HFMA briefing
February 2022

Property, plant and equipment

Accounting and valuation issues

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Background

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

This briefing looks at some of the issues NHS bodies should consider around accounting for, and the valuation of, PPE[1].

This briefing was first issued in December 2019, it has been updated to take account of subsequent comments and issues that arose during the audit of the 2020/21 accounts. Updated sections are highlighted in **bold.**

This briefing has been developed to help finance teams address difficult accounting issues – it is based on discussions with regulators, NHS bodies and their auditors to identify common difficulties and possible solutions. It is for NHS bodies to determine the accounting treatment for the transactions they enter into based on the facts of the matter and the requirements of the Group accounting manual.

PPE and capital expenditure

Definition of PPE

IAS 16 *Property, plant and equipment* defines PPE in paragraph 6 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.'

The Department of Health and Social Care (DHSC) *Group accounting manual*[2] (GAM) requires that NHS bodies categorise their PPE as follows:

- land
- buildings (excluding dwellings)
- dwellings
- transport equipment
- plant and machinery
- information technology
- furniture and fittings
- payments on account and assets under construction.

Initial measurement of purchased assets

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

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

[1] ***This briefing does not cover the valuation of right of use assets under IFRS 16***
[2] DHSC, *Group accounting manual 2021/22,* May 2021

- the cost of the item can be measured reliably.'

Paragraph 15 goes on to say:

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

The standard then sets out what can be included in the cost of an item of PPE and what cannot. **It is worth noting that the *Conceptual framework* defines an asset as:**

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

NHS bodies do not capitalise any purchases of assets for less than £5,000 in accordance with the requirements of the GAM. The exception to this is where a collection of assets that are part of a single collective asset – in this case they are capitalised as a grouped asset. To be capitalised as a group, each of the items in the group must meet all of these criteria:

- the total cost of the grouped asset is greater than £5,000
- functional interdependence – so they can only be used together
- acquisition at about the same date and planned disposal at about the same date
- under single managerial control, and
- each individual asset has a value of over £250.

For the purchase of a stand-alone item of equipment, determination of cost is usually straightforward – it is the amount that has been paid for that item of equipment including the cost of VAT where that is not recoverable. For items of equipment that require installation or have a service contract this is more complex and for large capital developments it is more complex still.

In essence, the amount included in cost (or capitalised) should be the costs directly attributable to getting the asset to a location and condition necessary for it to be capable of operating in the manner intended by management. It will include the purchase price plus irrecoverable taxes less discounts. Other costs which may be capitalised include:

- the costs of employing staff directly involved in the construction or acquisition of the assets
- delivery and installation costs
- costs related to site preparation **– this may include the costs of moving people and equipment out of a building and/ or demolition costs where the specific site has been identified**
- costs of testing that the asset is functioning properly
- professional fees where they directly relate to the acquisition or building of the asset.

Costs which should not be included in the initial measurement of the asset include:

- operating costs
- costs of training staff to use the new asset
- costs of relocating staff **and equipment** to the new asset
- **the costs of temporary accommodation during the project**
- costs relating to developing the initial business plan.

Effectively this means that any costs incurred before it is clear that there will be a specific asset should not be capitalised – this will include the costs of identifying the site or alternative options.

Demolition costs

The capitalisation of demolition costs will need to be considered on a case-by-case basis depending on whether the demolition cost is directly attributable to the cost of a new asset or that future economic benefits will flow to the entity as a result of incurring the demolition costs. There is very little guidance in the standard in relation to demolition costs so it is open to interpretation and it may well be that different audit firms take different views on this.

Where demolition costs are incurred without a clear plan for redevelopment then it is unlikely that those costs can be capitalised as the costs are not part of getting another asset into a condition that means it can be used.

For example:

- **where an existing building is demolished because it is no longer needed, while the land may be developed in the future, the costs are unlikely to capitalised where there is no plan to develop a specific asset and the value of the land is unaffected by the demolition. This is because there is no future benefit associated with the cleared site. However, if the demolition increases the value of the land for disposal, then the demolition costs may be able to be capitalised as part of the costs of getting the site ready for disposal**
- **where an existing building is demolished to prepare the site for the development of a new asset then consideration should be given to whether the costs of demolition are part of the cost of derecognising the old asset and should therefore be expensed as incurred. Paragraph 16 of IAS 16 states that an estimate of the costs of dismantling and removing an asset should be included in the cost of an item of PPE**
- **where buildings are purchased with the intention of demolishing the building to build a new asset on the site then the demolition costs may be capitalised as part of the costs of the new building**
- **where land and buildings are purchased with the intention of demolishing the building to hold the land for development then the demolition costs may be capitalised as part of the cost of acquiring the land. The cost of demolition is a cost of getting the land ready as an asset capable of being developed.**

The appendix to this briefing includes a table used in Australia to summarise the stages of a capital project and whether costs should be capitalised or expensed. The table is used to inform discussions about whether costs should be capitalised, but it is not guidance that is directly applicable in the UK.

For some capital projects, the determination of the cost at which an asset should be initially measured will involve detailed consideration of the requirements of the standard[3]. Any costs which do not meet the requirements of IAS 16 should be expensed as incurred.

Business case costs

NHS bodies are required to prepare a series of business cases for capital projects[4] – where the capital costs are above the specific thresholds set then approval from NHS England and NHS Improvement, the DHSC or HM Treasury is required.

For large projects, such as those set out in the DHSC's *Health infrastructure plan* (HIP)[5] funding is provided for the business case process. However, that funding is usually capital public dividend capital (PDC)[6].

NHS bodies need to determine whether business case costs are part of the capital cost of the asset or not. As stated above, and reflected in the appendix, the costs of initial business cases are not usually capitalised. This because at the early option appraisal stage, one of the options is to do nothing – in which case there would be no future economic benefits as no asset exists. Equally, there are likely to be several potential approaches or options being considered that may result in different assets being developed. Only one of the options will be able to be taken forward, but that decision is in the future. In that case, the cost of the asset may not be able to be measured reliably. While there is an expectation that the business case process will result in an asset at a future point in time, there is no clarity around the specific asset.

This means that where this early work is funded by capital PDC there may be a conflict between the accounting treatment and the nature of the funding. The terms of the funding do not affect the accounting treatment as that can only be determined with reference to accounting standards as interpreted by HM Treasury for the public sector.

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[3] ***NHS bodies can access the full standards via the Government Finance Function OneFinance portal***
[4] NHS England, *Business case guidance chart*, May 2018
[5] DHSC, *Health infrastructure plan*, October 2019
[6] DHSC, *Financial assistance under section 40 of the National Health Service Act 2006 - 2019/20*, January 2021

It will therefore be for NHS bodies to look at their specific circumstances to determine whether they are able to capitalise business case costs. Simply being on the list of the HIP projects is unlikely to provide sufficient evidence as the announcements are not specific enough. For example, for projects on HIP2 the funding is 'seed funding to enable trusts to proceed to the next stage of developing their hospital plans'. Those plans may not result in an asset.

The trusts that have received funding will need to consider the evidence in their communications with the DHSC to assess the likelihood that, while their business cases may include options, the reality is that only one will be pursued and, in their case, the business case process is to determine how the project will be managed and the details around it rather than to consider whether it will go ahead or not. This will be a discussion that NHS bodies will need to have with their auditors at an early stage. The alternative is to ask for the funding to be revenue in nature.

It is more likely that costs relating to business cases can be capitalised once the project moves beyond the strategic and outline business case stages as a single option will have been identified. However, the different elements of the business case development process should be reviewed individually to determine their accounting treatment. Some of the costs, such as design costs, are likely to meet the IAS 16 requirements but that is not the case for all costs. Each type of expenditure should be considered separately.

If business case costs are capitalised, then they should be subject to regular impairment reviews as the project may change to such an extent that there is no economic benefit to be derived from that early investment. The accounting treatment for impairment losses arising from a clear consumption of economic benefits or reduction of service potential is covered by the GAM.

Timing of expenditure

The government budgeting rules mean that capital expenditure for the NHS as a whole is capped at the DHSC's capital departmental expenditure limit (CDEL) each year. This annual limit makes the period in which the expenditure is recognised important. The consequence of not incurring expenditure in the year that the funding is made available is that either the funding could be lost or funding in the following year could be reduced.

As stated above, an asset needs to be controlled by an entity in order to meet the definition of an asset. The same applies when an asset is disposed of – the timing of a disposal is considered on page 16.

Transactions relating to non-current assets are not always clear cut. It is possible that assets are ordered and paid for but not delivered for some time or buildings could be used by an entity before they have been paid for. Ownership and control sometimes do not align, and the accounting treatment is based on control of an asset.

It is therefore important that the NHS body has evidence that it has control of an asset before it is recognised in the accounts or, when disposing of assets, that it no longer has control of an asset. To determine whether there is control, issues such as who bears the risks and rewards of ownership should be considered. This includes understanding which entity pays for insurance as well as who would bear the loss should the asset be destroyed.

Vesting certificates

Transfer of ownership of an asset or materials can be managed through a vesting clause or a vesting certificate[7]. It is important that the wording of these arrangements is clear and unambiguous, and that control has transferred[8] to the NHS body if it is intending to capitalise the expenditure.

[7] TaylorWessing, *Vesting certificates in construction contracts*, March 2020
[8] Designing Buildings Wiki, *Advance payment bond for construction contracts*, May 2021

From a value for money perspective, vesting arrangements should only be entered into for clear and genuine commercial purposes, not to achieve particular budgetary treatment[9].

The *Conceptual framework* defines control of an economic resource as

> **'the present ability to direct the use of the economic resource and obtain the economic benefits that may flow from it.'**

This includes the ability to preventing other entities directing the use of the asset or obtaining the benefits that flow from it.

Paragraph 4.25 of the *Conceptual framework* states:

> **'.. a principal may engage an agent to arrange sales of goods controlled by the principal. If an agent has custody of an economic resource controlled by the principal, that economic resource is not an asset of the agent. Furthermore, if the agent has an obligation to transfer to a third party an economic resource controlled by the principal, that obligation is not a liability of the agent, because the economic resource that would be transferred is the principal's economic resource, not the agent's.'**

In the case of vesting certificates, it will need to be clear that the asset is being held on behalf of the NHS body and cannot be transferred elsewhere other than with that body's authorisation. This should include reference to a specific asset (including serial numbers), if the asset can be substituted then this may be evidence that the NHS body does not have control. The type of asset needs to be considered. It could be that if it is something like building materials, for example bricks, then the NHS body has control of stock or inventory rather than a non-current asset.

There may be actions that have to be taken to make the vesting arrangement legally effective – there must be evidence that these actions have been completed. This may include paying for the asset or actions, such as obtaining insurance cover, relating to the ownership of the asset. Vesting arrangements can involve several layers of supplier and contractor so each of the appropriate steps need to have been considered at each stage.

Subsequent expenditure

As PPE is, by definition, held for more than a year, there are likely to be times when further expenditure is incurred relating to that asset. Whether this expenditure can be capitalised or not, is not always clear.

Expenditure on repairing and maintaining an asset is always expensed – this is expenditure incurred simply keeping the asset running as expected over the period it was expected to be used. These costs will usually be labour, consumables and small parts.

However, some assets have larger parts that require replacement at regular intervals throughout its expected life. The examples given in the accounting standards are furnaces that require relining and interiors of aircrafts (seats and galleys) that need to be replaced several times during the life of the aircraft. Another common example which is more appropriate to NHS bodies is lifts in buildings.

In the case of these larger parts, the cost of replacing them is recognised as part of the carrying amount of PPE. At the same time, any remaining carrying value of the parts that have been replaced is derecognised.

Unfortunately, the standard does not deal with cases where it is not so clear that the subsequent expenditure is not the replacement of an identifiable part but is the refurbishment of an asset. This could be considered maintenance to keep the asset in use or it could be extending its useful life or capacity.

An earlier version of the standard, there was specific guidance on subsequent recognition and slightly different recognition principles. However, that was removed because of 'difficulties in practice in making the distinction it required between expenditures that maintain, and those that enhance, an

[9] HM Treasury, *Managing public money*, June 2021 (paragraph A4.8.5)

item of property, plant and equipment. Some expenditures seem to do both' (paragraph BC5 of the Basis for Conclusions of IAS 16).

This means that all subsequent recognition needs to be considered in the same way that the purchase of a new asset would be considered. Therefore, subsequent expenditure should have future economic or service benefits in its own right rather than simply ensuring that the economic or service benefits of the existing asset will continue.

One way of considering whether subsequent expenditure should be capitalised would be to consider what would happen if the expenditure was not incurred. **Assets are repaired and maintained so they can be used for their full expected useful life, therefore if the expenditure is not incurred the expected useful life may not be reached. So, if the expected life and/ or service levels are reduced or not expected to be achieved, then it is likely that the expenditure should be considered as repairs and maintenance.**

Example of derecognition of the value of a replacement part

In year 1, a new piece of equipment is purchased for £10m. It is expected to be used for 10 years but halfway through this period a key component ***unexpectedly needs*** to be replaced. At the time of purchase, the value of that component is £2m. In year 6 the component is replaced, and the cost of the replacement is £3.5m.

In this example, the asset is not revalued during its useful economic life, but it is depreciated on a straight line over 10 years.

As the replacement is unexpected, component depreciation has not been applied so by the end of year 5, the equipment is valued at £5m – 5 years' worth of depreciation at £1m a year has been applied.

As the component was one fifth of the value of the equipment at purchase, we assume that of that £5m valuation, £1m relates to the component. Therefore, as well as the increase in the value of the equipment reflecting the purchase of the new component, £1m is written off to reflect the remaining value of the component.

If the fact that the component will have a shorter life than the equipment is known at the time of purchase, then component depreciation should be applied. It is discussed later in this briefing.

Depreciation

Once an item of PPE has been recognised on the statement of financial position, it is subject to depreciation. Depreciation is the systematic allocation of the depreciable cost of the asset over its expected useful life.

The depreciable cost is the difference between the value of the asset on recognition and the amount it is expected to be worth at the end of the life that the NHS body expects to use it for – its residual value. Often, the residual value will be nil, but some assets may have a disposal value even when the NHS body no longer has a use for it.

PPE is depreciated from the moment that it is available for use and the earlier of the date that it is classified as held for sale under IFRS 5 (see the next section) or the date that it is derecognised (usually sold or scrapped).

Most NHS bodies' PPE assets are depreciated on a straight-line basis.

The assessment of the useful economic life includes an assessment of how long the NHS body is planning to use the asset for as well as how long it is expected to be usable. This will be a judgement to be made by the finance team along with the estates team or the team that will be using the asset. As with all judgements, asset lives need to be kept under review.

Asset lives may change for a number of reasons and the accounting treatment will be different depending on the reason for the change:

- a decision is made to dispose of the asset – where this decision is made more than a year ahead of the disposal then the asset life should be revised to the expected date of disposal, the value of the asset may need to be reassessed as well (see the section of this briefing on disposal)
- the asset wears out or become obsolete earlier than expected – the asset will need to be assessed for impairment (see the impairment section of this briefing)
- the asset is not used as much as expected and therefore will be useful for longer than expected – the asset life should be revised to the new asset life and the depreciation charge adjusted accordingly. The adjustment will affect future depreciation charges but should not be applied retrospectively.

As asset lives are an estimate, it may be that a fully depreciated asset is still available for use. If this is the case, then the asset life does not need to be revisited unless there is an indication prior to full depreciation that the asset will be used for longer than expected. Fully depreciated assets should remain on the asset register while they are in use as they will need to be maintained, serviced and insured. Removing them from the register also increases the risk that they will be stolen or lost as they will no longer be tracked.

As illustrated in the example above, some items of PPE are composed of different parts which may have different useful economic lives. Paragraph 43 of IAS 16 states:

> 'Each part of an item of property, plant and equipment with a cost that is significant in relation to the total cost of the item shall be depreciated separately.'

Clearly where the useful life and depreciation method of significant parts of an item of PPE are the same, they can be grouped together.

Applying different useful asset lives to different parts of an asset is also known as component depreciation. One of the advantages of applying component depreciation is that it means that subsequent expenditure to replace a component should not require the write off or impairment of any part of the asset. **As the asset life is an estimate, the replacement of the component and the date that it is fully depreciated may not be the same, but component depreciation should minimise write offs and impairments.**

Example of component depreciation

Taking the example above, if the equipment and the component were depreciated separately then the depreciation charge for the first 5 years of the equipment's life would have been:

- depreciation of the equipment = £8m divided by 10 years = £800,000 in years 1 to 10
- depreciation of the component = £2m divided by 5 years = £400,000 in years 1 to 5
- depreciation of the replacement component = £3.5m divided by 5 years - £700,000 in years 6 to 10

The expense incurred as a result of the use of the asset is smoother than the other approach. It also reflects the actual cost of the asset as it is expected to occur from the outset. **It is worth noting that the application of component depreciation is not a choice as IAS 16 uses the word should.**

	Annual cost applying component depreciation	Annual cost without component depreciation
Years 1 to 4	£1.2m	£1.0m
Year 5	£1.2m	£2.0m
Years 6 to 10	£1.5m	£1.5m
	£13.5m	**£13.5m**

Subsequent measurement/ valuation

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

- cost model

- revaluation model

NHS bodies are, along with all public sector entities, required to use the revaluation model – the cost model is not available to them[10]. In the commercial world, most entities elect to use the cost model.

IAS 16, paragraph 31 states

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

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

Basis of valuation

The GAM 2019/20 sets out the basis of valuation of non-current assets in paragraphs 4.108 to 4.116 and annex 4 to Chapter 4. The valuation basis varies depending on the type of asset and the reason that it is being held by the NHS body. This briefing does not repeat that guidance, but it is summarised in the table below:

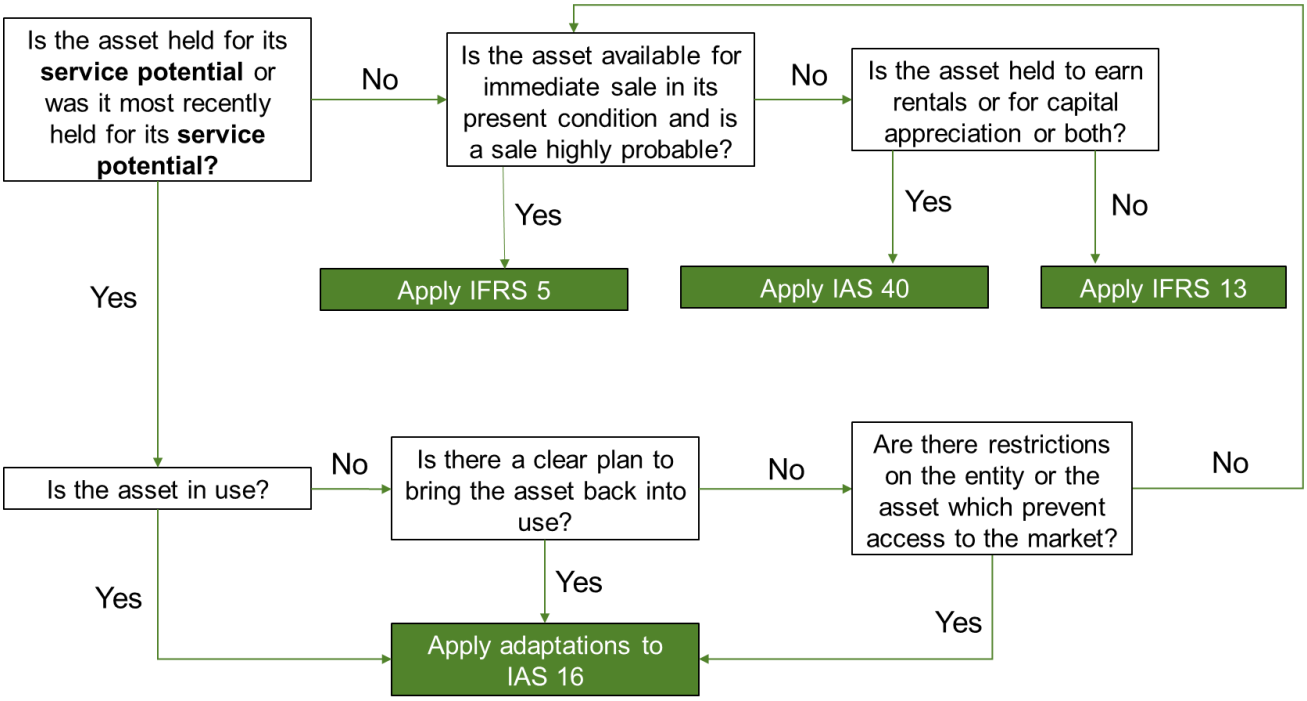
Asset	Reference to 2019/20 GAM	Valuation basis
Non-specialised asset in use held for its service potential	4.110 and 4.111	Current value in existing use (EUV)
Short-lived and/or low value assets	4.111	Depreciated historic cost as a proxy for EUV
Specialised asset in use held for its service potential	4.110 and 4.112	Depreciated replacement cost on a modern equivalent asset basis (DRC – MEA)
Assets which are held: • **to earn rentals and/ or** • **to increase in value through capital appreciation** **rather than for their service potential**	4.115	Fair value in accordance with IAS 40 and IFRS 13

Assets that meet the following criteria:
• **they are available for immediate sale in their present condition**
• **the sale is highly probable:**
  • **management is committed to the sale and it is unlikely there will be significant changes to the plan for selling the asset**
  • **an active programme to find a buyer has been started**
  • **the asking price is reasonable**
	4.115	Lower of carrying amount and fair value less costs to sell in accordance with IFRS 5

[10] Table 2, page 70, HM Treasury, *Financial reporting manual 2021/22*, December 2020

• **the sale is expected to be completed within a year**		
Surplus asset most recently used for its service potential – with restrictions on sale	4.113 and 4.114	Current value in existing use (EUV)
Surplus asset most recently used for its service potential – with no restrictions on sale	4.113 and 4.114	Fair value in accordance with IFRS 13
All other assets	4.116	Fair value in accordance with IFRS 13

The flow chart on page 102 of the GAM (replicated below) clearly sets out how the basis of valuation should be determined.



Apply IFRS 5	Measure the asset at the lower of: • the carrying amount before classification and • fair value less costs to sell
Apply IAS 40	Measure the asset at fair value The option for cost model is withdrawn
Apply IFRS 13	Measure the asset at fair value The option for cost model is withdrawn
Apply adaptations to IAS 16	Measure the asset at current value in existing use For specialised assets, this will be the present value of the asset's remaining service potential on a DRC – MEA basis

Frequency of valuations

IAS 16 requires that valuations should be 'made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using fair value at the end of

the reporting period'. In this context, fair value means the valuation basis which is applicable to the particular asset.

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

HM Treasury's *Financial reporting manual*[11] (FReM) suggests that appropriate approaches to valuation might include:

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

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

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

Where there has been a formal revaluation, paragraph 4.186 of the GAM states that cumulative depreciation is 'zeroed' as an in-year movement. The GAM does not define a formal revaluation other than to state it is not indexation. However, the involvement of a RICS qualified valuer, even if the revaluation is desk-based and uses indices is likely to be formal as they will have used their professional judgement and expertise, not simply applied indices.

The role of management

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

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

When making decisions and judgements, it is worth bearing mind the qualitative characteristics of useful financial information set out in the IASB's *Conceptual framework for financial reporting*[12]:

- relevant – the information is capable of making a difference in decisions made by users
- faithful representation – as complete, neutral and free from error as possible
- comparable – both between financial years and between NHS bodies
- verifiable – that different independent and knowledgeable observers could reach consensus that a particular depiction is a faithful representation
- timely
- understandable.

The valuer may advise on judgements and assumptions but responsibility for those judgements and assumptions lie with management. **To do this, management should challenge the assumptions made by the valuer and satisfy themselves that the assumptions are appropriate and free from bias.**

Adequate disclosure of these judgements and assumptions should be disclosed in the accounts. It is not sufficient to simply say that the valuation was provided by a professional valuer.

[11] HM Treasury, *Financial reporting manual 2021/22*, December 2020
[12] IFRS, *Conceptual framework for financial reporting*, March 2018 (log on is required)

Engaging valuation experts

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

However, the FReM and GAM require that the valuation is done in accordance with the Royal Institution of Chartered Surveyors (RICS) *Red book*[13], its UK supplement[14] and the guidance note on DRC valuation[15] which means that the valuation needs to be undertaken by a RICS qualified valuer. In practice, for NHS bodies, this will mean that an external valuer will need to be engaged as very few NHS bodies have staff members who have the appropriate qualification.

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

- satisfy itself that the valuer is appropriately qualified
- consider whether the valuer also has appropriate public sector experience[16]
- set the terms of reference for the valuation – this will include the basis on which the valuation is provided, for instance, the version of the *Red book* being used, and any supplementary guidance being used[17]
- agree the valuation basis for the PPE being valued
- provide accurate information on the PPE being valued
- agree any judgements and estimates with the valuer.

Once a valuation expert has been appointed, an engagement letter should be agreed and signed. This letter should be made available to auditors. Once the valuation report has been received, the NHS body will need to critically review the valuation before accepting it and including it in their accounts.

HM Treasury guidance[18] on asset valuations says the following about working with the valuer:

> 'Early and ongoing dialogue with the valuer is vital. Neither RICS guidance nor FRS 15 are tightly prescriptive regarding aspects of asset valuation methodology, particularly at the detail level of DRC. Within their confines, many subtle variations in approach or interpretation are possible and these can have a significant impact on the resulting figures produced. An instruction which simply asks for an asset valuation to be undertaken in accordance with RICS and FRS 15 will be insufficient to ensure that the entity receives a common result and consistency of approach over time, regardless of which valuer is used. Discussion between entity and valuer about the exact nature of the entity's bespoke requirements and how these can best be fulfilled is essential. Sufficient details about the exact approach employed must be captured for the benefit of future valuations, when it is likely that there will have been a change of valuer.'

Information on PPE

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

- a detailed list of the assets subject to the valuation
- the types of assets to be valued and how they are used and classified by the NHS body
- a comprehensive asset register listing all assets owned, leased or rented by the NHS body

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[13] RICS, *Red book*, 2019

[14] RICS, *Supplementary UK material*, 2018 which is effective from 14 January 2019

[15] RICS, *Depreciated replacement cost method of valuation for financial reporting*, 2018 which is effective from January 2019

[16] There is a RICS committee which discusses the valuation of public sector assets and liaises with the accountancy firms. It may be worth asking if the valuer is on that committee or has access to its outputs.

[17] In November 2018, the Royal Institution of Chartered Surveyors (RICS) updated and clarified their supplementary UK material on the RICS valuation professional standards and published a guidance note on undertaking DRC valuations for financial reports. This guidance was effective from 14 January 2019

[18] HM Treasury have included a paper *Guidance on asset valuation* in its application guidance for the *FReM*. The paper is old as it refers to RICS valuation paper 10 which has now been superseded by the Red Book and FRS 15 which has been superseded by IAS 16. However, it does contain some useful guidance on issues to consider in relation to modern equivalent asset valuations.

    - **the register will include all assets being used by the NHS body, even those that are fully depreciated**
- reference to where deeds or other documentation relating to the assets are held
- a list of recent asset disposals and additions
- an assessment of any incidents which may result in an impairment
- the capital programme and a schedule of recent capital expenditure
- **for assets valued on an MEA basis:**
    - **whether an alternative site should be used**
    - **any limitations or restrictions on location**
- the maintenance schedule/ log.

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

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

Decisions to be made

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

- is the asset being held for its service potential?
- is the asset specialised or not? What is the reason the asset is considered specialised? It may be due to its size or location but it is not enough simply to say the whole estate is specialised because it is a hospital or NHS owned building, the HM Treasury guidance indicates that the following questions need to be considered:
    - does it have specialised features?
    - does it include specialised adaptations?
    - does it have to be in that particular location?
    - can part of the estate be elsewhere?
    - which parts of the estate are needed to serve a particular population? Could part of the site (say, the administration block) be valued on an alternative or non-specialised basis?
    - is there any useful/ relevant evidence of recent market transactions in relation to similar types of asset (if there is then this is an indication that it is not specialised)?
- is the asset surplus to requirements? What is the evidence that it is surplus?
- if so, are there any restrictions on its disposal? What are they?
- **are any parts of the asset being used by other organisations? If so, does this impact on the valuation and the valuation basis?**
- if the asset is being valued on a modern equivalent asset basis:
    - what assumptions can be made about the size/ footprint of the modern equivalent?
    - **what impact, if any, would climate change have on the type of modern equivalent asset?**
    - **have the infection control requirements relating to Covid-19, such as ventilation and social distancing, had an impact on the assumptions made in relation to the size/ footprint of modern equivalent asset?**
    - should the valuation be based on the current site or an alternative site?
    - if any alternative site valuation is used, where should that alterative be?
    - what build costs should be included in the valuation?
- how should VAT be treated in the valuation? Where an NHS body builds an asset, the VAT is generally irrecoverable and should therefore be included in the valuation. However, if an asset is built by a non-NHS partner (for example a PFI partner or a subsidiary[19]) then the VAT may be recoverable and can be excluded from the valuation. This one assumption can make a 20% difference in the valuation.
- what allowances should be made for professional fees and contingencies in the valuation?
- what is the remaining useful life of the asset?

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

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

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

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

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

Equally, given that the last two years have been anything but normal, NHS bodies need to consider whether it is appropriate to continue to make the same assumptions. For example, have the Covid-19 pandemic, digital and technological advances or the climate change emergency had an impact on assumptions?

Whatever decisions are made, the NHS body's decisions and conclusions should be documented. Where third party information is being used and relied upon, the NHS body's review of this information, comments on it and the conclusion to rely on it should also be documented. **Auditors are likely to want to see evidence of discussions with valuers, particularly those around the assumptions that have been made.**

Once the valuation report is received, management need to critically review it. This will include, for example, looking for outliers and discussing the reason for those outliers. It is management's responsibility to accept the valuation so it is important to be comfortable with the report and the reasons that the valuer provides for reaching their conclusions.

The role of the auditor

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

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

- assessment of the qualifications, competence, objectivity and experience of the valuer
- inspection of the terms of engagement and instructions sent to the valuers
- review of the scope of the engagement with the valuer
- review of the accuracy and completeness of data provided to the valuer
- consideration of whether the methodology used to determine the valuation is appropriate and in line with industry practice
- evaluation of management's process for making assumptions and reaching a valuation
- assessment and challenge of the assumptions used by management and the valuer
- review of valuations against benchmarks
- testing of the accuracy of the data provided to the valuer
- reconciliation of the data provided to the valuer to accounting records
- re-performance of measurements of a sample of assets
- review of significant changes since the previous year or obtaining conformation that no changes have occurred since the previous year
- testing additions to ensure that an appropriate valuation basis had been adopted when they became operational
- testing the assumption that the NHS body will receive future benefits from the assets

- confirmation that the accounting for valuation changes is correct and in accordance with the requirements of the GAM
- using their own valuation experts to review the valuation.

The auditor will need to meet the audit requirements set out in the following *International standards of auditing* (ISAs)[20]:

- ISA (UK) 230 (updated January 2020) *Audit documentation*
- ISA (UK) 240 (updated January 2020) *The auditor's responsibilities relating to fraud in an audit of financial statements*
- ISA (UK) 315 (revised July 2020) *Identifying and assessing the risks of material misstatement*
- ISA (UK) 500 (updated January 2020) *Audit evidence*
- ISA (UK) 540 *(revised December 2018) Auditing accounting estimates and related disclosures*
- *ISA (UK) 620 (revised November 2019) Using the work of an auditor's expert*

Impairment

When a PPE asset's recoverable amount (the amount that it could be sold for or its value in use) is less than the amount that the item of PPE is currently measured at on the statement of financial position then the asset is impaired.

All assets should be reviewed for impairment each year – this includes items of PPE. IAS 36 *Impairment of assets* sets out indications of impairments that apply to items of PPE, these have been adapted for the NHS context:

- the asset is obsolete
- there is damage to the item of PPE which means it can no longer be used
- there are changes to the way that the item of PPE is, or is expected to be, used
- there are indications that the asset's value has declined
- the asset is no longer providing the service or service levels that were intended
- there are external indicators that the service that the asset is supporting can no longer be provided in the same way or that the asset will not be needed to provide the service
- the value of the asset has reduced.

In the public sector, the HM Treasury FReM and the GAM identify two types of impairments – the accounting treatment is different for each:

- impairments arising from a clear consumption of economic benefits or service potential. These are impairments as a result of
  - loss or damage
  - abandonment of projects
  - gold-plating or overspecification of PPE
  - the use of an asset for lower specification purpose

  The accounting treatment for these impairments is set out in paragraphs 4.143 to 4.148 of the GAM
- other impairments – these impairments arise from changes in market price or other issues which are not within the NHS body's control
  The accounting treatment for other impairments is set out in paragraphs 4.149 to 4.150.

Where the asset life of an asset is reviewed, and it is decided that the asset will have a shorter useful asset life than expected then the asset should be subject to an impairment review to check that the valuation for that asset is still appropriate. If there is no impairment, then the asset should be depreciated over the shorter period from that point onwards – this is sometimes called accelerated depreciation. If the asset is found to be impaired then the impairment should be accounted for in accordance with the GAM and the impaired valuation should be depreciated over the new, shorter asset life.

[20] FRC, *Current auditing standards*, accessed January 2022

Disposal of PPE

Disposal or derecognition of items of PPE occurs when the asset is disposed of or when there are no economic or service benefits to be had from its use (the asset is scrapped).

When the asset is derecognised then the difference between the asset's valuation and the consideration is taken as a gain or loss to the statement of comprehensive income. The consideration is recognised in accordance with IFRS 15 *Revenue from contracts with customers.* It is the amount that the entity expects to be entitled to in exchange for the transfer of the asset excluding any amounts, such as VAT, collected on behalf of a third party.

The sale of PPE, particularly property, will incur professional and other costs. These should be expensed as incurred.

The date of disposal/ derecognition

Paragraph 69 of IAS 16 states:

> 'The date of disposal of an item of property, plant and equipment is the date the recipient obtains control of that item in accordance with the requirements for determining when a performance obligation is satisfied in IFRS 15.'

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.'

It is important that when an asset is being sold, particularly at the end of a financial year, that the point at which control is transferred is clearly identified. There have been at least two high profile cases where disposals expected to take place in a financial year were determined, at audit, not to have taken place because control was not transferred. It is particularly important in cases where the sale takes place between an NHS body and another entity in its group – a subsidiary or NHS charity. In these cases, the NHS body will have control of the subsidiary so it may be that the transfer of control cannot be demonstrated.

Indicators of control include:

- taking on the risks associated with ownership of the item of PPE, so costs of damage to the asset would have to be covered, insurance taken out. In the case of a building, if someone claimed compensation due to an accident in that building the entity controlling the building would be liable
- the entity has legal title – although in itself this may not demonstrate control
- taking the benefits of ownership – such as rental income but also getting the benefit of being able to provide services
- determining what services the asset is used to provide and who those services are provided to
- determining who can use/ access the asset and who cannot and when they can use or access it.

Valuation of assets on disposal

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

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

These differences may be better explained by some examples.

Example of assets being sold on consolidation of a multi-site hospital

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

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

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

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

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

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

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

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

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

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

Example of the disposal of part of a site which is still being used

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

Like many hospitals, the site has expanded over the years. The main hospital is a three-storey building but there are various single storey extensions. The site includes some pleasant landscaping

which is not necessary for service delivery (or car parking) but is used by patients and staff when the weather allows.

In developing the valuation, it is agreed that:

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

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

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

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

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

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

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

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

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

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

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

Impact on financial position

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

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

Appendix: capitalisation of the stages of a project

This table has been taken from the capital works accounting policy published by the Australian Capital Territory (ACT) Government.

It should not be used as definitive guidance on when costs should and should not be capitalised but it does provide a starting point for discussion. Once a decision has been made whether costs should be capitalised or not, the decision should be documented as a management judgement. Where the judgement may have a material effect on the financial statements, this should be disclosed in accordance with IAS 1.

The notes have been added by the HFMA as a result of discussions with the Accounting and Standards Committee.

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
Phase 1 – Concept development	Project concept brief	Staff costs: • Project team • Everyday operational[21]	 Expense Expense
Phase 2 - Feasibility study (financial and economic business case)[22]	Proposal requesting capital works funding for a feasibility study	Staff costs: • Project team • Everyday operational Consultant costs Travel costs	 Expense Expense Expense Expense
	Feasibility study (needs assessment)	Staff costs: • Project team • Everyday operational Consultant costs Travel costs	 Expense Expense Expense Expense
	Forward design proposal and cost benefit analysis (both prepared using feasibility study results)	Staff costs: • Project team • Everyday operational Consultant costs Travel costs	 Expense Expense Expense Expense

[21] These are costs incurred as part of the everyday operations of an agency, and would be incurred regardless of whether the capital works project proceeds

[22] This would probably be the outline business case stage and some of the final business case stage

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
Phase 3 - Forward design	Engage project director/manager	Staff costs: • Project team • Everyday operational Procurement costs: • Project management costs Travel costs	 Capitalise[23] Expense Capitalise Capitalise
	Design agent produces the required design documents	Architectural / Design consultant costs Quantity surveyor costs Specialist consultant costs Travel costs	Capitalise Capitalise Capitalise Capitalise
	Design acceptance	Staff costs: • Project team • Everyday operational	 Capitalise Expense
	Business case proposal for construction funding (using results from feasibility study and forward design)	Staff costs: • Project team • Everyday operational	 Capitalise Expense
Phase 4 – Construction	Pre-construction relocation (Staff are moved to temporary accommodation ([where applicable])	Staff costs: • Project team • Everyday operational Removal costs Rental costs Minor fit out costs	 Capitalise Expense Capitalise Expense Expense

[23] Costs should only be capitalised once a site has been identified and confirmed. If the site or asset has not been identified, then costs should be expensed. Where the final business case has not been approved and there is the possibility that the project will not go-ahead costs should continue to be expensed. At the end of the financial year, the decision to capitalise or not should be reviewed with respect to the progress of the project to date.

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
	Project director/ manager goes out to tender for construction	Staff costs: • Project team • Everyday operational Procurement costs: • Project management costs • Tender costs Insurance Costs Travel Costs	 Capitalise Expense Capitalise Capitalise Capitalise Capitalise
	Project director/ manager engages builder and other construction contractors	Staff costs: • Project team • Everyday operational Procurement costs: • Project Management costs • Construction costs	 Capitalise Expense Capitalise Capitalise
	Defect period commences after formal handover. Staff, through project director (or project manager), ensure defects list is completed and defects fixed.	Staff Costs: • Project team • Everyday operational	 Capitalise Expense
Phase 5 - Fit-Out	Tender for project manager	Staff costs: • Project team • Everyday operational Tender Costs	 Capitalise Expense Capitalise
	Project manager selected for fit-out	Staff costs: • Project team • Everyday operational Project management costs Consultant costs	 Capitalise Expense Capitalise Capitalise
	Purchase of fit-out items	Asset purchase costs	Capitalise
	Installation of assets	Fit-out costs	Capitalise
Phase 6 – Post-Construction Relocation	Moving into completed building (where applicable)	Staff costs: • Project team	 Expense

PHASE	STEPS	COST ITEMS	ACCOUNTING TREATMENT
		• Everyday operational Removal costs	Expense Expense
Phase 7 - Running Costs	There are costs that agencies should take note of after the project completion stage for planning their future funding requirements.	Depreciation Ongoing repair and maintenance Insurance cost	Expense Expense Expense
Whole of Project Costs	There are a number of costs that may be incurred during any phase of a capital works project.	Training costs - all phases Meeting costs - all phases Steering Committee costs - all phases Borrowing costs- all phases	Expense Expense Expense Expense

About the HFMA

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

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

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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