NHS England and NHS Improvement Board meetings held in common

Paper Title: **Capital Strategy Update**

Agenda item: 2 (Private session)

Report by: Julian Kelly, Chief Financial Officer

Paper type: For discussion

Summary/recommendation:
This paper contains an update on capital strategy, specifically relating to:

- Potential reforms to the capital regime and the long-term approach to allocating and managing capital
- Health Infrastructure Plan update
- Proposals to streamline the business case approvals process

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Proposals for reforms to the capital regime

1. As part of the NHS Long Term Plan, the NHS committed to reforming the capital regime to ensure capital funding is prioritised and allocated efficiently, supports the transformation of services and increased productivity, and allows for effective planning and control. These reforms are needed to remove the existing fragmentated funding sources, short-termism of decision making and uncertainty for local health economies, and should include:

    - A clear articulation of responsibilities of each tier of the system.
    - A strengthened role for systems in prioritising available resources for investments which maximise efficiencies within an affordable envelope,
    - Maintaining incentives for surplus asset disposals and delivery of revenue surpluses.
    - Underpinning the regime with strengthened national controls on foundation trust capital expenditure (as part of the NHS's legislative proposals).

2. To implement and operate this revised capital regime effectively it will be necessary that the NHS has confidence in a long-term capital settlement at a level that covers operational spend and gives scope for additional strategic investment.

A clear articulation of responsibilities and a strengthened role for systems in prioritising resources

3. **Operational or 'business as usual' capital** spend on maintenance, clinical equipment and routine IT should be self-funded by providers through tariff prices, this is a key incentive to maintain and improve organisational financial performance. The efficient allocation of resources under such a regime is

dependent on financial equilibrium being restored across the system, so that all providers could adequately fund depreciation and generate surpluses. In the interim, it would be necessary to continue to provide finance on a case-by-case basis for trusts unable to fund urgent maintenance work themselves.

4. **Strategic capital** (small and medium-sized new builds and investment in cost-reducing service transformation and schemes to enhance workforce productivity) would be allocated to ICSs/STPs on a multi-year basis, for prioritisation across organisations. This allocation would incorporate a number of existing funding streams, simplifying the process of accessing capital.

5. ICSs/STPs would need to submit multi-year plans for approval, the key allocative principles being how they deliver key LTP commitments and how they have prioritised those investments most critical to driving out revenue cost in line with agreed deficit reduction trajectories.

6. **Capital for major redevelopments and new builds** (e.g. >£100m) would continue to be held and allocated nationally due to the difficulties of managing the financial profile of such developments locally.

Maintaining incentives to generate revenue surpluses and dispose of assets

7. Positive incentives need to be generated by the capital and revenue regimes working together, therefore the generation of revenue surpluses should be linked to the ability to access capital funding.

8. To support this, some or all of the stock of revenue surpluses could be considered in calculating CDEL envelopes at an STP level. This preserves the incentive for cost-conscious financial discipline and effective prioritisation at a system level. This requires a settlement which allows the allocation of a reasonable level of budget cover to such surpluses over a period of time.

9. Asset disposals would similarly be incentivised by allowing permissible capital spend within a system to increase (i.e. setting system CDEL limits on a net basis).

Strengthened national controls

10. DHSC must live within its capital budget, set and voted upon annually by Parliament. To avoid this annual process impairing effective, long-term capital planning, we propose that a new regime will provide indicative multi-year planning envelopes over a rolling five-year period, which will be confirmed annually.

11. The NHS capital allocation will be split into three main themes:

    - NHS provider (system-driven) – capital typically self-financed and including operational investment;

- NHS provider (nationally-driven) – nationally strategic projects as well as major schemes. These projects largely require centrally-held sources of finance; and
- NHS other – covering other capital such as NHSX tech capital.

12. For NHS provider capital expenditure, we will provide clearer and more transparent links between local level spending plans and national level spending limits by using capital envelopes that are directly derived from the NHS' total CDEL allocation. We will also ensure that the capital allocations take into account accumulated cash reserves and anticipated revenue surpluses to ensure there continues to be a benefit for those systems that have delivered and maintained overall financial balance.

13. Setting these envelopes at the right level is crucial to the success of the new regime, so we will work closely with the NHS to develop this methodology. To be fully effective, the capital regime requires broad support from the sector, and therefore any system level capital 'envelopes' need to be set at a realistic level. The extent to which we are able to move to the new capital regime in 2020/21, including the use of system level affordable capital envelopes will therefore depend on the aggregate level of affordable NHS capital, and the balance of this quantum between the three themes discussed above.

14. In the longer term, we are considering options for individual organisations or systems who do not engage fully in prioritisation processes.

15. At present capital controls are in place for NHS trusts in the form of capital resource limits, but as a result of the statutory framework, there are no equivalent arrangements for foundation trusts, particularly solvent foundation trusts. This risks the regime being toothless and, in a situation where prioritisation is required, control is being enacted through (as now) limits on emergency capital loans and NHS trust CRLs, rather than on the basis of genuine priority.

16. As part of the NHS's current proposals for legislative change there is an opportunity for new legislative powers to set capital limits for foundation trusts.

17. Any such legislative change will take time to implement; in the short term we could (subject to consultation with the sector) use regulatory powers to set a delegated limit for foundation trust boards such that solvent foundation trusts would need approval from NHS England and Improvement for capital investment business cases.

18. We suggest careful consideration with DHSC and HMT as to when and how to undertake consultation on these regulatory powers. To be effective we believe they need to be used to address specific cases of poor behaviour rather than a generally applicable feature of the capital regime.

Health Infrastructure Plan (HIP)

Background

19. In September 2019, DHSC published the 'Health Infrastructure Plan'[1] which sets out a long-term, rolling five-year programme of investment in health infrastructure. In additional to new announcements on large hospital rebuilds, the HIP also covers capital to modernise diagnostics and technology, modernise estates and help eradicate critical safety issues.

20. The full shape of the investment programme will be confirmed when the DHSC receives a multiyear capital settlement at the next capital review.

21. The HIP commits to a new large hospital building programme, in rolling, five-year phases. Initially, there are two phases, the HIP1 and HIP2 projects are at various stages of development (summarised below).

Current position

22. Meetings with Trusts are currently taking place to take stock and report on project status and required support. DHSC are producing initial guidance to cover details of support available, and the DHSC's plans for approval process. The first two phases are:

    - HIP1 – comprising £2.7bn to fund 6 new large hospital builds, aiming to deliver by 2025. These are: Whipps Cross; Epsom, St Helier & Sutton; Leeds General Infirmary; Princess Alexandra Hospital; Leicester General, Leicester Royal & Glenfield; and Watford General.

    - HIP2 – a further 21 schemes aiming to deliver between 2025 and 2030. These schemes have the green light to go to the next stage of developing their plans (with the aim of being ready to deliver from 2025 or potentially earlier where feasible). The Government has committed £100m seed funding to help these schemes develop their business cases and is expecting to receive applications for drawdown on these funds by the end of December 2019. The overall level of funding available for these schemes is still to be confirmed.

23. Each project will require extensive business case development, service planning, and procurement work. There may also be a requirement for public consultation on service change for these schemes. The national and regional teams will be seeking to ascertain the overall affordability, strategic fit and general maturity of each of the hospital upgrade plans, agreeing deliverable programmes from final approvals to starting on site.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835657/health-infrastructure-plan.pdf

24. DHSC have drafted a HIP Guidance document to cover various aspects of governance of the programme and proposals to support projects through the approvals process, and initial details of the seed funding for HIP2 projects.

25. Site visits for HIP1 Trusts are currently underway and will be complete by early December and teleconferences with HIP2 schemes have taken place over the last 3 weeks. Ahead of the publication of the HIP guidance, these schemes are submitting a data return by 29th November to allow appropriate focus on facilitating delivery. Following this submission Trusts will submit applications for seed funding by the end of December 2019.

26. To ensure focus and delivery of these capital schemes, we have established a joint DHSC/NHSE/I Programme Board that will have oversight of the programme (including HIP 1 & 2, Waves 1-4 STP capital schemes and the 20 hospital upgrades announced in August 2019).

27. The HIP also confirms £200m investment in diagnostics equipment. This funding will be split equally across 2019/20 and 2020/21 and ensures trusts are able to replace Mammography, CT and MRI machines more than ten years old. The 78 trusts that will benefit from this funding was announced on 30 October[2].

Capital Delivery and Business Case Approvals Process

28. The HIP publication also signalled that central government would be putting in place a number of measures to assist in more rapidly progressing business cases through the approvals process whilst at the same time maintaining a balance between control and delivery.

29. The HIP proposes two sets of changes – one to offer more assistance for providers in developing their business cases, and the other to streamline the approvals process for submitted cases.

30. To improve the business case development process, DHSC propose to:
    a) Roll out the DHSC/NHSE/NHSI Better Business Case training package across the NHS;
    b) Grant a portion of a scheme's funding earlier in the business case process (i.e. prior to Full Business Case approval), where a convincing case can be made for the benefit of this; and
    c) Undertake a training needs analysis with Trusts and regional teams to develop local skills and knowledge to ensure business cases are developed to a sufficient standard, reducing the need for external consultant use.

31. To streamline the approvals process for business cases, DHSC propose to:
    a) Formalise the plan of using alternative bid documentation in place of a Strategic Outline Case (subject to completion of a current pilot) where

[2] https://www.gov.uk/government/news/78-nhs-trusts-to-receive-new-cancer-screening-machines

organisations have bid for central funding through a competitive process – saving up to 6-12 months. DHSC have confirmed that the first tranche of 6 HIP schemes will pilot a SOC approval process where the 'traditional' SOC is replaced by a significantly reduced business case gateway document alongside a reduced value for money assessment. We understand that DHSC will issue guidance to these schemes imminently to confirm these arrangements;

b) Formalise an approach where DHSC and NHSE/I triage cases that need extra support (due to high complexity/local sensitivity) or can be fast-tracked (due to smaller scale/lower complexity); and
c) Create a single investment committee process for consideration of major schemes (i.e. one joint committee between DHSC and NHSE/I), to reduce the number of central approval layers.

Next steps

32. We are currently discussing with DHSC the extent to which the reforms outlined above can be implemented from 2020/21 with a view to setting out details in the NHS 2020/21 operational planning guidance. We think they should be.

33. We are in the process of putting in place the improvements to the capital delivery and business case approval proposals set out above. The key issue for operational planning guidance for 2020/21 is the extent to which we seek to move management and control of total capital expenditure to a STP/ICS level, guided by nationally set system-level capital envelopes.