Joint Capital Resource Use Plan 2026/27

Region	**Midlands**				
ICB	**Leicester, Leicestershire & Rutland ICB**				
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Background

The LLR ICB Joint Capital Resource Use Plan (JCRUP) sets out how the Integrated Care System (ICS) intends to use capital resources across 2026/27.

The plan responds to national expectations for:

- Regionally led capital planning
- Transparency, coordination and strategic prioritisation
- Alignment to the NHS 10 Year Plan and Spending Review 2025 settlement, which emphasise long term investment stability, digital transformation, estates safety, and shifting care from hospital to community.

The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act) sets out that an ICB (Integrated Care Board) 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 & Well-being Boards and NHS England
- may revise the published plan - but if they consider the changes significant, they must re-publish the whole plan; if the changes are not significant, they must publish a document setting out the changes.

In line with the amended 2006 Act, ICBs are required to publish these plans before or soon after the start of the financial year and report against them within their annual report.

Introduction

NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) was legally established on 1 July 2022 under the provisions of the Health and Social Care Act 2022.

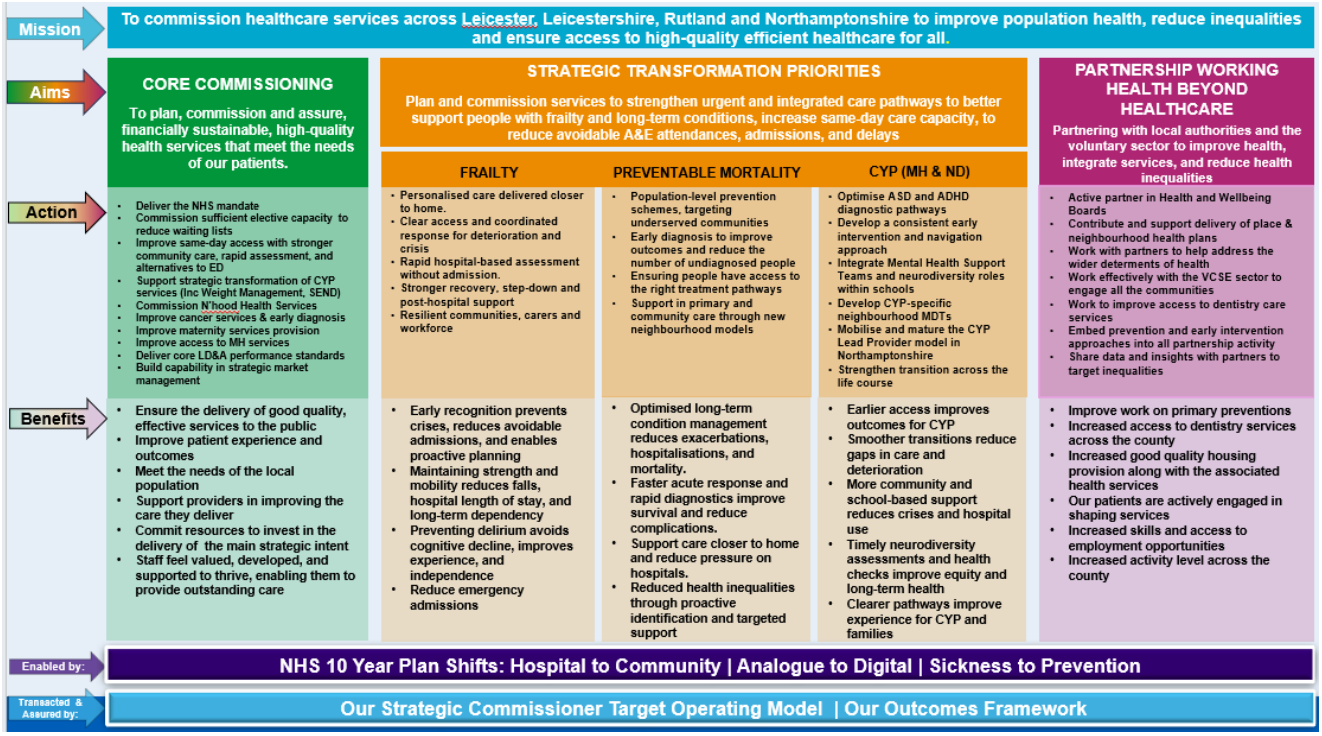
The ICB works in partnership with the two NHS trusts within LLR: University Hospitals of Leicester (UHL), which provides acute, specialist and emergency hospital services, and Leicestershire Partnership NHS Trust (LPT), which delivers mental health, learning disability, autism and community health services.

The LLR Integrated Care System (ICS) covers a population of over 1.1 million residents across rural, market towns and urban areas. Our health and care services are delivered across a significant estate footprint, including but not limited to, 227 community pharmacies, 132 GP Practices, three acute hospital sites and a number of community hospitals and mental health facilities.

The ICS has an ICS Estates Forum consisting of estates leads in the ICB, trust partners, local authority and other delivery partners. That forum is overseeing the development of the Estates Infrastructure Strategy. It reports to Health Partners' Executive by exception.

Visions, Values and Strategic Objectives

LLR ICB: Commissioning Priorities



Strategic Priorities

- **The 10 Year Health Plan** for England reinforced the need for our ICBs to focus on delivering three strategic shifts:
    - **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and reducing inequalities in health.
    - **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
    - **analogue to digital**: Harnessing technology and data to transform care delivery and decision-making.

- **The ICB 5 Year Strategic Commissioning Plan** identified the following strategic transformation priorities:
    - Frailty
    - Preventable Mortality
    - Children and Young People – Mental Health and Neurodiversity.

  To enable delivery of these strategic priorities, transformational working will be required which will include neighbourhood working and increased use of digital.

- **System Green Plan:** The LLR ICS vision is to: Embed Net Zero Carbon (NZC) and sustainability goals into the transformation of healthcare across LLR and the system for integrated care, to provide the most effective outcomes for patients, the wider community and the environment. This will build on the commitments already made by many of our system members and will be steered by the LLR Green Board working collaboratively with wider partners across the city and counties.

  We are supporting the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions by 2045 and we are prioritising interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues across LLR.

The LLR ICB JCRUP supports and contributes to the strategic priorities of the LLR system by facilitating neighbourhood working and enabling care to be delivered closer to home, while ensuring that existing infrastructure is sustained. Prioritisation criteria have been developed to reflect these strategic priorities, ensuring that approved schemes align with the overall strategic direction of system partners.

2026/27 CDEL allocations and sources of funding

National Capital Framework

NHS England's capital guidance for 2026/27–2029/30 sets out:

- A £44bn multi-year national capital settlement (SR25), including protected operational capital and targeted programmes for diagnostics, urgent care, RAAC, community, mental health and digital transformation.
- Expanded capital freedoms, higher delegated limits, and regional leadership in strategic estates planning.

- Strong expectation that systems must prioritise affordability, risk management and alignment with the 10-Year Health Plan.

Regional Requirements

NHS England (Midlands) requires all providers and ICBs to:

- Submit capital plans via the prescribed financial planning templates.
- Demonstrate compliance with operational capital envelopes.
- Use SHAPE for estates mapping and scheme recording (national mandate)

The total CDEL Plan for the System in 2026/27 is £144.846m (see Annex A). The two main sources for this capital funding are:

- Internally generated funds from within Provider Trusts and Foundation Trusts, mostly from depreciation (which is determined by the System Operational Capital allocation)

- National NHS programme funding (received via Public Dividend Capital), which includes £25.071m funding to support the delivery of constitutional standards and £35.799m to support the National Hospital Programme.

The plan will be updated for any additional National NHS programme allocations notified during the financial year.

The Operational Capital Departmental Expenditure Limit (CDEL) allocated to the LLR system for 26/27 is £68.787m, consisting of base operational capital of £2.256m for the ICB/Primary Care and £60.225m of provider capital. Capitalisation of expenditure due to the implementation of IFRS16 is now included within the systems CDEL limit and the operating capital includes 'business as usual' capital and IFRS16 lease capital.

In addition, the ICB has received £2.700m of funding for a pre-committed scheme at Hinckley District Hospital, along with £3.606m strategic capital to support ICB infrastructure, hospital to community initiatives and demand management programmes.

In addition to the operational capital, national funding for specific programmes is also available. The LLR capital plan for 26/27 includes an additional £48.488m funding for national programmes and £25.071m for constitutional standards and left shift.

UHL has an additional £2.500m funding available from grants/charitable funds.

Capital prioritisation

Due to the shortfall in funding available to meet the needs of existing estates, both providers have undertaken a local prioritisation process to ensure the capital allocations are used to fund the highest risk schemes are first.

Within UHL, the development of the four-year capital plan was overseen by the newly established Strategic Capital Group, with support from the Capital Monitoring and Investment Committee to ensure that limited capital resources were prioritised for key strategic and operational requirements. An initial high level draft plan for 26/27 was prepared based on the national operational capital allocations and projected national funding for schemes that sit outside of the operational envelope.

This provisional plan was based on targeted allocations for specific, large operational or strategic schemes the Trust has committed to do (e.g. Urgent Treatment Centre (UTC), Aseptic and Electronic Patient Records (EPR)). It also included multi-year schemes the system had previously supported, as well as revenue sustainability schemes, theatre and ward refurbishment programmes, demand and capacity schemes and Clinical Management Group (CMG) schemes, in addition to the core infrastructure allocations for Estates, IT and Medical Equipment (including MES and associated enabling work). These core allocations reflected requests from programme leads, which were then proportionately scaled back to ensure a balanced plan was submitted. The overriding aim of the core operational allocations is to secure an equitable split of the limited funding available. Therefore, plans across all areas were subject to a confirm and challenge risk review to ensure that schemes were appropriately prioritised across the core infrastructure areas, according to relative risk. A summary of those schemes and associated risks that could not be funded within the available envelope has been provided to those charged with governance to ensure that the final approved recommended plan includes the correct mix of schemes that minimises risk to the organisation.

Within LPT, all new service bids were prioritised & reviewed at the Capital Management Group (CMG). Following the significant reduction in BAU Capital allocations for 2026/27 and beyond, CMG scrutinised all schemes proposed. This included estates backlog & rolling programmes, IM&T rolling programmes, and pre-committed schemes. Estates Backlog & Rolling programmes were reduced overall by £3.888m.

All other capital bids have been deferred to future years until funding becomes available. The impact of the reduced capital allocation is only allowing LPT to address critical short-term solutions; any longer-term Estates and IM&T investment to support their strategic plan is restricted.

A small number of these pressures have been mitigated by applying to fund them through Constitutional Standards/Left Shift (CS/LS) allocations. The majority of the CS/LS schemes however were new and not in the original LPT plan. As at month 1 NHSE is yet to confirm funding for these schemes; this will increase the chances of slippage during the period.

LLR ICB have worked in collaboration with their 'cluster' partner, Northamptonshire ICB in relation to ICB strategic capital. The ICBs have used a structured, weighted prioritisation model consistent with NHS England expectations and which considered the following areas:

- Clinical: Outcomes & Patient Focus
- Estates: Productivity/Efficiency & Environmental
- Strategic Fit:
    - Health Equity

    - 10-year plan priorities: hospital to community, analogue to digital, treatment to prevention
    - Leicester, Leicestershire, Northamptonshire and Rutland (LNR) strategic priorities: frailty, preventable mortality, CYP MH and ND
- Finance: Service efficiencies, capital funding & revenue implications
- Associated Risk if not progressed

The resulting prioritised schemes to be funded in 26/27 are outlined below in table 1 below.

Capital Expenditure Plans

Key priorities for 2026/27:

University Hospitals of Leicester NHS Trust (UHL)

- Diagnostics & Elective Recovery
    - Expansion of diagnostic capacity aligned with national constitutional standards capital programmes.
    - Continued investment in UEC Capacity, including development of the urgent treatment centre.
- Digital Investments
    - Continued development of EPR modules and critical digital infrastructure to support the analogue-to-digital shift in the 10-Year Plan.
- Estates Safety
    - Works aligned with the national £9.3m estates safety allocation.
- Critical Backlog Maintenance
    - Targeted reduction of high/very-high risks.
    - Medical equipment replacement
    - Digital modernisation, including investment in infrastructure and further roll out of the EPR programme.

Leicestershire Partnership NHS Trust (LPT)

- Mental Health, Learning Disability & Autism (MHLDA) Capital
    - Aligned to national programmes for MHLDA services, including ward improvements and community facilities.
- Community Estate Modernisation
    - Investment supporting shift from hospital to community settings.
- Digital Enablement
    - Continued network upgrades, community digital tools and mobile workforce technologies.
- Safety & Compliance
    - Ligature risk reduction, fire compliance and statutory works.

LLR ICB

- Neighbourhood Working
    - Investment supporting shift from hospital to community settings
    - Investment to support primary care estates
- Digital Enablement
    - Continued network upgrades, community digital tools and mobile workforce technologies.

Operating Capital

LPT:
The LPT capital operational plan has been reduced by approximately 30% due to a change in NHSE apportionment methodologies. This presents a significant risk given that no support has been provided to Trusts that have lost large parts of their capital funding. LPT has adjusted its operational plan to remain compliant, removing over £6m of assumed capital.

Constitutional Standard and Left Shift funding is welcomed and will support some service development but has limited impact to LPT's operational capital as it targets predominantly new areas. Spending in additional areas will add further pressure to the future operational plan as the Trust seeks to maintain these assets.

LPT has a significant amount of backlog maintenance totalling £21.93m (24/25 ERIC), of which £6.734m is high risk. Due the changes in NHSE apportionment methodology LPT has reduced its planned backlog maintenance spend by £3.888m. £1.55m has since been provided through Critical Infrastructure Risk funding. Funding is prioritised to higher risk areas and ongoing risks will be managed as part of usual management processes

UHL:
The core operational funding allocation of £50.8m is less than the annual cost of depreciation and asset replacement, after committing funding for new emerging infrastructure risks (e.g. cyber security), large operational schemes (such as ward and theatre refurbishment) and other strategic schemes (Aseptic, EPR) that are not supported through national capital allocations. However, the Trust has endeavoured to achieve an equitable split of the constrained funding available, with schemes appropriately prioritised across the core infrastructure areas, according to relative risk. But effectively this still means that all core allocations have been 'rationed' to support a contribution to only the highest priorities in each area, resulting in a number of risks not being funded. For example, only breakdowns of critical medical equipment can be funded (£3m) (as opposed to a planned medical equipment replacement in line with recommended lives) and the Trust continues to carry a material backlog maintenance and critical infrastructure requirement. Of this, £13.2m will be funded through a combination of operational (£3.8m) and National Estates Safety (£9.4m) in 26/27.

LLR ICB:
The ICB has a ringfenced allocation of £2.256m for GP IT which will be split between IT equipment (£1.94m) and estates (£0.315m). The additional £2.700m allocation for Hinckley District Hospital will be used to remodel the site in line with neighbourhood models of care.

A combined approach to the prioritisation and use of ICB strategic capital is being taken with Northamptonshire ICB with whom LLR work in a 'cluster' arrangement. Both ICBs have combined resources and agreed capital schemes collaboratively across the LNR patch.

As outlined above, a prioritisation process has also been completed within both LLR and Northamptonshire ICBs to develop detailed plans for the use of the ICBs' strategic capital with proposed schemes fall under the following categories:

- Neighbourhood/Demand Management
- UEC Mitigation Schemes
- Primary Care Estates
- Digital
- 5 Year Strategy

The resulting prioritised schemes to be funded across LNR in 26/27 are outlined below in table 1 below:

Table 1:

Scheme	LNR Amount (£'000)	LLR Share (£'000)	Northants Share (£'000)
Rutland Memorial Hospital (LLR): Refurbishment and Xray equipment	650	380	270
Moulton Surgery Design - work up RIBA 3+ design to provide requirements for contractor tender	1,020	597	423
PRISM 2.0 – Future-Proof Referral Platform	174	102	72
Centralised Care Planning	200	117	83
ICB HQ Premises Finance Lease (LLR)	475	278	197
Transitional Costs: Refurbishment of offices	200	117	83
Total Approved Schemes to date	**2,719**	**1,591**	**1,128**
Balance of funding – schemes TBC during 26/27	***3,442***	***2,015***	***1,427***

IFRS 16

26/27 leases capitalised under IFRS 16 total £7.568m which is included within the operational capital. This fund must accommodate the capitalisations of property and equipment included within all IFRS 16 lease contracts (either explicitly or implicitly), which will include new leases and extensions or remeasurements. The UHL figure of £6.725m relates to various leases including the extension and remeasurement of existing renal satellite leases. The LPT figure of £0.843m relates to uplifts for RPI and occupancy changes.

Organisations will be monitored in year against their total operating capital (including IFRS16).

National Programmes

During the 26/27 planning round, NHSE provided indicative allocations for Estates Safety (£9.339m UHL; £1.550m LPT), and the National Hospital Programme (£35.799m UHL), which relates to approved funding for the cost of enabling works at the LRI site, to facilitate future development of this site, as part of the New Hospitals Programme.

£1.800m funding for Mental Health Out-of-Area Placements was deferred in 2025/26 by LPT and is therefore available to spend in 26/27.

Allocations for Constitutional Standards & Left Shift amount to £25.071m and will be spent in the following areas:

- **Diagnostics** - £15.250m, of which £14.350m will be spent on consolidating Community Diagnostics Centre facilities at the Leicester General Hospital site.

- **Urgent and Emergency Care (UEC)** - £2m to co-locate an Urgent Treatment Centre (UTC) with an Emergency Department

- **Mental Health, Learning Disability and Autism (MHLDA)** - £4.821m which includes spend on a 24/7 Neighbourhood MH Centre in Leicester City and co-location of a MH Emergency Department (ED) alongside ED services at the Leicester Royal Infirmary.

- **Community** - £2m including spend to improve access to Community Health Services in Coalville.

- **Primary Care Utilisation and Modernisation Fund (UMF)** - £1m to refurbish existing primary care facilities to increase capacity.

Charity and Grant Funded Programmes
UHL will receive total contributions of £2.5m from grants and charitable donations towards capital schemes in 26/27. This is mainly due to National Institute for Health and Care Research (NIHR) funding of £1.5m for the Aseptic development, which has been matched by the Trust, plus a further £0.8m from other charitable sources, supplemented by £0.5m from the Trust's own Charity for other approved development bids.

The 2026/27 capital plans have been developed by individual organisations, with regional collation undertaken for the Constitutional Standard and Left Shift allocations. The system has collaborated through the LLR System Capital Group (SCG) to shape a unified approach. Plans have been approved in summary form by organisational Boards.

Overview of ongoing scheme progression

The two most significant schemes, costing over £10m are:

1. <u>The National Hospital Programme being undertaken at UHL - £35.799m</u>

   This relates to approved funding for the cost of enabling works at the LRI site, to facilitate future development of this site, as part of the New Hospitals Programme.

2. <u>Consolidation of Community Diagnostics Centre facilities at the Leicester General Hospital site - £14.350m</u>

   This investment will provide an opportunity to consolidate CDC facilities at the LGH site, including the removal of insourced capacity. Spend will continue into future years:

   £3.075m 27/28
   £3.075m 28/29
   £0.850m 29/30
   £21.350m total spend across 4 years

   Construction is planned to start in April 2027, completing in April 2028. Operational use is planned to start in June 2028.

   The scheme will increase diagnostic capacity and productivity across a number of modalities to support DM01 compliance. It will not only provide extra capacity but will also release capacity at the acute sites for UEC.

Consolidation of CDC facilities at the LGH site will contribute towards the delivery of the NHS 10-Year Plan by:

- providing diagnostic capacity at cold site/ city centre in the community and away from acute sites. (Hospital to community)
- being managed on the UHL electronic patient record (EPR), with an aim to integrate with primary care systems, such as System One and LLR Shared Care Record. (Analogue to digital)
- offering more rapid diagnostics and earlier diagnoses for patients. (treatment to prevention)
- providing care in the right place, at the right time which will improve longer term outcomes for patients

Risks and contingencies

Existing Estate:

- Operational capital allocations are not sufficient to meet the needs of existing estates within organisations. A key risk is an inability to deliver all essential backlog maintenance projects and medical equipment replacement. Backlog maintenance liability is increasing and building conditions are deteriorating, affecting the Trusts' operating environment, impacting on the patient experience and service delivered. The deferral of schemes to future years creates an even larger financial pressure in 27/28 and beyond.
- LPT has received c£4m less operational capital allocation in 2026/27 than in 2025/26 so this challenge will be amplified.
- Strategic capital allocations from NHSE are specific in nature and there is a risk that organisations are being asked to undertake new developments while not being sufficiently funded to maintain their existing estate.
- UHL's operational capital allocation (excluding IFRS16) is currently £50.8m. As indicated above, this envelope is not enough to support both the costs of replacing the Trust's existing assets (measured through depreciation), with the gap widening, as well as contribute towards growth and new investment, therefore only allowing the Trust to address critical short-term solutions; any longer-term investment to support the strategic plan is severely restricted.
- LPTs system capital allocation (excluding IFRS16) is currently £9.1m, which is £33.2m below the capital requirement of £42.3m. The revised capital allocation formula has seen a significant reduction in BAU capital funding for LPT. The only mitigating factor is that a small number of schemes have been able to be submitted against the Constitutional standards/Left shift funding. Due to the level of reductions required to achieve a balanced capital programme, the Estates rolling programmes and Estates Backlog are reduced by £3.9m; and a 'risk managed shortfall' of £340k will be managed internally from slippage against other schemes.

Timescales

- Delays in approval of proposed schemes by NHSE causes operational issues in terms of being able to physically spend the funding within the stipulated financial year, (especially for large schemes requiring procurements).
- National pots of capital funding still being held centrally by NHSE which are yet to be allocated out to providers/ICBs. If confirmed late in the financial year, will again cause

operational issues in terms of being able to physically spend the funding within the stipulated financial year.

Revenue Implications

- The long-term revenue impact of large strategic capital schemes can be difficult to predict at early stages of development as clinical models and impacts will not yet be know.
- Schemes therefore carry of risk of not being affordable in terms of revenue once detailed modelling is possible and undertaken.
- Increase in capital charges due to large capital schemes being undertaken.

Costs:

- Risks facing the 26/27 capital plan include increasing inflation which may result in actual costs being higher than planned, shortages in building supplies and equipment which may result in delays to schemes as well as premium costs, pressure from services to increase capacity beyond that included within the capital plan and increased breakdowns due to usage.

Mitigations

- Organisations have had to prioritise use of operational capital allocations to ensure the highest risk schemes are funded first.
- Regular communication is in place with the regional NHSE team to confirm approval of schemes and processes for bidding for future funding.
- The operational issues caused by late notification of funds by NHSE has been escalated to the regional team.
- Consideration of the revenue implications of capital schemes is recognised, however a strategy is required to ensure this message is cascaded across organisations to increase staff awareness.
- The system has not over planned delivery against its CDEL allocation, however both system providers are maintaining a live list of schemes which could be brought online quickly should slippage occur in year. These lists have been ranked in order of need from an organisational perspective
- Capital leads are currently undertaking Equalities and Quality Impact Assessment (EQIAs) for those schemes that pose a risk if not delivered in 2026/27. For any that pose significant risk, the current plan will have to be reprioritised to enable these to go ahead. LPT are currently presenting a balanced capital plan, however when the EQIA review is complete, some schemes may need to be reinstated back onto the programme and other schemes may need to be paused until further capital funding becomes available.

Governance and Assurance

A LLR System Capital Group (SCG) meets monthly to review current spend, forecast spend, and future system capital plans. Issues are escalated through organisations' finance committees and the Health Partners' Executive. Monthly capital monitoring is submitted to NHSE Midlands:

- **LNR System Capital Group** reviews capital plans, YTD spend and forecasts.
- **Organisation Finance Committees** assure affordability and compliance.
- **Monthly monitoring** is conducted with the ICB and providers and submitted to NHSE Midlands.

Summary

The ICB has worked together with system partners to plan its utilisation of the allocated capital spending allowance for 2026/27.

Schemes have been chosen based on the risk to service delivery, strategic fit and value for money through an organisation and system prioritisation process.

Annex A – LLR System 2026/27 Capital

Capital Departmental Expenditure Limit (CDEL)	UHL	LPT	LLR Provider Total	LLR ICB	LLR Total
	£m	£m	£m	£m	£m
Confirmed 26/27 Operational Capital Allocations					
Operational Capital	50.772	9.122	59.894	0.000	59.894
Freedoms & Flexibilities	0.000	0.331	0.331	0.000	0.331
Primary Care (GPIT) - BAU	0.000	0.000	0.000	2.256	2.256
Precommitments from 2526	0.000	0.000	0.000	2.700	2.700
Strategic Capital	0.000	0.000	0.000	3.606	3.606
Total Operational Capital	50.772	9.453	60.225	8.562	68.787
National Programme Allocations					
Estates Safety (CIR)	9.339	1.550	10.889	0.000	10.889
National Hospital Programme (NHP)	35.799	0.000	35.799	0.000	35.799
NHSE MH OAPS deferred funding from 25/6	0.000	1.800	1.800	0.000	1.800
Total National Programme Capital	45.138	3.350	48.488	0.000	48.488
Constitutional Standards & Left Shift					
Diagnostics	15.250	0.000	15.250	0.000	15.250
Urgent and Emergency Care (UEC)	2.000	0.000	2.000	0.000	2.000
Mental Health, Learning Disability and Autism (MHLDA)	0.000	4.821	4.821	0.000	4.821
Community	0.000	2.000	2.000	0.000	2.000
Primary Care Utilisation and Modernisation Fund	0.000	0.000	0.000	1.000	1.000
Total Constitutional Standards & Left Shift	17.250	6.821	24.071	1.000	25.071
Confirmed 26/27 Grant/Charity Funded Schemes	2.500	0.000	2.500	0.000	2.500
Total CDEL 2026/27	115.660	19.624	135.284	9.562	144.846