Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts

November 2016
About NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
Contents

1. Overarching principles ................................................................. 5

2. Capital regime ............................................................................... 7
   Background .................................................................................. 7
   General capital planning principles ............................................. 7

3. Capital investment and property transactions ................................. 8
   Delegated limits for capital investment and property transactions .... 8
   Equipment leases and property leases (except local improvement
time trusts and third-party development schemes providing buildings
for healthcare/service provision) .................................................. 12
   Managed equipment and managed service schemes ....................... 13
   Energy services performance contracts ........................................ 13

4. Capital investment and property transactions business case approval
   process .......................................................................................... 14
   Development of business cases using the five case model ................. 14
   Approval process and business case documentation ....................... 15
   Further information: SOC, OBC and FBC approval process ............. 20
   Timetable for capital investment and property transaction business cases .... 22
   Private finance initiative and local improvement finance trust schemes .... 23
   Disposals ..................................................................................... 24
   Overage or claw back provisions ................................................... 25
   Joint business cases ..................................................................... 25
   Consortium investments .................................................................. 25
   External financing and delegated limits .......................................... 26
   DH capital investment financing applications ................................... 26
   Non-DH financing .......................................................................... 26
   NHS Improvement review process ................................................. 27
   Post-project evaluation ................................................................... 28

5. NHS-trust specific guidance ......................................................... 30

6. Glossary and acronyms .................................................................. 30

7. Contact details ................................................................................ 30
The following annexes referred to in this guidance are published separately:

Annex 1: Business case core checklist
Annex 2: Clinical quality review guidance (applicable to foundation trusts in financial distress and to all NHS trusts)
Annex 3: Guidance for producing the strategic outline case
Annex 4: Strategic outline case – technical requirements
Annex 5: Business case key stage documentation for foundation trusts in financial distress and NHS trusts, and NHS Improvement delegated limits
Annex 6: Technical guidance applicable to foundation trusts in financial distress and to all NHS trusts
Annex 7: NHS trust-specific guidance
Annex 8: Post-project evaluation templates for foundation trusts in financial distress and all NHS trusts
Annex 9: Roles and responsibilities
Annex 10: Template recommendation report
Appendix 11: Whole-life cost – template recommendation report
Annex 12: Disposal of land/property – template recommendation report
Annex 13: Guidance for foundation trusts that are not in financial distress
Annex 14: Glossary and list of acronyms
1. Overarching principles

1.1 NHS Improvement recognises that for some trusts improving their infrastructure is key to improving services. The process described in this guidance relates to the approval of capital expenditure and attempts to provide a balance between:

- allowing NHS trusts and foundation trusts the freedom to manage their own capital investment up to an agreed threshold and
- ensuring that there is sufficient governance and assurance for the approval of capital investments, particularly given the capital departmental expenditure limit (CDEL) set by Her Majesty’s Treasury (HMT) within the current Spending Review period.

Achieving sufficient assurance and governance at the same time as enabling investment to develop trusts in a sustainable way will be an extremely important strand of NHS Improvement’s work going forward.

1.2 The capital regime (see Section 2) described in this guidance is applicable to all NHS trusts and foundation trusts.

1.3 Existing thresholds for reporting and review remain in place for foundation trusts that are not deemed to be in financial distress. Foundation trusts that are not deemed to be in financial distress should report a capital investment or property transaction to NHS Improvement if it is significant or material. Such transactions include, but are not limited to:

- projects funded through private finance initiatives
- significant and material capital investments
- joint ventures
- transactions that attract Competition and Markets Authority reviews.

Foundation trusts that are not deemed to be in financial distress should refer to Annex 13 which sets out in more detail the framework for capital investment.

1.4 The capital delegated limits and business case approval process (see Sections 3 and 4) applies to any foundation trust deemed to be in financial distress (see paragraph 1.5) and to all NHS trusts.

1.5 The Department of Health (DH) considers a foundation trust to be in financial distress if any of the following apply:

- in financial special measures
- in breach of its licence (financial or non-financial breaches)
in receipt of interim financing (received or planned).

1.6 Distress financing includes all interim capital and revenue support loans, interim revenue and interim capital support public dividend capital and interim revolving working capital support facilities.

1.7 This guidance sets out the overarching principles relating to the:

- capital regime (Section 2)
- delegated limits for capital investment and property transactions (Section 3)
- capital investment and property transactions business case approval process (Section 4)
- NHS trust-specific guidance (Section 5)
- the reporting and review framework for significant capital investments in foundation trusts not deemed to be in financial distress (Annex 13).

1.8 This guidance clarifies the rules and requirements regarding the review and approval of capital investment and property transactions. It should help NHS trusts and foundation trusts to negotiate the processes involved as smoothly as possible: to produce well-planned business proposals using only the necessary time and resources, with a clearly articulated financial case that delivers significant benefit to patients.

1.9 This guidance replaces all previous guidance relating to the capital regime and investment business case approval process published by the NHS Trust Development Authority (NHS TDA) or Monitor, and is effective from its publication date. It applies to both NHS trusts and foundation trusts.

1.10 It should be noted that if DH cash financing is required, this is subject to a separate application process as described in Section 4.

1.11 Further technical guidance is included in Annexes 1 to 14 and in the links in the guidance.
2. Capital regime

Background

2.1 The 2015 Spending Review set the level of capital available to the NHS.

2.2 Financial discipline is necessary in a tight spending environment. Resource spending is increasing in real terms but capital expenditure will be more constrained. As a result this is a medium-term challenge for the NHS.

2.3 In this context trusts should be aware that access to Department of Health (DH) capital financing will be more restricted than in previous years and expenditure that scores against the DH capital departmental expenditure limit (CDEL) will be subject to increased control and scrutiny going forward. Trusts should also note that all capital expenditure, however financed (whether through self-generated resources, DH financing or borrowing from financial institutions, local government or other sources), scores against the DH departmental spending limit.

General capital planning principles

2.4 Trusts are required to draw up capital investment plans and associated capital cash management plans in line with local investment priorities, agreed strategic plans and affordability. NHS Improvement is required by DH to work with trusts on the following areas:

- review of the deliverability and local affordability of trust capital plans
- testing of trust capital cash management plans to ensure they can be financed by the trust
- testing that capital investment plans have been completed in accordance with the guidance set out in this document, the planning framework for the year being considered and any further national guidance issued by DH or Her Majesty’s Treasury (HMT)
- review of the affordability of trust capital plans against the national CDEL set by DH and HMT
- review of requests to DH for capital financing from foundation trusts in financial distress and all NHS trusts
- review of capital investment plans to ensure they reflect nationally prioritised and approved sustainability and transformation plans.
3. Capital investment and property transactions

Delegated limits for capital investment and property transactions

3.1 Her Majesty’s Treasury (HMT) and the Department of Health (DH) have confirmed the delegated limits for capital investment and property transactions. Delegated limits will apply to foundation trusts in financial distress and to all NHS trusts, and are applicable with immediate effect. A foundation trust is deemed to be in financial distress if any of the conditions listed in paragraph 1.5 apply.

3.2 Delegated limits apply to capital investment and property transactions business cases including asset disposal business cases, and business cases for IT, leased equipment, leased property, managed equipment, managed service and energy service performance contract schemes where the delegated limits apply to whole-life costs, not just capital costs (see paragraphs 3.21 to 3.27). NHS Improvement and DH are responsible for approving business cases with capital and/or whole-life cost values over an agreed delegated limit; see Table 1 below.

3.3 DH has confirmed that the following levels of delegated approval will be required for capital investment business cases going forward:

- Capital schemes with an investment value in excess of £15 million will require NHS Improvement and DH approval before they can be taken forward by an NHS trust or a foundation trust in financial distress.

- Capital schemes with an investment value in excess of £30 million will require NHS Improvement Resources Committee and DH approval before they can be taken forward by an NHS trust or a foundation trust in financial distress.

- Capital schemes with an investment value in excess of £50 million will also require NHS Improvement Board approval. After being approved by the NHS Improvement Resources Committee and NHS Improvement Board, these schemes will require approval from DH and HMT.

Organisations are asked to note that the delegated approval limits will apply to all capital schemes, including projects undertaken by any NHS trust and by any foundation trust in financial distress. Where a scheme is considered to be novel, contentious or repercussive, providers are required to consult NHS Improvement. NHS Improvement may decide that the case requires approval. DH and HMT may also need to approve such cases. The decision on what constitutes a novel, contentious or repercussive case lies with NHS Improvement, DH and HMT, with HMT being the final arbiter.

3.4 This section provides clarity on the levels of delegated authority applicable to foundation trusts in financial distress and to all NHS trusts, and the process
for review and approval that needs to apply to capital investment and property transactions before the authorisation stage.

3.5 All trusts have delegated authority to approve capital investment business cases with a financial value for the proposed capital investment or property transaction of up to £15 million (capital costs or whole-life costs for applicable cases) subject to paragraphs 3.14 to 3.20 below. NHS Improvement expects trusts to apply robust governance and assurance processes in the approval of business cases below £15 million that are reviewed under the trusts’ own governance arrangements. NHS Improvement anticipates that business cases below £15 million, subject to internal trust approval processes, should follow best practice in producing the business case and use HMT guidance regarding the five case model (see paragraph 4.2 for further detail), as well as following the trusts’ own governance policies and procedures. NHS Improvement expects that for trusts’ own governance purposes, the same principles of best practice and robust governance should be applied in the production and approval of business cases by those foundation trusts not deemed to be in financial distress.

3.6 All capital business cases over £15 million should be subject to appropriate governance processes, including approval from the trust board before being submitted to NHS Improvement. NHS Improvement anticipates that the approvals required in this guidance build on the good governance processes already in place in NHS trusts and foundation trusts, and that most of the documentation NHS Improvement and DH require to approve investment decisions should already be available in organisations.

3.7 The NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of finance and then DH will be required to approve business cases between £15 million and £30 million. The decision will be reported to the NHS Improvement Resources Committee as part of the regular reporting cycle.

3.8 Decisions regarding approval of business cases for capital investment and property transactions over a threshold of £30 million and up to a threshold of £50 million will be made by the NHS Improvement Resources Committee and then DH before they can be taken forward by an NHS trust or a foundation trust in financial distress.

3.9 Recommendations regarding approval of business cases for capital investment and property transactions over a threshold of £50 million will be made by the NHS Improvement Resources Committee and will require full approval from the NHS Improvement Board before being sent to DH and HMT for approval. Business cases that are subject to whole-life cost rules, where the whole-life cost exceeds £50 million, will not require NHS Improvement Board approval but will require NHS Improvement Resources Committee approval (unless these cases are specifically referred to the NHS
Improvement Board for a decision by the NHS Improvement Resources Committee). NHS Improvement will discuss individual whole-life cost business cases over £50 million with DH. DH will liaise with HMT to determine what approval is required.

3.10 NHS Improvement will approve NHS capital investment and property transaction business cases up to a threshold of £50 million. Business cases with an investment value between £15 million and £50 million also require DH approval. Any capital business cases over £50 million will be subject to a more detailed approval from DH before submission to HMT for final approval. Strategic outline cases (SOC), outline business cases (OBC) and full business cases (FBC) over £50 million will require approval from the NHS Improvement Resources Committee and/or NHS Improvement Board before being submitted to DH/HMT for approval.

3.11 Foundation trusts in financial distress and all NHS trusts will be required to notify NHS Improvement of capital investment cases with a value between £7.5 million and £15 million being approved by their own boards and not captured by the above, so that NHS Improvement can review those trusts with high numbers of sub-£15 million schemes.

3.12 Foundation trusts in financial distress and all NHS trusts should not incur expenditure, other than essential fees, on capital schemes until the FBC has been approved by the appropriate approving official, committee, board, DH or HMT as set out in Table 1 below. Until such approval is received, all costs are incurred at the trust’s own risk and a secured source of funding must be identified by the trust to cover this expenditure.

3.13 The authorisation levels for foundation trusts in financial distress and for all NHS trusts for investment cases and property transactions (including disposals and cases subject to whole-life cost rules) are summarised in Table 1 below. Further details are included in Annex 5.

3.14 Irrespective of the delegated limits set out in this document, capital investment schemes or property transactions that are deemed novel, contentious or repercussive, or to have novel, contentious or repercussive financing arrangements, may also require NHS Improvement, DH and HMT approval. The approving officer may refer any proposal that may be considered to be novel, contentious or repercussive, regardless of size, to the NHS Improvement director of finance, Resources Committee or Board for a view and/or approval decision.

3.15 Trusts should discuss all cases that could be deemed to be novel, contentious or repercussive with their NHS Improvement executive regional managing director and/or the regional finance team before proceeding so that the regional team can advise on the approval process. Regional finance teams may refer decisions on approval processes for these cases to the NHS Improvement Capital and Cash Team, where required.
### Table 1: Delegated limits for foundation trusts in financial distress and all NHS trusts

<table>
<thead>
<tr>
<th>Financial value of the capital investment or property transaction*</th>
<th>Approving person/committee/board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £15 million</td>
<td>Trusts approve under their own governance arrangements (subject to paragraphs 3.14 and 3.18)</td>
</tr>
<tr>
<td>£15 million to £30 million</td>
<td>NHS Improvement executive director of resources/deputy CEO or NHS Improvement director of finance and DH</td>
</tr>
<tr>
<td>£30 million to £50 million</td>
<td>NHS Improvement Resources Committee and DH</td>
</tr>
<tr>
<td>Over £50 million</td>
<td>NHS Improvement Resources Committee, NHS Improvement Board, DH and HMT**</td>
</tr>
</tbody>
</table>

* Financial value applies to capital investment and property transactions, asset disposal and whole-life cost business cases.

** Investment business cases subject to whole-life cost rules where the whole-life cost exceeds £50 million will not require NHS Improvement Board approval but will require NHS Improvement Resources Committee approval (unless these cases are specifically referred to the NHS Improvement Board for a decision by the NHS Improvement Resources Committee). NHS Improvement will discuss individual whole-life cost cases that exceed £50 million with DH to confirm whether or not DH and HMT approval is required for the business case.

3.16 Where the accounting treatment of a capital investment is deemed novel, contentious or repercussive, it is likely that the trust will be required to obtain written confirmation of the acceptance of the proposed accounting treatment from its external auditors and to submit this confirmation as supporting evidence to NHS Improvement alongside the formal business case submission.

3.17 NHS Improvement is in regular discussion with DH regarding business case approvals. DH reserves the right to require business cases that are deemed novel, contentious or repercussive, regardless of size, to also be subject to a DH and HMT approval process. The decision on what constitutes a novel, contentious or repercussive case lies with NHS Improvement, DH and HMT, with HMT being the final arbiter.

3.18 Foundation trusts in financial distress and all NHS trusts are asked to note that the £15 million proposed delegated limit can also be lowered at NHS Improvement’s discretion if any of the following apply:

- business cases are considered to be novel, contentious or repercussive
- trusts are in the highest risk categories of distress based on segmentation analysis
• trusts have excessive numbers of business cases with investment values below £15 million. Where this is the case, the lower delegated limit should be agreed by the relevant executive regional managing director and trusts notified of this in writing.

3.19 Where lower delegated limits are applied trusts should notify the relevant executive regional managing director/regional finance team of all business cases between the agreed lower delegated limit and the original limit of £15 million that are likely to require NHS Improvement approval. The need for approval will be confirmed by the relevant executive regional managing director/regional finance team.

3.20 Where a capital business case falls between the trust’s original delegated limit and its new lowered limit, it is reviewed and approved by the relevant executive regional managing director and team. The relevant executive regional managing director will have discretion to approve the business case without it going through further levels of approval, eg NHS Improvement executive director of resources/deputy chief executive, director of finance or Resources Committee.

Whole-life cost schemes

3.21 For IT, leased equipment, leased property, managed equipment, managed service and energy service performance contract schemes, the delegated limits apply to whole-life costs, not just capital costs. DH/HMT whole-life cost rules apply to contracts with capital and revenue costs over the life of the contract. Schemes with whole-life costs in excess of trust delegated limits will require NHS Improvement and DH approval in line with the delegated limits outlined above.

3.22 The levels of authorisation for these business cases are in line with those set out in Table 1 above. Schemes of these types with a whole-life value in excess of £50 million will be reviewed on a case-by-case basis in consultation with DH to ascertain whether DH or HMT approval will be required.

3.23 The limits apply to the whole-life cost of the transaction, rather than just the capital cost. The definitions that apply to these delegations and further guidance on business cases subject to whole-life cost calculations are set out in Annex 6.

Equipment leases and property leases (except local improvement finance trust and third-party development schemes providing buildings for healthcare/service provision)

3.24 For finance leases of equipment and buildings, it is the whole-life cost payable under the contract, excluding VAT, that is compared to the delegated limit. To clarify, this includes any servicing and materials that must be paid for under
the contract, even if these are itemised separately, and any enabling capital expenditure that is required, eg premises alterations to accommodate the equipment or, in the case of property, to make it suitable for the occupier’s use.

3.25 The relevant term over which to calculate the whole-life cost is the contractual term. In the case of property, any break points that are exercisable only by the occupier should be ignored, as should any statutory right of renewal.

Managed equipment and managed service schemes

3.26 A managed equipment service (MES) or managed service scheme (MSS) is an arrangement with a private sector service to provide installation, management, maintenance, disposal of equipment or services, as well as training and reporting. These contracts are generally for five years upwards and as such it is the whole-life cost of the contract that should be compared to the delegated limits in Table 1 above.

Energy services performance contracts

3.27 Energy services performance contracts (ESPC) are contracts with an energy services company delivering an organisation’s energy and carbon strategy, and typically run for 15 to 25 years. Funding is usually, but not exclusively, provided by a third-party investor. The trust pays a unitary payment to the supplier but gains the benefit of guaranteed savings. In developing this type of investment proposal, trusts should ensure that the business case clearly describes the accounting treatment, with supporting written external auditor advice where this treatment is open to interpretation. In addition, the business case should include a robust public sector comparator which has been fully costed and appraised against the other shortlisted options. The business case should also confirm the expected realisation of guaranteed savings arising under the contract and the rates of return. Whole-life cost rules will apply to these contracts and should be compared to the delegated limits in Table 1 above.
4. Capital investment and property transactions business case approval process

4.1 NHS Improvement will require assurance that a capital investment business case has been subject to an appropriate level of scrutiny and governance by the trust proposing the investment, before the case is submitted to NHS Improvement. As part of the approval process NHS Improvement will ask trusts to demonstrate that:

- the investment proposal is consistent with the trust’s clinical strategy and supports the provision of high quality care
- the investment proposal is consistent with and supported by the sustainability and transformation plan
- the investment proposal demonstrates a high level of engagement with clinical staff and the use of appropriate staff and patient feedback
- the quality, safety, productivity, affordability, value for money and workforce implications associated with the investment proposal are robust, well thought through and described in the business case
- there is a clearly identified source of financing
- the staff experience is taken into account, eg health and wellbeing and health and safety considerations
- there is a clear and credible approach to enhancing the delivery of patient care and performance standards
- issues relating to the sustainability of the wider local health system have been addressed and the proposed solution adequately assists the health system in managing present and future issues
- the trust has the resource and capacity to deliver the investment programme within a realistic timeframe.

Development of business cases using the five case model

4.2 For major spending proposals (cases over £15 million), there are three key stages in the development of a project business case, which correspond to the key stages in the spending approval process. These are the strategic outline case (SOC), outline business case (OBC) and full business case (FBC) (see Annex 5). Her Majesty’s Treasury’s (HMT) standard five case model should be followed at each key stage in the development of business cases. This model comprises the following five key components:

- strategic case
- economic case
- commercial case
- financial case
- management case.

4.3 The NHS Improvement model and associated NHS Improvement business case core checklist also consider clinical quality in the development of business cases with a patient-facing or clinical aspect. The NHS Improvement business case core checklist has been developed in collaboration with the Department of Health (DH), NHS Digital (formerly the Health & Social Care Information Centre (HSCIC)) and NHS England.

4.4 Detailed guidance on the production of business cases using the five case model can be found in HMT’s Green book.¹

Approval process and business case documentation

4.5 Business cases requiring NHS Improvement approval should be sent by trusts to the relevant executive regional managing director and/or regional teams in the first instance. For foundation trusts in financial distress and all NHS trusts, NHS Improvement will expect, as a minimum, to receive an OBC and FBC for all investment business cases with a value exceeding £15 million and a SOC for any business cases over £15 million that require DH finance. For cases that exceed £30 million, NHS Improvement will expect to receive a SOC, OBC and FBC (or equivalent for a private finance initiative (PFI) preferred solution; that is, PFI appointment business case (ABC), PFI confirming business case (CBC), etc). A SOC will not be required for disposal cases. In addition, the business case core checklist in Annex 1 will need to be completed and submitted to NHS Improvement with each OBC and FBC version of the business case, including the clinical quality checklist for all business cases with a patient-facing or clinical aspect. Further clinical quality review guidance is included in Annex 2.

4.6 A summary of the business case key stage documentation is set out in Table 2 below. The business case core checklist (see Annex 1) should be completed in accordance with Table 2 below. For any novel, contentious or repercussive cases involving clinical services, we recommend that the checklist is completed. Further details of the approval process and documentation requirements is given in Annex 5.

4.7 The executive regional managing director is requested to provide assurance that the business case has been subject to an appropriate governance and

clinical engagement process, and that the proposed investment is affordable and represents good value for money to the taxpayer.

**Table 2: Business case key stage documentation**

<table>
<thead>
<tr>
<th>Financial value of the capital investment or property transaction</th>
<th>Key stage documentation</th>
<th>Business case core checklist required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £15 million</td>
<td>Trusts internal governance process</td>
<td>No</td>
</tr>
<tr>
<td>£15 million to £30 million</td>
<td>OBC and FBC required (SOC also required for any scheme requiring DH finance)</td>
<td>Yes, plus the clinical quality checklist for all business cases with a patient-facing or clinical aspect</td>
</tr>
<tr>
<td>£30 million to £50 million</td>
<td>SOC, OBC and FBC required (or SOC, PFI/PF2 ABC, PFI/PF2 CBC) (for the purposes of this document, PFI/PF2 includes LIFT*** )</td>
<td>Yes, plus the clinical quality checklist for all business cases with a patient-facing or clinical aspect</td>
</tr>
<tr>
<td>Over £50 million</td>
<td>SOC, OBC and FBC required (or SOC, PFI/PF2 ABC, PFI/PF2 CBC)</td>
<td>Yes, plus the clinical quality checklist for all business cases with a patient-facing or clinical aspect</td>
</tr>
</tbody>
</table>

* Table 2 is applicable to foundation trusts in financial distress and to all NHS trusts. If NHS Improvement requires the business case to be approved, the trust is required to submit the business case and the business case core checklist, including the clinical quality checklist for any business cases with a patient-facing or clinical aspect.

** Private finance 2 (PF2) is the new approach to public private partnership.

*** LIFT, local improvement finance trust.

4.8 The financial values in Table 2 above apply to capital investment and property transaction business cases including asset disposal business cases and whole-life cost business cases. Note that a combined OBC and FBC will not be accepted by NHS Improvement. Where these are received, the trust will be asked to prepare separate business cases.

4.9 Business cases submitted to NHS Improvement must have been approved by the relevant trust board and the trust should be prepared to submit a copy of the board minutes recording this approval.

4.10 Business cases submitted to NHS Improvement by trusts must be congruent with the trust’s long-term service and financial strategy, and this will be tested as part of the business case review.
4.11 The trust should demonstrate affordability through a review and triangulation of quality, workforce and efficiency considerations. Further clinical quality review guidance is given in Annex 2.

4.12 The primary expectations for key stage documents are summarised in Table 3 below and these areas will be tested in the NHS Improvement review of the business case.

Table 3: Primary expectations for key stage documents

<table>
<thead>
<tr>
<th>Key stage document</th>
<th>Outline expectation</th>
</tr>
</thead>
</table>
| Strategic outline case (SOC) | - Strategic rationale and benefits of the investment are clearly set out and demonstrate underlying health need for the investment.  
- Alignment of the scheme to clinical strategy and commissioning intentions:  
  o the trust board has an approved clinical strategy informed by national service quality reviews  
  o for the purposes of sustainability, the capital scheme proposal is in line with commissioning intentions  
  o the capital scheme proposal is aligned to the delivery of the clinical strategy  
  o the impact of the capital scheme proposal on existing service configuration has been assessed  
  o the clinical strategy is aligned to the trust’s workforce strategy.  
- Confirmation that one or more deliverable and affordable solutions exist to deliver the strategic objective before cost is incurred preparing an OBC.  
- The proposed timetable for the business case is set out, including when the trust board can expect to receive the business case.  
- The indicative financial value of investment is included.  
- Project management arrangements for the business case are outlined.  
- The intended procurement method is set out.  
- For schemes with a value below £50 million, NHS Improvement will discuss with the trust the requirement for letters of commissioner support to be in place at this stage of the business case production, but it is good practice to have these letters in place as early as possible.  
- For schemes in excess of £50 million, note that letters of commissioner support are required at SOC stage.  
- There is evidence of senior and relevant clinical leadership and ownership of the business case. |
<table>
<thead>
<tr>
<th>Key stage document</th>
<th>Outline expectation</th>
</tr>
</thead>
</table>
| **Outline business case (OBC)** | • The five case model covering the strategic, economic, financial, commercial and management cases is followed; this also includes clinical quality.  
• Clinical quality is specifically considered and is a core theme running throughout the five components.  
• There is a link between the clinical and workforce strategy.  
• The executive summary is clear regarding the recommended solution.  
• The strategic context, rationale and benefits of the investment are clearly set out and demonstrate underlying health need for the investment.  
• Options for appraisal are formulated and described in sufficient detail.  
• Benefit criteria against which options are to be evaluated are developed and lead to a clear preferred option.  
• Criteria have been provided to measure the success of the development.  
• The trust has demonstrated that activity and capacity planning meets the requirements of the commissioners/local health system and is robust.  
• The overall impact, financial and non-financial (including full quality impact assessments), has been assessed and evaluated.  
• A clear statement of affordability and funding sources is provided for capital and revenue.  
• Letters of commissioner support are required.  
• There is evidence of senior and relevant clinical leadership and ownership of the business case.  
• A self-assessment business case core checklist is complete and returned, including the clinical quality checklist for all schemes with a patient-facing or clinical aspect. |
| **Full business case (FBC)** | • As for OBC above, with content updated or confirmed for the final version of the business case.  
• The executive summary is clear regarding the recommended solution.  
• Financial figures are confirmed and final.  
• The clinical quality case is clearly demonstrated.  
• There is a clear statement of affordability and funding sources are provided for capital and revenue. |
<table>
<thead>
<tr>
<th>Key stage document</th>
<th>Outline expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Outstanding issues from OBC stage review raised by NHS Improvement have been addressed.</td>
</tr>
<tr>
<td></td>
<td>• The trust has demonstrated that activity and capacity planning assumptions and modelling are consistent with the delivery of the clinical strategy and aligned with workforce plans, service developments and efficiency programmes.</td>
</tr>
<tr>
<td></td>
<td>• Final letters of commissioner support are required.</td>
</tr>
<tr>
<td></td>
<td>• A self-assessment business case core checklist is complete and returned, including the clinical quality checklist for all schemes with a patient-facing or clinical aspect.</td>
</tr>
</tbody>
</table>

4.13 At conclusion of the FBC, the development of the business case across the five components of the five case model is complete with full consideration of clinical quality. This is illustrated in Figure 1 which also shows its development relative to the SOC and OBC.

**Figure 1: The five case model and clinical quality**

4.14 A joint DH, NHS Digital, NHS England and NHS Improvement business case core checklist is given in Annex 1. A bespoke NHS Improvement clinical quality checklist has been added to the core checklist and should be completed for all business cases with a patient-facing or clinical aspect. The checklist is for use by both trust project teams and NHS Improvement in reviewing and providing assurance on capital investment and property transaction business cases. Project teams should treat the checklist as a combination of guidance and advice on material which should be included in a business case.
4.15 The checklist represents minimum guidelines for the inclusion of information in the business case. HMT’s *Green book* and related five case model guidance should be followed to produce a complete business case.

**Further information: SOC, OBC and FBC approval process**

4.16 It is good practice for trusts to produce a SOC for significant business cases for the trust’s own governance and assurance purposes.

4.17 For business cases that do not require DH finance, with a value between £15 million and £30 million, it will not be necessary for trusts to submit a SOC to NHS Improvement unless specifically requested to do so. However, it is good practice for the trust to produce a SOC for its own governance and assurance purposes.

4.18 For business cases with a value between £15 million and £30 million that require external finance, trusts will be required to submit a SOC to NHS Improvement.

4.19 A SOC is not required for land or property disposal business cases irrespective of the value of the disposal.

4.20 Where business cases with a value between £15 million and £30 million are reliant on DH financing, they will require review and approval of a SOC by the NHS Improvement director of resources/deputy chief executive or NHS director of finance and DH.

4.21 A SOC will be required from trusts for all investment business cases over £30 million, including whole-life cost cases.

4.22 All SOCs for schemes with a value between £30 million and £50 million are subject to review and approval from the NHS Improvement Resources Committee and DH.

4.23 For schemes with a value between £30 million and £50 million the SOC will also require formal NHS Improvement executive regional managing director approval to ensure it fits with the overall trust strategy and the local health system strategy. The trust will be notified in writing of the decision on the SOC, setting out any points for the trust to incorporate in the OBC.

4.24 All SOCs for schemes with a value in excess of £50 million will need to be approved by the NHS Improvement Resources Committee, NHS Improvement Board, DH and HMT.

4.25 Where approval is required, a SOC will need to be approved by NHS Improvement (and DH and HMT where relevant) before a trust takes an OBC to its board for approval. SOC approval will need to be in place before an OBC is taken to the NHS Improvement Resources Committee for approval. Similarly, an OBC will need to be approved by NHS Improvement (and DH
and HMT where relevant) before a trust takes an FBC to its board for approval.

4.26 NHS Improvement will expect to receive, as a minimum, a SOC, an OBC and an FBC (or equivalent for PFI/PF2 preferred solutions; that is, a PFI/PF2 ABC, PFI/PF2 CBC, etc) for all investment business cases with a value exceeding £30 million (for disposals, a SOC will not be required). In addition, for all business cases over the trust’s own delegated limit, the business case core checklist in Annex 1 should be completed and submitted with each OBC and FBC version of the business case, together with a completed clinical quality checklist for all business cases with a patient-facing or clinical aspect.

4.27 NHS England’s guidance *Planning, assuring and delivering service change for patients* published in November 2015² is a good practice guide for anyone involved in service change or reconfiguration proposals, including trusts. The guidance sets out the required assurance process commissioners should follow when service reconfigurations are being considered.

4.28 The government has mandated four tests of service reconfiguration as follows:

- strong public and patient engagement
- consistency with current and prospective need for patient choice
- clear, clinical evidence base
- support for proposals from commissioners.

4.29 NHS England’s guidance sets out the roles and responsibilities that organisations involved in service change and reconfiguration proposals will undertake, including NHS England’s and NHS Improvement’s role in assurance and decision-making. Commissioners are expected to identify the range of service change options that could improve outcomes within available resources and provide credible high level capital costings for the infrastructure changes implied by each change option. In particular, commissioners are expected to discuss with NHS Improvement and DH where proposals are reliant on access to DH finance. Only those options that are sustainable in service, economic and financial terms should be exposed publicly.

4.30 To inform an assessment of proposals against the four tests of service reconfiguration above, NHS England requires that the lead commissioner, as the proposing body, should develop a pre-consultation business case (PCBC) ahead of public consultation demonstrating an evaluation of the options against a clear set of criteria. The PCBC should be refreshed following formal public consultation. The final decision-making business case (DMBC) will then

reflect the final proposal arrived at through this public consultation, which should ensure that it is sustainable in service, economic and financial terms, and can be delivered within available capital funding and capital departmental expenditure limit (CDEL) envelopes. Provided it contains sufficiently mature analysis, the approved PCBC and DMBC can be used to inform a SOC as required under NHS Improvement’s approvals guidance.

4.31 NHS England’s guidance confirms that formal consultation may not be required in every case, and this decision should be made in collaboration with the local oversight and scrutiny committee.

4.32 Annexes 3 and 4 provide more detailed guidance on the production of a SOC which aligns with DH and NHS England requirements.

Timetable for capital investment and property transaction business cases

4.33 NHS Improvement will work on an indicative 8 to 12 week approval cycle from submission of the business case to NHS Improvement to the presentation of the business case to the NHS Improvement director of resources/deputy chief executive/director of finance or Resources Committee for approval (see Table 4 below). The review period will include time for the NHS Improvement review, feedback and clarification, providing satisfactory responses are provided by trusts. The indicative review period for DH approval may need to be extended if DH raises further queries after NHS Improvement approval.

4.34 The indicative 8 to 12 week cycle is based on business cases with a financial value below £50 million. If a business case has a financial value over £50 million, additional time will need to be added to a trust’s timetable to secure NHS Improvement Board approval and DH/HMT approval.

4.35 The indicative timetable is also dependent upon the scheduled meeting dates for the NHS Improvement Resources Committee and NHS Improvement Board. Therefore, these meeting dates will need to be factored into any approval timetable.

4.36 The timetable is reliant on the quality of business cases being satisfactory for NHS Improvement review and on trusts supplying adequate responses within reasonable timescales. Where this is the case, the approval process can be shorter than the indicative 8 to 12 week cycle. Where this is not the case, NHS Improvement reserves the right to stop the business case review process ‘clock’ until the trust supplies satisfactory responses. In these cases trusts need to be aware that the review process will be extended. In addition, if external advice is required to support the business case review and assurance process, the review period may also be extended.

4.37 Table 4 below summarises the delegated limits and business case documentation requirements effective from the date of publication of this guidance.
Private finance initiative and local improvement finance trust schemes

4.38 Any schemes involving PFI/PF2 or local improvement finance trust (LIFT) schemes (new schemes or amendments such as contract variations, deed of variations, early termination) irrespective of value need to be discussed with NHS Improvement and DH before approval and may require full DH approval. These cases should be forwarded to the NHS Improvement Capital and Cash Team (email: NHSI.CapitalCashQueries@nhs.net) who will liaise with DH accordingly.

Table 4: Delegated limits and business case documentation requirements for foundation trusts in financial distress and all NHS trusts*

<table>
<thead>
<tr>
<th>Financial value of the capital investment or property transaction</th>
<th>Approving person/committee/board</th>
<th>Key stage documentation</th>
<th>Indicative review timescale for each stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £15 million</td>
<td>Trust board</td>
<td>In accordance with the trust's internal governance process but NHS Improvement will expect trusts to adopt the best practice approach</td>
<td>Not applicable</td>
</tr>
<tr>
<td>£15 million to £30 million</td>
<td>NHS Improvement executive director of resources/deputy chief executive or NHS Improvement Director of finance and DH</td>
<td>OBC and FBC required (SOC also required if DH finance required)</td>
<td>8 weeks</td>
</tr>
<tr>
<td>£30 million to £50 million</td>
<td>NHS Improvement Resources Committee and DH</td>
<td>SOC, OBC and FBC required (or SOC, ABC, CBC or LIFT stage 1 and 2 equivalent for PFI/PF2 or LIFT)</td>
<td>8–12 weeks</td>
</tr>
<tr>
<td>Over £50 million</td>
<td>NHS Improvement Resources Committee, NHS Improvement Board, DH and HMT</td>
<td>SOC, OBC and FBC required (or SOC, ABC, CBC or LIFT stage 1 and 2 equivalent for PFI/PF2 or LIFT)</td>
<td>Minimum 8–12 weeks (for NHS Improvement approval stage only)</td>
</tr>
</tbody>
</table>

* DH has defined foundation trusts in financial distress to be those trusts in financial special measures, in breach of their licence (financial or non-financial breaches) or in receipt of distress financing (received or planned).

Disposals

4.39 A trust will need to submit a business case to NHS Improvement where disposal proceeds are above its delegated limits. If the trust is seeking to use the disposal proceeds for reinvestment in its capital, the business case will need to make the case for both the disposal and the retention of proceeds.
The trust may be able to retain and reinvest the proceeds subject to business case approval from NHS Improvement. As a minimum, the disposal and retention business case will need to give an indication of what the retained receipts will be used for, e.g. reinvested in healthcare buildings/infrastructure.

4.40 The levels of authorisation for these business cases are in line with those set out in Table 1 above. Further detail is included in Annex 5.

4.41 NHS organisations are obliged to enter details of the property onto the e-PIMs register in accordance with health building note (HBN) 00-08 to enable other public sector organisations to come forward to purchase the land and/or property. Once land and/or property has been identified as surplus to a particular NHS organisation’s need, it should:

- check what legal interest it holds and whether the property is registered in its name on the land registry
- check whether property is required to be returned to the Secretary of State for Health where it was part of a Transfer Order carried out as part of the NHS reforms of 1 April 2013
- circulate details to nearby NHS organisations, NHS Property Services and local authorities, and register details of the land and/or buildings on e-PIMS. This notification should allow six weeks to two months for a purchaser to emerge before placing the property on the open market.

4.42 This is covered by section 4.0 of the HBN 00-08: The efficient management of healthcare estates and facilities.3

4.43 Once the NHS organisation is satisfied that there is no public sector requirement for the land and/or property, marketing of the land and/or property can commence.

4.44 Registering disposals on the e-PIMs register is a requirement for disposals of any value. In addition, for the trust’s own governance purposes, it is expected that all disposals will be fully supported by a business case. A cost–benefit analysis of the disposal options should inform the business case. Business cases over the trust’s delegated limit will require approval from NHS Improvement at both OBC and FBC stages.

4.45 The trust should obtain written professional advice on the most appropriate method and timing of revaluations, to ensure that the business case can demonstrate compliance with relevant accounting standards. This written

advice should be submitted as supporting evidence to NHS Improvement alongside the FBC submission.

**Overage or claw back provisions**

4.46 Where the sale price may not reflect the potential increase in value during development, the inclusion of overage or claw back provisions in the sale documentation should be considered. These provisions reserve to the vendor the right to further payments if certain circumstances occur – effectively a ‘share’ in any future increase in value of the site. Professional advice should be taken on overage and claw back options throughout the disposal process to ensure that they are relevant and appropriate for the transaction.

4.47 Further guidance is included in HBN 00-08. ⁴

**Joint business cases**

4.48 Where two or more schemes have similar timelines and strategic rationales, and it makes sense to batch them together to achieve best value for money due to economies of scale, it is recommended that the business case approval process should not be circumvented by progressing schemes individually. These cases should be discussed with the relevant executive regional managing director and/or regional team before proceeding.

**Consortium investments**

4.49 If a consortium of trusts is making an investment, the delegated limits of the consortium members are not cumulative: where a scheme goes above the delegated limit for any single trust or foundation trust in financial distress in the consortium, it will require NHS Improvement approval.

4.50 For other members of the consortium, if the value of the scheme also exceeds their delegated limit, it will require NHS Improvement approval. If the scheme is below a trust’s delegated limit, the investment should be dealt with under the trust’s internal governance processes. For any consortium investments greater than £50 million, the consortium should contact NHS Improvement to establish whether DH and HMT involvement in the approval of the scheme will be required.

**External financing and delegated limits**

4.51 Capital expenditure financed from an external source, such as DH financing, donations, grants and foundation trust commercial loans, should be included in the approval value of a scheme when deciding if a business case needs approval. For example:

---

• an NHS trust/foundation trust in financial distress has a delegated limit of £15 million
• it is developing a business case for an £18 million project
• this project is being funded by a £5 million charitable donation and £13 million from the trust’s own internal resources.

4.52 In this case, the trust will still require business case approval from NHS Improvement as the overall capital investment of £18 million is above the trust’s delegated limit.

DH capital investment financing applications

4.53 Where an NHS trust or financially distressed foundation trust's capital investment requires DH financing a financing application must be made to NHS Improvement. NHS Improvement will review the application, and when validated, will present the case to the DH/Independent Trust Financing Facility with or on behalf of the Trust.

4.54 Where an NHS trust or financially distressed foundation trust's capital business case is above the trust’s delegated approval limit and requires DH capital financing, the financing application will need to be submitted to NHS Improvement alongside the FBC. NHS Improvement will work with the trust with the aim of submitting a financing application to the DH/Independent Trust Financing Facility (ITFF) at the first available meeting after the approval of the FBC. Where an NHS trust or financially distressed foundation trust’s capital business case is below the trust’s delegated approval limit but it requires DH capital financing, NHS Improvement will require the trust to submit the trust board approved FBC alongside the financing application.

4.55 An FBC that is reliant on DH financing can be approved by NHS Improvement; however, it will be approved with the caveat that a financing solution must be in place before a scheme can be progressed. Therefore, the trust should ensure that a financing application is completed in a timely manner and required format so that it can be submitted to DH or to the next available ITFF meeting after FBC approval. In normal business circumstances this is expected to be within one month of FBC approval. Trusts should not commit spend against schemes reliant on DH financing until financing has been approved and the trust has been notified of this approval. Any expenditure incurred by the trust ahead of financing approval is at the trust’s own risk and should be matched by an identified alternative source of funding.

Non-DH financing

4.56 Foundation trusts in distress and NHS trusts may borrow from private sector sources or other governmental departments (such as local authorities) only if the transaction delivers better value for money than financing through DH. Because non-government lenders face higher costs, in practice it is usually
difficult for private sector borrowing to satisfy this condition unless efficiency gains arise in the delivery of a project (eg a PFI). Any proposal to access private sector funding or funding from other governmental departments must therefore be discussed with NHS Improvement in the first instance. DH and HM Treasury agreement will also be required before the trust can enter into any such proposal.

4.57 This guidance consolidates and builds on existing guidance on capital investment issued by DH and has been developed in line with the principles set out in Managing public money,\(^5\) published by HMT in May 2012. In accordance with NHS legislation this guidance also includes NHS Improvement specific guidance around capital business case approval and delegated limits.

**NHS Improvement review process**

4.58 The responsibility for the preparation of business cases rests with the NHS trust or foundation trust. NHS Improvement will seek assurance that a trust has subjected the business case to an appropriate governance and clinical engagement process, and that the proposed investment is affordable and represents good value for money to the taxpayer. A business cases should not be submitted to NHS Improvement until it has been approved by the trust board.

4.59 The roles and responsibilities in the review of business cases are outlined in Annex 9. NHS Improvement’s regional teams will undertake the review of trusts’ business cases and will complete a recommendation report. This report will be subject to a central assurance process by the NHS Improvement Capital and Cash Team before being considered by NHS Improvement’s executive director of resources/deputy chief executive, director of finance, Resources Committee or Board in line with Table 4 above to discharge the governance arrangements set out in this guidance.

4.60 The recommendation report will follow the five case model and summarise each of the sections in the business case. This will also include clinical quality considerations. The NHS Improvement template recommendation reports are included in Annexes 10 to 12 for information: to ensure that trusts are aware of the format of NHS Improvement approvals and to allow business cases submitted by trusts to reflect these requirements. The NHS Improvement template recommendation reports will also link to the business case core checklist included in Annex 1. The three template reports cover the following types of business case:

- capital investment and property transactions where whole-life cost rules do not apply

• capital investment and property transactions where whole-life cost rules do apply
• disposal of land/property.

Post business case approval

4.61 Following approval of a business case by NHS Improvement, trusts will receive formal written confirmation of approval at all stages of the approval process; that is, at SOC, OBC and FBC stages. The letter will set out the approval granted along with any conditions of approval, including key actions required by the trust either before or during the next stage in the approval process, or as part of the implementation of the business case.

4.62 Where the final value of the completed scheme is forecast to be more than 5% or £2 million (whichever is lower) in excess of the value approved in the FBC, NHS Improvement reserves the right for schemes to require further approval from NHS Improvement. This condition also applies to circumstances where the approval value of the scheme is forecast to be more than 5% or £2 million (whichever is lower) in excess of the value approved in the previous stage of the approval process (that is, FBC value in excess of OBC value). In these circumstances the trust will be required to submit a report detailing the reasons for the cost increase (or describe reasons for the cost increase in the FBC), its governance arrangements in respect of the scheme and measures it is taking to ensure that schemes it implements in future do not experience similar cost overruns.

Post-project evaluation

4.63 To enable learning and for good governance, it is a best practice requirement that trusts complete post-project evaluations. Post-project evaluations should identify whether the overall objectives and benefits identified in the original business case have been delivered and should highlight any areas of improvement that can be applied to future investments. Post-project evaluations should be submitted to NHS Improvement when completed. NHS Improvement reserves the right to request the outputs from those completed for earlier projects that were subject to approval from NHS Improvement (or previously NHS TDA). Post-project evaluations for previously approved business cases may be required before new business cases requiring NHS Improvement approval are reviewed. Annex 8 provides a pro forma developed jointly by NHS England and NHS Improvement which can be used by trusts to complete the post-project evaluation exercise. This should be a two-stage process with the first stage being an initial review within six months of business case approval, and the second a further review two years after commissioning a new service and/or facility.

4.64 The evaluation should address the following questions:
• Were the project objectives achieved?
• Was the project completed on time, within budget and according to specification?
• Are users, patients and other stakeholders satisfied with the project results?
• Were the business case forecasts (success criteria) achieved?
• Overall success of the project – taking into account all the success criteria and performance indicators, was the project a success?
• Organisation and implementation of project – did the trust adopt the right processes? In retrospect, could it have organised and implemented the project better?
• What lessons were learned about the way the project was developed and implemented, and how will these be applied to future projects?
• What went well? What did not proceed according to plan?
5. NHS trust-specific guidance

5.1 Annex 7 provides supplementary guidance that is applicable to NHS trusts only and should be read in conjunction with the full guidance. This covers:

- NHS trust limits guidance – capital resource limits
- joint ventures/special vehicles/strategic estates partnerships
- funding for capital investment and property transactions.

6. Glossary and acronyms

6.1 For clarity, Annex 14 provides a glossary and list of acronyms.

7. Contact details

7.1 Should you wish to contact us in relation to this guidance, please email the NHS Improvement Capital and Cash Team.

NHSI.CapitalCashQueries@nhs.net