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Capital guidance 2022 to 2025

April 2022

Contents

NHS capital

Spending Review 2021 provided the NHS with a three-year capital settlement covering 2022/23 to 2024/25. This guidance forms the basis of the capital guidance to 2024/25, but will be updated annually to confirm envelopes where relevant and set out any changes or additional envelopes. Final envelopes will be set as far as possible in advance of the relevant financial year.

Overview of the NHS capital settlement for 2022/23 to 2024/25

The 2021 Spending Review confirmed:

- £4.2bn over the SR21 period to make progress on building 40 new hospitals and to upgrade more than 70 hospitals.
- £2.3bn over the SR21 period to transform diagnostic services with at least 100 community diagnostic centres (CDCs) across England to permanently increase diagnostic capacity.
- £2.1bn over the SR21 period for innovative use of digital technology so hospitals and other care organisations are as connected and efficient as possible.
- £1.5bn over the SR21 period to support elective recovery, through for example new surgical hubs, increased bed capacity and equipment.
- Around £450m over the SR21 period for mental health, to complete the programme to replace mental health dormitories with single en-suite rooms and invest in NHS mental health facilities.
- In line with the Delivering a ‘Net Zero’ National Health Service strategy, capital investment should contribute to the NHS’s over-arching goal to reduce carbon emissions, and improve local air quality, and staff and patient health. Further details can be found on page 14 of this document.

For 2022/23, the NHS capital allocation will be split into three categories:

1. **A system-level allocation (£4.1bn)** – to cover day-to-day operational investments which have typically been self-financed by organisations in integrated care systems (ICS) or financed by DHSC through normal course of

business loans or system capital support PDC (previously known as emergency capital PDC). From 2022/23 onwards this also includes £0.1bn of capital for investment in primary care estates and IT. In 2021/22 this was £3.9bn (excluding primary care).

2. **Nationally allocated funds (£1.1bn)** – to cover nationally strategic projects already announced and in development or construction, such as hospital upgrades ('STP schemes') and new hospitals. In 2021/22 this was £1.2bn.

3. **Other national capital investment (£2.7bn)** – including national programmes such as elective recovery, diagnostics and national technology funding and the mental health dormitory programme. In 2021/22 this was £1.7bn.

NHS operational capital

Operational capital methodology review

The NHS Long Term Plan committed to reforming the NHS capital regime. In 2020/21 we moved to a model of system-level operational capital envelopes to improve value for money and provide systems with greater power and responsibility for prioritising their local capital expenditure. The reforms to the capital regime have been broadly welcomed, with feedback that they have improved system working and encouraged greater system-level prioritisation of capital investment needs. However, a number of specific issues have been raised which we wanted to explore for future envelopes.

To inform future envelopes and provide external and independent scrutiny of our current approach, NHS England and NHS Improvement commissioned Richard Murray, Chief Executive of The King's Fund, to lead an independent review of the capital envelopes methodology and make recommendations. The final report can be found here:

https://www.england.nhs.uk/publication/review-of-the-current-capital-allocation-methodology-for-system-envelopes

Summary of recommendations and NHS England and NHS Improvement response

As far as possible we have reflected Richard Murray's recommendations in the operational capital envelopes for 2022/23 to 2024/25, while seeking to avoid potential

uncertainty created by making any major changes year-on-year. We will continue to consider some of the longer-term recommendations as part of future capital envelope rounds.

Summary of recommendation	NHS England and NHS Improvement response
Depreciation Keep the £ for £ funding of depreciation. PFI/IFRIC adjustments should be capped. The 2021/22 methodology was based on forecast outturn data. This should be reviewed and consideration given to using the latest audited data.	Depreciation continues to be funded £ for £. PFI/IFRIC adjustments have been capped at a level that ensures no trust receives negative depreciation. Depreciation will be based on 2020/21 final accounts.
Gross asset values (GAV) There is significant correlation between GAV and depreciation. NHS England and NHS Improvement should move towards reducing the weighting of GAV over time.	We have reduced the weighting of GAV in the formula, from 19% to 13%.
Backlog maintenance Operational capital envelopes are central to maintaining the current estate. Over time, the formula should increase the weight attributed to the backlog, alongside work to increase confidence in the backlog data.	We have increased the weighting that backlog maintenance has in the formula, from 9% to 13%.
Prior year surpluses Positive incentives are provided by the inclusion of prior year surpluses. However, distant, historical surpluses should not impact current envelopes.	Prior year surpluses will continue to form part of the formula but on a five-year rolling basis.
Cross-system providers (ambulance, mental health, community, specialised) The simplest approach is to continue with one-to-one system mapping but to provide clearer guidance to providers and systems on collaborative, co-ordinated working across revenue and capital.	We accept this and have strengthened guidance in this area.
Scope of capital envelopes Scope of capital envelopes should be broadened to give ICSs greater responsibility and flexibility for managing capital budgets and priorities. Or allocations of national programmes should be made alongside operational capital envelopes to give greater transparency and certainty.	Although major schemes will need to continue to be managed nationally, we recognise that greater transparency and certainty is important. For 2022/23 to 2024/25 we have included primary care BAU capital within system envelopes. We have also given greater guidance and indicative funding allocations for diagnostic, digital

Summary of recommendation	NHS England and NHS Improvement response
	and elective recovery capital alongside operational capital envelopes to help with capital planning.
Multi-year certainty and forward look NHS England and NHS Improvement should use the three-year capital settlement agreed in the 2021 Spending Review to give systems certainty over envelopes.	We have issued three-year operational capital envelopes and provided systems with greater transparency over their overall capital budgets (see section below for more details on our approach to multi-year envelopes).

Methodology for system envelopes

The table below summarises the basis on which envelopes will be allocated in 2022/23.

Distribution methodology	Summary of approach, data source and changes from 2021/22	2022/23 £bn	%
Depreciation	Continues to be funded on a £ for £ basis (adjusted for PFI), based on provider 2020/21 accounts. PFI/IFRIC deductions capped so that no trust receives negative depreciation.	2.2	56%
Gross asset values	Based on provider 2020/21 final accounts gross assets excluding PFI. Gross asset values represent a smaller proportion of the overall envelope compared to 2021/22.	0.5	13%
Backlog maintenance and CIR	Based on the 2020/21 ERIC data (adjusted to remove backlog element relating to RAAC given separate RAAC funding allocations). Backlog maintenance represents a higher proportion of the overall envelope compared to 2021/22	0.5	13%
Prior year surpluses	Based on financial performance 2016/17 to 2019/20. We are excluding 2020/21 due to disparities/volatilities created by COVID funding.	0.3	7%
RAAC	Allocated on a bespoke risk-assessed basis to those trusts/systems with the most urgent issues to resolve. This funding is allocated on a ringfenced basis.	0.2	5%
Primary care	Capital for primary care for BAU and GPIT capital will also be included in system envelopes in 2022/23. This funding will be allocated on a ringfenced basis and represent a minimum level of spend, i.e. with a system-level agreement an ICS can transfer more from provider to primary care, but not vice versa.	0.1	3%

Distribution methodology	Summary of approach, data source and changes from 2021/22	2022/23 £bn	%
Nationally approved prior commitments and priorities	Allocated to systems to reflect a small number of large, nationally approved prior commitments and national priorities.	0.1	4%

The table below sets out what expenditure is included and excluded from the system operational capital envelopes in 2022/23.

Included	Excluded
• Depreciation • Other internal cash • System capital support PDC – new and previously approved • Normal course of business loans • Other loans/commercial borrowing • Replacement diagnostic (e.g. CT and MRI machines) and radiotherapy equipment • Backlog maintenance and critical infrastructure risk • RAAC hospital fail safe and small block replacement • BAU digital/IT investments, including match funding • Finance leases (see below section on IFRS 16) • Primary care (BAU and GPIT) capital • Child and adolescent mental health (CAMHS) additional capacity provision	• STP waves 1 to 4b (nationally agreed elements) • NHP (nationally agreed elements) and other large schemes previously agreed to be nationally funded and outside envelopes • Nationally-funded technology projects • Other nationally-led programmes, for example: – diagnostic programmes (for example CDCs, imaging networks) – mental health dorms – elective recovery Targeted Investment Fund • Residual interest • Other primary care capital, including L&D

Operational capital framework

The operational capital regime for 2022/23 will broadly remain the same as it did in 2021/22. However, there will be some changes, specifically:

Multi-year capital envelopes

We want to give systems as much certainty over future capital envelopes to help improve planning, programme delivery and value for money. Alongside this

guidance we will confirm full ICS-level operational capital funding envelopes for 2022/23 and 'baseline' operational capital envelopes for 2023/24 and 2024/25.[1] These will be based on 2022/23 envelopes and include RAAC allocations for each year, but exclude the element related to prior year surpluses, which will continue to be calculated and allocated on an annual rolling basis. In aggregate this will give systems certainty over more than 90% of their operational capital envelopes, which should allow systems to proactively plan capital investments into the future.

Risk management and contingency

Systems working with the NHS England and NHS Improvement regional teams are responsible for managing their in-year operational capital CDEL expenditure within their affordable envelopes. This includes managing the risks of both under and overspends, and the level of contingency that may need to be held to respond to pressures that may arise in year. As part of this approach:

- We are not withholding a national contingency, though neither have we nationally over-programmed anticipating slippage.
- Systems may wish to over-programme or have reserve schemes in hand to ensure they maximise use of their capital envelope, while ensuring they do not overspend at year end. We will accept systems or regions over-programming by up to 5% at the planning stage, so long as this is based on a clear plan for which elements of plans could be scaled back or deferred if necessary.
- All risks that emerge in year will need to be managed from within system envelopes through natural or proactive slippage, or the holding of contingency at system level.
- As part of managing risk, systems and regions may want to discuss whether it is prudent to hold a contingency to deploy and manage risks in year.

As in previous years, overspends against 2022/23 envelopes will be deducted from the 2023/24 capital envelopes.

Trusts that operate across system borders

Capital envelopes for trusts that operate across system borders will continue to be made to a host ICS. However, we recognise that more needs to be done to ensure

[1] The Health and Care Bill will introduce statutory provisions for systems, subject to its passage through Parliament. These include a provision for an annual capital resource limit (set by NHS England) for each ICB and its 'partner' trusts (section s223M of the 2006 National Health Service Act, as inserted by clause 24). If the Bill is passed and implemented in 2022/23, system envelopes will be reflected in annual capital resource limits for each ICB and its partner trusts.

capital pressures are recognised across all relevant ICSs. In relation to how systems and cross-border trusts work together, we note that:

- The Health and Care Bill states that statutory NHS providers (NHS trusts and foundation trusts) will be formal partners of the integrated care boards (ICBs) for which they are eligible to nominate an ICB board member; to be eligible they must deliver services to the ICB and meet the criteria to be specified in regulations. Various financial duties would apply to each ICB and its partner trusts. In particular, each ICB and its partner trusts would be subject to capital resource limit on their combined capital resource use, and would have to seek to achieve any financial objectives set by NHS England and NHS Improvement in respect of capital. Each ICB and its partner trusts would be required to agree an annual system capital plan, in advance of the start of the financial year. In practice, this will require trusts to agree multiple system and capital plans and be involved in the governance and decision-making of multiple ICBs.
- NHS organisations will know in advance of 2022/23 planning how NHS providers will be mapped, and what resources have been made available to them, as set out in system funding envelopes. NHS providers would need to work with the ICB they are mapped to, and other NHS providers mapped to that ICB would need to agree how they will collectively deliver a balanced financial position, including managing any in-year issues or risks. These discussions should not be isolated from the relationships organisations will have with other systems.
- NHS trusts and foundation trusts that are formal partners of more than one ICB would be required to confirm that their operational and financial plans are compatible with and aligned to all relevant system plans. The ICBs would be expected to work together and with those providers to ensure full alignment.
- Systems should be mindful of the impact their decisions have on services delivered for other systems, of which the NHS provider may be a partner, and the resources available for other providers or services. Collective financial duties sit alongside other duties on NHS organisations that will need to be delivered.

Foundation trust capital resource limits

Parliament and HM Treasury set the Department of Health and Social Care (DHSC) CDEL each year and DHSC is legally obliged not to spend above this limit, this applies to all capital (operational and national).

Under existing foundation trust licence conditions there is no power to restrict overall capital expenditure. Foundation trusts have freedom to determine their levels of capital spend each year independently; their freedom to invest is constrained only by their ability to finance projects. This creates a risk that DHSC will overspend against CDEL, or that capital is poorly prioritised across the NHS as a whole, leading to poorer value for money and negative impacts on capital availability for NHS trusts. Prior to the introduction of the current capital regime, the risk of breaching CDEL due to unconstrained spending by foundation trusts was actively managed by DHSC constraining capital spend across the budget areas where there is greater control. This approach can have adverse consequences for the health system by:

- creating uncertainty about whether certain investments can proceed until late in the financial year, with implications for timely delivery of projects and maximising cost efficiency
- limiting the ability of DHSC to provide capital financing to organisations in financial distress to address urgent and emergency capital priorities
- an increased risk that overall capital is not prioritised effectively, leading to poorer value for money across the NHS as a whole.

This risk of solvent foundation trusts spending more capital annually than is budgeted for centrally has grown with recent increases in the availability of finance to them due to:

- increased cash reserves as a result of the recent revenue regime
- the willingness of private and other public sector organisations to lend to NHS foundation trusts at attractive interest rates.

The Health and Care Bill includes a new discretionary power allowing NHS England and NHS Improvement to make an order imposing a limit on the capital expenditure of an NHS foundation trust. We must publish statutory guidance about the circumstances in which we are likely to make an order and the method we would use to determine the limit. Subject to the passage of the Bill, we would expect the power and guidance to be in place at some point in 2022/23. In advance of that, the following paragraphs set out our policy intention for how the power would be used.

The power would be used as a last resort where a foundation trust is actively pursuing capital expenditure that is not affordable within ICS capital envelopes, thereby creating a risk of DHSC breaching its CDEL limit. It is expected that system, regional and national mechanisms should mitigate the risk, however this discretionary power is

intended to complement how the capital regime operates to support system working and will only be exercised where this risk has not been mitigated.

The following scenarios illustrate circumstances that would result in an NHS England and NHS Improvement review of a foundation trust's actions with a view to imposing a capital limit:

- a foundation trust submits a capital plan that is not aligned with and/or exceeds the level of capital notionally allocated to the organisation through the ICS process of prioritising capital envelopes
- data submitted through the monthly reporting process indicates the year-to-date expenditure or forecast outturn capital expenditure by a foundation trust is above the affordable plan
- capital spending on unplanned projects in-year is without prior notification and discussion with NHS England and NHS Improvement.

The power would be applied to individual, named foundation trusts and separately to each organisation if there were a requirement to impose limits on multiple organisations at the same time.

To identify whether there is a requirement to impose a capital limit on spending by foundation trusts, NHS England and NHS Improvement would consider the following sources of evidence (note this list is not exhaustive):

- capital plans submitted prior to the start of the financial year
- information from ICS leads and NHS England and NHS Improvement regional bodies about relevant actions and decisions to date by the organisation in question
- monthly reporting data about levels of capital spend by the organisation in question and other members of its ICS
- information received via any other route identifying potential actions by the named foundation trust that create a risk for an ICS in managing its capital envelope (or to DHSC in managing its CDEL).

As soon as NHS England and NHS Improvement identify a foundation trust whose actions create a risk to its ICS managing spend within its capital envelope and/or DHSC's management of CDEL, we would consult the trust board we are considering using our power over to impose a limit under section 42B of the National Health Service Act 2006. If after review, investigation and dialogue with the trust, we decide to

impose a capital limit on the foundation trust in question, we would then make and publish the order imposing the limit, and publish (on our website) a report which includes: the reasons for imposing the limit, the representations made by the trust and the amount of the limit on the trust's capital expenditure. Despite the above, it is advantageous to the system to resolve any disputes promptly so as to reduce uncertainly for other providers and ensure that ICS priorities can be delivered. Ultimately, an overspend by a foundation trust means that other providers would need to cut their capital expenditure (and/or risk a reduction to their envelopes in future years) to stay within envelopes.

The limit would remain in place for the period specified in the order made by NHS England and NHS Improvement, which we would normally expect to be a single financial year. We anticipate that a limit would only be revised in year if additional national programme capital were awarded.

Primary care capital

From 2022/23, £0.1bn of primary care BAU estates and GPIT capital will be included within ICS capital envelopes. This will allow systems to take a more cohesive approach to capital across all organisations within a system. For the period 2022/23 to 2024/25, systems will be able as part of their system planning process to increase capital investment in primary care (so long as system plans are in aggregate affordable within the system envelope), but systems will not be able to reduce investment in primary care below that included in their allocation.

Critical infrastructure risk (CIR) and RAAC

For 2022/23 and beyond CIR capital forms part of the overall operational capital envelopes and will not be separately identified within system envelopes. No additional national/central funding will be available for CIR or backlog maintenance during 2022/23. We expect systems to prioritise investment in CIR to address the most significant backlogs, particularly where CIR has been highlighted (including by the Care Quality Commission) as presenting a quality or safety risk, or materially impacting on patient care. Subject to ongoing assessment of local prioritisation of operational capital allocations, and the condition of the estate, we expect that sufficient investment is made such that levels of critical infrastructure risk are falling across the estate by the end of 2024/25. As set out in more detail below, from 2022/23 we will ask trusts to report on planned, forecast and actual expenditure on CIR, with the aim of improving the data received in respect of how capital expenditure is being targeted to address critical infrastructure risk.

Separate funding for RAAC hospitals was provided at the Spending Review and will be ringfenced within operational capital envelopes (where relevant) for investment in the necessary failsafe work.

Radiotherapy equipment

It is expected that the majority of radiotherapy equipment, particularly linear accelerators, will need to be replaced at 10 years of age, in order to continue to make progress on LTP priorities, including enabling local access to cutting-edge radiotherapy treatments like SABR. The responsibility to plan for radiotherapy equipment replacement resides with ICSs, using their system operational capital allocations. ICSs will therefore need to develop replacement plans as part of their multi-year capital plans, in partnership with specialised commissioners, Cancer Alliances and Radiotherapy Operational Delivery Networks, based on an assessment of equipment age, capacity and demand, opportunities to improve access and service risk.

Mental health trusts

System envelopes include allocations for mental health trusts, including activity covered by provider collaboratives. Systems must prioritise urgent patient safety projects for mental health trusts such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients, and plans for investment in CAMHS T4 services (see 2022/23 priorities and operational planning guidance for more detail). For advice on which trusts are likely to need to address these issues, please contact the national and regional mental health teams.

System capital support PDC

In previous years we have provided a separate system envelope for emergency financing. In 2022/23, we are providing a single CDEL envelope figure for systems.

Systems are still able to apply for cash to support capital investment that is prioritised and affordable within these envelopes and initial estimates of system capital support requirements should be provided in plans. For 2022/23, all financing applications will need to be submitted to NHS England and NHS Improvement by 30 November 2022 to ensure that they are processed and capital expenditure is made before 31 March 2023. We would like to receive financing applications as early in the new year as possible; the timings of approvals will depend on the speed of query resolutions.

Funding will only be available where trusts have insufficient cash to self-finance investments. We do not anticipate large numbers of applications as we expect providers to be able to proceed with capital schemes using their internal cash reserves wherever possible. Where cash balances are low, and other working capital metrics support a request to DHSC for system capital support PDC, we will assess these on a case-by-case basis before seeking DHSC approval.

Net Zero

In October 2020, NHS England and NHS Improvement published the Delivering a 'Net Zero' National Health Service strategy setting out a comprehensive plan to respond to climate change and improve the health of the nation, by becoming the world's first 'net zero carbon' national healthcare system. Two clear targets have been set:

- for the emissions we control directly (the NHS Carbon Footprint) – net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus) – net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Systems should ensure that all capital expenditure takes account of the impact on the organisations' carbon emissions, and where appropriate local air pollution, and staff and patient health.

When undertaking capital procurement in relation to maintenance, repair or construction of NHS estate, purchasers should refer to Delivering a 'Net Zero' National Health Service and the Estates Net Zero Carbon Delivery Plan. Where possible, the impact on carbon emissions should also be calculated and reported to the organisation's governing body. It is important that all organisations have plans in place for heat decarbonisation and to ensure that heating systems, insulation and ventilation are upgraded to reduce carbon emissions where possible as part of backlog maintenance, and that LED lights are used in place of less efficient systems.

Providers should note that the Public Sector Decarbonisation Scheme, which provides public sector bodies with grant funding to support estates decarbonisation, will also open for applications during 2022/23, for funding available during 2023/24 and 2024/25.

During 2022/23, NHS England and NHS Improvement will introduce a limited number of additional data collection requirements to better understand system capital spend aimed at reducing carbon emissions and reaching net zero. Initially, the collection will focus on energy efficiency, ultra-low and zero emission vehicles and infrastructure for

associated vehicles, cycling and active travel infrastructure. Further guidance will be provided in 2022/23. In future years we will work with systems to develop category areas covering all aspects of net zero capital spend.

UEC ambulances

An additional £20m of funding a year will be available over 2022/23 to 2024/25 to support ambulance trusts to replace and expand the emergency ambulance fleet. Each trust will receive a share of funding as part of a national roll out of zero emission ambulances and supporting infrastructure. The remainder of the funding will be used for the purchase of double-crewed ambulances (DCAs) in line with the national specification. This will be provided on a matched funding basis and linked to the age profile of the existing fleet and the performance of each trust. Systems will need to prioritise investment in DCAs in their capital plans to benefit from this funding. Further detail will be shared in due course.

NHS national capital

Assurance and approval of national programme capital

A number of significant national programmes for capital investment are to be delivered over the period 2022/23 to 2024/25, including the Targeted Investment Fund (TIF), diagnostics, mental health and RAAC. There will be a standard approach to the assurance and approval of capital investment under these programmes. National programme teams will discuss the scope of the investments with providers to ensure that the process is proportionate to the requirements of the programmes. Individual organisations that receive central technology funding will be required to follow the appropriate digital business case approvals process. ICBs and trusts should speak to their regional teams before developing a business case for digital investment to ensure the correct processes are followed.

In general terms, the expectation will be that:

- Schemes funded by national programmes will not normally require strategic outline cases (SOCs); the strategic case for change will be approved through a programme business case (PBC) for the whole programme.
- For schemes below £5m, a programme of works and financial information will be required to be provided to national programme teams. These investments will be assured and approved by national programme teams, with oversight

from NHS England and NHS Improvement and DHSC national capital assurance teams.

- For schemes between £5m and £15m a single short form business case will be required to be provided. A standard national template for this will be issued by NHS England and NHS Improvement. Approval will be required from NHS England and NHS Improvement and DHSC.
- For schemes between £15m and £50m both an outline business case (OBC) and a full business case (FBC) in line with HM Treasury Green Book requirements will be required to be provided. Approval will be required from NHS England and NHS Improvement and DHSC.
- For schemes that are £50m and above both an OBC and a FBC in line with HM Treasury Green Book requirements will be required to be provided. Approval will be required from NHS England and NHS Improvement, DHSC and HM Treasury.

The reporting and monitoring requirements of national programmes will be set out by programme leads. Funding will be issued through the usual DHSC MOU process.

In respect of the elective recovery TIF, given the desire to invest at pace and accelerate delivery, we are willing to discuss the above business case process on a case-by-case basis, especially for any priority capital investments that have significant spend in 2022/23. Please contact nhsi.capitalcashqueries@nhs.net to discuss any such cases.

Revenue support for capital investments

We recognise that pressures created by deprecation, PDC dividend charges or other short-term revenue costs can sometimes inhibit necessary capital investment. This is especially the case where associated efficiency or productivity gains accrue over a longer time period. National capital programmes will therefore be allocated a specific non-recurrent revenue support fund to assist with some of the short-term revenue costs of capital. This will be allocated on a case-by-case basis.

Capital to support elective recovery

The ongoing uncertainties and challenges of COVID-19 and demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic.

2022/23 represents the first year on the path to recovery, and plans need to set out the activity, financial plans and transformation goals for elective delivery, including how the ICS will address identified health inequalities. These plans should reflect four key delivery themes:

- expand capacity to reduce waiting times and reduce the extent to which care is disrupted by other pressure in the system
- prioritise treatment based on clinical urgency, making use of alternative providers if people have been waiting a long time for treatment
- transform the physical estate and plan the approach to separating elective care delivery and moving the location of services to drive productivity
- enable greater transparency on waiting times and develop tailored offers of support and advice for patients while they wait.

Where possible, plans should reflect the additional revenue and capital funding available for elective recovery over the period. The Spending Review 2021 included £5.9bn additional capital funding (over the three years to 2024/25) to support the NHS in delivering on these themes, including £1.5bn extra to continue the TIF to help elective services recover; £2.3bn to transform diagnostic services including at least 100 community diagnostic centres (CDCs); and £2.1bn for digital technology.

Alongside planning guidance we will issue indicative multi-year allocations of the additional capital available to support increased diagnostic capacity through CDCs, and additional elective activity through the TIF. While the final approach and allocations will be subject to Government approval of the programme business case, this will provide a set of guiderails to support the development of business cases and ensure we can give systems clarity over the capital resources available to them to support activity as early as possible. Where systems feel that a different balance between these two distinct funding streams would help maximise activity over the next three years, we are willing to consider net-neutral proposals for flexibility between these pots. Any such proposed changes to the value or profile of each funding stream must demonstrate how they will deliver increased activity overall, will be subject to Government approval and must be raised with regional and national NHS England and NHS Improvement teams as soon as possible.

The TIF is a capital fund to support the delivery of additional elective activity: £700m is available in 2022/23, £500m in 2023/24 and £300m in 2024/25. The fund is intended to provide any additional capacity necessary to support systems in delivering on the activity assumptions set out in the Elective recovery planning supporting guidance.

This guidance also sets out the submission requirements in relation to activity plans, assurance and monitoring arrangements and what support is available.

We have issued our regional teams with indicative regional three-year allocations for this funding based on weighted populations. Regional teams have been asked to urgently work with systems to agree system-level allocations for this funding. We expect regions to prioritise investments and allocations of funding where they can have the maximum aggregate impact on elective activity.

We are asking systems, working with regional teams, to propose a shortlist of investments (deliverable within their TIF allocation) that can have a material impact on activity in their region. Systems must set out for each proposed investment the profile of spend across three years and the expected impact on activity and capacity.

To enable a step-change in activity or transformation of service delivery we expect this funding to be targeted rather than evenly spread, and for all proposals to be over £5m. It is our expectation that potential investments below this level should be funded from operational capital.

Investments will only be considered where they support a sufficiently ambitious, credible plan for elective delivery, as set out in the Elective recovery planning guidance. Systems must demonstrate how their capital proposals will achieve a material quantified increase in elective activity and ringfenced elective capacity. Proposals could include:

- the creation of ringfenced elective surgical hubs, either as standalone units or as separate green hubs within existing hospital sites
- additional day surgery units/day theatres to maximise activity and minimise length of stay
- additional permanent and modular theatres or other significant upgrade works to rapidly increase surgical throughput and improve productivity
- additional critical care capacity to facilitate greater elective throughput and increase resilience
- investment in outpatient space to deliver more productive outpatient clinics
- significant reconfiguration or refurbishment of existing clinical spaces that currently negatively impact on clinical productivity
- estates optimisation to improve clinical workflow and logistics (adjacencies) and the mix of clinical and administrative space to improve productivity

- other major proposals that deliver significant productivity savings which can be re-invested in additional activity or be used to enable separation of elective and emergency activity (‘green’/‘cold’ site facilities).

All proposals will be subject to business case approvals, in line with the approach we are taking across all national schemes, and should make use of national frameworks/procurement models, where applicable, to speed up delivery. Business cases can begin to be submitted for approval as soon as regional and system allocations are agreed.

Diagnostics

Following publication of the Richards’ Review in October 2020, a national programme of diagnostic service transformation has been established. Delivery of this programme over the next three years is supported by the £2.3bn provided in the 2021 Spending Review.

In 2022/23, ICSs should:

- Increase diagnostic capacity to support elective recovery to a minimum of 120% of pre-COVID activity levels, designed around local needs.
- Develop three-year investment plans for establishing CDCs and ensure timely implementation of new CDC locations in 2022/23. Indicative three-year capital funding allocations for diagnostics will be set out alongside system envelopes for this purpose. All plans will need to demonstrate how they meet the CDC design criteria including clear evidence that they will be fully deliverable from a staffing point of view and can contribute to system level transformation and efficiencies. Systems will be able to access dedicated 2022/23 revenue funding to contribute to the set up and running of CDCs. Revenue will be allocated to align with the programmes of work or agreed capital business cases. Revenue support will also be available in 2023/24 and 2024/25.

  Large new build projects to establish CDCs will only be considered on an exceptional basis and will require scrutiny at national level with OBC and FBC required. These will only be supported if it can be demonstrated that new build is the only viable approach to increasing diagnostic capacity and addressing health inequalities.
- Ensure that pathology and imaging networks complete the delivery of their diagnostic digital roadmaps. Existing plans should be refreshed to take account of progress made in 2021/22 and recent advances in digital approaches prior to final funding allocations being confirmed. Implementation

of the Pathology Unified Test List in all newly purchased pathology systems is a mandatory requirement as is the implementation of the National Genomic Test Directory in NHS genomic laboratory hubs. Through implementation of digital diagnostic investments systems are expected to deliver, as a minimum, the 10% improvement in productivity by 2024/25, as has already been delivered by exemplar early adopters.

- Develop plans to achieve Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in all endoscopy units. A capital reserve will be held at national level to support applications to refurbish or rebuild and equip endoscopy units that are unable to meet the required standard within their existing facilities.
- Utilise the three-year capital allocations for endoscopy to increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations.
- Cancer Alliances will receive capital funding to expand the Targeted Lung Health Check (TLHC) programme, continuing progress towards full national rollout. Capital funding will be allocated to Cancer Alliances in 2022/23 on the basis of their remaining unscreened population and the CT capacity already funded within the Cancer Alliance to deliver the programme. Cancer Alliances should put in place plans (in co-ordination with CDC planning) over the course of Q4 2021/22 and early 2022/23 to make the required investment for the expansion of the TLHC programme to 40% of the total eligible population in 2023/24 (including that population already covered by any existing projects).
- ICSs will receive capital funding to deliver the 36-month cycle for breast screening and the programme quality standards. Capital funding for 2022/23 will be allocated to ICSs on the basis of the previously notified requirement to procure new screening units and the impact on restoration of the 36-month cycle. NHS England Public Health Commissioning and Operations team, in conjunction with regional directors of commissioning, will set out funding allocations ahead of 2022/23.
- Utilise three-year capital allocations for additional digitally connected imaging capacity to support demand growth and ensure that all acute sites have a minimum of two CT scanners. Imaging networks should collaborate with their ICSs to deliver the capabilities for imaging research and development, and the integration of artificial intelligence, with a cloud first approach. Funding

allocations will be confirmed following submission of imaging network capital investment plans.

- Ensure all pathology networks reach as a minimum a ‘maturing’ status for delivery of pathology services on the pathology network maturity framework by 2024/25.
- Utilise their operational capital envelopes to replace aged diagnostic equipment, specifically MRI and CT scanners and other diagnostic equipment near the end of its economic life. Systems should set out what is possible to eliminate the backlog of diagnostic equipment currently over 10 years old by the end of the financial year 2024/25. We will also develop our reporting to be able to track the age and state of the relevant asset base. In addition to replacing aged equipment, all imaging networks should have forward capital investment plans that identify capital funding for rolling replacement, and any upgrade or optimisation of the existing asset base necessary to meet forecast capacity growth.

Additional capital funding for targeted lung health check, screening mammography, diagnostic digital, further investment in endoscopy and other additional imaging equipment will be communicated as soon as possible, via NHS England and NHS Improvement regional diagnostic leads.

Mental health

Capital funding outside system envelopes will be prioritised to support critical pressures in the UEC pathway for mental health. This will allow us to meet our stated NHS Long Term Plan commitments around crisis care provision and ambulance response, as well as to support very significant pressures in the UEC pathway which, given the impact of the pandemic on mental health prevalence and acuity, are likely to continue for some time.

Examples of investment include:

- safe spaces and sanctuaries (including health-based places of safety for people detained under s136 of the Mental Health Act) for the police/ambulances to convey people to instead of emergency departments (EDs); or to be diverted to by mental health services
- dignified spaces in or near EDs; this may include adapting existing spaces or bays to be calmer and safer in line with Royal College of Psychiatrists standards for mental health assessment spaces

- crisis beds or intermediate step up/down services to support flow through inpatient mental health wards, and more timely transfer to mental health from ED
- specific types of mental health inpatient bed gaps in certain areas, e.g. psychiatric intensive care units that do not currently exist in some places and cause delays in transfer from ED while an out-of-area bed is found.

Capital planning and reporting

The planning assumptions set out in this document are based on the current drafting of the Health and Care Bill, and so remain subject to the passage of the proposed legislation. As such, this document includes the following references which should be interpreted as:

- **Integrated care boards (ICBs)** – where this document refers to actions for ICBs that are required to be completed before the passage of the Bill, these actions should be completed by clinical commissioning groups (CCGs) working with designate ICB leaders.
- **Systems** – for the purposes of this guidance, 'systems' are defined to be the ICB and partner NHS trusts and foundation trusts.

Once the passage of the Bill is completed, the ICB position reported within the System Financial Plan Template should be reflected in the budget and profile loaded to the ledger for ICB monthly reporting.

Planning

As part of the 2022/23 planning process, draft and final system and provider capital plans will be collected, with the following planning templates to be completed:

- provider – financial planning return (FPR)
- system – integrated planning return (IPR).

System capital planning returns will be collected for the first time in 2022/23.

System and provider planning returns require three-year capital plans to be submitted and demonstrate compliance with the ICS capital envelopes for the next three years. Please note while envelopes have been issued for three years, the provider financial

planning return requires detailed capital plans to be completed for a further two years – a total of five years. For the purposes of the planning submission providers and systems should assume future operational capital allocations will be broadly in line with the three-year allocations issued, and complete years 2025/26 and 2026/27 on that basis. However future allocations remain subject to the outcome of future spending reviews and future allocation policies.

The system integrated planning return template will be pre-populated with the ICS capital envelope value for 2022/23, as well as the multi-year capital envelopes for 2023/24 and 2024/25. Systems will be required to complete this template and provide the total charge against the envelope for each component organisation, i.e. all providers and the ICB.

The provider organisation financial plan collection enables providers to submit a more detailed and profiled capital plan that reflects the final plan position within their system plan.

Systems will be expected to submit a fully compliant plan at final submission. However, as outlined above, for all years including 2023/24 and 2024/25, we will accept systems or regions over-programming by up to 5% of envelope value at plan stage, so long as this is based on a clear plan for which elements of plans could be scaled back or deferred if necessary.

Systems are required to ensure the total charge against envelope reported in each provider and ICB planning return is consistent with the total charge reported in the system integrated planning return. A series of alignment checks will be undertaken with a resubmission process for any misalignment of key data.

Where provider plans are not consistent with their system position, the relevant provider and system returns will both be rejected and both will be asked to immediately resubmit aligned plans.

The requirements for systems and their component organisations for 2022/23 planning have changed and this guidance should be read alongside the relevant technical guidance:

- for the provider financial planning return (FPR) templates, please refer to the document Technical guidance for provider financial planning 2022/23
- for the system financial plan template, please refer to the document System finance plan guidance 2022/23.

For guidance on the submission process and timetables, systems should refer to the 2022/23 submission guidance which will be published in January 2022.

IFRS 16 leases

IFRS 16 will be implemented in the NHS from 1 April 2022.

Given the scale of the exercise, and the need to liaise with the DHSC and HM Treasury, not all details for 2022/23 are finalised at present. No CDEL cover has currently been allocated within system capital envelopes in respect of IFRS 16.

Given the above, the 2022/23 provider planning returns have been designed in such a way as to collect the required level of information in respect of IFRS 16 and calculate a provider charge against capital envelopes both before and after IFRS 16. Therefore, providers are asked to complete their returns on an IFRS 16 compliant basis.

System capital plans, and provider capital plans in aggregate, will be assessed for compliance against their system capital envelopes using the charge against capital envelopes **before IFRS 16** at this stage.

Following the conclusion of discussions with HM Treasury, any changes to system envelopes in respect of IFRS 16 will be communicated to providers and systems so these can be reflected in the planning submissions.

Providers are asked to refer to the NHS England and NHS Improvement IFRS 16 leases implementation webpage for additional technical advice and guidance.

In-year reporting and monitoring

In 2021/22, to improve transparency on the deployment of capital within the NHS and impact at a local level, enhanced reporting was introduced and ICSs were required to explain variances against plan for key categories of spend. Delivery reporting (quarterly) was introduced for key categories including RAAC and diagnostics. This reporting will continue in 2022/23 and enable the local NHS and central government to assess unmet need for capital and target future resources. As outlined above, additional collection requirements will be introduced in 2022/23 to better understand system capital spend that is aimed at reducing carbon emissions and reaching net zero.

Overall, these additional reporting requirements seek to improve the links between spend and delivery, as well as to maximise the use of the overall NHS capital envelope.

Every ICS/ICB[2] is expected to spend within its envelope, and NHS England and NHS Improvement will monitor performance against the ICS capital envelopes in 2022/23 on a monthly basis. We will provide each ICS/ICB with regular information to support local monitoring and decision-making. It is important that providers/systems provide robust and realistic central forecasts for capital expenditure in year. Where in-year reporting indicates a potential overspend, then ICSs will be expected to agree local actions to address potential overspends, supported by their regional teams.

Given the early issuance of capital envelopes, we expect a flatter spend profile with less end-loaded spend. In addition, the multi-year envelopes should allow for greater planning and flexibility at system level.

Operational capital envelopes are ringfenced; therefore providers/systems cannot use any underspends on national programmes to balance operational capital envelopes.

Local overspends have in-year system implications, reducing the budget available for other organisations within ICSs to invest in their prioritised projects and impacting on DHSC's ability to release funding for system capital support PDC (previously known as emergency capital PDC) and national strategic projects.

Categorisation of spend

In 2021/22, to provide more granular data on capital spending and support national capital planning, providers were asked to report capital spend against a more detailed set of categories than in previous years. These are set out in the table below and will be incorporated in 2022/23 planning and reporting templates.

For 2022/23, with the aim of improving the data received in respect of capital expenditure to address critical infrastructure risk, we will be including two new categories in the planning and reporting templates:

- Backlog maintenance – Significant and high risk (CIR)
- Backlog maintenance – Moderate and low risk.

To accommodate the above, but not increase the number of capital spend categories, we have removed the 'Backlog maintenance – Land, buildings and dwellings'

[2] Subject to the passage of the Health and Care Bill.

category, and amalgamated ‘Other – Investment property’ with ‘Other’ and renamed it ‘Other – including Investment property’.

2021/22 capital spend categories		2022/23 capital spend categories	
1	New build – Land and dwellings	1	New build – Land and dwellings
2	New build – Theatres and critical care	2	New build – Theatres and critical care
3	New build – Wards	3	New build – Wards
4	New build – Diagnostics	4	New build – Diagnostics
5	New build – A&E/AAU	5	New build – A&E/AAU
6	New build – Non-clinical	6	New build – Non-clinical
7	New build – Car parking	7	New build – Car parking
8	New build – Multiple areas/other	8	New build – Multiple areas/other
9	Routine maintenance (non-backlog) – Land, buildings and dwellings	9	Routine maintenance (non-backlog) – Land, buildings and dwellings
10	Backlog maintenance – Land, buildings and dwellings	10	Backlog maintenance – Significant and high risk (CIR)
11	IT – Clinical systems	11	Backlog maintenance – Moderate and low risk
12	IT – Other software	12	IT – Clinical systems
13	IT – Hardware	13	IT – Other software
14	IT – Telephony	14	IT – Hardware
15	IT – Cybersecurity, infrastructure/ networking	15	IT – Telephony
16	IT – Other	16	IT – Cybersecurity, infrastructure/ networking
17	Fire safety	17	IT – Other
18	Plant and machinery	18	Fire safety
19	Equipment – Non-clinical	19	Plant and machinery
20	Equipment – Clinical theatres and critical care	20	Equipment – Non-clinical
21	Equipment – Clinical diagnostics	21	Equipment – Clinical theatres and critical care
22	Equipment – Clinical other	22	Equipment – Clinical diagnostics
23	Fleet, vehicles and transport	23	Equipment – Clinical other
24	Fixtures and fittings	24	Fleet, vehicles and transport
25	Other – Intangible assets	25	Fixtures and fittings
26	Other – Investment property	26	Other – Intangible assets
27	Other	27	Other – including Investment property

Providers are asked to ensure that financial systems are set up to report at this level of detail within 2022/23 plans and, going forward, through the in-year monthly monitoring process. Information will be reported back to systems using this categorisation.

Disposals, surplus land and ICS infrastructure strategy

Each ICS must make it clear within its estates strategy and in future in its ICS infrastructure strategy, which estate is surplus to requirements both in the short term and in a future disposal pipeline. This is key to efficient use of estates and maximising land values in the medium to long term.

Capital proceeds will be available to the system to invest in line with the system estates strategy in the year of disposal and, in subsequent years, subject to overall prioritisation and affordability within system-level envelopes. The usual business case rules and process continue to apply. 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.

The net book value of disposed assets is recorded as a 'credit' to CDEL and therefore increases CDEL spending power in the year that it occurs – that is, additional in-year capital expenditure can be made to offset this credit and this will not increase CDEL expenditure or consequently increase the charge against ICS capital envelopes. However, where a net profit on disposal, over and above net book value (NBV), is re-invested in capital expenditure, this expenditure is charged to CDEL and does increase the capital expenditure charged against the ICS capital envelope; it will need to be prioritised and managed to ensure this is affordable within the system envelope.

Other sources of finance

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

However, all expenditure financed through loans from external sources (including commercial borrowing and private finance) counts as a capital resource charge and will therefore score against the ICS capital envelope in the normal way.[3]

[3] At HM Treasury 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 NHS England and NHS Improvement or DHSC before proceeding with any private finance funding arrangement, even where the terms are different from those of a PFI/PF2 deal, to discuss whether the arrangement is likely to be viable.

As outlined above, IFRS 16 will be implemented in the NHS from 1 April 2022. Further information on the implementation of IFRS16 and the impact on CDEL and system capital envelopes will be provided as soon as possible.

Nationally allocated funding

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

Queries

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

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