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Guidance on NHS system capital envelopes for 2020/21

2 April 2020

Introduction

A new approach to capital funding is being introduced in 2020/21, the main purpose of which is the allocation of a capital envelope for each STP/ICS. This will provide greater clarity and confidence on the level of capital resource available, support system working and discussion on capital priorities, and enable faster access to national capital funding for critical safety issues.

This note sets out in more detail how these arrangements will operate.

However, while the COVID-19 response is underway, we do not expect organisations to resubmit plans, given the likelihood that this will have a material impact on capital plans, priorities and levels of expenditure.

Capital requirements agreed as part of COVID-19 costs will be funded on top of the allocations described below. Separate guidance will be issued to set out the process for accessing this funding.

NHS operational capital funding

Following the announcement of a net increase of £683m funding for NHS operational capital at the Budget, the NHS provider capital allocation for 2020/21 has been set at £5.8 billion, compared to a forecast outturn of £4.5 billion in 2019/20. This increased total financial envelope will allow trusts to continue with affordable self-financed spending, taking account of normal slippage, and around £200m extra funding for emergency capital requirements and to invest in backlog maintenance compared to 2019/20. Alongside this record budget for NHS operational capital in 2020/21, the government is backing the NHS with historically high

levels of investment to drive national strategic investments. The Secretary of State has also confirmed that future phases of the Health Infrastructure Plan (HIP) will give the NHS opportunities to put forward further new hospital projects for the next phases of the programme.

In this first step, the NHS provider capital allocation will be split into three categories:

1. A system-level allocation (£3.7bn) – to cover day-to-day operational investments (which have typically been self-financed by organisations in the ICS/STP or financed by DHSC through emergency loans).

2. Nationally allocated funds (£1.5bn) – to cover nationally strategic projects already announced and in development and/or construction such as hospital upgrades, diagnostics machines, and new hospitals.

3. Other national capital investment (£0.8bn) – including national technology capital provided by NHSX. Elements of this may be subsequently added into system-level or national level allocations during the financial year.

These figures include a small overallocation across the three elements given the uncertainties on capital delivery in 2020/21. This will be reviewed in the second half of the year and any necessary adjustments made at that stage.

System-level allocation

In line with the reforms set out in the Health Infrastructure Plan (https://www.gov.uk/government/publications/health-infrastructure-plan), to provide clearer and more transparent links between local spending plans and national spending limits, every ICS/STP will receive a 2020/21 capital spending envelope derived from the system-level allocation.

While providers remain legally responsible for maintaining their estates and for setting and delivering their organisational level capital investment plans, every ICS/STP will have to account for ensuring overall capital spending across their system remains within these budgets. Consequently, organisational plans and the deployment of discretionary emergency capital will ultimately need to be consistent with these budgets and reflect system-wide discussions on prioritisation. This supports the move to system planning, and the development of ICSs covering the country by April 2021, as part of the NHS Long Term Plan.

Commissioner BAU capital for primary care and learning disability will also be allocated at ICS/STP level, initially on a ring-fenced basis. Movement between provider capital and

primary care capital allocations within the system can be accommodated where it would maximise efficiency and is consistent with STP/ICS transformation plans and the objectives for which the funding is provided.

We expect that the majority of system-level expenditure will be self-financed by providers, through depreciation or other sources of locally held cash. Where a provider does not have sufficient cash to support emergency capital investments that have been prioritised within the ICS/STP affordable capital envelope, providers will be able to apply to NHS England and NHS Improvement and DHSC for finance to be provided as PDC, replacing the current system of emergency capital loans. In other circumstances, a DHSC loan facility may be available where it can be demonstrated that the investment has been prioritised within the affordable STP/ICS allocation and is affordable to the provider by way of loan principal and interest repayment.

The system level spending envelope for each ICS/STP will be notified shortly, with supporting information on the methodology used to allocate capital this year. The methodology will be kept under review each year to ensure available capital is best allocated against need and reflects where systems have cash as a result of successful delivery of their revenue position. We hope to be able to set these allocations over a multi-year period in future, subject to the outcome of the Spending Review.

Reporting and monitoring

While the COVID-19 response is underway, we do not expect organisations to resubmit plans, given the likelihood that this will have a material impact on capital plans, priorities and levels of expenditure.

However, every STP/ICS is expected to spend within their envelope, and we will monitor performance against the ICS/STP capital envelopes in 2020/21. Capital requirements agreed as part of COVID-19 costs will be funded on top of these envelopes. We will provide each STP/ICS with regular information to support local monitoring and decision making. It is important that providers and systems provide regular realistic and central forecasts for capital expenditure in year in order to support this, on a more robust basis than has been the case in the recent past. Where in-year reporting indicates a potential overspend then ICS/STPs will be expected to agree local actions to address potential overspends, supported by their regional teams.

Any local overspend will have wider system implications, reducing the budget available for other ICS/STPs to invest in their prioritised projects and impacting on DHSC's ability to release funding for emergency capital and national strategic projects. Spending in excess of the allocated envelope will be taken into account when calculating future years' capital

spending envelopes for relevant ICS/STPs as well as the way that the system overall is controlled and monitored. The future oversight framework will also take account of this.

For NHS trusts, there will be a revised process for issuing CRLs and making any subsequent adjustments to align these with ICS/STP plans and affordability.

Disposals and surplus land

Ensuring that each STP/ICS is clear, within its estates strategy, which estate is surplus to requirements both in the short term, and in a future disposal pipeline, is key to efficient use of estates and maximising land values in the medium to long term.

In previous financial years, profits on asset disposals contributed towards meeting or over-delivering revenue control totals, which has encouraged a focus on asset receipts covering short-term revenue costs. For 2019/20, profits on disposal did not count towards revenue control total – providers that are expected to deliver disposals during 2019/20 were set an additional target as part of their control total, but this does not contribute to their PSF/FRF achievement.

For 2020/21, capital proceeds will be available to the system to invest in line with the system estates strategy in the year of disposal and the two subsequent years in addition to the system-level allocations. The usual business case rules and process continue to apply and significant disposals that are expected to result in large capital proceeds will be managed on a case-by-case basis and require discussion with NHS England and NHS Improvement and DHSC as appropriate.

Other sources of finance

In line with government budgeting rules, capital receipts from external charitable sources will provide additional spending power on top of the issued ICS/STP capital envelope, in the year that the funding is received.

However, all expenditure financed through loan/finance lease funding from external sources (including commercial borrowing and private finance) counts as a capital resource charge and will therefore score against the STP/ICS capital envelope in the normal way.[1]

The implementation of IFRS16 for the NHS has been delayed until 1 April 2021.

[1] At HMT instruction, DHSC will no longer approve taxpayer funded, privately financed, off balance sheet Design Build Finance Operate and Maintenance (DBFOM) projects within the public sector. For that reason we strongly encourage organisations to contact NHSEI or DHSC before proceeding with any private finance funding arrangement, even where the terms are different to that of a PFI/PF2 deal, to discuss whether the arrangement is likely to be viable

Nationally allocated funding

Most national programmes are subject to specific HMT conditions and Ministerial delivery requirements. Where expected spend profiles change they need to be notified to NHS England and NHS Improvement and DHSC (as part of existing delivery monitoring where this is already in place) and any reassignment agreed across all parties.

Wider reforms to the existing capital system

Alongside this new approach to capital allocations, the government also committed in the Health Infrastructure Plan to a series of reforms to better support the effective delivery of projects – particularly the nationally strategic projects that have required multiple approvals and lengthy delivery timescales. These include:

- Schemes named in the Health Infrastructure Plan have a designated regional capital estates delivery lead, who will be in regular contact to see if and how we can assist you in your delivery. Where specialist advice is required, for example on procurement or disposals, please also continue to link with your dedicated Strategic Estate Lead who will be able to identify the appropriate support in the first instance.

- We have already established a new single Investment Committee with the Department to enable a single joint approval route for business cases. This is to support a revamped business case review process, both in terms of requirements (for example ensuring the level of consideration at SOC stage is appropriate and does not hold up the move to OBC) and transparency.

- Greater emphasis is placed on advice and support in developing business case, routing decisions directly to a single national approval point. We will also roll out the DHSC/NHS England and NHS Improvement Better Business Case training package across the NHS. All of which will provide a more balanced approach to national vs local oversight.

- Where you are delivering a nationally strategic project – whether a major project such as a hospital upgrade or a new hospital, or a smaller programme such as recent central capital investments in diagnostics and winter preparedness – NHS England and NHS Improvement and the Department will work with you to more closely understand your critical path through to building/construction and completion; identify decision-points and/or potential issues that need to be resolved, and support you in doing so. Your regional delivery lead should already be in touch with you where this applies.

Queries

Queries on this guidance can be sent to NHSI.CapitalCashQueries@nhs.net.