Review of the current capital allocation methodology for system envelopes

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About the authors

Richard Murray is the Chief Executive of The King's Fund. Richard was appointed as Chief Executive in January 2019, after five years as the Director of Policy. Before joining the Fund in January 2014, Richard was chief analyst at NHS England and previously held a number of roles at the Department of Health, including director of strategy, director of financial planning and chief economist.

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1 Purpose of the Review

The NHS Long Term Plan (LTP) committed to reforming the NHS capital regime. In 2020/21, the NHS moved to a model of system-level operational capital envelopes with the aim of improving value for money, speeding up emergency finance approvals and providing systems with greater power and responsibility for prioritising their local capital expenditure. The same methodology was broadly used for allocating operational capital across 2020/21 and 2021/22.

These reforms have generally been welcomed; with feedback that it improved system working and encouraged greater system-level prioritisation of capital investment needs. Nevertheless, a number of issues have been raised about the allocation methodology and given this approach has become a more permanent feature of the NHS financial framework, there is a desire to ensure the methodology is independently reviewed to ensure it is fair and robust for future years.

2 Duties and Responsibilities

The Terms of Reference for the review are included in *Appendix A*. In summary, we were asked to consider and report on the following questions in relation to the capital allocation methodology adopted in 2021/22.

- What are the strengths/weaknesses of the current methodology?
- What improvements can be made from the current methodology, and what changes to the methodology/ies should NHS England and NHS Improvement (NHSE&I) adopt for 2022/23?
- What lessons can be learned from the well-established revenue need-based allocation process?

3 Overview of NHS capital departmental expenditure limit

The NHS capital regime sits within a wider context of the Department of Health and Social Care's capital programme. The fundamental framework of the current NHS capital regime was set out in the Department of Health and Social Care's Health Infrastructure Plan (September 2019, p 15).

> *To reflect local and national requirements, budget allocations will be split into NHS and Non-NHS sectors, confirmed in advance of each financial year. The NHS allocations will be split into three main themes:*
>
> *a. NHS provider (system-driven) – capital typically self-financed and including operational investment;*
>
> *b. NHS provider (nationally-driven) – nationally strategic projects as well as major schemes. These projects largely require centrally-held sources of finance; and*
>
> *c. NHS other – covering other capital such as NHSX tech capital.*
>
> *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. 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.*

For 2021/22, the NHS capital allocation broadly followed this outline.

1. A system-level allocation (£3.9 billion) – to cover day-to-day operational investments. In recent years these have typically been self-financed by organisations themselves or financed by the Department of Health and Social Care (DHSC) through emergency loans. This allocation includes funding for Critical Infrastructure Risk (CIR), high- and severe-risk RAAC (reinforced autoclaved aerated concrete, a building material posing specific and high-risk maintenance issues) hospitals, some diagnostic equipment and Covid-19 responses. This category corresponds to the NHS provider (system-driven) element in the Health Infrastructure Plan.

2. Nationally allocated funds (£1.2 billion) – to cover nationally led strategic projects already announced and in development and/or construction such as hospital upgrades (Sustainability and Transformation Partnerships (STP) capital-funded schemes) and new hospitals. This category corresponds to the NHS provider (nationally driven) element in the Health Infrastructure Plan.

3. Other national capital investment (£1.1 billion) – including national programmes such as community diagnostic hubs (CDHs), national technology funding and the continuation of the Mental Health Dormitory Replacement Programme that commenced in 2020/21. This broadly matches the NHS (Other) category from the Health Infrastructure Plan.

4 Recap of the operational capital formula (2021/22)

In both 2020/21 and 2021/22, NHSE&I broadly followed the same approach to allocating the approx. £3.9 billion of operational capital to systems. The table below summarises the data sources used in the modelling.

Data sources	Aggregate values (£bn)	% of total
Depreciation less PFI/IFRIC financing costs The full value of trust depreciation (based on Provider Reported 2020/21 Month 7 Forecast Outturn, excluding PFI finance costs) is included within system envelopes.	**2.2**	**56**
Gross asset values Allocated based on Provider 19/20 Final accounts gross assets excluding PFI	**0.8**	**19**
Backlog maintenance Allocated based on total reported backlog figures taken from 2018/19 NHS Estates Returns Information Collection (ERIC)	**0.4**	**9**
Prior-year surplus Allocated based on previous 6 years of reported financial performance 2014/15–2019/20	**0.3**	**8**
Nationally approved prior commitments Allocated to systems to reflect a small number of large nationally approved prior commitments	**0.2**	**5**
RAAC (reinforced autoclaved aerated concrete) Allocated to support fail-safe works in Trusts most affected by RAAC issues	**0.1**	**3**
Total	**3.9**	**100**

5 Engagement with stakeholders

Over the course of summer and autumn 2021, the authors and NHSE&I engaged with key stakeholders from across England to gather feedback on the overall operational capital methodology. Engagement included separate meetings with organisations as well as 'regional roadshows' where stakeholders from systems were invited to discuss the operational capital methodology.

During these events we presented an overview of the current methodology and provided opportunities to ask questions and give specific feedback and suggestions as to how this methodology could be improved in future years.

The list below summarises the organisations/groups we engaged with as part of this review:

- NHS Providers
- NHS Confederation
- HFMA
- Association of Ambulance Chief Executives
- CFOs and deputies from NHS trusts, foundation trusts and clinical commissioning groups
- integrated care system (ICS) finance leads
- NHSE&I regional leads
- NHSE&I estates leads
- individual experts in NHS finances.

An independent expert panel was established to assist with this Review. The panel comprised provider and ICS CFOs from areas/trusts that are familiar with some of the key issues that exist around the capital allocations formula.

Meetings were held with panel members at the beginning of, during and in the final stages of the Review.

6 Key issues: methodology and capital regime

Throughout the engagement period we received a high volume of feedback on both the operational capital methodology and the NHS capital regime as a whole.

We welcomed and encouraged a full range of differing perspectives on how best to improve the operational capital methodology. While there was not unanimous agreement on every area, there were a number of consistent themes or messages on the ways in which the methodology could be improved.

At the broadest level there was widespread agreement that given prioritisation decisions needed to be made, an allocation methodology was necessary and that it was appropriate (within the current direction towards a 'system-led' NHS) that this allocation should be made to ICSs. All also recognised that 'nationally driven' providers schemes, such as new hospitals, needed to be handled at national level.

A number of issues raised about the impact of the methodology related more closely to issues of the quantum, ie, that many systems faced more demands for spending than could be met within the allocation. In general, though these issues clearly pose a challenge to system and provider leaders, they are not of themselves related to the allocation formula.

This is largely because most systems must target their capital departmental expenditure limit (CDEL) headroom on maintenance of the existing estate and in this context the largely backward-looking formula (dominated by depreciation, Gross Asset Value (GAV) and backlog maintenance) is appropriate. Over timec, if its scope should widen, a different approach – more akin to the revenue formula – would be needed and we touch on this further in recommendations.

Turning to the individual elements of the current methodology.

Depreciation

- Depreciation is not a direct reflection of capital need but over time is a reasonable proxy for the need to invest in maintenance and replacement of the NHS's asset base and so its use within the methodology was understood and supported.
- The use of depreciation within the formula also helps to align cash and CDEL given depreciation is funded (and cash backed) within commissioning contracts.
- Generally, fully funding depreciation was supported. However, it was noted that the current methodology is heavily weighted on depreciation and creates issues in generating CDEL headroom when providers have significant PFI estate or when a large proportion of assets that require replacement have been already fully depreciated.
- We also heard concerns from local finance directors over whether the overall NHS financial architecture was sufficiently aligned. The use of alternative site valuation, for example, may have a different impact on revenue costs than on capital availability.
- In rare instances, it was noted that some (PFI) trusts are being unduly penalised through the methodology, specifically a small number of trusts that end up with a 'negative depreciation' allocation due to the deduction of PFI/IFRIC financing costs.
- We heard that there may be issues of scope that are worth further exploration. For example, assets that are shared or hosted where a requirement to depreciate the assets could create a disincentive to host them.

Gross asset values

- Gross asset values represent previous capital investment decisions rather than future priorities and/or need, ie, use of GAV (and depreciation) ensures the provision of CDEL to those systems that have already benefited from investment overtime.

- While it was recognised that much of the work of the current methodology focuses on the maintenance (in the broadest sense) of the existing estate, depreciation and GAV are both measures of this estate and represent, to a large extent, a double count. This was confirmed by the very high correlation between the distribution of depreciation and GAV.
- In light of this double count, the general consensus was the gross asset value element should be reduced to allow for a greater focus on 'need', eg, to allow for addressing of backlog maintenance and critical infrastructure issues.

Backlog maintenance

- Backlog maintenance is a key indicator for trust prioritisation but a relatively low driver of the formula. It was generally suggested that backlog maintenance should constitute a larger proportion of the allocation methodology.
- The main issue with this approach is the quality of ERIC data, which was seen as variable. Approaches to trust oversight of ERIC returns seems mixed, and this is not audited data. This is a material problem for any allocation methodology that needs to use objective data that contains significant error.

Prior-year surpluses

- The feedback on the use of prior-year surpluses in the capital allocation formula was mixed, with a wide range of views.
- On the one hand, some felt that it should not be included in the operational capital formula at all as this should be focused on need. This is especially true when the quantum is low compared to need, ie, all available headroom should be directed at essential spending.
- Others felt that it should be included, but questioned the use of six years' historical data, particularly as some trusts will have benefited from large payments and bonuses in this period from the nationally administered 'sustainability funding' regimes (including sustainability

and transformation funding, provider sustainability funding and financial recovery funding) and Covid-19 may also create some windfalls.

- For others these issues took second place to the role as an incentive for financial performance (as noted in the Health Infrastructure Plan) and helped to give a clearer line of sight to the benefit of clinical engagement in efficiency savings programmes.
- With a lack of clear consensus, the decision on prior-year surpluses is partly operational, ie, over how many years surpluses are measured, and partly more fundamental – the role of surpluses as an incentive, and where to lodge them in the system, ie, they could be used as incentives, but possibly not within the operational capital allocation which in any case goes to systems, not to individual providers.

Nationally approved prior commitments

- It was recognised that the NHS was working within a finite capital allocation envelope in aggregate, however the following points were noted relating to nationally approved prior commitments:
    - regions/systems would prefer greater clarity on how NHS England and Improvement allocates this element of the methodology
    - existing commitments are not adequately considered, specifically some national capital programmes rely on internal trust contributions that are not appropriately factored into envelopes.

RAAC (reinforced autoclaved aerated concrete)

- There was general recognition of the need to support trusts that have RAAC issues, and the benefit for these systems of being able to see the capital allocated for RAAC alongside other operational capital.

Sources of financial data

- There were differing views on whether using the latest audited data (eg, provider accounts) was preferable to using the latest available forecast outturn.
- There was a general recognition that the data needs to be robust, reliable and consistent to ensure allocations are fair. This is essentially a pragmatic decision based on an assessment of data quality.
- For depreciation specifically, most finance directors we heard from suggested end-of-year figures should be used rather than latest forecast outturn, though it was noted that particular care should be taken in using 2020/21 accounts because of the atypical impact Covid-19 has had on capital depreciation.

Trusts that operate across ICS boundaries

- There was universal feedback that those trusts that operate across system boundaries face specific challenges especially when it comes to agreeing additional capital for investment/transformation rather than just asset replacement. This is most acute for ambulance trusts, but others (some mental health, community and specialist trusts) face similar issues.
- However, there was no consensus on an alternative to approach to that currently adopted.
- Splitting allocations between systems for these trusts would not be an effective solution, the unintended consequence being that access to capital may become more challenging. Additionally, it would contradict the approach that has been agreed for revenue allocations in 2022/23 (and prior years).
- A number of contributors suggested that the NHS planning guidance should be more explicit as to how cross-boundary trusts should work with the respective systems they operate across.

Multi-year envelopes

- In recent years, the NHS has received only single-year capital settlements. Operational capital allocations have therefore been structured on a short-term, year-to-year basis. This has had an impact on providers'/systems' ability to invest in large multi-year capital programmes and manage pressures across a number of years.
- We heard concerns that annual allocation and management of capital budgets lead to more short-term tactical decisions rather than strategic investment decisions and were a poor match for an unpredictable capital environment where the risk of slippage may be high due to Covid-19, construction supply costs or labour availability
- Unanimous view was that the NHS should endeavour to provide multi-year capital envelopes and give as much certainty as possible.

Scope of envelopes

- While there was a recognition that major schemes needed to be managed at national level, there was a general view that the scope of capital envelopes should be broadened to give ICSs greater responsibility and flexibility for managing capital budgets and priorities. Having too many capital budgets held at different levels and administered in different ways (eg, with different bidding processes and timelines) will increase the complexity and challenge of capital planning at ICS level.
- In particular, there was a feeling that primary care, digital and diagnostics expenditure needed to be considered alongside operational capital.
- Whatever the final decision taken over these budgets, for any national programmes there was a strong preference for allocations to be made early, alongside operational capital envelopes so that systems had visibility over the full capital available to them and that the system for accessing these budgets should be as simple and as clear as possible.

Alternative distribution methodologies

- There wasn't a strong feeling that the current formula missed any key elements or that there was an obvious alternative that should be used.
- Many expressed the concern that the operational capital quantum did not allow much (or any) headroom for 'strategic' investments that targeted future need or transformation. Instead, much of the available operational capital pot was eaten up by depreciation and backlog maintenance and therefore the methodology's high weighting on these elements was appropriate.
- If, however, over time either the quantum should increase or the scope of operational capital begin to include some budgets currently held centrally, then this 'backward-looking' formula risks not meeting future need. In this case the methodology could be supplemented with a 'needs' element similar to that in the revenue formula.

7 Key issues and recommendations

After calibrating all the feedback from the engagement sessions and with the support of the expert panel, our final recommendations for the consideration of NHSE&I on the 2022/23 operational capital methodology are summarised below.

2022/23 operational capital methodology recommendations

Depreciation (less IFRIC and PFI financing costs)

- Keep the £-for-£ funding of depreciation within the formula.
- The PFI/IFRIC adjustments should be capped at a level that ensures that no trust has registered a negative depreciation allocation (as a minimum).
- The 2021/22 methodology was based on forecast outturn data from provider returns. This should be reviewed and consideration applied to using the latest (2020/21) audited data.

Gross asset values

- Analysis demonstrates there exists a significant correlation between gross asset values and depreciation. Over a period of time, the formula should move towards reducing and then removing the weighting given to GAV. As described below, the pace of change should be managed as an iterative process.
- If gross asset values are reduced in weighting, we are in favour of increasing the weighting to backlog maintenance (*see* section below).

2022/23 operational capital methodology recommendations

Backlog maintenance

- Central to operational capital envelopes is the objective of maintaining the current estate. This is particularly true when the overall operational capital settlement remains tight. As such, depreciation is key, as is backlog maintenance.
- Over time, the formula should move to increase the weight attributed to the backlog. The pace should be determined by two factors:
  - quality of data (more detail below)
  - methods to increase the confidence in the backlog estimates. This could be through a mix of audit or Board sign-off for estimates, along with a reserve power to set aside (or investigate) outliers or excessive movements in estimates.
- Generally, there should be an objective to smooth any immediate impact through:
  - no sudden changes to the methodology, ie, the impact of gross asset value should be reduced over time
  - an overall pace of change policy could be adopted to prevent sharp movements, for example, the adoption of a cap and collar rule
  - the future path of allocations should be set out for systems so they can plan over time.

Prior-year surpluses

- There are positive incentives provided by the inclusion of prior-year surpluses. However, it is also noted that:
  - some surpluses have been distorted by past national policies, eg, provider sustainability funding, financial recovery funding, etc
  - there may also be similar issues of attribution through financial movements during Covid-19, these will create measurement issues for this indicator.
- Distant, historical surpluses should not have an impact on current allocations, therefore there should be a five- or six-year (maximum) cut-off.
- It is recognised that a relatively low proportion of the formula is driven by this element, but it is very skewed and so accounts for more of the differences across geographies than might be expected.

2022/23 operational capital methodology recommendations

- More fundamentally there are issues around prior-year surpluses including this incentive element. In years where the quantum is relatively generous, allowing allocations to be influenced by prior-year surplus may be acceptable as essential backlog/depreciation spending can still be financed. However, in years of low quantum, moving allocations based on surpluses risks placing some ICSs (or some providers within ICSs) in the difficult position of cutting back on essential capital spending. While it may be important to keep incentives in the system, forcing this trade-off between essential capital spending and incentives does not look equitable. Clearly, this is a judgement based on the quantum. If it is felt that this incentive cannot be 'housed' within operational capital then other budgets, eg, 'strategic' capital could take the strain.
- Over time, the use of prior-year surpluses as an incentive depends upon wider financial architecture. We note this below.

Trusts that operate across ICS boundaries
(ambulance, mental health, community, specialised)

- For cross-system providers, there are three options that could be adopted to assist them in accessing a greater capital envelope share:
  - allow the regional teams to control an element of operational capital envelopes to ensure that cross-system trusts within that patch are allocated an amount that reflects their asset ownership across the region
  - create multi-ICS budget holders to house envelopes for cross-system trusts
  - include more explicit information in the planning guidance as to how cross-system providers and ICSs should work together.

  The simplest approach (which also follows revenue allocations) is to remain on a one-to-one system mapping and to provide clearer guidance to providers and systems on collaborative, co-ordinated working within the capital planning guidance. However, whether this is the most pragmatic way forward in the immediate future at a time of great demands placed on systems is not clear and there may be a case for a simpler interim solution (eg, allocate to regions). In so far as there was a common view on this issue, it leant towards multi-ICS budgets (ie, allocations would be made to the group of ICSs that the ambulance trust covered, the second option above). What is clear is that doing nothing is the least good option and whichever solution is preferred for 2022, it is likely to need further evaluation.

2022/23 operational capital methodology recommendations

Pace of change

- There are concerns over data quality and that capital has a 'long tail', ie, previous commitments have a material impact. On this basis, a slow/gradual pace of change is recommended to annual capital allocations, preferably with the use of caps and collars which were successfully used in the first two years of the regime.
- Ultimately, the reliability of data (financial and estates/ERIC) is paramount to ensuring that capital envelopes land in the areas of most need. In future, the reliability of the data should be a focus when calculating capital envelopes.

Scope of capital envelopes

- An issue raised unilaterally from stakeholder feedback was that systems would like to have as much control as possible across the various national capital pots, including primary care and NHSX funding. Our recommendation is that over time capital envelopes include as many of these funding streams as far as practical. We recognise that at present there are concerns over specific HM Treasury conditions and risks around deliverability of programmes in the near term as ICSs become statutory bodies. However, with the path of reform firmly set on a system/ICS-based future, the retention of substantial central funding (excepting that element of specialist commissioning that can only take place at national level) is clearly anomalous. As ICSs increasingly determine local prioritisation they will be best placed to make these allocation decisions.

Multi-year certainty and forward look

- NHSE&I should use the three-year capital settlement agreed in the 2021 Spending Review to give systems certainty over allocations.
- At the same time, NHSE&I should make maximum use of this period to address any issues that remain in terms of data quality. NHSE&I should also consider making on-going review of the operational capital funding methodology a responsibility of the Advisory Committee on Resource Allocations (ACRA), potentially through a dedicated capital sub-committee.

8 Concluding remarks

Based on the work conducted for this review, we believe the current methodology is fundamentally sound for the purpose of allocating operational capital funding to ICSs. The changes we have recommended should improve or enhance the methodology over time, but do not alter the underlying allocative approach.

The remit of this Review was focused on how available operational capital funding is allocated to ICSs. But we would make three wider observations.

First, the allocation process cannot sit entirely independently from the overall quantum of capital funding available to the NHS. Fundamentally, the full ambitions of the NHS capital regime will not be achieved – even if improvements to capital allocations are implemented – if the overall amount of NHS capital investment is insufficient. And more operationally, if sufficient operational capital investment becomes available to the NHS such that it can move beyond the maintenance of the existing estate, then the allocation methodology should be supplemented with a 'needs' element alongside the more 'backwards-looking' maintenance elements that are given significant weight in the current formulae. This will also become necessary if, over time, more budgets currently managed centrally for strategic capital investments are moved to ICSs.

Second, the process of allocating NHS operational capital cannot sit entirely independently from the wider capital regime or overall NHS financial architecture. For example, we heard that capital investment through the new hospital-building programme sits outside operational capital budgets, but the equipment needs and resulting capital investment for these facilities comes from local envelopes. The revenue consequences of capital investment are not always fully reflected in financial envelopes, and different incentives across revenue and capital regimes may affect local decisions over whether to host or lease – rather than procure and own – assets.

The importance of the wider financial architecture was also reflected in views on the role of prior cash surpluses within the methodology. While there are some measurement issues around these cash balances, we think that behind this disagreement may lie a greater uncertainty about the future financial

architecture and the role of cash, retained surpluses and the freedom to invest. These questions lay beyond the scope of the Review but may explain why there was least agreement on the role of these historical cash surpluses.

Third, there are some fundamental principles of sound planning that were reflected in our discussions for the Review and are applicable to both the allocation of NHS operational capital and the wider financial architecture. Though we are sure these will come as no surprise, we would fail to represent the voices we heard through the engagement unless we repeated them.

These include:

- clarity over which behaviours the financial regime is attempting to support or incentivise
- simplicity in design, including minimising the number of different capital budgets that operate on different timelines and under different administration regimes
- stability and predictability, including setting multi-year budgets where possible and giving early notification of capital funding made available in-year.

Lastly, we found the engagement of the NHSE&I team with us and with the finance directors and experts we met during the review to balance both clarity and openness. While any allocation methodology is inevitably a zero-sum game – for every winner there must be a loser – we think this approach was welcomed by all who took part.

Acknowledgements

We would like to thank the expert independent panel members, the stakeholders we engaged with, and NHS finance directors for their valuable input and guidance. The help and support of the NHSE&I capital team, including Maneesh Acquilla, Chris Jackson, Ian Tankard and colleagues, was essential in supporting this review and is gratefully acknowledged.

Appendix A Terms of reference

1. Purpose

The NHS Long Term Plan (LTP) 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, speed up emergency finance approvals and provide systems with greater power and responsibility for prioritising their local capital expenditure. We broadly adopted the same methodology for allocating operational capital across 2020/21 and 2021/22. The reforms to the capital regime have been broadly welcomed, with feedback that it has improved system working and encouraged greater system level prioritisation of capital investment needs. However, a number of issues have been raised through regional and system level engagement about the allocation methodology, which we want to explore for future allocations. In addition, given this approach has become a more permanent feature of the NHS funding allocation landscape, we want to think more systematically about how we keep the methodology up to date, fair and robust for future years.

Julian Kelly (NHS England & NHS Improvement Chief Financial Officer) has therefore commissioned an independent review to provide external and independent scrutiny. The review will be asked to assess the current allocations methodology, engage with key stakeholders on the current regime and potential improvements, and make recommendations for NHS England & NHS Improvement to consider ahead of Operational Capital envelopes for 2022/23 being agreed and published.

2. Duties and Responsibilities

This time-limited, independent review will be supported by an expert panel of key external stakeholders and an NHSE/I secretariat.

The key duties and responsibilities of the independent review is answer and report on the following questions in relation to the capital allocation methodology adopted in 2021/22:

- What are the strengths/weaknesses of the current methodology?
- What improvements can be made from the current methodology, and what changes to the methodology(s) should we adopt for 2022/23?
- What lessons can we learn from the well-established revenue need-based allocation process? For example, should we explicitly include health inequalities/deprivation in the methodology, and should we establish an independent body (like ACRA[1]) to advise on future methodological changes?

3. Membership

Matthew Style (Director of Strategic Finance) is the NHSE/I SRO for this review with the independent panel being led by the Independent Chair, other members will be appointed shortly. It is envisaged that the panel will comprise of provider or ICS CFOs from areas/trusts that are familiar with some of the key issues that exist around our capital allocations formulae, such as:

- Trusts with significant PFI estate
- Trusts with material backlog maintenance issues
- Cash rich Foundation Trusts
- Trusts with RAAC issues

[1] https://www.england.nhs.uk/publication/advisory-committee-on-resource-allocation-acra-terms-of-reference/

Members with a wider perspective on the issues – for example, with experience of allocating capital or tackling investment challenges in other bits of the public sector – may also be invited to join the panel. Members will be drawn both from the finance and wider professional/ leadership communities.

Maneesh Acquilla (Head of Strategic Capital) will act as the NHSE/I operational lead.

4. Meetings

Meetings will be chaired and held at a frequency designated by the Independent Chair and will be held virtually via Microsoft Teams as a default, unless specified otherwise. The agenda for these meetings will be set by the Independent Chair and operational leads with supporting material and analysis prepared by the NHSE&I secretariat and other NHSE&I teams. The standing agenda for the meetings will consist of the following items:

- Introduction and review updates
- Completed engagement
- Deliverables and risks
- Upcoming engagement
- AOB

5. Reporting

The NHSE&I secretariat will be responsible for the preparation, distribution and coordination of papers for discussion, as commissioned by the Independent Chair. Once the review is complete a summary outputs document will be produced by the NHSE&I secretariat, under the direction of the Independent Chair, and the Chair asked to make a summary of recommendations for NHSE&I to consider.

6. Work programme

The work programme for this review will be centred around the questions listed in Section 2 (*Duties and Responsibilities*) of the Terms of Reference. In addition, NHSE/I will establish an external expert panel to inform and test proposals and ensure there is widespread acceptance of outcomes. We therefore envisage the group will comprise of provider or ICS CFOs from areas/trusts that are familiar with some of the key issues that exist around our capital allocations formulae, such as (but not limited to):

- Trusts with significant PFI estate
- Trusts with material backlog maintenance issues
- Cash rich Foundation Trusts
- Trusts with RAAC issues

The review will be supported by an NHSE&I secretariat, who will provide background material and explanations of the current system, support the review, lead/support in wider engagement and provide analysis of the impact of different proposals to help to inform recommendations.

Initially, this would include the following initial actions:

- Setting out details of the current methodology used and the pros and cons with each constituent element and their respective data sources, including:
    - Depreciation (FOT vs Plans)
    - Backlog Maintenance (ERIC data)
    - Gross Asset Value (FOT vs Outturn, PFI adjustments)
    - Historic Revenue Surpluses (numbers of years, org vs system level)
    - Emergency Financing
    - Cap and collars to smooth changes year on year
    - Bespoke Adjustments / Issues – how (if at all) should we capture issues not considered in the main allocation's methodology
    - Funding for specific issues e.g. RAAC, Diagnostics, residual interest

- Setting up a process of engagement with key stakeholders for the review lead and expert panel to probe a wider set of interested stakeholders on the key questions above.

In addition to the above, the review is asked to be mindful of the following key issues, namely:

1. The review must have regard to the important role that capital allocations (and therefore the access to capital) plays in the revenue framework, as an incentive for financial delivery
2. Consideration as to how we deal with capital allocations of providers that operate across more than one ICS, including but not limited to ambulance trusts.

7. Timing

We would like to be able to take the outputs of the review and review recommendations into consideration for system level capital envelopes for 22/23.

We would therefore ask the review team to complete their engagement and make recommendations to NHSE&I by the end of October 2021.