

NHS capital explainer: what do NHS trusts need to know?

Capital funding is constrained across the NHS at the moment. Providers have raised concerns about the complexity and lack of information over how this limited funding is allocated to both individual organisations and sustainability and transformation partnerships (STPs).

This factsheet explains the current capital regime in which providers operate and sets out the routes for accessing the limited capital funding currently available.

What counts against the capital budget?

Each government department is delegated expenditure limits (DEL) for both revenue and capital. These are referred to as RDEL and CDEL respectively. It is a requirement for all departments to produce and share with Her Majesty's Treasury (HMT) accurate and timely in-year forecasts of DEL spending and risks against delivery. These combined departmental plans, known as supply estimates, are presented to Parliament and voted on at the beginning of the financial year. A breach of any voted limits will result in an investigation, report and possible penalty, along with what is known as an Excess Vote in Parliament. Under no circumstances is a department allowed to breach its expenditure limits and there are serious consequences if it does.

For health spending, while the Department of Health and Social Care (DHSC) is responsible for managing CDEL, it is local NHS organisations that are responsible for most (but not all) spending decisions against this limit. Therefore the DHSC and its arms length bodies require significant oversight over capital funding. This is managed differently between NHS trusts and foundation trusts (please see below for more information).

Most capital investment decisions taken by trusts and foundation trusts count against CDEL. These include:

- Internal cash, unspent revenue or depreciation used to finance expenditure
- DHSC borrowing in the form of loans
- DHSC public dividend capital (PDC)
- Other forms of borrowing (e.g. local government, commercial loans)

The only exceptions are off balance sheet finance (PFI, PF2, LIFT)* and schemes funded by current capital assets (subject to receipt) or charitable donations.

* These are private finance schemes which the NHS use to fund major capital programmes. A trust usually contracts a private firm to complete major capital projects, with the private company handling the up-front costs. The project is then leased back to the NHS over several years.

This makes it imperative for the central bodies to maintain a clear line of sight over capital expenditure across the NHS. Given the complexity in managing the national CDEL, DHSC have no option but to rely on trust planning, forecasting and delivery of capital programmes, to ensure scarce capital resource is maximised. In part because of these complexities, in 2017/18 there was a £0.4bn underspend against the DHSC capital budget.

What are the current trends in capital funding and spending?

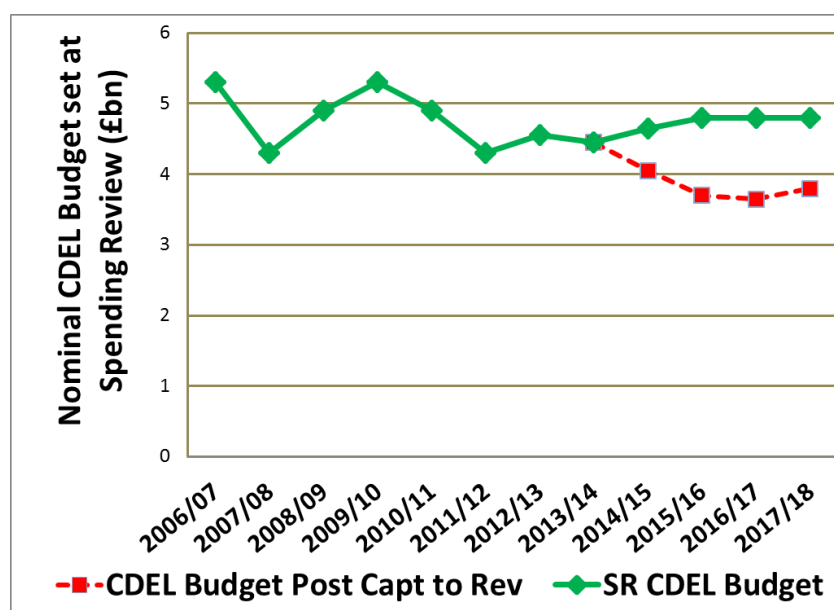
In recent years, capital underspends, capital to revenue transfers and a general lack of access to capital financing has meant many trusts have had to delay, cancel or rethink capital investment. For some this has meant major decisions about estates and infrastructure have not been made, which is contributing to a growing backlog maintenance.

The 2015 spending review provided flat funding for capital (in cash terms), of £4.8bn for the period 2015-2021. Various budgets and statements from HMT have topped up these annual limits, with the 2017 Spring and Autumn Statements providing an additional £3.9bn capital funding up to 2022/23.

However, in recent years, we have seen a consistent annual transfer from the capital budget to the revenue budget, peaking in 2016/17 when £1.2bn was reallocated reducing the capital budget by 22%. Over the last four years, net capital to revenue transfers have amounted to around £4bn in total.

During 2017/18 the DHSC notified the HMT that it would be transferring £1bn of its capital expenditure limit to its revenue budget. The decision to transfer from capital to revenue budgets may be based on the reprioritisation of the DHSC's funds over the course of several years. Decisions to transfer may also be made in year based on projected capital use in the sector. There is no option for government departments to carry forward underspends that are not forecast in advance of November/December during any given financial year, which means that transfers have been made on the best available information about capital expenditure plans in the NHS.

Figure 1: Trends in capital budgets, net of CDEL to RDEL switches



This meant that in 2017/18, the capital budget was actually £5.2bn post transfer[†], with providers allocated £3.3bn of this pot. Despite the considerable effort put into capital planning and forecasting, the sector still underspent against its allocation. The latest available data reveals net capital expenditure by providers in 2017/18 was £3.1m – a £267m underspend against the planned budget.

We understand that DHSC and HMT are planning to continue to reduce the level of transfer from the capital to revenue budgets, down from its peak in 2016/17. It is the intention that all transfers will be eradicated by the end of the original spending review period.

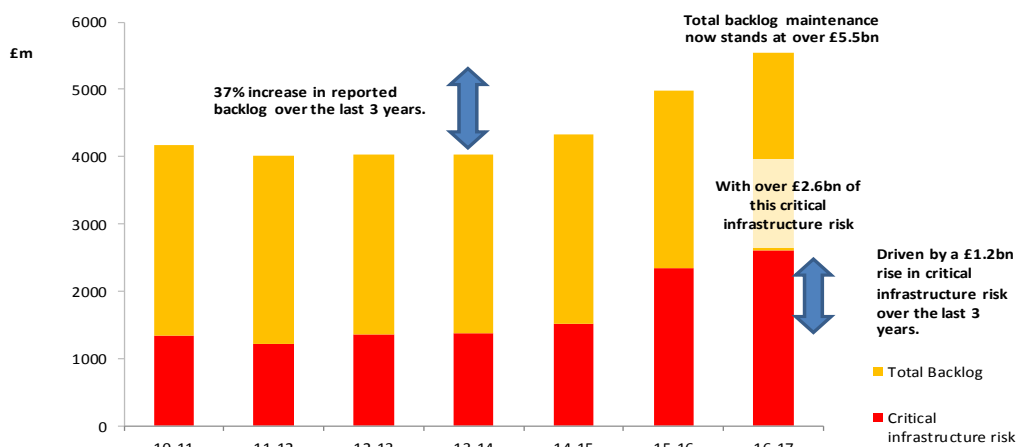
In 2017/18 the majority of capital expenditure was financed by NHS providers themselves (77%) through internally generated funds, cash from surpluses, depreciation and monies loaned from the DHSC or externally. As in previous years, most other capital expenditure is funded and allocated directly by the DHSC and its arms length bodies, with an even smaller portion raised via private finance.

Backlog maintenance

Over the same period, trusts and foundation trusts have been facing a growing backlog maintenance bill. This backlog now stands at £5.5bn, over £2.6bn of which is critical or high risk infrastructure risk. Data from the Estates Return Information Collection (ERIC) 2016/17 suggests critical backlog maintenance is a bigger issue for acute providers than community, mental health or ambulance trusts.

[†] This figure includes around £1.1bn worth of central research and development which only counted against the CDEL from 2016 onwards.

Figure 2: Backlog maintenance trends reported by NHS trusts and FTs in ERIC returns



How are trusts and foundation trusts managed differently?

Different rules still exist for trusts and foundation trusts. Under current legislation foundation trusts retain much more legal freedom when it comes to capital expenditure. In practise however, due to the recent funding constraints, few foundation trusts have been able to retain the same flexibilities they had when they were first established, when surpluses and significant investment were the norm.

Oversight

Foundation trusts, as long as they not in financial special measures, in breach of their license or in receipt of distress funding, have legal freedoms over capital expenditure. Nevertheless, all significant or material capital investment or property transactions, regardless of funding source, must be reported to NHSI. Following submission, the foundation trust and NHSI will then agree whether a more detailed review is needed, led by the regulator.

NHS trusts meanwhile are subject to capital resource limits (CRLs) set by NHSI and based on depreciation and agreed spending plans. Each trust's CRL restricts the maximum amount of capital expenditure that may be incurred in-year. They are allocated in two ways – firstly as part of the initial limits based on the trust's depreciation, but secondly they can also be allocated in-year for additional expenditure as agreed with NHSI in conjunction with DHSC (e.g. as financing through agreed loans or PDC or through the allocation of the central programme budgets). Trusts must not overspend against their CRL and forecast underspends should be identified and flagged to NHSI during the year, and ideally no later than quarter two. CRLs cannot simply be carried forward; this underlines the importance of accuracy in provider plans.

NHS trusts (as well as NHS foundation trusts in financial distress) are also subject to delegated limits on capital spending. These limits (the thresholds of which can be [found here](#)) apply to whole-life costs not just capital costs. Delegated limits apply to IT purchases, leased equipment, leased property, managed

equipment, managed service and energy service performance contract schemes. Business cases must be submitted for central approval for any investment with a financial value that meets the threshold.

Central support and funding

Both foundation trusts and trusts can apply for centrally supported financing, in the form of loans, public dividend capital (PDC), grants or other central payments. Historically, the main route for central support for Foundation Trusts has been via the Independent Trust Financing Facility (ITFF) and for Trusts the Trust Development Authority and subsequently NHS Improvement. The ITFF was set up to advise the Secretary of State on the provision of financial assistance, which the DHSC may consider but is not obliged to follow. In recent years there have been four main types of support funding offered, which often require application via the ITFF (as set out in the [section 42A guidance](#) and summarised below). While the ITFF still retains a role in providing advice on loan funding, in reality insufficient levels of capital funding has meant there is less availability of such loan funding.

Traditionally there have been a number of streams of central support available for capital. These have included the normal course of business loan application via NHSI (for trusts and FTs in financial difficulty) or the ITFF (for all other FTs); interim loan applications for urgent requirements which trusts are unable to self fund, via NHSI; and strategic investments (usually in the form of PDC) for specific programmes, such as A&E, cyber security and cancer task force initiatives. More recently trusts and foundation trusts have been able to apply for PDC through the STP capital process.

What will future funding look like?

The current prioritisation for capital funding therefore offers a variety routes for providers to access capital investment. Greater clarity and simplification of funding routes would be welcome not least because of the complexity and disparate information available. Budgets are ring-fenced for national programmes (cyber security, digitisation and A&E reconfigurations for example). For local spending decisions however, there is greater certainty around the STP funding route due to the multi-year commitments made by the government last year.

STP capital financing

In the 2017 Spring Budget the Chancellor announced additional investment of £325m over the next three years to support pioneering STP areas in planning next generation health and care services. In July 2017 schemes were announced across 15 of the most advanced STPs, with overall costs (going beyond the three funding years) of £440m. Later that year in the autumn statement, the chancellor announced a further £2.6bn to be allocated to the highest quality STP schemes. So far £1.45bn has been announced:

- £219m to 12 schemes across 10 STPs on day of the statement in November 2017
- £760m to 40 schemes across 21 STPs in March 2018
- £36m to 6 ambulance trusts to fund new ambulance fleet and infrastructure to support performance this winter.

In July 2018, all STPs submitted capital bids for the residual £1.48bn capital fund. This covered medium-small sized schemes, and separately, larger schemes. Due to the nature of these bids, STPs were asked to prioritise capital schemes once they had been identified, as well summarise surplus land and housing opportunities across the patch.

Successful bids will be announced in the autumn but the government has suggested there will be further opportunities to access STP capital in the future. Bids must score well against the six DHSC/HMT criteria: transformation, patient benefit including demand management and delivery of core targets, value for money, financial sustainability, alignment with estate strategy and deliverability. Large schemes (in excess of £100m) will be assessed separately and are subject to longer decision making timescales. It should be remembered that even if STP capital is approved, business case approval from NHSI, DHSC, and HMT will subsequently be required for all schemes, irrespective of value.

DHSC capital regime review

The Autumn Budget 2017 announced that the additional £3.5bn capital funding for the NHS will be complemented by work to review and improve the rules that inform trusts' use of capital funding, to help make sure that they can maintain their facilities most effectively. The review is being undertaken internally by DHSC, working together with key stakeholders, including HMT, NHSI and NHSE. The review aims to determine options for better ensuring that capital funding is generated and deployed to best effect to maintain and enhance the NHS estate and other capital assets. It is expected to run until autumn this year and will inform options for consideration by ministers. Any policy or operational changes made as a consequence will be set out publicly.

The DHSC's CDEL for future years will be set out in the 2019 government spending review, but it is likely that STPs will continue to feature strongly in the allocation of this. It is also not clear what the role of the joint regional structures will have in the future decision making process of allocating funds, but work is in progress to resolve current uncertainty in the system.

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