Social Care	9.9	12.1	12.6
Defence	20.3	18.3	18.9
Science, Innovation and Technology	10.5	13.1	13.8
Transport	20.5	20.7	20.5
Devolved nations	10.9	11.2	10.3
All other departments	28.2	40.2	42.1
Total capital DEL	**100.3**	**115.6**	**118.2**

Source: Table 2.2, Autumn statement 2023, HM Treasury

System capital allocations

In 2023/24, the NHS capital allocation for providers is £7.7bn[260]:

- £4.1bn system allocation – this includes funding for critical infrastructure risks, diagnostic equipment, and Covid-19 responses and must cover day-to-day operational investments
- £1.2bn nationally allocated funds to cover strategic projects already announced and hospital upgrades/ new builds
- £2.4bn other national capital investment such as community diagnostic hubs, national technology funding and the mental health dormitory replacement programme.

Allocations at a system level, and the needs for a revised capital allocation process, were described in the health infrastructure plan (HIP)[261]. The HIP identified three key requirements to make NHS infrastructure fit for the future:

- a new five-year rolling programme of investment in NHS infrastructure that takes a strategic approach to improving hospitals, primary and community care estates, and health infrastructure
- a reformed system underpinning capital to ensure it reaches the frontline when and where it is needed
- backing the wider health and care sectors with funding to strengthen health infrastructure in related sectors that support the NHS.

The NHS system capital allocation is largely based on the overall value, and the depreciation costs, of the NHS provider estate[262].

[260] NHS England, Capital guidance update 2023/24, January 2023
[261] Department of Health and Social care, *Health infrastructure plan*, updated October 2019
[262] Murray R, Anandaciva R., *Review of the current capital allocation methodology for system envelopes*, March 2022

Capital resource limit

System allocations are provided to integrated care boards (ICBs), with each organisation receiving a capital resource limit (CRL) for the financial year.

It is for integrated care systems (ICSs) to determine which capital projects at which NHS bodies get priority. This will be managed through the integrated care boards (ICBs), and each ICB and its partners trusts are subject to a capital resource limit (CRL) on their combined capital resource.

Each ICB and its partner trusts are required to agree an annual system capital plan, in advance of the start of the financial year. As some trusts will operate across several ICS, this will require some trusts to agree multiple system and capital plans and be involved in the governance and decision-making of multiple ICBs' capital programmes.

For ICBs, 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 ICBs will themselves 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 local improvement Finance Trust (LIFT) arrangements are held and managed by Community Health Partnerships Ltd (see later in this chapter).

Performance against the CRL must be reported in the annual report and accounts. The organisations should not spend more than the 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 agreed in advance and built into submitted plans.

For an ICB, its own CRL represents the amount of financing given to it for capital expenditure. For NHS trusts, the CRL consists of both internally generated resources (through depreciation) together with any central capital financing provided.

NHS foundation trusts do not have a CRL. In theory, they can 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 breach the national CDEL limits. The *Health and Care Act 2022* includes a clause that enables the DHSC to impose capital spending limits on NHS foundation trusts. This could be enforced where foundation trusts are not considered to be working effectively to prioritise capital expenditure within their system, and risk breaching either the system allocation or national CDEL.

External financing limit (EFL)

This was established to control the amount of cash that could be spent on capital in a year. It is set to include all sources of capital financing:

- from the DHSC in the form of public dividend capital (PDC)[263] and/ or loans
- through internal sources by building up cash balances
- via 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

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

no tolerance above the EFL target; 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).

ICBs and NHS foundation trusts do not have an EFL.

14.3 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.

Joint capital resource use plan (JCRUP)

ICBs and their partner trusts are required[264] to prepare their JCRUP before the start of the financial year. The JCRUP should align with other relevant local plans and strategies - for example, the system's joint forward plan (JFP) and the ICS infrastructure strategies. ICBs will report performance against the JCRUP in their annual report.

NHS England publish guidance[265] on the completion of plans as part of the annual planning process.

Affordability

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

- the appropriateness of the investment in relation to the local system/ organisation's service requirements, whether this be infrastructure or equipment
- the risk of not investing, or of investing in a low-risk area at the expense of being able to address a higher risk
- on-going maintenance costs, both as regards the new investment, or from not investing (older estate and equipment will generally have much higher maintenance costs)
- depreciation costs. Non-current assets wear out over their 'useful life' and an annual (non-cash) charge is made to the revenue account to reflect this (see later for more about depreciation)
- the cost of financing – for example, the impact on PDC dividend. This is a cash charge paid to the DHSC that is based on the average net assets of the organisation. An increase in non-current assets will result in an increase in the dividend charged (see later in this chapter for more about PDC). Interest charges from finance leases or loans are also a financing cost.

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 to develop a business case to consider the options available, their impact and affordability. The scale of the investment will determine how detailed the business case needs to be. NHS England provides

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[264] UK Government, Health and Care Act 2022
[265] NHS England, *Guidance on developing joint capital resource use plans 2024/25,* December 2024

detailed guidance on the development and completion of business cases[266]. 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/ opportunities and an agreed corporate view of the best way forward. The business case proposal will be 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
- 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 are subject to a system of 'delegated limits'[267]. This means that the capital value of a project determines what approvals are required.

Foundation trusts that are in financial distress have less flexibility and are subject to the same limits as NHS trusts. Business cases with a financial value of less than £25m can be approved by the provider body's board. Above this level, external approval is required as shown below.

General delegated limits for trusts and foundation NHS trusts that are in distress

Financial value of the capital investment	Approving person or group
£25m to £50m	NHS England and DHSC joint investment committee (JIC)
Over £50m	NHS England and DHSC joint investment committee (JIC), and HM Treasury

[266] NHS England, *Capital investment and property business case approvals guidance for NHS trusts and foundation trusts*, February 2023
[267] NHS England, *Capital investment and property business case approval guidance for NHS trusts and foundation trusts*, February 2023

NHS foundation trusts that are not deemed to be in financial distress have greater autonomy and have delegated approval limits up to £50m.

The table above provides general limits, but specific limits for certain transactions may apply. These are updated and detailed in the *Capital investment and property business case approvals guidance for NHS trusts and foundation trusts* guidance. For example, digital schemes have specific limits, and any scheme that is considered novel, contentious or repercussive will need approval irrespective of value.

14.4 Sources of capital

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

As mentioned earlier, it is unlikely that ICBs will have significant levels of non-current assets. However, if an ICB does enter a capital programme, the only source of funding available to it is internally generated funds, leases or a capital allocation provided by NHS England.

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 projects. 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, and this is known as depreciation (or amortisation for intangible assets). 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 – for example, maintenance or sustaining the working capital[268] position.

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

[268] 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.

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*[269] [270], the DHSC is required to produce guidance in relation to the powers that it has to provide financial assistance to NHS providers[271]. 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 no longer issue loans, other than in exceptional circumstances. Instead, public dividend capital (PDC) is 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 will need the approval of the DHSC to borrow from outside of the group. NHS foundation trusts that are not in financial distress can borrow externally if 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 cannot be entered into since the Chancellor's announcement in 2018.

Private finance initiative (PFI)

PFI schemes were used for several 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 that 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.

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[269] UK Parliament, *National Health Service Act 2006*
[270] Section 42A of the NHS Act 2006 which was inserted by section 163 of the Health and Social Care Act 2012
[271] Department of health and Social Care, *Secretary of State's guidance under section 42A of the NHS Act 2006*, updated January 2023

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 DHSC. 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 an 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 changed. The change has an impact on what is charged against CDEL as well as the profile of revenue expenditure over the life of the lease. More than just an accounting change, it also affects 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 with a liability to pay for that right[272]. At the commencement of a lease, the lessee's initial measurement of the right-of-use asset is at cost, which in general, will be the same as the initial measurement of the discounted lease liability. This will ensure that the accounts will include the assets being used by an organisation to provide services, together with the associated liabilities, and the impacts on cashflows.

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.

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. Operating leases were treated as an in-year rental cost.

Lessors will continue to distinguish between operating and finance leases. This means that where 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.

NHS accounts for 2022/23 was the first reporting period for the application of IFRS 16. Annual reports included supporting notes explaining the impact of the new standard and including the movements from prior year reported figures.

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.

[272] 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 charge to expenditure when they arise.

Some NHS bodies may 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 that results in a timing difference between the recognition of the income and expenditure. This timing difference is adjusted for when determining whether the NHS body has met its financial duties.

For more about NHS charitable funds, see chapter 19.

14.5 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 (x)	
Less	the net book value of donated assets and grant funded assets
Less	charitable funds (before any consolidation adjustments for charitable funds)
Less	net cash balances in government banking service (GBS) accounts (excluding short term working capital facilities)
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
Equals	Total relevant net assets

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

Depreciation and amortisation

Depreciation is calculated annually to reflect the cost of 'using up' the asset during its useful life – several 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 that are subject to revaluation, the depreciation charge and total value of the assets held will vary each year.

Amortisation is the equivalent for intangible assets and is charged on a straight line basis; amortisation is seen as a system of spreading the cost of an asset, rather than as an amount that has been used up

Interest

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

14.6 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[273] but also because there can be a significant level of judgement and estimation in the valuation of the assets.

Accounting standards

HM Treasury publishes a *Financial reporting manual (FReM)*[274] 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[275] 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
- IAS 36 Impairment of assets
- IAS 38 Intangible assets
- IAS 40 Investment property
- IFRS 5 Non-current assets held for sale and discontinued operation
- IFRIC 12 Service concession arrangements
- IFRS 16 Leases.

[273] 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.
[274] HM Treasury, *Government financial reporting manual: 2023-24, December 2023*
[275] International Financial Reporting Standards Foundation, *Issued standards, 2023*

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, and for equipment assets, this will, by its nature, be a reasonable estimate of their initial fair value. Equipment is usually valued at depreciated historic cost where they have short useful economic lives or low value.

Property assets will require annual review to ensure the valuation included is a reasonable estimate of fair value. The nature and timing of a revaluation is dependent on several factors which are discussed below.

For NHS organisations, identifying the fair value for property 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, are 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[276].

Assets that 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.

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' (the equivalent to depreciation for intangible assets) as a proxy for fair value. However, where a market value is readily available then this should be used.

In March 2023 HM Treasury published a consultation document regarding asset valuations[277]. Valuation would be dependent on asset category; for example – specialised assets such as hospitals, would be valued on historical cost (currently is deprecated replacement cost and assumes a modern equivalent asset replacement). The consultation closed in May 2023 and responses are being reviewed

[276] HFMA, *Property, plant and equipment: accounting and valuation issues*, February 2022
[277] HM Treasury, *Thematic review of non-investment asset valuation for financial reporting purposes – consultation paper*, March 2023

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 taken to a specific revaluation reserve held within the financing section of the organisation's statement of financial position.

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 that 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 that 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, leases are a complex area in accounting terms.

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 has changed. Under the old arrangements, operating lease rentals were charged to revenue as they were incurred, usually on a straight-line basis. Now, interest payments are higher at the start of the lease and lower at the end whereas depreciation charges are on a straight line over the length of the lease.

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 several 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 that 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 be remeasured when the index changes. Moving PFI liabilities to an IFRS 16 basis is applicable for 2023/24. Guidance has been issued to support the transition[278].

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

[278] NHS England, *Financial accounting updates — International Financial Reporting Standard 16 Leases implementation,* updated December 2023

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.

14.7 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)
- impairments (i.e., a loss in value) including any reversals
- cumulative depreciation charges and estimated life
- closing value on 31 March of each financial year.

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.

Key learning points

- 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.
- Capital expenditure is funded from several sources: internally generated resources; leases, grants and donations. NHS organisations also have access to public dividend capital (PDC).
- 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 ICBs.
- LIFT schemes are held by Community Health Partnerships Ltd.
- Commissioners have limited access to sources of capital funding.
- 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 online learning courses that are available. The directory of resources can be found here.