

Investing to save

The capital requirement for a more
sustainable NHS in England

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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About this report

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Contents

- 4** Key points
- 5** Introduction
- 7** Capital: unleashing productivity
- 9** A decade of decline: how did we get here?
- 12** A change of direction: creating a sustainable NHS
- 24** What capital do health leaders need?
- 28** Viewpoint: a fresh start
- 29** Appendix: Background methodology
- 32** References

Key points

- It is a worldwide experience that as society ages, becomes wealthier and adopts less healthy lifestyles, healthcare becomes more expensive. The UK is no exception. Providing staff with the right tools and space to perform their jobs through capital investment is how to become more productive and to use the resources available most efficiently.
- However, the UK has invested less in health capital over several decades when compared with comparable nations. The result is a less productive service hampered by, among many other things, Victorian estates, too few diagnostic machines and outdated IT systems that cannot communicate across between hospitals.
- As the examples in this report demonstrate, NHS leaders across the country continue to invest in novel ways to make the service more productive and have more ideas should the government commit funding. Capital is the number one issue NHS leaders tell us is holding back their progress. To better understand this, we have asked ICS leaders how much they need to meet the NHS Long Term Workforce Plan's ambitious productivity targets.
- NHS leaders are calling on all political parties to commit to a **£6.4 billion annual capital funding increase for the NHS at next year's three-year Spending Review**. As we enter a general election year, there has never been a more urgent time to set out an ambitious plan to put the NHS on a path to financial sustainability. NHS leaders are committed to working closely with the new government to ensure this money is used as swiftly and effectively as possible.

Introduction

Demand for healthcare services has grown significantly across the UK and throughout the globe. As populations age, demand will accelerate further, with greater prevalence of complex health conditions and higher expectations of a longer healthy life.¹ By 2040, for example, the number of people living with a complex condition will increase by a third to 1 in 5,² while the number of working-age people will increase by only 4 per cent.³

The costs of treating people grow exponentially as populations age, with average demand for health services in OECD countries increasing by 4 per cent a year.⁴ On top of these demographic trends, the COVID-19 pandemic has exacerbated the backlog of care, which services are struggling to address.

Unless there are radical improvements in the health and care system's productivity – that is, its ability to treat more people better with the same amount of resources – the UK risks spending an ever-increasing share of GDP on revenue for healthcare to keep up with demand. This includes both delivering a higher volume of care for the same cost in each setting (technical efficiency) and improving the allocation of resources to the most effective interventions (allocative efficiency).

Improving efficiency in both areas will be necessary to meet the challenge of rising demand. But shifting resources 'upstream', towards earlier and more preventative interventions closer to patients' homes, will be a significant change to the model of care we today. For instance, we know that a clinical intervention costs four times as much as a public health intervention to add an extra year to life expectancy. Meanwhile, we know that every

Improving efficiency will be necessary to meet the challenge of rising demand

pound spent on primary and community care correlates with a £14 increase in economic activity, more than investment in other care settings.^{5,6}

The NHS Long Term Workforce Plan rightly includes an ambitious 1.5-2 per cent productivity target and a welcome cross-party consensus that something needs to change.⁷ Institute for Financial Studies (IfS) analysis shows that the Workforce Plan fails to account for the significant financial outlay required to pay for massive increase in staff.⁸ The IfS concludes that to avoid spending an ever-rising share of GDP on revenue for healthcare services, the NHS's productivity must rise significantly.

A growing chorus – including the Institute for Government and the Public Accounts Committee⁹ – argue that there needs to be a new long-term capital strategy. This paper begins the conversation by asking how much money NHS leaders will need as part of this new strategy.

Capital: unleashing productivity

To help meet the challenge of ever rising demand for care by using resources more effectively, the Health and Care Act 2022 created integrated care systems (ICSs), bringing together all partners responsible for planning and delivering health and care across England to keep people as healthy as possible with their collective resources.¹⁰ⁱ However, lack of capital could derail ICSs' ability to achieve their four objectives and put the health and care system on a more sustainable footing. **ICS leaders consistently say that investment in capital spending is their priority for any additional spending on the NHS after the next general election.**

Healthcare becomes more expensive as a society ages. The number of people in England aged 65 and over increased by more than 400,000 alone in the five-year period from 2017/18 to 2021/22. Over the same period, the number of people aged over 85 increased by 3.1 per cent to 1.4 million.¹¹ The likelihood of living with multiple or complex long-term health conditions, disability and/or frailty rises directly in line with age, and with it the likelihood of needing to draw on care and support. Yet the UK's healthcare productivity has averaged a mere 0.9 per cent over the past 25 years.¹² The biggest reason for this is that the NHS has lower capital investment than other healthcare systems internationally and other industries domestically – it is therefore no surprise that it has struggled to achieve greater than 0.9 per cent annually.ⁱⁱ Staff find it harder to work when buildings are outdated and IT systems do not work.

i ICSs have four core aims: (1) to improve outcomes in population health and healthcare, (2) to tackle inequalities in outcomes, experience and access, (3) to enhance productivity and value for money, and (4) to help the NHS support broader social and economic development.

As in other sectors, capital investment is key to boosting productivity and transforming long-term care. However, the National Audit Office (NAO) has highlighted numerous times how a lack of capital investment inhibits successful long-term investment to increase productivity.^{13,14} Further studies show how productivity continues to lag behind pre-COVID-19 levels.¹⁵ Something needs to change. Greater capital investment is needed, with more flexibility for ICSs to invest in the most pressing local needs and the best opportunities to boost productivity in their area.

Capital investment is key to boosting productivity and transforming long-term care

ii For a detailed discussion of the role capital investment plays in healthcare productivity and the recent English travails, see the Institute for Government's recent report: https://www.instituteforgovernment.org.uk/sites/default/files/2023-06/nhs-productivity-puzzle_0.pdf

A decade of decline: how did we get here?

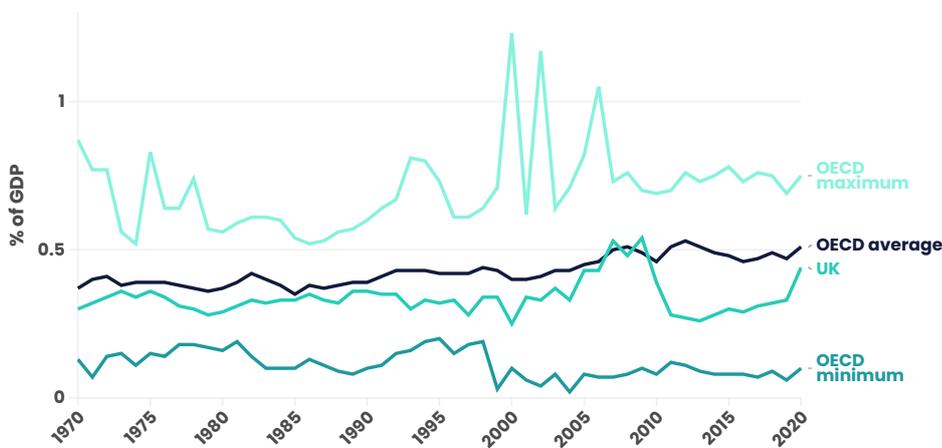
Every year NHS England collects data from each hospital in England, setting out their maintenance backlog. This data set – the Estates Return Information Collection, commonly known by its acronym (ERIC) – is the most up-to-date picture of the state of the NHS estate. October 2022's data shows that the total backlog has reached £10.2 billion;ⁱⁱⁱ that number is a third of the cost of the New Hospital Programme in leaking roofs, broken lifts and outdated IT systems waiting to be fixed, not to mention the still developing extent of reinforced autoclaved aerated concrete (RAAC).

Capital investment is more than just fixing roofs. It is about investing in the infrastructure – buildings, medical equipment, IT and digital tools – needed to continually become more efficient at treating patients as care becomes more expensive and the population ages.¹⁶ The NHS uses capital funding to undertake a vast range of projects, from changing models of care within an integrated care system to small-scale investments to ensure the public gets value for money in their public service.

ⁱⁱⁱ We use 2021/22 returns. While 2021/22's results were released in October 2022, 2022/23's won't be released until December 2023 and therefore cannot be included in this report. <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2021-22>, <https://www.gov.uk/government/publications/reinforced-autoclaved-aerated-concrete-raac-in-hospitals-management-information>

But the recent RAAC issue in schools highlights the state of much of the UK’s public capital infrastructure.^{17,18} It is no surprise given the lack of investment and it is a problem that stretches across multiple governments. The NHS is a case in point: the UK has consistently spent less money on capital investment than its OECD peers for more than five decades.

Figure 1: Gross capital formation in healthcare as a percentage of GDP, by OECD country, 1970–2020



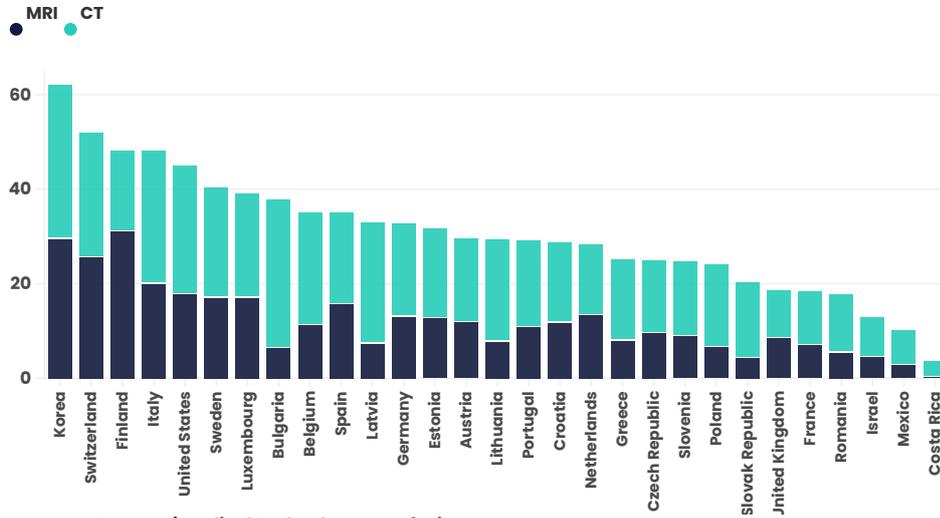
Source: Institute for Government analysis of OECD, 'Gross fixed capital formation in the health care system', 2022 and OECD, 'Gross domestic product (GDP)', 2022. Notes: The average is weighted by the size of the country's GDP. When a country has no data for a particular year, it is excluded from the analysis. 2020 is the last year for which the UK has data. Adapted from Health Foundation analysis.

The situation deteriorated to the extent that between 2014/15 and 2018/19, the capital budget was raided to pay for holes in the revenue budget.¹⁹

The UK’s capital investment per health worker is even worse, with the proportion of capital per worker decreasing by around a third since the turn of the century.²⁰ This can be seen in material terms when comparing how many MRI scanner or diagnostic machines the UK has compared with similar countries, as shown in figure 2.²¹ Health Foundation analysis confirms that had we matched the EU14 average in the ten years to 2019, the UK would have spent another £33 billion – the equivalent of a whole New Hospital Programme.²² More capital funding means the entire NHS can buy the equipment it needs.

Figure 2: The UK lags behind most other OECD nations on CT and MRI scanners

2021 comparison, per million population



Source: OECD.Stat | Medical Technology Data for in hospitals only, UK based on OECD estimates

A change of direction: creating a sustainable NHS

As several of the case studies in this chapter demonstrate, capital projects offer an opportunity to increase the productivity of healthcare services. Take digital transformation, for example. Investment in frontline digitisation – which ranges from electronic patient records (EPR) to further development of shared care records and population health management platforms – is key to increasing efficiency for both the NHS and its patients. Digitisation can help integrate services across different settings and release valuable clinical time to be spent looking after patients. ICSs and trusts need capital funding to cover implementation, initial development and configuration of the system and then a run cost component (typically based on user volumes).

Capital projects offer an opportunity to increase productivity

Case study: Electronic bed management at Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust has invested in an electronic bed management system to manage patient flow across two acute hospitals, an 80-bed community hospital, and two hospices. As a result, capacity, including community placements, is coordinated centrally. For example, the trust can redirect incoming ambulances between hospitals to minimise handover delays and waiting times. The logistics and allocations teams are based in one room, with clinical support on hand and a range of dashboards on large screens. This enables real-time, comprehensive data to be discussed live, supporting the prioritisation of activity and a joined-up approach.



Results and benefits

The new digital system has successfully improved productivity and patient care by:

- reducing A&E bed allocation time by 86 per cent
- reducing the time between confirmed to discharge and actual discharge by 64 per cent
- freed up an average of 15 additional beds per day since going live, saving £2.1 million per year
- released 2,300 hours of ward staff each month, equating to an estimate of £620,000 of savings per year.

Case study: Digitally-informed early intervention in Dorset Integrated Care System

The Dorset Intelligence and Insight Service (DiiS) links health and social care across the county, enabling clinicians to design services based on what is required, and to intervene much earlier when people need support.

DiiS brings together millions of data records from settings including primary care, mental health and social care, as well as from other sources that have an impact on health; 800,000 patient records are updated nightly across Dorset, with other feeds updating every 15 minutes. An analytics team at DiiS makes this data accessible to clinicians through interactive tools and dashboards.

Results and benefits

By identifying the most pressing points of need, both for the whole community and the individual, healthcare leaders in the region can make spending decisions on a much more informed basis. This enables healthcare providers in Dorset to allocate resources with maximum efficiency across the population.

Case study: Empowering patients and maximising clinical time through Dorset Care Records (DCR)

The Dorset Care Record (DCR) is an integrated shared care record that brings together key information from health and social care partners in Dorset. It comprises an online clinical portal (DCR) that brings together information from all partners within the DCR partnership agreement, enabling health and care professionals to have a holistic view of patients' health with all relevant information at their disposal. It also empowers patients, providing a patient portal (myDCR) where patients can access their own data.

Results and benefits

On an administrative level, the DCR has saved healthcare practitioners 25 minutes per user per day compared to previous ways of working and a reduction in printing of four sheets per day. Assuming a user growth in line with the 100,000 records accessed target, this would give a gross benefit of £4.6 million for the 2022/23 financial year.

More widely, the digitally-enhanced understanding of patients' needs should enable the ICS to reduce admissions, improve discharge from acute care and reduce enquiries to GPs, with much wider financial and clinical benefits.

The primary and community care estate

As ICSs look to improve allocative efficiency by providing more care out of hospital, closer to patients and at an early stage before ill health worsens, developing the primary and community care estate will be critical. The physical space for seeing patients in primary care is becoming inadequate, often relying on outdated buildings that are unsuitable for large-scale primary care. The Fuller review reported that 2,000 of 9,911 primary care premises in England

are not fit for purpose, while noting that, with proper investment, 'estates [can be] a catalyst for integration rather than a barrier to it.'²³

New estate can expand the number of patients seen in primary care to improve access and provide appropriate modern space for services to be shifted out of secondary into primary care, where it can be delivered at lower cost and closer to the patient.

Case study: Shifting services out of hospital into modern primary care estate in Norfolk and Waveney Integrated Care System

In Norfolk and Waveney ICS, St Stephens Gate Medical Centre in Norwich was built on an old hospital site and opened in 2006. The GP partnership invested money to use all aspects of the health centre, creating a space for NHS day surgery.

This required investment in the air handling unit for the theatres and making the space fit for purpose for cataract surgery, hand surgery, hernia repair, YAG laser capsulotomy, spinal assessment, and skin lesions. Norwich and Norfolk Day Surgery Unit, known as N2S, delivers the day surgery, with GP partners owning and employing N2S staff.

The service has a collaborative arrangement with the local secondary care provider to transfer patients that are complex and require a general anaesthetic; this collaborative approach maximises the use of both spaces acting to reduce wait times and improves the patient journey. The pre-agreed tariffs for surgery are below standard NHS tariffs, making the procedures value for money while relieving pressure on secondary care.

The result is high satisfaction levels from patients and staff and shorter waiting times.



Results and benefits

The result is high satisfaction levels from patients and staff and shorter waiting times. The new estate enables patients to be given certain treatments in a primary care, rather than in an acute care setting.

The whole estate is supported with notional rent payments as the site is used exclusively for NHS activity. Supporting primary care with the capital for bricks and mortar is important, but having the flexibility and budget to increase notional rent is vital. As activity, surgical and medical moves from secondary care into primary care and the community, notional rents will need to increase; this can be mitigated with increased shift of pathways and activity, lower costs and increased patient satisfaction.

Case study: A community health hub in Devon ICS

Devon ICS developed plans for a new Cavell Centre as one of six locations involved in the national NHS England Cavell Programme pilot scheme. The £40 million three-storey building in Plymouth would have provided a community health hub, housing GPs alongside outpatient services provided by University Hospitals Plymouth NHS Trust, including diagnostics and x-ray and community services delivered by Livewell SouthWest, such as mental health, community health and wellbeing services. It would also have included a pharmacy, community kitchen and dining area, café and bookable interview and meeting voluntary sector rooms.

NHS Devon ICB and local partners were encouraged to develop the business case at pace, using £2.6 million of national funding, while national NHS colleagues sought to identify the main funding needed, potentially from underspends elsewhere in the national budget. Extensive local engagement was undertaken, expectations were raised in the local community and planning permission was achieved by the project team.



Missed opportunities

However, once the project got to ‘shovel ready’ stage, the ICB was advised by national colleagues that there was not any central capital funding, with a suggestion that the ICB should consider funding it through its own limited annual capital allocation. NHS Devon’s capital budget for 2023/24 is fully allocated to critical and high-priority projects across the entire NHS estate in Devon, Plymouth and Torbay.

Although NHS Devon has since sought alternative ways of making the scheme happen, none have so far proven affordable or viable. Therefore, because of a national lack of capital investment, the project cannot currently go ahead and improvements in productivity and care – and an opportunity to help regenerate one of the most deprived areas in the country – have been missed.

Case study: Preventing hospital admissions in Bedfordshire, Luton and Milton Keynes through community diagnostics in deprived areas

Bedfordshire, Luton and Milton Keynes Integrated Care System developed plans for a new community diagnostic centre (CDC) in Luton and South Bedfordshire, costing just under £25 million, to address pockets of some of the poorest health outcomes nationally, particularly in the diagnosis and treatment of cancer, where many patients are often diagnosed too late to support a good prognosis.

Diagnostics is recognised as a priority in the NHS Long Term Plan and the Luton CDC development is one of the most important healthcare developments in the region, located in an area of significant economic and health deprivation and a transport hub which serves the rest of south Bedfordshire. Luton Borough Council is supportive of the proposal which



aligns to the overarching strategy of levelling up within Luton and eliminating poverty.

Missed opportunities

However, given the lack of capital made available in the last Spending Review, the Luton and South Bedfordshire CDC was not able to go ahead. In the absence of a diagnostic centre serving Luton and south Bedfordshire, improvements in access, performance and health outcomes will be missed with unfavourable ramifications:

- Increased pressure will be placed on the acute trust, the Luton and Dunstable hospital, and its workforce. The hospital is poorly served in terms of public transport and does not have current flexible capacity to support growth in imaging demand or improved access.
- The additional community diagnostic centre services would separate high-volume ambulatory flows and release capacity within the acute hospital site to focus on non-elective, inpatient and cancer pathways, resulting in performance improvements and better patient outcomes. This will also support outpatient pathways to treat patients in a timely manner and support continuing delivery against the national elective access targets.
- The CDC would also support GPs to manage long-term conditions and decide on the optimum clinical pathway for patients with non-specific cancer symptoms, leading to improved access, patient experience and better outcomes.
- Access to timely diagnostics closer to the patient/communities would have a significant impact on increasing the likelihood of improving stage of diagnosis by removing the access related barriers. People in the most socio-economically deprived areas in England are 20 per cent more likely to have their cancer diagnosed at a late stage than people in the least deprived areas.



- The service could provide 64,554 additional diagnostic appointments per annum, releasing benefits equivalent to £27.6 million through factors such as reduced length of stay, early cancer detection and reducing outsourcing costs. The absence of the CDC will ultimately allow the gap in health inequalities to increase and miss vital opportunities to improve health outcomes through early diagnosis and treatment of ill health and improve efficiency.

The mental health estate

Time and again our members assert that many parts of the mental health estate are not fit for purpose. NHS Digital data for 2021/22 shows that 15.5 per cent of mental health and learning disability sites in England were built pre 1948.²⁴ Yet only two of the 40 successful bids for the New Hospitals Programme were for mental health facilities.

This affects patient care. Old, dilapidated estates are not therapeutic environments and do not encourage recovery, and therefore length of stays are longer. The 2018 review of the Mental Health Act stated that ‘Poorly designed and maintained buildings obstruct recovery by making it difficult to engage in basic therapeutic activities (getting outdoors or social interaction with others) and contributing to a sense of containment and control’.²⁵ Mixed-sex accommodation also still exists across the country, which increases the risk of sexual safety incidents and increases the need for expensive out-of-area placements.

Case study: Powering brain research with a state-of-the-art modern mental health hospital

Oxford Health’s Warneford Hospital (one of the bases for Oxfordshire’s inpatient mental health provision) is one of the oldest inpatient units still in use across the entire NHS estate.

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The Care Quality Commission raised concerns about the quality of the estate, and the trust has therefore developed a plan to build a new state-of-the-art facility on the same site. A modern environment will give greater opportunities to improve the therapeutic care provided there, reduce lengths of stay and provide an attractive workplace for staff.

Anticipated results and benefits

The Warneford Hospital redevelopment proposal sets out the case for an investment of £213 million to build a modern mental health hospital at the heart of a new and globally significant brain health science campus at Warneford Park. With secured funding, the new estate will, among other benefits, improve therapeutic recovery and reduce hospital stay, allowing better and more productive patient flow. The trust also expect wider benefits across the rest of their services including key emergency services, police and primary care and better recruitment and retention rates of hard-to-find staff.

The NHS investment is part of a wider programme of transformation in the Warneford campus. These plans are driven by a unique collaboration between Oxford Health NHS Foundation Trust, the University of Oxford and a philanthropic donor. The public investment in a new mental health hospital will unlock private investment from the university and the philanthropist.

This would create a research centre and post-graduate college at Warneford Park forming a brain health science campus. This supports the UK Life Sciences' ten-year vision 'to put in place infrastructure to assist the NHS in solving the most pressing health challenges of our generation now and in the future'. Research at the brain health science campus could potentially return in the region of £1.54 billion per annum to the UK economy based on a very conservative estimate; this is a benefit-to-cost ratio (BCR) of 13.55 for the taxpayer.

The acute care estate

In acute care, safety concerns relating to outdated buildings can lead to cancelled appointments, wasted resources and poor patient experience, undermining productivity.

Hospitals are looking to monitor people's health at home, through virtual wards, which have been on the rise since the pandemic. Receiving healthcare at home can reduce the risk of infection and support mobility and wellbeing, while being far more cost efficient to run.²⁸ An evaluation of the Croydon model published in 2021 estimated that a cost saving per virtual ward patient of £742.44 compared to treating people in hospital.²⁹ Yet virtual wards require investment in the appropriate digital technology for hospitals to safely and effectively care for patients at home to unlock these savings, which they can reinvest in patient care.

Lack of capital across different care settings, covering digital and physical infrastructure and mental and physical health, is not just leading to missed opportunities to improve productivity, but actively undermining productivity.

Case study: Replacing crumbling, Victorian buildings in North West London with fit for purpose facilities

St Mary's Hospital, part of Imperial College NHS Trust, is a leading provider of clinical care, education, research and a major trauma centre in London. However, today its ageing estate, some of which is over 175 years old, is in rapid decline. Without a complete overhaul of its facilities, it will likely have to close services.

The trust has developed proposals for state-of-the-art clinical facilities for adults and children across three main hospital buildings with a total of 840 beds, plus dedicated research, education and innovation spaces. This would also include a



hub for primary, community and mental health services as well as social care, community and voluntary sector services. There would also be a clinical life sciences cluster in partnership with industry and research, providing flexible commercial and lab space for life sciences businesses to start, develop and grow.

Anticipated results and benefits

The development would:

- Futureproof the NHS by creating capacity for a growing population and enabling new ways of working and closer collaboration with partners across our integrated care system.
- Maximise operational efficiency by separating planned and emergency care and drawing on user-focused design and care pathways.
- Expand capacity for London's busiest major trauma centre and enabling helicopter access for the first time.
- Improve access to a wide range of healthcare for some of the most deprived communities in the UK.
- Provide a key, accessible hub for integrated care for the local population.
- Support seamless care management, diagnostics, monitoring, logistics and improved patient and staff experience through fully integrated digital technology.
- Help meet net carbon zero buildings to help deliver sustainable healthcare.
- Catalyse wider healthcare research and innovation through the development of a life science cluster in partnership with industry and academia, helping to deliver a significant economic benefit locally and nationally.



Repairing the backlog would cost £1 billion while more extensive refurbishment and some new building and a life sciences cluster would cost £1.2-1.7 billion. However, with capital funding stretched over a new electronic patient record system and expanding the same-day emergency care unit, the NHS does not currently have the capital funding available to go ahead with redeveloping the hospital. The plans remain on hold.

As well as missing out in productivity and economic growth opportunities, just maintaining the status quo is costing money which could have been spent on patient care. In the current buildings, Imperial College NHS Trust currently spends £7 million a year just on repairs at St Mary's just to stay operational, although this cannot sustain the buildings indefinitely. Additionally, due to estates problems, staff waste 10 to 15 per cent of their time, which could have been spent with

What capital do health leaders need?

Spreading innovation

One key principle of integrated care systems is their autonomy to decide among themselves how best to spend money to serve local communities. This is evident in the wide range of case studies explored in this report.

But what, as a thought experiment, might some of these examples look like if we scaled across the country? Take the Maidstone and Tunbridge Wells example. In its latest report to NHS England, Maidstone reported 688 available general and acute beds. At that size the trust saves a total of £2.72 million a year via its bed management system, which equates to £3,955.95 a year per bed.

There are 103,818 available general and acute beds in England. If we applied Maidstone's system to all these beds, there would be a £411 million a year saving. There are 156 trusts with general and acute beds in the latest occupancy return, so the average bed base is 665.5 beds.³⁰ That's £2.63 million saved per year for each trust based on freed beds per day and released staff hours on the ward. It is worth noting that every hospital will have its own challenges requiring different solutions and there won't be a one size fits all solution and that some digital solutions fall into a complex allocation between capital and revenue spending. Nonetheless, it clearly demonstrates the scale of the possibility available as we seek to reduce historically high waiting lists and improve patient flow.

We have previously described how health leaders find accessing capital difficult, that the business case sign-off process is opaque and how national programmes are too acute focused, leaving little for mental health, community and primary care.³¹ Others have echoed our concerns that NHS short-term funding cycles inhibit long-term capital investment and clarity.³² Meanwhile, stories abound about antiquated analogue processes putting patients at risk.³³

After such a prolonged period of underinvestment, it is impossible to escape the fact that the NHS simply needs more capital funding after such a prolonged period of underinvestment. As, the Hewitt review concluded:

‘...a lack of capital, inflexibility in use of capital and the layering of different capital allocation and approvals processes from different departments and agencies are major barriers to improvement and productivity.’³⁴

The upcoming general election allows a rare opportunity to reassess how to get the NHS back on track.

What do NHS leaders want?

At the NHS Confederation, we have conducted a series of interviews with integrated care board (ICB) chief financial officers (CFOs) about how much money they need to meet the NHS Workforce Plan’s productivity targets over the next Spending Review periods. We asked about the capital needs in their systems, where capital is driving productivity, where such productivity boosts are being held back, and what scale of capital investment would be needed to meet the productivity target. Leaders told us of ambitious plans to further embed technology and expand care which has been hampered by years of poor settlements.

From these conversations and our own research, **we are calling for the total NHS national budget to increase from £7.7 billion by an additional £6.4 billion per year to at least £14.1 billion for each year of the 2024 Spending Review.** This excludes the budget for programmes such as the New Hospital Programme, which are managed centrally by the Department of Health and Social Care rather than assigned to NHS England.

This number comprises three funding streams and we use as our base the NHS England capital guidance update 2023/24 as we believe this best represents the amount of capital that ends up with our membership.

Firstly, our analysis, based on system leaders' own projections, estimates that ICS capital allocations for transformation (the amount given directly to ICSs to manage their capital needs) **would need to increase by £1.7 billion per year.**

Secondly, there would also need to be a commensurate increase in other aspects of the NHS capital budgets, with both the 'Nationally Allocated Funds' and 'Other National Capital Investment' increasing by **£470 million and £940 million** respectively.

Finally, we also are not starting from scratch; the built-up maintenance backlog should be eliminated as soon as possible. Without a committed plan to fix what we already have, we cannot begin to transform care and increase productivity by the levels necessary over the next decade. That is why in addition health leaders need enough money to eliminate the backlog and start afresh. Given the size of the backlog, we propose eliminating the £10.2 billion backlog **in three £3.3 billion equal payments** over the Spending Review period.^{iv}

^{iv} We do not take a position on how this funding should be allocated, instead focusing on the overall amount. However, we envision some sort of allocation based on systems and trusts reported ERIC returns.

Taken together these measures equate to **raising the total NHS national budget by £6.4 billion per year to at least £14.1 billion** for each of the three Spending Review years.^v

While this would be significant additional investment, it is small comparative to the £161.1 billion NHS revenue spend – revenue spend which it will help to control and get best value from.³⁵ This would help the NHS achieve its productivity plans and limit the need for growth in revenue spend. CFOs were clear that after years of underinvestment, the scale of the financing required cannot be ignored.^{vi}

With this money, ICS leaders are more confident that they can meet the NHS Workforce Plan productivity target through investment in new IT systems to streamline patient flow, diagnostic equipment to better identify ill patients and treat them sooner and cheaper, and new estates to safely accommodate the forthcoming increase in patients.

“We have insufficient capital to fully realise benefits from digital investment; partial solution mean that workarounds are [...] required rather than being seamless. Digital investment is also required to address cyber security issues.”

Integrated care system CFO

“In common with most systems, constrained funding for maintenance backlog and essential medical equipment restricts our ability to address all underlying issues and secure funding for strategic investment for service transformation.”

Integrated care system CFO

^v You can see further detail on our working in the appendix.

^{vi} We assume a three-year Spending Review as was 2021's.

Viewpoint: a fresh start

While a £6.4 billion increase to £14.1 billion annual investment may look like a large increase, put into the context of a decade-and-a-half of underinvestment, this will help put England on the path to meeting the ambitious productivity goals of the Workforce Plan. This would in turn reduce the need for ever growing revenue expenditure. An increased overall envelope of capital funding should also be combined with a review of the entire NHS capital regime, as recommended in the Hewitt review, to ensure the flow of those capital funds is swiftly and most effectively distributed, avoiding delays in approval for projects will lead to increased costs due to factors such as rising construction costs.³⁶

Investment in NHS capital today will help relieve pressure on NHS revenue and services tomorrow, putting the NHS on the path to longer-term financial sustainability. Meanwhile, such investment in healthcare helps to boost economic activity and provide a springboard for economic growth, raising tax revenues.³⁷ There is a clear return on investment.

The 2024 Spending Review provides the opportunity – whichever party is in government – to begin to transform the healthcare system into a more productive and safer health service. At the NHS Confederation, we are committed to working with the government to develop innovative ways to fund the health system that deliver value for money for the taxpayer and high-quality outcomes for patients. We will continue to work with the government and other stakeholders to identify a way forward.

Investment in
NHS capital
today will help
relieve pressure
on NHS services
tomorrow

Appendix: Background methodology

We asked ICS finance leaders the following question:

“NHS England has set an efficiency target of up to 2 per cent annual growth until 2030. What is the % annual increase in your capital budget you would need to meet this in the next spending review period (2025/26 – 2028/29)?”

On average, ICS CFOs told us they needed a 39 per cent increase in their capital allocations to be able to hit the productivity target. We then used this data against population figures for the systems that responded, to work out an increase in capital per head for our sample and extrapolated it nationwide based on NHS England’s stated capital allocations in their 2023/24 NHS capital guidance³⁸ – there are a number of ways to account for national capital budgets, but we have chosen NHS England’s allocations as we believe this best represents the most transparent accounting for the capital that reaches our membership. We also applied the same increase to the two other national NHS funding pots, which NHS England controls, as outlined in the table below.

Budget	2023/24 Capital Settlement ³⁹	Annual capital settlement required for next three-year Spending Review period
System Level Allocation	£4,100,000,000 ^{vii}	£5,705,948,496
Nationally Allocated Funds	£1,200,000,000	£1,670,033,706
Other National Capital Investment	£2,400,000,000	£3,340,067,412
Total	£7,700,000,000	£10,716,049,614

The final figures then include the addition of the cost of eradicating the maintenance backlog per year across three years:

NHS capital backlog ⁴⁰	Total capital backlog	Capital backlog split across three-year Spending Review period
Total	£10,248,193,735	£3,416,064,578

^{vii} At the time of writing only the 2022/23 capital allocations for each ICS were published (despite NHS England having published the *overall* planned allocation for 2023/24) so we have used these numbers to guide as we don't anticipate any material change in allocation proportionality between years.

Therefore, to calculate the total annual NHS capital investment required each year of the three-year Spending Review period:

Annual capital settlement required for next three-year Spending Review period	Capital backlog split across three-year Spending Review period	Total required annual capital investment over three-year Spending Review period
£10,716,049,614	+ £3,416,064,578	= £14,132,114,192

The current annual NHS capital allocation is £7.7 billion, so this would require a £6.4 billion a year of additional spending at today’s prices, more than doubling existing capital spend to £14.1 billion. In this exercise we have focused just on the NHS capital budget and not the entire health and social care budget. It is beyond the scope of this analysis, but we would assume a commensurate increase in the wider Department of Health and Social Care capital budget would need to accompany the NHS increase.

While some of the extant budget does go towards maintenance upkeep, the existence of the backlog demonstrates this has been far from enough to date. Therefore, we have included enough money to eliminate the existing backlog over the course of the presumed three-year Spending Review period.^{viii,ix}

^{viii} This is calculated from the survey data we received from finance leaders. They provided us with the required budget increases to their allocation per year across the next spending review period (2025/26 to 2028/29) to meet the proposed NHS England productivity target. We used this data against population figures for the systems who responded to work out an increase in capital per head for our sample, which was then applied nationally. The final figures then include the cost of eradicating the maintenance backlog per year across three years.

^{ix} In addition to the NHS capital budget there would necessarily be a commensurate increase needed in the DHSC’s remaining capital budget – but we have focused our analysis on what NHS health leaders need. Capital projects do often have a revenue impact, for instance maintenance and running costs for buildings and digital systems, which should be considered but we have not included this in our high-level analysis.

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