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

Annex 7: NHS trust-specific guidance

November 2016

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1. Introduction

1.1 This guidance is supplementary to the core guidance and is applicable to **NHS trusts only** and should be read in conjunction with the full guidance document.

2. NHS trust limits guidance – capital resource limit

2.1 The capital resource limit (CRL) is applicable to NHS trusts only and controls the amount of capital expenditure an NHS trust may incur in a year. NHS trusts require CRL to cover all capital expenditure and must not incur expenditure in excess of this limit.

2.2 Each NHS trust will be set an initial CRL by NHS Improvement. This will change during the year if additional capital resources are allocated. Additionally, NHS trusts credit the carrying value of asset disposals to CRLs. This may, at the discretion of the Department of Health (DH)/NHS Improvement, allow the trust to use the proceeds of such disposals to incur capital expenditure.

2.3 CRLs can be allocated to NHS trusts in two ways:

- As part of initial limits where an NHS trust’s initial CRL is based on the trust’s depreciation. Trusts should be aware that, other internally generated sources, such as an NHS trust’s income and expenditure (I&E) surplus, and unspent revenue and capital cash will need to be approved by NHS Improvement before additional CRL is set and expenditure can be committed against these sources of funds. If this approval is required, NHS trusts should contact the NHS Improvement Capital and Cash Team.

- When approved, CRL will be allocated in-year for additional expenditure as agreed with NHS Improvement, eg as financing through agreed loans or exceptional public dividend capital (PDC) or through the allocation of central programme budgets. In addition, CRL adjustments relating to asset disposals, grants and donations will only be actioned on confirmation of the receipt of funds from the NHS trust.

2.4 NHS trusts must not overspend against their CRL. This is a regulatory and departmental duty. It is a requirement that NHS trusts have a confirmed source of funding prior to committing capital expenditure. Forecast underspends should be identified and flagged to NHS Improvement during the year and no later than Quarter 2. NHS Improvement in conjunction with DH may adjust CRLs accordingly.

2.5 There is no carry forward of underspends of CRLs. CRLs will be set each year for NHS trusts based on agreed spending plans for that year.

2.6 NHS trusts are permitted to credit the carrying value of asset disposals to the CRL, to enable them to use the proceeds of disposals to incur capital expenditure when the disposal has happened. NHS trusts should notify NHS Improvement when
disposals have taken place and the proceeds received so that an adjustment can be made to the NHS trust’s CRL. CRL adjustments need to be approved by NHS Improvement before capital expenditure is incurred against this funding source. It is therefore important that the NHS trust carefully considers the likely timing of any capital receipts in its plan, to ensure that these assumptions are realistic. NHS trusts should not commit capital expenditure until a disposal has happened and disposal proceeds have been received. NHS trusts that commit capital expenditure in advance of a disposal taking place do so at their own risk and will not receive CRL cover until the disposal has happened.

2.7 Where NHS trusts have cash that they wish to use for capital expenditure, they should not commit to additional capital expenditure in-year without having in place the accompanying CRL cover. CRL cover must be agreed by NHS Improvement and DH, and posted in the NHS trust’s limit reports before the NHS trust commits expenditure against this limit. Any expenditure incurred ahead of CRL approval is incurred at the NHS trust’s own risk and needs to be covered from the trust’s own internally generated resource should approval not be given. Any in-year request to increase CRL will be reviewed by NHS Improvement on a case-by-case basis against national resources in conjunction with DH. It may be refused as an in-year adjustment and the NHS trust asked to include the requirement in next year’s plan. Inclusion in future year plans will not necessarily guarantee CRL cover as this will remain subject to a review of affordability of plans at a national level.

3. Joint ventures/special vehicles/strategic estates partnerships

3.1 NHS Improvement will review NHS trust proposals to enter into partnership arrangements, eg joint ventures, joint arrangements or special vehicles, on a case-by-case basis. These schemes may require NHS Improvement or Secretary of State approval to proceed.

3.2 NHS trusts should note that any proposal to enter into a strategic estates partnership (SEP) will need to be formally approved by NHS Improvement before the arrangement can proceed. NHS Improvement approval is required to enter into the partnership arrangement regardless of whether the proposal has developed individual business cases.

3.3 Where an NHS trust is considering entering into a SEP, it should contact the relevant NHS Improvement regional team in the first instance to understand what information is required for the proposal to be considered by NHS Improvement. NHS trusts should note that in addition to the initial proposal to enter into the SEP, individual business cases that are developed as a result of the partnership will be subject to the delegated limits of approval as detailed in this guidance. Any individual business cases developed under a SEP with a value over an NHS trust’s delegated limit, or that involve external or third-party financing as a funding source, will also require NHS Improvement approval. NHS trusts are asked to note that NHS Improvement will expect NHS trusts proposing to enter into a SEP to do this
through a contractual joint venture arrangement. NHS Improvement will not expect NHS trusts to propose entering into corporate joint ventures for this type of arrangement.

3.4 For any proposals involving a joint venture, special vehicle or SEP, NHS trusts should provide a paper outlining as a minimum the following:

- an executive summary outlining the proposed joint venture/special vehicle/SEP
- purpose and benefits of the proposed joint venture/special vehicle/SEP
- associated risks
- legal implications
- proposed accounting treatment and audit opinion
- details of any commercial arrangements.

4. Financing for capital investment and property transactions

4.1 It remains the expectation that the following sources may be used to finance capital expenditure in the order of priority set out below:

- internally-generated funds (including depreciation, I&E surplus, unspent capital and revenue cash subject to approval by NHS Improvement)
- net book value of asset disposals – subject to confirmation that the NHS trust has received the proceeds
- grants and donations – subject to confirmation that the NHS trust has received the proceeds
- pre-approved external finance (loans or PDC)
- interest-bearing loans – these will continue to be a potential source of financing after the other potential sources listed above have been exhausted. However, access to such financing is likely to be restricted over the spending review period due to affordability and the national reduction to the CDEL budget
- PDC for capital investment – this will only be available in exceptional circumstances or through central DH programmes.

4.2 Guidance on the DH process for providing loans, PDC or guarantees of payment and an overview of the interim support finance arrangements for NHS foundation trusts and NHS trusts is given in Annex 6, paragraphs 3.14 to 3.16.