Delivering value with digital technologies
Briefing: October 2022

Accounting for digital technologies

Looking at the detail

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Delivering value with digital technologies

Digital technologies such as digital medicine, genomics, artificial intelligence and robotics have a huge potential to transform the delivery of healthcare.[1]

These technologies can empower patients to participate actively in their care, with a greater focus on wellbeing and prevention. They also support the prediction of individual disease risk and personalise the management of long-term conditions.

The HFMA, supported by Health Education England, is delivering a 12-month programme of work to increase awareness amongst NHS finance staff about digital healthcare technologies, and enable finance to take an active role in supporting the use of digital technology to transform services and drive value and efficiency.[2]

The HFMA briefing *Accounting for revenue and capital: implications for the digital age*[3] explores the key funding and accounting issues that need to be considered when developing business cases for digital transformation projects. That briefing provided high level examples of the likely accounting treatment for digital projects.

This briefing continues to highlight the importance of capital and arriving at the correct accounting treatment for digital projects which may or may not be capital. It is intended to help finance teams as well as others involved in digital projects by providing more detail on the questions that need to be asked when determining the accounting treatment for a digital investment.

The briefing sets out the process that NHS bodies and their auditors follow when determining the appropriate accounting treatment. Finally, it considers the impact of the Health and Care Act 2022 on accounting for digital projects.

[1] HFMA *Introduction to digital healthcare technologies*, July 2021
[2] HFMA *Delivering value with digital technologies*
[3] HFMA, *Accounting for revenue and capital: implications for the digital age*, December 2021

Introduction

Accounting for innovative digital technologies is complex because it is not always clear whether the NHS body is purchasing an asset that, in accounting terms, is capital expenditure or a service that is revenue or a mixture of the two. It is therefore vital that the financial impact is considered at an early stage in the development of business cases.

In the NHS, all expenditure is classified as either capital or revenue. In essence, to be classified as capital, expenditure needs to result in the purchase or the lease of an asset. If there is no asset, then the expenditure will be revenue in nature.

This briefing expands on the earlier briefing *Accounting for revenue and capital - implications for the digital age*. It also considers the impact of the *Health and Care Act 2022* on accounting for digital projects.

Capital expenditure is money spent on purchasing an asset (tangible or intangible) that has the potential to earn income or will be used to provide services in the future. The asset will be controlled by the organisation and used for more than a year.

Tangible assets include buildings but also computers and equipment. Intangible assets can include software that is either developed in house or specifically for the NHS body.

Revenue (or resource) expenditure is usually described as day-to-day running costs. Any expenditure that does not meet the definition of capital is revenue.

The briefing covers the following issues:

- a summary of the importance of capital with regards to digital investment
- an outline of how the accounts are prepared, the role of management and auditors, and what happens if they disagree
- a series of questions to assist finance teams and those developing and procuring digital innovations understand and document the detail of the arrangement they have entered into and what that might mean in terms of accounting
- an overview of the impact of the system working requirements in the Health and Care Act 2022 on digital projects.

This briefing does not repeat the detail and worked examples already covered in *Accounting for revenue and capital - implications for the digital age*.

The importance of capital

All expenditure is classified as capital or revenue in the NHS because public sector budgets are split this way. Through the spending review and estimates process, resource is allocated to public sector bodies. The amounts allocated to each government department forms a hard spending limit that the department is not allowed to overspend.

In the March 2022 spring statement, the Department for Health and Social Care (DHSC) set both a resource[4] departmental expenditure limit (RDEL) and capital departmental expenditure limit (CDEL) (see **table 1**). This flows through the NHS via allocations to NHS England, integrated care boards (ICBs) and providers.

At each stage, these organisations are given an allocation or budget that cannot be overspent. Any overspend at the ICB, NHS England or DHSC level, even £1, will be irregular as it is not in accordance with the wishes of Parliament and will result in audit qualifications. It will also be clawed back from future allocations.

[4] This is often referred to as revenue – it is the day to day running costs of an organisation

Table 1: DHSC departmental expenditure limits

	2020/21 £bn	2021/22 £bn	2022/23 £bn	2023/24 £bn	2024/25 £bn
Resource departmental expenditure limit (RDEL)	136.3	146.1	167.9	173.4	177.4
Capital departmental expenditure limit (CDEL)	8.6	9.2	10.6	10.5	11.3

Source: HM Treasury, *Spring statement 2022*, March 2022

Just over half of the DHSC's CDEL is spent by NHS providers. In recent years, the DHSC's underspend against CDEL has generally been less than 2% of the total budget[5] and demand for capital projects has always exceeded the funding available.

In 2020/21, NHS providers overspent against their combined capital budget for business as usual activities. This was offset by underspends in other, mainly Covid-19 related, national budgets so the DHSC remained within the total expenditure limit. This illustrates the importance of each part of the whole system containing expenditure within their allocated budget. It also underlines the importance of robust forecasting, reporting and managing performance against plan.

Capital expenditure incurred by NHS providers can be self-financed from the bodies' own cash balances. If an NHS provider does not have available cash, then it can apply to the DHSC for funding – this usually is given in the form of public dividend capital (PDC). The memorandum of understanding that NHS providers agree to when they accept PDC often specifies that the funding can only be used to finance capital expenditure. Therefore, any of the expenditure incurred on the project that does not meet the definition of capital cannot be funded from the PDC.

Recently, additional resources specifically for digital projects have been funded from PDC with the expectation that expenditure on the digital project will meet the definition of capital. This is not always the case as this briefing will discuss.

Capital is important within the NHS because:

- there is a hard limit on the amount of capital expenditure that can be incurred each year
- demand for capital projects always exceeds the available resource
- the accounting follows the substance of the transaction rather than the source of funding – digital projects will usually include some revenue elements and, increasingly, are totally revenue in nature
- funding for digital projects often comes from capital allocations in the form of PDC for provider bodies.

Preparing the annual accounts

NHS bodies are required to prepare their accounts in accordance with international financial reporting standards (IFRS) as adopted for the public sector by HM Treasury and, for the NHS, in the DHSC's *Group accounting manual*.

When determining whether expenditure on digital projects is capital, revenue or a mixture of both, it is these principles-based standards that accountants will refer to. As the standards are principles based, there will be an element of judgement required and it may well be that similar looking arrangements are accounted for differently by different NHS bodies. The judgments will be made by each NHS organisation's own finance team and will reflect the culture, experience and appetite for risk of that team.

The role of audit

NHS bodies' accounts are audited by independent audit firms. They will also use the standards to assess the accounting treatment proposed by the NHS body and may come to different conclusions from the NHS body. Currently, the regulatory arrangements for audit firms are in flux and audit firms

[5] DHSC, *Annual report and accounts 2020/21*, January 2022

are under increased scrutiny. The pressure to improve the quality of audit has focused on applying professional scepticism, particularly to judgements and estimates made by management. This means that issues such as the accounting treatment of large, new projects will be reviewed in detail. Again, the conclusion reached by each auditor will depend on the facts of the arrangement, and the impact on the financial position of the NHS body overall as well as the audit firm's culture and approach to audit risk.

Materiality

Different accounting treatments could be adopted for similar arrangements because seemingly small details are different. It could also be due to different judgements being made about the arrangements in place. Financial statements prepared in accordance with IFRS require judgements and estimates to be made when preparing them. Therefore, given the same transactions, two accountants would be unlikely to produce exactly the same set of accounts. However, the accounts do need to be materially correct so that they provide a true and fair view.

IAS 1 *Presentation of financial statements* defines materiality as:

> 'Information is material if omitting, misstating or obscuring it could reasonably be expected to influence decisions that the primary users of general-purpose financial statements make on the basis of those financial statements, which provide financial information about a specific reporting entity.'

The assessment of whether a transaction is material will in part be based on the size of the organisation financially.

Materiality is assessed cumulatively as well. At the end of the audit there may be errors in the accounts identified by the auditor that the NHS body decides not to correct because they do not make a material impact on the accounts. However, these errors will be carried forward as part of the audit of the following year's accounts which means that adjustments identified in that year, that are not material in themselves, could be material when combined with the unadjusted errors carried forward.

What happens if the finance team and the auditors disagree?

If the NHS body's board, as advised by the finance team, determine that a particular transaction is capital in nature, then the accounts will reflect a new asset for the NHS body. If they determine it is revenue, then the expenditure will be recognised in the year it is incurred. Even those transactions that are capital in nature are likely to include some revenue elements. The finance team will prepare working papers that set out their analysis of the accounting treatment, along with evidence to support their conclusion.

Auditors will review the working papers and the supporting evidence and will reach their own conclusion on the appropriate accounting treatment. This may involve consulting with their technical accounting experts. Where the auditor reaches a different conclusion to management, then it is the entity's management that need to decide how to proceed following full and frank discussions with the auditor and, possibly, NHS England or the DHSC.

Where the amounts are not material, management may decide not to alter the accounts. However, the auditor will report the transaction as an error in their report to those charged with governance in accordance with *International auditing standard 260*[6] as an unadjusted error.

In the NHS, those charged with governance are the members of the audit committee who will have to decide whether the accounts should be adjusted or whether to accept the immaterial error in the accounts. Where the error is left in the accounts, it will be carried forward to the next year meaning that there will be less scope for immaterial errors in the next set of accounts.

Where the amounts are material, the auditor will not be able to sign a true and fair opinion on the accounts. Usually, this will mean that management will amend the accounts as it is not acceptable to prepare a set of accounts that are not true and fair.

[6] FRC, *ISA (UK) 260 Communication with those charged with governance*, November 2019

However, amending the accounts as a result of the audit will impact on the financial position of the NHS body. As accounts are prepared after the year-end, the expenditure will have been incurred meaning that performance against expected positions will be different. If expenditure that was treated as capital in the draft accounts is determined to be revenue in nature, then either any surplus will be lower than expected, a surplus may actually be a deficit, or a deficit will increase. The conditions attached to PDC that it must be spent on capital expenditure will not be met, which means it may have to be returned, leaving the NHS body with a cash flow issue.

Accounting standards

Accounting standards do not specifically refer to capital and revenue expenditure. Instead, the *Conceptual framework for financial reporting* that underpins all accounting standards refers to recognition of assets, liabilities, and equity. Income and expenses are defined in relation to movements in assets, liabilities, and equity.

Paragraph 4.18 of the framework states:

> 'There is a close association between incurring expenditure and acquiring assets, but the two do not necessarily coincide. Hence, when an entity incurs expenditure, this may provide evidence that the entity has sought future economic benefits, but does not provide conclusive proof that the entity has obtained an asset. Similarly, the absence of related expenditure does not preclude an item from meeting the definition of an asset. Assets can include, for example, rights that a government has granted to the entity free of charge or that another party has donated to the entity.'

The framework defines an asset as:

> 'a present economic resource controlled by the entity as a result of past events.'

However, the framework is not a standard in itself; it sets out the objectives of and the concepts for financial reporting. It is the accounting standards themselves that need to be considered in detail.

International reporting standard (IAS) 16 *Property, plant and equipment* defines property, plant and equipment (PPE) as:

> 'tangible items that:
>
> - are held for use in the production or supply of goods or services, for rental to others, or for administrative purposes; and
> - are expected to be used during more than one period.'

It goes on to say 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.'

International accounting standard (IAS) 38 *intangible assets* defines an intangible asset as 'an identifiable non-monetary asset without physical substance.'

The definition of an asset set out in the accounting standard aligns with the definition for a tangible asset, as it is:

> 'a resource:
>
> - controlled by an entity as a result of past events and
> - from which future economic benefits are expected to flow to the entity.'

Assessing the accounting treatment

In order to determine whether the project is capital or not , the following need to be considered:

What are the future economic benefits for the NHS body?

- for NHS bodies, this is likely to relate to the provision of services rather than income generation. Are there specific healthcare services that will benefit from this investment/ project?
- are there other organisations that will also receive future economic benefits?

Which organisation has the rights to receive cash, goods or services or use the asset or benefits from its value?

- what are those rights?
- are those rights likely to be exercised or not? Even if they are unlikely to be exercised, are the rights exercisable?

Who has control[7]?

- which entity directs the use of the asset?
- which entity obtains the economic benefits that flow from the arrangement?
- which entity takes any risks?

Understanding the arrangement

The accounting treatment for any transaction is always based on the detail of the transaction itself. It is therefore important to review and understand the substance of the transaction. This will include the expected outcome of the project.

In terms of digital projects, it is important to understand exactly what is being purchased and what hardware and software is involved. The list below includes the type of questions that should be asked. It is not exhaustive but is intended to help identify whether the NHS body has an asset. The questions are worded in such a way that they can be applied to different types of arrangement, but they will need to be tailored for each particular circumstance.

General questions

Asking these questions will help frame other questions. Understanding the contract will help with the assessment of control. It will also support any value for money assessment of the proposal.

- what exactly is being paid for?
- what is being delivered to staff and patients? How are the benefits from the expenditure being delivered?
- are there consumables involved? If so, how are these paid for? Who supplies the consumables and is using a single supplier part of the contract?
- does the contract include limits? For example, on the time that the hardware can be run, the number of units that the arrangement delivers over a time period?
- who decides when, where and how the software/ hardware will be used?
- what are the arrangements for terminating the agreement? Often the termination arrangements will be useful when assessing control and risks and rewards.
- What are the payment arrangements? If the full amount needs to be paid before the supplier will deliver, then this indicates that an asset may be being purchased. If payment in advance is agreed or discussed as part of the procurement negotiation, then this is an indication that a prepayment is being made for goods or services.

Hardware and software

Specific hardware is likely to be capital in nature as there will be a tangible fixed asset. Where software is to be run on specific hardware the costs are capitalised as part of the tangible asset, for example, an operating system. Standalone software can be capitalised as an intangible asset where it meets the definition in IAS 38. Software is now provided as a service in some instances on a subscription basis – software as a service is revenue in nature.

[7] Paragraph 33 of IFRS 15 states: ‘Control of an asset refers to the ability to direct the use of, and obtain substantially all of the remaining benefits from, the asset. Control includes the ability to prevent other entities from directing the use of, and obtaining the benefits from, an asset.’

- does this arrangement require specific hardware? Or is this simply another system/ app accessed on employee's laptop or a patient's phone?
- are the hardware and software inextricably linked? Can the hardware be used without this software?
- what happens to hardware/ software at the end of the contract?
- where is software and data being stored? Cloud-based solutions will still require a physical server somewhere. Does the NHS body have exclusive rights to specific servers owned by a third party, does the NHS body own its own servers on site or off site or is the data storage managed and arranged by the suppliers?

Supplier involvement

The involvement of the supplier might indicate that the project is bespoke to the NHS body and therefore the NHS body has control of an asset. However, sometimes set-up costs are simply initial revenue costs that cannot be capitalised as part of the asset.

- does this arrangement require specific set up/ implementation by the supplier?
- does the arrangement include on-going support from the supplier? If so, is this a separate part of the contract? If not, could it be separated?
- is there organisation specific set up required for the arrangement? Does software need to be configured specifically for each NHS body? Who determines what can be tailored/ is bespoke and what cannot?
- what are the arrangements for upgrading or modification? Is this the responsibility of the supplier or the NHS body?
- if the NHS body wants to modify or upgrade the system, are they required to use the original supplier or can they use a new supplier?

Operational decisions

Operational decisions will help to understand who has control. The more operational decisions the NHS body can make, the more likely it is that they have an asset.

- who decides if it can be used in a different location or to deliver healthcare to a different set of patients?
- can the supplier stop the NHS body moving the location of the healthcare service or the type of patients that benefit from the arrangement?
- who owns the rights to the software? Is the software being provided as a service so updates and developments will be made by the supplier and applied to their timetable? Is it bespoke software to the NHS body? Or is it a mix of the two – software as a service that has been configured to the NHS body's specification?

Risks and rewards

Risks and rewards are indicators that an NHS body has an asset.

- which organisation is responsible for insurance covering any assets or takes any risks relating to the outputs?
- who is responsible for ensuring that services continue to be provided in the event of breakdown or failure of an asset?
- who is responsible for maintenance?
- who benefits from any income relating to the arrangement?
- is there specific staff training required? If so, who is responsible for ensuring that there are appropriate numbers of staff receive the training? Which organisation bears the cost of training new staff?

Understanding the difference

In terms of the financial statements, this very simple example shows the difference between a transaction being revenue or capital. The calculations are included in the appendix.

An NHS body spends £500,000 on a digital transaction. The set-up costs such as training and dual running costs are £15,000 in the first year of the arrangement. In this example, there is no inflation. The arrangement will last 10 years.

Prior to the arrangement being entered into, the NHS body has £1m cash held in the Government Banking Service (GBS) bank account and has a cumulative surplus of the same amount.

Revenue transaction

It is determined that the transaction is a service contract that will be paid for in equal instalments over the 10-year period.

The cost of the transaction is £65,000 in the first year and £50,000 in subsequent years with a total cost of £515,000 over the 10 years.

Unless the arrangement is paid for in advance, the cash flow will mirror the costs of the transaction.

Capital transaction

It is determined that the transaction is capital in nature so the £500,000 will be capitalised as an asset in the first year when it is purchased. This will be depreciated on a straight-line basis over the 10 years at £50,000 per year. So far, the only difference between the arrangements is the cash flow as it is assumed that the transaction will be paid for in full in the year of purchase.

However, NHS providers are required to pay PDC dividend on their relevant net assets each year at a rate of 3.5%. This is to recognise that there is a cost of purchasing assets. The PDC dividend works as an interest payment on cash injections provided by the DHSC but, unlike interest on a loan, it is not tied to the amount of PDC held by the NHS provider body but is calculated based on the average relevant net assets held by the body in the financial year.

The calculation of relevant net assets is set out in the DHSC *Group accounting manual*. Specific assets such as those funded by grants and donations as well as assets purchased in 2020/21 as a result of the Covid-19 pandemic are not included in the calculation. Also excluded from the calculation is any cash balance held in the Government Banking Service (GBS) bank account. For this particular asset, the PDC dividend will be £78,750 in total over the 10 years.

Capital transactions have an impact on the revenue position of the NHS body and this needs to be taken into account when preparing business cases and applying for funding.

Whether a transaction is capital or revenue in nature will depend on the details of the arrangement. It is important to understand the financial impact of each type of expenditure, but it is not a choice that is made by the NHS body. The key focus when entering into a new arrangement must be value for money and what is the best arrangement for the patient.

Comparison

The following charts set out the impact the different accounting treatments have on the financial position of the NHS body.

Figure 1 shows the cost of the transaction each year. For the revenue transaction it is the service cost plus the additional set-up costs in the first year. For the capital transaction the PDC dividend is an additional cost, which is higher at the start of the arrangement and gradually reduces over the 10-year period.

Figure 1: Net expenditure year on year

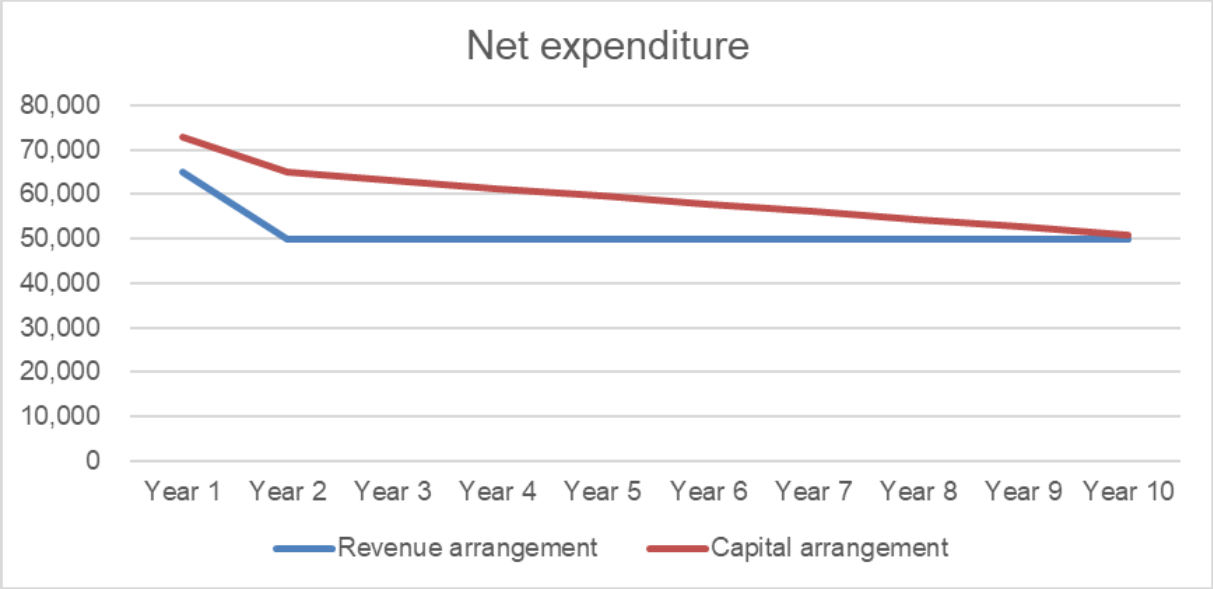
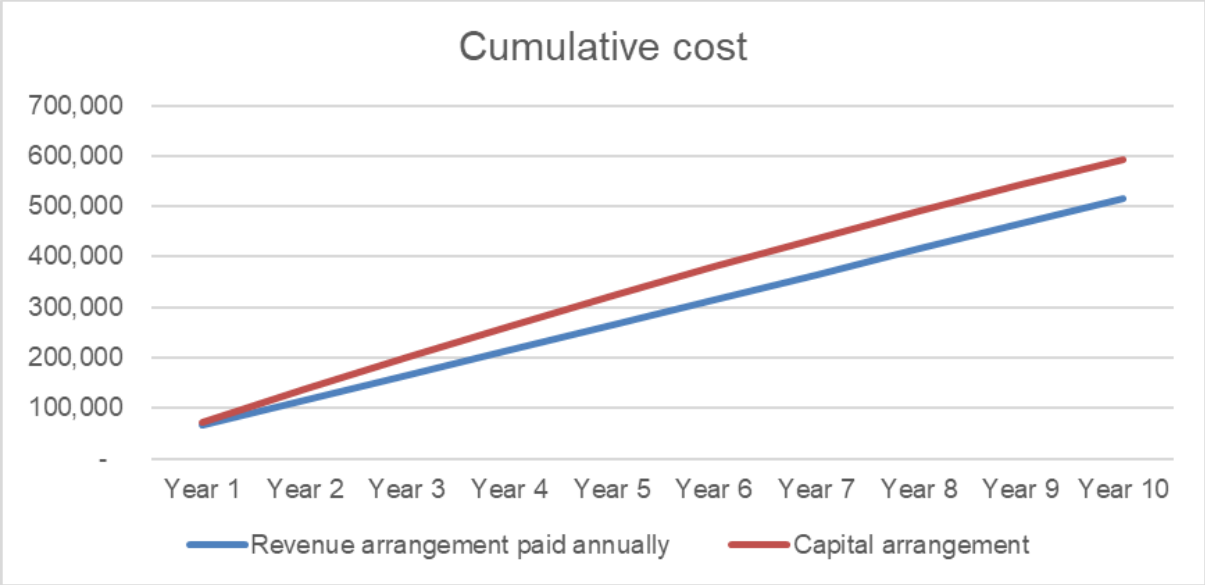


Figure 2 shows the cumulative cost of the projects. Again, the difference is the PDC dividend.

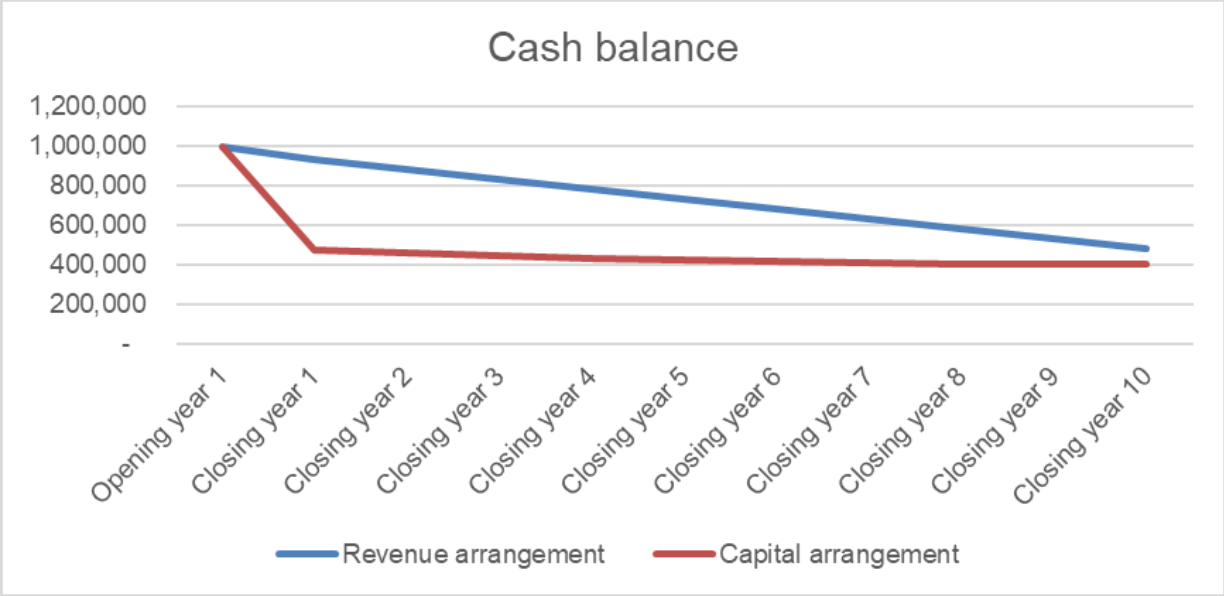
Figure 2: Cumulative cost over 10 years



Finally, the impact on the cash balance of the organisation is shown in **figure 3**. The capital transaction immediately reduces the cash as the asset is paid for when it is acquired. However, the subsequent cash cost is relatively small, as it is the cash payment to the DHSC for the PDC dividend.

For the revenue transaction, the impact is simply the service charge each year plus the set-up costs in the first year.

Figure 3: The impact of the digital transaction on the trust's cash balance over 10 years



The impact of the Health and Care Act 2022 on system-wide digital innovations

The move towards integration and closer working means that NHS bodies within a system are looking to share IT platforms across the ICS.

Prior to the commencement of the Health and Care Act 2022, NHS bodies did have powers to work together but the process was not straightforward. Cross-organisational digital innovations would usually be hosted by one provider body with formal, or informal, agreements with the other NHS bodies along a patient pathway. The host organisation would be given the funding for the digital solution and would deal with the capital/ revenue accounting issues discussed above.

Integrated care boards (ICBs) were established on 1 April 2022. Under paragraph 23b of Schedule 2 of the Health and Care Act 2022, ICBs have the power to acquire and dispose of property. The 2022 Act also amended the NHS Act 2006 to give ICBs powers to:

- promote innovation (s14Z39 of the NHS Act 2006)
- promote integration (s14Z42 of the NHS Act 2006)
- have regard to the wider effects of decisions (s14Z43 of the NHS Act 2006)
- make payments by way of grant to partner NHS trusts or NHS foundation trusts and voluntary organisations that provides services (s14Z48 of the NHS Act 2006).

All of these powers combined, may mean that ICBs can take the role of host. And the grant making power may mean that it can pay for the digital innovation for partner NHS provider bodies.

What remains unchanged is that for all digital innovations that involve more than one NHS body, a series of memoranda of understanding (MoU) or service level agreements (SLA) will need to be put in place between all parties involved to ensure that the arrangements for using the system are clearly set out as well as the funding arrangements. These arrangements will also cover information governance and wider management issues.

In financial terms there is a risk to acting as the host for these arrangements. The delivery of any digital solution will involve third party suppliers. Contracts between those suppliers and the host NHS body will be legally binding and will commit the host NHS body to a specific arrangement over a period of time. Early termination would usually come at a cost. MoUs/ SLAs between NHS bodies are not legally binding. Therefore, it is possible for NHS partners to pull out of arrangements leaving the host organisation responsible for the contract with the third party.

The funding, whether it is capital or revenue, will come with conditions that apply to the host organisation but not to the other organisations using the digital solution. As well as these financial and legal risks from acting as host for digital solutions, there is also the additional administrative burden for the host of managing the arrangement with partner NHS bodies. The same accounting considerations apply to determine whether the expenditure is capital in nature, no matter the host organisation.

The system-wide role and view of the ICB may make system-wide digital innovation more straightforward. As the main commissioner for the system, the ICB acting as host could require the use of the hosted system in contracts for the provision of healthcare.

For an ICB to incur capital expenditure it will need to be part of the ICB's allocation and will need to be cash backed. ICBs are not able to accept PDC so this would not be an appropriate funding route. Therefore, the capital regime for the NHS will need to reflect the changes made by the 2022 Act as some of the capital allocation for ICBs will need to be backed with cash rather than simply being permission to incur capital expenditure. Any proposal for the ICB to host a capital digital innovation would need to be discussed and agreed with NHS England and the DHSC at an early stage.

Conclusion

Without change to the public sector budgeting arrangements, there will always be a hard limit on capital expenditure. It is likely that demand for capital projects will be greater than the resource available.

It is important to account for digital innovations appropriately and the move to cloud-based arrangements may mean that increasingly expenditure is revenue in substance. This is a problem where the associated funding is capital unless there is a mechanism for transferring capital budgets to revenue.

In order to account appropriately for digital projects it is important to understand the project in detail. The section above on Assessing the accounting treatment seeks to support both finance and digital professionals with this challenge.

Finally, the move to integrated working may mean that ICBs can take a lead in system-wide digital projects and innovations that follow the patient pathway. This will not change any of the issues identified above but may make system working easier and move the risk from individual provider bodies to the ICS and therefore the whole system.

Appendix

Worked example showing the difference between a capital and a revenue transaction

Background

The transaction costs £515,000 in total. £15,000 is the start-up costs and is a revenue cost in year one. The digital project will have a 10-year life span.

Revenue

The impact on the income and expenditure account would be operating costs as follows

	Opening year 1	Closing year 1	Closing year 2	Closing year 3	Closing year 4	Closing year 5	Closing year 6	Closing year 7	Closing year 8	Closing year 9	Closing year 10	Total
Service charge		50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	500,000
Set up costs		15,000										15,000
Total		65,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	515,000

The balance sheet would reflect the cash balance and the cumulative surplus/deficit for the period.

Asset net book value	0	0	0	0	0	0	0	0	0	0	0
Cash	1,000,000	935,000	885,000	835,000	785,000	735,000	685,000	635,000	585,000	535,000	485,000
Total net assets	1,000,000	935,000	885,000	835,000	785,000	735,000	685,000	635,000	585,000	535,000	485,000
Cumulative surplus	1,000,000	935,000	885,000	835,000	785,000	735,000	685,000	635,000	585,000	535,000	485,000

Capital

The impact on the income and expenditure account would be operating costs as follows

	Opening year 1	Mid year purchase	Closing year 1	Closing year 2	Closing year 3	Closing year 4	Closing year 5	Closing year 6	Closing year 7	Closing year 8	Closing year 9	Closing year 10	Total
Purchase of asset		500,000											
Depreciation of asset			50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	500,000
Set up cost			15,000										15,000
PDC dividend			7,875	14,875	13,125	11,375	9,625	7,875	6,125	4,375	2,625	875	78,750
Total	0		72,875	64,875	63,125	61,375	59,625	57,875	56,125	54,375	52,625	50,875	593,750

The balance sheet would reflect the capital asset that would be written down over 10 years, the cash balance, and the cumulative surplus/deficit for the period.

	Opening year 1	Mid year purchase	Closing year 1	Closing year 2	Closing year 3	Closing year 4	Closing year 5	Closing year 6	Closing year 7	Closing year 8	Closing year 9	Closing year 10
Asset net book value	0	500,000	450,000	400,000	350,000	300,000	250,000	200,000	150,000	100,000	50,000	0
Cash	1,000,000	500,000	477,125	462,250	449,125	437,750	428,125	420,250	414,125	409,750	407,125	406,250
Total net assets	1,000,000	1,000,000	927,125	862,250	799,125	737,750	678,125	620,250	564,125	509,750	457,125	406,250
Cumuulative surplus	1,000,000	1,000,000	927,125	862,250	799,125	737,750	678,125	620,250	564,125	509,750	457,125	406,250

This briefing is part of the *Delivering value with digital technologies* programme that the HFMA is undertaking, supported by Health Education England. The programme aims to increase awareness amongst NHS finance staff about digital healthcare technologies, and enable finance to take an active role in supporting the use of digital technology to transform services and drive value and efficiency. For more information click here.

About Health Education England

HEE's Digital Readiness Education Programme aims to create an uplift of digital skills, knowledge, understanding and awareness across the whole multi-disciplinary health and care workforce to support new ways of working. It is developing, delivering and maintaining – through the NHS Digital Academy service - a range of learning and development products and offerings for both the future/incoming workforce and for the current workforce, including senior leaders, digital (DDAT) experts and the wider workforce. Increasing workforce digital adaptability supports improved health and care services. It is for everyone, at all stages of their career journey.

This includes learning products that are person-based (e.g., the Digital Self-Assessment Toolkit, or the PGDip for Digital Health Leadership with Imperial College, or online learning modules for the finance profession); team based (e.g., Digital Boards and ICB development offers in collaboration with NHS Providers, or the Digital Futures programme with Yale); or technology based (e.g. our DART-Ed programme delivering training around Machine Learning and AI). All this is supported notably through the Informatics Skills Development Networks we have now helped establish across all regions.

For more information visit the Digital Readiness Education Programme website or follow the programme on Twitter @HEE_DigiReady.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

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