Classification: Official

NHS England

Capital guidance update 2024/25

Publication reference: PRN889

NHS England published the NHS capital guidance 2022 to 2025 in March 2022, and subsequently supplementary guidance for the 2023/24 financial year. Both still apply and set out the basis of the capital framework and allocations for the period 2022/23 to 2024/25.

This document should be read in conjunction with that guidance, and provides supplementary guidance specifically for 2024/25.

Queries on this guidance should be sent to: england.capitalcashqueries@nhs.net

Contents

Overview of the NHS capital settlement for 2024/25

The 2024/25 NHS capital allocation will be split into three categories as follows:

1. **A system-level allocation (£4.1bn)** – to cover day-to-day operational investments that have typically been self-financed by organisations in integrated care systems (ICSs) or financed by the Department of Health and Social Care (DHSC) through normal course of business loans or system capital support PDC. From 2022/23 onwards this also includes £0.1bn of capital for investment in primary care BAU and GP IT.
2. **Nationally allocated funds (£1.9bn)** – to cover national strategic projects already announced and in development or construction, such as new hospitals and hospital upgrades (Sustainability and Transformation Plan schemes).
3. **Other national capital programme investments (£2.0bn)** – includes national programmes such as elective recovery, diagnostics, technology funding and mental health dormitory eradication.

The above sums do not include IFRS 16 adjustments – these are covered later in this document.

NHS operational capital

Prior year revenue and UEC performance allocation for 2024/25

Alongside the NHS capital guidance 2022 to 2025 we set out full integrated care board (ICB) operational capital funding allocations for 2022/23 and ‘baseline’ allocations for 2023/24 and 2024/25. This gave systems certainty for over 90% of their capital allocations for the next 3 years to support forward planning. These baseline allocations remain unchanged.

Finance incentive

In 2023/24 the prior year revenue performance allocation of £300m (c7% of the operational capital envelopes) was allocated at system level, with a system needing to deliver a surplus, breakeven or agreed stretch position to receive a share of this fund. In 2024/25, the £300m total allocation will be split equally between a revenue performance/finance incentive and a UEC performance related incentive.

For 2024/25, the finance incentive element will operate in broadly the same way as the 2023/24 scheme – that is, financial performance will be assessed on a system basis, and where:

a) ICBs break even in 2023/24 they will earn 100% of their fair share of the £150m capital available in 2024/25.

b) Systems with which NHS England has explicitly agreed a deficit plan will earn 50% of their fair share of the £150m if they deliver that plan.

c) Systems that do not meet either of the above will not receive a share of the £150m.

Depending on affordability; we may be able to offer additional capital in 2024/25 depending on system revenue performance. Further details to follow.

UEC incentive

The winter letter sent in July 2023 states that:

> "While we are making good progress towards achieving our overall ambitions, we want to encourage providers to achieve even better performance over the second half of the year. We will therefore be launching an incentive scheme for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25.
>
> We are asking providers to meet two thresholds to secure a share of this money:
>
> - Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
> - Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24."

In line with this letter, to be eligible to earn a share of the £150m providers must:

- have a Type 1 A&E department, and
- achieve an average of 80% A&E 4-hour performance over Q4 of 2023/24, and
- complete at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

Each trust that achieves both UEC targets above will earn an equal share of the £150m, up to a nominal maximum value of £5m.

In addition to the above, there are three other routes through which trusts will be eligible for additional capital funding in 2024/25:

1. The 10 trusts delivering the highest level of 4-hour performance during March 2024 will each receive £2 million.

2. The 10 trusts who deliver the greatest percentage point improvement in March 2024 (compared to January 2024 performance) will each receive £2 million.

3. The next 10 trusts who deliver the greatest percentage point improvement in March 2024 (compared to January 2024 performance) would each receive £1 million.

These will be based on the trust footprint data, attributing the attendances of the nearby type 3s to the relevant local type 1 A&E service to create a better 'like-with-like' comparison between major A&E providers[1].

Trusts who have already qualified for capital through the original incentive scheme described in the winter letter will not be eligible to receive further funding through the additional mechanisms. However, it would be possible for a single trust to qualify for a maximum of two of the three capital awards above (that is, to be both one of the best performers nationally having achieved this through the greatest performance improvement), meaning the maximum award could be £4 million.

Due to the nature of these allocations, they will be transacted on a ringfenced basis at provider level. We expect any capital a provider earns through the schemes above to stay with that provider, in addition to its system allocation.

A&E and ambulance handover data

Details of the data that will be used to assess individual trust performance against these metrics is contained in the Urgent and emergency care winter incentive – operational measurement guidance. This document states the following:

A&E data

We will use all types of A&E performance from the published monthly A&E attendances and emergency admissions data to identify those providers with a Type 1 A&E that achieve 80% all-type A&E 4-hour performance over Q4 of 2023/24. Performance will be assessed at acute trust footprint level and will therefore include any Type 3 activity mapped to the trust.

Reductions in the percentage of patients spending 12 hours in A&E will be monitored via the 12-hour element of the Supplementary emergency care data set analysis publication.

[1]The attribution is either as agreed at local A&E delivery board level or is based on using SUS to split type 3 provider activity to relevant type 1 providers. The acute trust footprint data can be found on the last tab of each monthly publication file (Statistics » A&E Attendances and Emergency Admissions 2023-24 (england.nhs.uk)), and no change is required in how data are submitted for the monthly publication.

Ambulance handover data

We will use ambulance handover data from the daily ambulance collection to identify those providers with a Type 1 A&E that complete at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

Planning assumptions for prior year revenue and UEC performance allocation

To support capital planning, systems can assume the level of revenue performance allocation and appropriate percentage they will receive based on the expected 2023/24 system revenue performance outturn; this will be included in the total indicative 2024/25 provider capital allocation. Systems are expected to submit a provider plan that complies with this indicative allocation.

The revenue performance allocation is a planning assumption at this time. Once this share of the allocation is confirmed, providers and systems will be expected to manage capital plans and revise their capital forecasts in line with the final 2023/24 allocation.

With respect to the UEC incentive scheme, no assumptions should be made within the planning submission at this time. Allocations will be confirmed once the 2023/24 Q4 is available, and we can determine who is eligible for a share of the incentive scheme.

As in previous years, overspends against the final 2024/25 envelopes will be deducted from the 2025/26 capital envelopes.

Other operational capital programmes

During 2022/23 we approved supplementary capital allocations (on top of system envelopes) for several national operational capital programmes – ambulance replacements, maternity neonatal cots and aseptic medicines. To help systems deliver these programmes and provide greater flexibility to manage this spend alongside other system capital investments over the Spending Review period, uplifts to system operational capital envelopes were made in 2022/23 in line with agreed profiles. Where allocations are multi-year, uplifts will be applied to 2024/25 system operational capital envelopes as part of the capital planning exercise.

Where systems are unable to deliver the schemes that the supplementary capital allocations are intended to support ahead of March 2025, trusts should notify the national NHS England Capital and Cash team as soon as possible.

Capital allocations beyond 2024/25

Government has not yet awarded a capital settlement beyond 2024/25, as this will be confirmed at the next Spending Review.

At the time of publishing there have been no formal notifications with respect to a Comprehensive Spending Review (CSR) process. Therefore, we are unable to issue any guidance on the next capital settlement (quantum's, period covered or specifics around programme budgets).

Land and property disposals and multi-year CDEL credits

Detailed guidance was issued last year. We remind systems, they will need to notify NHS England of the planned underspend at planning stage or, if this is not possible, at the earliest opportunity in the financial year and, at the latest, in advance of the month 6 submission.

NHS national capital programmes

Progress on the delivery of outcomes and benefits from key national capital programmes must be reported monthly through the Capital Delivery Oversight Group.

Trusts and systems should note the key operational practices and considerations for national programmes described below.

Modern methods of construction (MMC) is a core government and NHS policy when developing modern infrastructure and there is a requirement that MMC will be utilised as the default on all construction projects. There is a national NHS target that any scheme over £25m will look to achieve MMC at 70% for new builds and 50% for refurbishments. Where there are exceptions and targets cannot be achieved, a full and complete explanation and justification must be provided including of options explored to attain the required target. These targets will be reviewed at business case approval stages.

Where national funding PDC is issued under an MoU, trusts should ensure this is drawn down as soon as each element of the work is complete to support best practice reporting of actual in-year spend. Profiling and forecasting accuracy are essential to ensure programme funding can be utilised effectively in-year.

The National Estates team are rolling out a national capital reporting tool that will aid this process. The expectation will be that all estates schemes, which are part of a national programme delivered through PDC, will begin to use this platform.

All the operational outcomes and benefits as a result of the capital investment are recorded, including efficiencies, savings, and reductions in risk. This will provide lessons learnt for future allocations and an evidence base to support future funding requests to HM Treasury.

RAAC

Separate funding for RAAC hospitals was provided in the last Spending Review. These funds are allocated to those trusts in the national RAAC programme to undertake failsafe and eradication works. Since the Spending Review, more trusts have found RAAC at their sites and they too have been onboarded onto the national programme. We have allocated funds to these organisations from the ringfenced RAAC budget for investment in necessary failsafe work. While seven hospitals with RAAC that requires full replacement have been transferred to the New Hospital Programme (NHP), they remain part of the RAAC programme with regards to the failsafe works. There is currently no ringfenced capital available for RAAC beyond this Spending Review period.

Diagnostics

At the date of publishing, NHS England has approved 171 community diagnostic centres (CDCs) and 132 of these are operational.

In 2024/25, ICBs should build on the work delivered to date and ensure they have robust and deliverable plans in place to:

- Deliver the levels of activity required to remove elective and cancer backlogs locally; ensuring that they deliver an improved 6WW by March 2025 based on the target % agreed locally with NHS England so that 95% of patients wait <6 weeks by March 2026.
- Deliver the third year of their 3-year investment plans for establishing CDCs and digitally enabled pathology and imaging networks, and for expanding acute imaging and endoscopy capacity through ensuring:
  - all CDCs meet their approved activity plans, drawing on the available dedicated revenue funding, with opportunities for exceeding those plans identified and delivered where possible,
  - endoscopy investments enable levelling up to the guide level of 3.5 rooms per 100,000 population over 50 years of age by March 2025; and help achieve or retain Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in all endoscopy units,

  - nationally 100% of pathology networks to reach as a minimum a ‘maturing’ status, and at least 70% of imaging networks reach as a minimum a ‘maturing’ status with 30% to reach ‘thriving’ status, for delivery of services using the respective network maturity frameworks by the end of 2024/25, while delivering a minimum 10% improvement in pathology and imaging service productivity by March 2025 through implementation of digital diagnostic investments,
  - all acute sites have a minimum of two CT scanners, while collaborating with imaging networks to deliver the capabilities for imaging research and development and the integration of artificial intelligence, with a cloud first approach.
- Use operational capital envelopes to replace aged diagnostic equipment, working towards eliminating the backlog of diagnostic equipment over 10 years old by the end of 2024/25. Trusts must also complete the reporting in the monthly financial returns so that progress can be tracked.

Regions will receive capital funding to support the maintenance and transformation of the NHS screening programmes to increase activity/productivity and reduce health inequalities.

Technology transformation

Funding has been provided to ICSs to support the digital and data planning process and providers should work with their ICB to ensure digital planning alignment.

A minimum £400m funding for 2024/25 will be available to ICSs to meet minimum digital foundations, especially electronic patient records, and scale up use of digital social care records in accordance with What Good Looks Like. Allocation of capital funding for Frontline Digitisation and other tech programmes will focus on the parameters set in the associated programme business cases and may include a level of local match funding as defined by the transformation programme teams. The focus will be for every provider to have an e-PR.

Depreciation

The Government has agreed additional revenue resources for the NHS to support depreciation and amortisation expenditure, where the expenditure is within the scope of the technical ring-fence as defined in the HM Treasury Consolidating Budgeting Guidance.

Further information is available in the Revenue finance and contracting guidance for 2024/25.

PFI and LIFT transactions

Trusts should notify NHSE England where there is a risk of a PFI or LIFT project terminating due to default of the Project Co party at the earliest opportunity. Trusts should not enact any option to terminate a contract for Project Co default without the consent of NHSE and DHSC. NHSE and DHSC will advise trusts as to steps that need to be taken should this risk arise.

Voluntary termination of PFI or LIFT projects will only be considered in exceptional circumstances and where these demonstrate value for money and will require a Green Book compliant business case. Any proposal would need system support including identified funding for any associated cash and capital or revenue consequences. Trusts considering voluntary termination of a PFI or LIFT contract should contact NHS England at the earliest opportunity. These transactions will be considered novel and contentious and require NHSE, DHSC and HMT approval.

Trusts need to ensure they are aware of the expiry date of any PFI or LIFT agreements, key dates for decisions and any consequential financial costs for example payment for assets and condition review requirements. Where Trusts are in PFI or LIFT facilities or other leased premises where NHSPS are the head tenant / freehold owner, these properties should also be captured in the ICB Infrastructure Strategies.

Trusts should additionally contact NHSE for advice in respect of any proposed contract changes or settlement agreements which have the potential to impact on balance sheet treatment. Further guidance will be issued in the new year.

Capital planning and reporting as part of the changes made by the Health and Care Act 2022

Joint capital resource use plan for ICBs and their partners

The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act), sets out that an ICB and its partner NHS trusts and foundation trusts:

- must before the start of each financial year prepare a plan setting out their planned capital resource use,
- must publish that plan and give a copy to their integrated care partnership, health and wellbeing boards and NHS England,
- may revise the published plan – but if they consider the changes are significant, they must republish the plan; and if the changes are not significant, they must publish a document setting out the changes.

To support ICBs in meeting these requirements of the amended 2006 Act, please refer to the document Guidance on developing joint capital resource use plans 2024/25 (england.nhs.uk).

This joint capital plan guidance will cover the following:

- the overall funding allocations the system is assumed to be working to, with an explanation of assumptions (and related risks) associated with the assumed source and quantum of funding for the ICB and its partner providers,
- how the system should prioritise available resource for investments in the ICS wider local strategic priorities and maximise efficiencies within an affordable allocation,
- notable risks and/or contingencies associated with the capital plan, alongside any proposed mitigations,
- detail of how ICB plans support cross-system working.

In line with the amended 2006 Act, ICBs are required to prepare these plans before the start of the financial year, so by 1 April, and before publishing and sharing the final plans, and to report against them within their annual report.

Further guidance on the completion of ICB plans is provided in Guidance on developing joint capital resource use plans 2024/25 (england.nhs.uk) and any further queries should be directed to england.capitalcashqueries@nhs.net.

ICB infrastructure strategies

NHS infrastructure must be planned strategically at both a national and system level to make the case for long-term investment in the estate to address necessary backlog maintenance, support the recovery of our core services, and produce flexible solutions that meet the future needs of patients and staff, while also ensuring the most efficient and productive use of our resources.

The NHS Property and Estates: why the estate matters for patients – Robert Naylor Review (2017) and Next steps for integrating primary care: Fuller Stocktake Report (2022)' both highlighted the need for local systems to review the space available in their area and develop infrastructure plans to identify local estate needs, and to support the NHS to prioritise funding to meet these needs as capital becomes available.

NHS England has been working with a number of ICSs on the production of draft strategies for their systems. The national NHS Estates team has taken the learning from these to produce a technical toolkit and a series of templates and frameworks, and, when

published we encourage each system to use these to produce a 10-year strategy. Use of the templates is especially important for making the case for capital and better alignment on key strategic initiatives.

The infrastructure strategy should encompass requirements from local NHS trusts and primary care networks, national strategic plans, and current infrastructure priorities (such as NHP schemes or CDC rollout). There should be a focus on integrating a workforce plan that embeds estates and specialist skills/expertise into the model for delivery of system design changes. Lastly, all ICS strategies should be underpinned by a complete understanding of the current asset base. This should involve the mapping and identification of all infrastructure assets using the framework of core, flex, and tail.

All the above will ensure there is a coherent and consistent approach, while also enabling appropriate flexibility for systems to innovate and create a strategy that is appropriate for the context and maturity of their ICS.

The national NHS Estates team are keen to work collaboratively with each system and encourage you to discuss and draw on the support of your Regional Estates Delivery Director and Strategic Estates Lead, as well as our partners in Community Health Partnerships and NHS Property Services. The team will also run regular webinars to support the development of your strategies over the coming months; details of these can also be found on the Hub.

For further information and support, please contact the national NHS Estates Strategy and Planning team at england.estatesandfacilities@nhs.net.

Capital planning

As part of the 2024/25 financial planning process, NHS England will collect system and provider capital plans, and these should be completed in the following planning templates:

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

System and provider planning returns require the submission of 1-year capital plans that demonstrate compliance with the system operational capital allocations for 2024/25.

The system integrated planning return template will be pre-populated with the indicative system operational capital allocation value for 2024/25. When completing this template

systems should provide the total charge against the allocation for each component organisation – that is, all providers and the ICB.

Systems are expected to submit a fully compliant plan at final submission.

However, as in 2022/23 and 2023/24, we will accept systems or regions over-programming by up to 5% of operational capital allocation value at plan stage in 2024/25, so long as this is based on a clear plan that allows elements to be scaled back or deferred if necessary.

The 2024/25 planning requirements for systems and their component organisations have been updated and this guidance should be read alongside the Revenue Finance and Contracting guidance for 2024/25.

Please also refer to the submission guidance for further details of the plan collections as part of the planning process and the submission deadlines.

IFRS 16

IFRS 16 was implemented in the NHS from 1 April 2022 and all new leases and lease amendments within the scope of IFRS 16 will score against CDEL, and accordingly an adjustment has been applied to 2024/25 CDEL budgets to reflect the incremental CDEL impact of the IFRS 16.

Provider IFRS 16 CDEL budget

For 2024/25, the IFRS 16 CDEL budget cover will be managed at a system level by providing an uplift to system operational capital allocations and to provide additional CDEL to cover for the incremental CDEL impact of IFRS 16 in 2024/25.

At plan stage, no IFRS 16 uplifts will be made to system operational capital allocations. Providers and systems in aggregate will be monitored against their allocation before or excluding the incremental impact of IFRS 16.

The 2024/25 provider planning returns have been designed to collect the required level of information in respect of IFRS 16 and calculate a provider charge against system capital allocations both excluding and including IFRS 16. Therefore, systems and providers are asked to complete their returns on an IFRS 16 compliant basis and should refer to the relevant technical planning guidance for further information.

To confirm the final IFRS 16 uplifts to operational capital allocations, each system will be allocated an indicative share of £800m CDEL uplift (up from £615m in 2023/24). This allocation will be calculated in line with the core methodology used in calculating the system operational capital allocation formula and may be adjusted to reflect specific pressures as they arise where these cannot be managed within system allocations.

To support the above, providers and systems should work with regional teams, to identify anticipated 2024/25 expenditure which falls under the scope of IFRS 16, and in particular expenditure which is committed or need to be committed shortly, schemes which are essential to proceed in 2024/25, i.e., leases that need to be signed due to impact upon services, and overall provide rationale for the local prioritisation and management of such expenditure within affordable system operational capital allocations. The plan submission will also inform the confirmation of the IFRS 16 uplifts.

No uplifts will be made to allocations at plan stage. However, as a guide for the first plan submission, providers, and systems in aggregate, should include within their 2024/25 plan submission a level of IFRS 16 expenditure which is in line with the 2023/24 IFRS 16 uplift to system operational capital allocations plus up to (but no greater than) a 30% increase, which reflects the increase in the overall budget between 2023/24 to 2024/25.

For final plan submission, the expectation is, having undertaken the above with regional teams, the level of IFRS 16 expenditure will be in line with the expected final IFRS 16 uplifts.

Please note, in completing the provider planning returns with the anticipated level of IFRS 16 expenditure, this is only a planning assumption and does not represent a final confirmed allocation.

During 2024/25, once each system share of the IFRS 16 uplift to operational capital allocations has been confirmed, it will be included within the system operational capital allocation value for 2024/25, which will be pre-populated in the system integrated financial return (IFR) template.

From that point onwards, systems will be monitored and expected to manage their operational capital expenditure against their total system operational capital allocations **including** the incremental impact of IFRS 16.

Providers, and systems in aggregate will need to ensure the full impact of IFRS 16 implementation has been considered when deciding how the uplift is managed and

prioritised in 2024/25, to ensure capital plans are prioritised and managed within the total system operational capital allocations.

As set out above, overspends against the final 2024/25 allocations will be deducted from the 2025/26 capital allocations. For clarity this includes the impact of IFRS 16 to reflect the uplift to system allocations for a share of the additional IFRS 16 CDEL budget

All new leases, lease modifications and remeasurements and other lease charges/ credits within the scope of IFRS 16 will score against CDEL and the default position is that this applies to those transactions that are **both internal and external to the DHSC group.**

Once the final 2023/24 position re IFRS 16 CDEL outturn becomes known, and particularly the impact of intra-group arrangements upon the reported CDEL position, further guidance will be shared in respect of possible adjustments to the reported position due to consolidation eliminations, however for planning purposes all leases and lease amendments will score to the reported CDEL position, and therefore against system operational capital allocations. No intra-group adjustments should be assumed at plan stage.

The IFRS 16 CDEL uplift has been agreed with HMT and DHSC based on an estimate of the level of CDEL cover required to mitigate the incremental CDEL impact of IFRS 16 application and we are required to report IFRS16 related CDEL expenditure as part of our national reporting and monitoring arrangements.

Where systems are not fully utilising the IFRS 16 allocation uplift awarded to them, to cover the incremental impact of IFRS 16, and instead seek to use the cover for non-IFRS 16 system operational capital expenditure, further explanations and rationale will be sought to understand such switches and justify asset purchase decisions instead of leasing.

ICB IFRS 16 CDEL budget

As in 2022/23 and 2023/24 the uplift that NHS England received to the capital mandate in respect of the incremental CDEL impact of IFRS 16 will be managed nationally as a single allocation.

The IPR returns (06b ICB Capital tab) have been designed to capture the required information to inform the 2024/25 capital requirements for IFRS16, ICBs are asked to complete their returns on an IFRS16 compliant basis to inform the requirement against the national allocation.

Allocation of this capital mandate against schemes in the plan is being nationally managed. Funding for schemes against this nationally managed allocation will be confirmed once the final uplift to NHS England capital for 2024/25 is confirmed and communicated through NHS England regional finance teams.

Overall, where providers and ICBs are anticipating significant new lease and lease amendments within scope of IFRS 16 in 2024/25, these should be discussed with NHS England regional finance teams at the earliest opportunity. In addition, these should also be captured within the 2023/24 in-year returns for providers (PFRs) and ICBs (IFRs).

Capital delegated limits and capital business case requirements

Previously, operating leases would have scored against RDEL, and revenue expenditure controls would have applied.

New leases and lease amendments within the scope of IFRS 16 will now score to capital budgets and providers will need to seek business case approval for business cases including lease expenditure that exceeds the delegated limits as set out in the latest guidance on capital investment and property business case approval for NHS trusts and foundation trusts which can be found via the following link.

NHS England » Capital investment and property business case approval guidance for NHS trusts and foundation trusts

This guidance sets out the lease arrangement information that must be included in any business case submitted for approval.

Therefore, providers must identify lease arrangements as part of their capital planning and ensure the required approval processes are factored into capital scheme timetables. In the first instance, providers should identify any lease arrangements captured by the delegated limits and discuss these with NHS England regional finance teams.

For ICB capital expenditure relating to IFRS 16, approval is required in line with the limits in the NHS England Standing Financial Instructions.