NHS Providers

NO MORE STICKING PLASTERS

Repairing and transforming the NHS estate

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CONTENTS

1 INTRODUCTION

Appropriate capital funding is needed to bring long neglected parts of the NHS estate into the 21st century for staff and patients. From fixing leaking roofs and broken boilers, to transforming estates to make them fully digitised and sustainable, and enhancing diagnostic capacity, capital investment has the potential to transform the NHS – improving patients' experience and making it more efficient and effective.

Capital also plays an important role in supporting the work of NHS organisations as 'anchor institutions'. As an employer of 1.4 million people, the NHS creates value in local communities, and supports social, economic, and environmental aims. However, many NHS organisations are currently unable to support their local communities' health and wellbeing through the use of land and estates due to the poor condition of their infrastructure.

This report explores the state of capital funding and allocations across the NHS provider sector and how trusts can access capital. We highlight the extent of the dilapidated estate and make the case for strategic capital investment at both the system and national level to drive productivity, improve patient care, and enable much-needed transformation across the NHS.

KEY POINTS

2

- **Future fiscal events**
  - Trusts welcomed the multi-year capital budget set at the October 2021 Spending Review (SR), following a sustained period of underinvestment since 2014/15. This investment has the potential to improve productivity and performance across health systems.
  - Capital budgets must not be raided to fund additional revenue pressures over the period of this SR.
  - Policy makers must be cognisant of the productivity improvements that could materialise from an increase in the national capital departmental expenditure limit (CDEL).
- **Maintenance and utilisation of the estate**
  - Deteriorating NHS infrastructure and estates risk patient safety and quality of care.
  - A greater proportion of capital investment needs to be spent on new assets to generate substantive and recurrent productivity improvements.
  - The government must expedite the process of replacing unsafe reinforced autoclaved aerated concrete (RAAC) planks.
  - The Department of Health and Social Care (DHSC) should publish its long-term capital strategy, outlining the ambitions for transforming the wider health and care estate, including how it will effectively address the maintenance backlog.
- **Strategic investment: improving productivity and patient care across the whole system**
  - The operational ask of the NHS, including national priorities to recover elective and emergency care and improve productivity, cannot be delivered without adequate capital investment.
  - Capital investment has not kept pace with rising demand over the last ten years, and the NHS bed base is significantly lower than equivalent OECD countries. Trusts require the right bed capacity, including general and acute beds, but also intermediate care, rehabilitation beds and step-down mental health support.
  - Strategic capital investment allocations must be underpinned by a whole-system approach to estate transformation. Mental health and community services have the potential to play a key role in improving productivity and supporting the delivery of the government's recovery plans.
- **Transforming the NHS estate**
  - Digital investment remains a vital enabler to transform delivery, enable full interoperability, improve productivity and reduce the costs of service provision.
  - Sufficient capital investment must be provided to meet the ambitions of the New Hospitals Programme. There is also an urgent need to accelerate the programme and enable more trusts already on the scheme to begin construction.
  - Capital investment is essential to enable the NHS's ambition to become the world's first net zero carbon national health system.
  - The government should explore how the NHS can maximise value from land disposal and use the NHS estate more efficiently.

- **System planning: ensuring appropriate prioritisation**
  - Integrated care boards (ICBs) now play a significant role in capital planning. The needs of acute, ambulance, community and mental health trusts must be given appropriate consideration as part of the operational capital prioritisation process.
  - Foundation trusts need clarity about the extent to which they can spend retained surpluses for capital investment, and any flexibilities that can enable trusts to incur additional capital expenditure without breaching the national CDEL.
  - There would be value in enabling systems to become more integral to managing strategic capital investments in future.
  - Following the winding down of public private partnerships, policy makers should consider how trusts' access to strategic capital can be broadened and made more accessible, and how trusts can innovatively partner with communities and industry to increase investment across their estates.

CAPITAL SPENDING ACROSS THE NHS

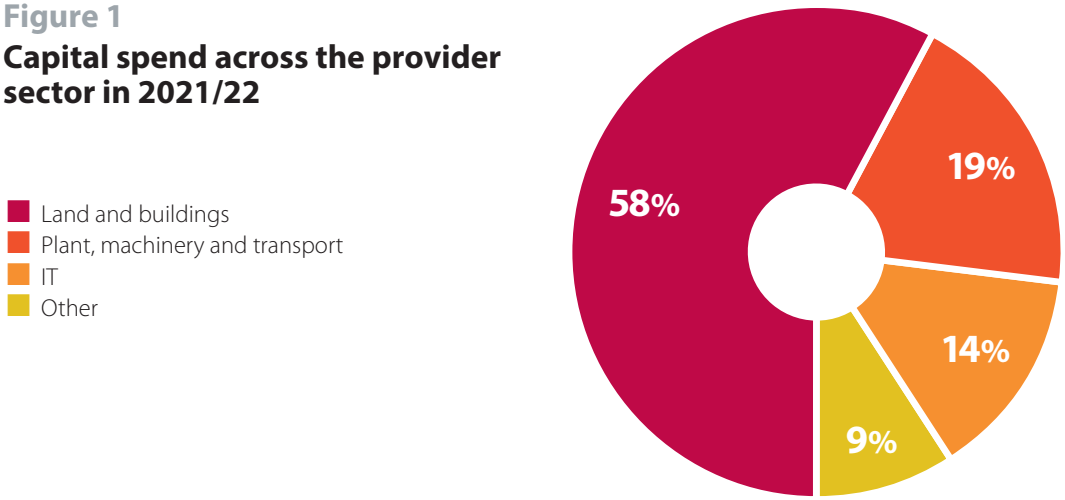
3

NHS capital flows

How much does the NHS spend on capital projects and where does this money come from?

The Department of Health and Social Care's (DHSC's) capital budget is used to finance capital investment in the NHS.[1] In 2021/22 NHS providers spent 75% of DHSC's capital budget.[2] Just over half of NHS capital expenditure covers land and buildings. The remaining proportion is used for plant, equipment and transport (which includes diagnostic equipment like MRI and CT scanners), and information technology.[3]

Figure 1
Capital spend across the provider sector in 2021/22



The NHS capital regime is broadly split between operational capital and nationally allocated capital. Operational capital covers day-to-day investments such as maintenance renewal self-financed by trusts through retained surpluses or via loans from DHSC and public dividend capita (PDC).[4] There are also nationally held capital funds which cover strategic projects like new hospitals and hospital upgrades. Other national capital investment includes elective recovery, diagnostics programmes, and digital funding.

The NHS has been unable to enter into new public private partnerships since 2018. Until that point these were a well-used financing route for major building programmes. Assets were financed via public finance initiative (PFI) providers who then leased them back to the public sector with contracts which often included estates and facilities management costs. However, these contracts carried significant annual unitary charges.[5]

1 Capital expenditure refers to spend on assets – tangible and intangible – that are used for more than one year.

2 Department of Health and Social Care, 'Annual report and accounts 2021-22', January 2023.

3 NHS England, 'Consolidated NHS provider accounts 2021/22', January 2023.

4 Public dividend capital reflects the cost of capital utilised by providers and is a charge made by DHSC based on a trust's average net relevant assets.

5 The Institute for Public Policy Research, 'The make do and mend' health service: solving the NHS capital crisis', September 2019.

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Raiding capital budgets to boost revenue

Following significant cuts in public spending, the NHS capital budget was raided between 2014/15 and 2018/19 as DHSC prioritised day-to-day spending at the expense of vital long-term investment. In the short term it was easier to cut investment than day-to-day spending. During this period DHSC transferred £4.3bn from the capital budget into the revenue pot.[6]

As The Health Foundation has shown, had the UK matched EU14 levels of capital spending as a share of GDP it would have invested £33bn more in health-related assets between 2010-2019.[7] This would have amounted to a 55% uplift against actual health capital spending during this period.

The relative lack of capital investment limited the scope for productivity improvements. As the long-term plan highlighted, the NHS uses its assets and infrastructure more intensively than equivalent health economies.[8] The Health Foundation notes the 'capital thinning' across the NHS over the last decade, whereby capital per worker fell – this is a proxy measure used to assess overall capital investment levels. Given trusts have been using their infrastructure and equipment for longer – which meant the value of their assets depreciated less each year – the value of capital increased only marginally between 2010/11 and 2017/18.[9]

6 National Audit Office, 'Review of capital expenditure in the NHS', February 2020, p.7.

7 The Health Foundation, 'How does UK health spending compare across Europe over the past decade?', November 2022.

8 NHS England, 'The NHS long term plan', January 2019, p.108.

9 The Health Foundation, 'Briefing: failing to capitalise capital spending in the NHS', March 2019, pp.10-12.

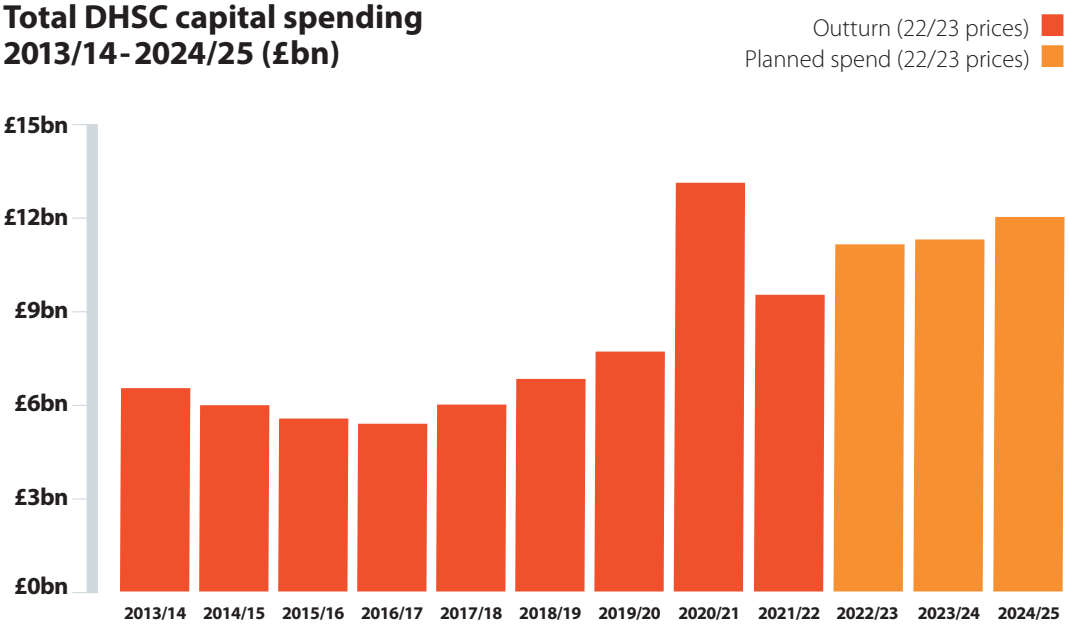
Current levels of capital investment

Recent capital announcements represent a major uplift to the NHS capital budget

There has been major growth in DHSC's capital budget over recent years. This has resulted in a substantial increase in capital allocations across the provider sector. Capital investment across the NHS over the current Spending Review (SR) period (2022/23 - 2024/25) is expected to average £8bn per annum, whereas annual capital spending averaged £3bn between 2010-19.[10]

Figure 2

Total DHSC capital spending 2013/14 - 2024/25 (£bn)



Source: NHS Providers analysis of HM Treasury data (calculated using December 2022 GDP deflators).[11]

Trusts welcomed the multi-year capital budget set at the October 2021 SR. This was the first multi-year settlement since 2015, and providers have since been given indicative capital allocations for 2023/24 and 2024/25. After years of underinvestment, the capital settlement has given trusts and systems greater certainty for medium-term financial planning.

The government expects to allocate £12bn over the SR period for maintenance and improvements across the estate.[12] For 2023/24, NHSE has allotted £4.1bn to operational capital envelopes and £3.6bn to nationally allocated funds and other national capital investment.[13]

10 NHS England, 'Board meeting: 2023/24 financial position and the future financial outlook', October 2022.

11 HM Treasury: 'Public Expenditure Statistical Analyses 2022', July 2022; 'Autumn Statement 2022', November 2022; 'Supplementary Estimates 2022-23', February 2023; 'December 2022 GDP deflator series, November 2022. Office for Budgetary Responsibility, 'November 2022 GDP deflator forecasts', November 2022. We have included DHSC's Covid-19 capital spend across 2020/21 and 2021/22. The capital profile for 2022/23 - 2024/25 appears higher than outlined at the October 2021 Spending Review due to the reclassification of leases as part of the IFRS16 accounting standards.

12 UK Parliament, 'Hospitals: repairs and maintenance – question for Department of Health and Social Care', December 2022.

13 NHS England, 'Capital guidance update 2023/24', January 2023, p.9.

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As section four highlights, this increase included nationally allocated capital to support elective waiting list recovery, improve digital technology, transform diagnostic services, create new surgical hubs, expand bed capacity and improve equipment. This investment was largely targeted at hospital settings.

Inflationary pressures and the medium-term outlook for health capital spending are concerning

In the Autumn Statement the government confirmed that departmental capital budgets announced at the SR would remain the same at flat cash levels.[14] However, given the current and anticipated level of inflationary pressures over the remainder of the SR period, the cash settlement is forecast to decrease in real terms.

After 2024/25, the Office for Budget Responsibility (OBR) forecasts that the government's total capital envelope will fall by 1.2% in real terms per annum rather than increasing at the same level of nominal GDP growth.[15] CDEL spending will fall to 3.3% of GDP in 2027/28, thereby reversing half of the March 2020 Budget uplift.[16]

Inflation is limiting trusts' capacity to deliver capital projects within initial cost estimates. In some cases, trusts are delaying (or abandoning) projects because costs have spiralled; others are rephasing and rescaling planned works. There are also capacity and capability issues affecting delivery. While construction price inflation has somewhat stabilised, supply chains remain constrained and input cost inflation – impacting labour and materials – is leading to higher costs over the SR period.[17] Inflation will ultimately eat away at the nominal capital settlement.

14 HM Treasury, 'Autumn Statement', November 2022.

15 Office for Budgetary Responsibility, 'Economic and fiscal outlook', November 2022, p.38.

16 Office for Budgetary Responsibility, 'Economic and fiscal outlook', November 2022, pp.36-37.

17 Arcadis, 'Market view: winter 2022', December 2022.

4 REPAIRING THE DILAPIDATED ESTATE

The 2021 SR funding injection followed years of prolonged underinvestment in estates and facilities across the NHS, and the capital maintenance backlog remains a major concern for trusts. While the SR uplift was welcome, the concern remains that national capital expenditure limits do not fully reflect the NHS' investment needs. Indeed, as The King's Fund notes, "the full ambitions of the NHS capital regime will not be achieved – even if improvements to capital allocations are implemented – if the overall amount of NHS capital investment is insufficient".[18]

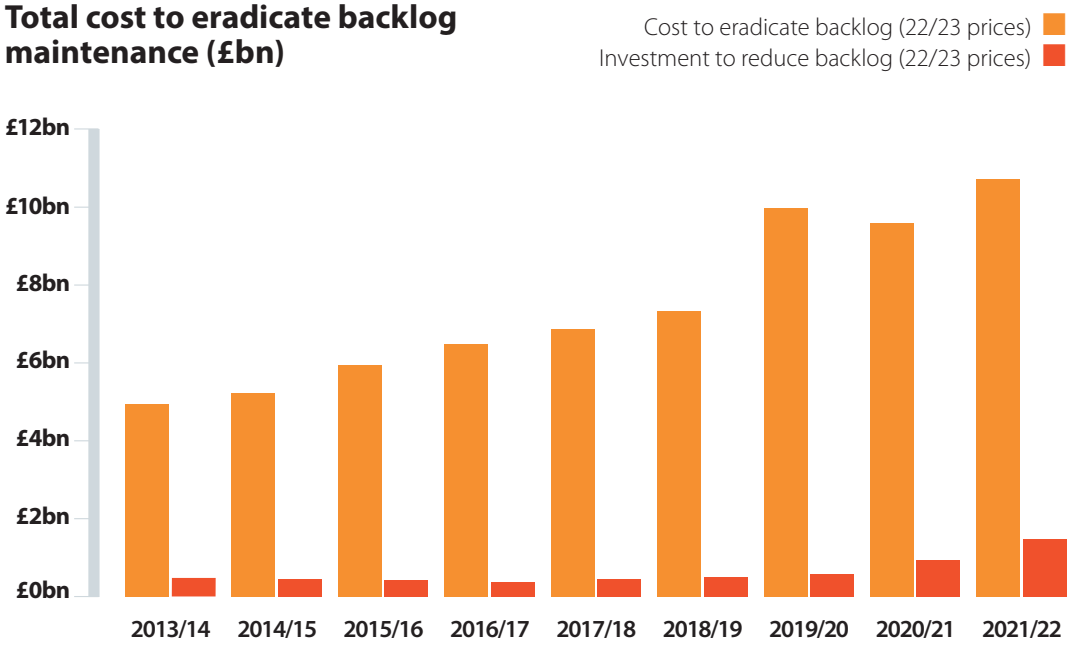
As we cover in this section, the level of the maintenance backlog and the extent of dilapidated infrastructure ultimately reduces the ability of trusts to transform their estate and make vital productivity improvements.

Investment in estate renewal and scale of maintenance backlog

The latest estates return information collection (ERIC) data for 2021/22 shows a major deterioration of the 'backlog maintenance' across the NHS estate. This is a measure of how much needs to be invested to restore assets to suitable working condition (based on a set of assessed risk criteria). The backlog refers to work that should already have taken place.

Figure 3

Total cost to eradicate backlog maintenance (£bn)



Source: 2021/22 estates returns information collection (calculated using December 2022 GDP deflators).

18 The King's Fund, 'Review of the current capital allocation methodology for system envelopes', March 2022, p.21.

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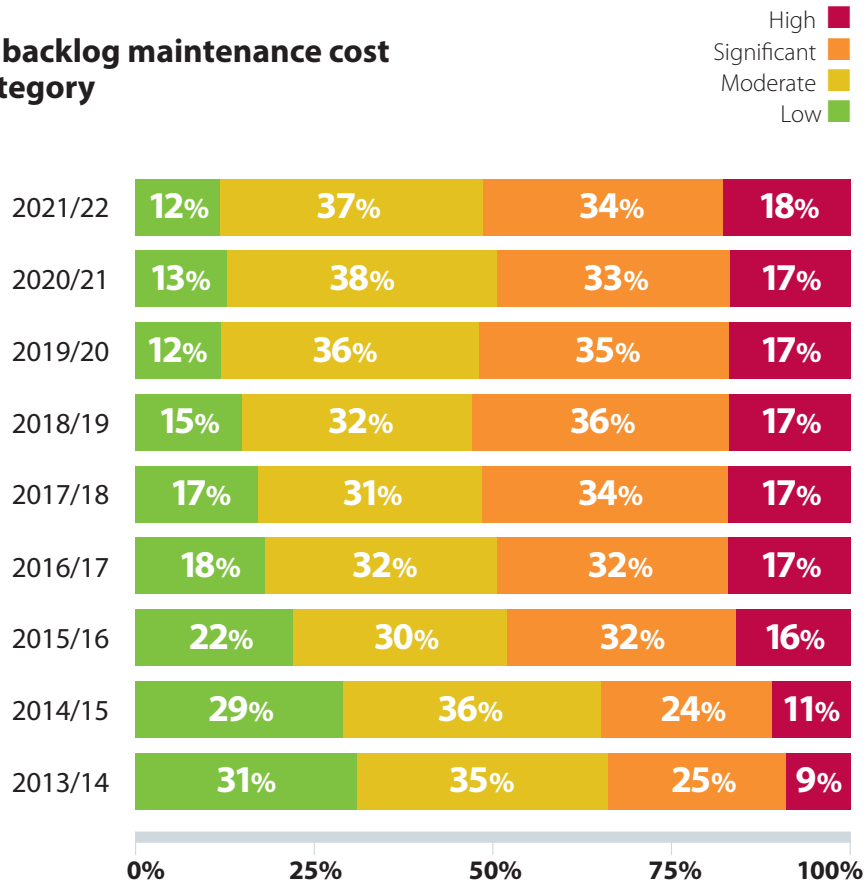
Since 2010/11, the total backlog has doubled which highlights the sustained underinvestment in the NHS estate. Despite a major increase in capital investment in 2021/22 totalling £1.47bn (in 2022/23 prices) to reduce the maintenance backlog, the latest data shows that the backlog increased to £10.75bn.

The need to prioritise critical infrastructure risk

In 2021/22 the total cost to eradicate the highest maintenance risk was £1.89bn in 2022/23 terms – four times the 2013/14 level. The proportion of the backlog which presents a high or significant risk has increased to 52% – £768m more in 2022/23 prices. 'High risk' refers to repairs which must be urgently addressed to prevent catastrophic failure or major disruption to clinical services, and significant risk is where repairs demand priority management and short term spending. Positively, the number of estates and facilities related safety incidents fell by over 40% when compared to 2020/21 figures.

Figure 4
Percentage of backlog maintenance cost in each risk category



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There is a recognition across government and by trusts of the need to provide more granular levels of data on the scale of infrastructure risk across the estate. The Public Accounts Committee has recommended that DHSC and NHSE should provide an annual progress update about how ICSs are managing to address the maintenance backlog.[19]

Reinforced autoclaved aerated concrete (RAAC) planks

There is also a significant estates risk presented by reinforced autoclaved aerated concrete (RAAC) planks used in construction between the 1960s and 1980s.[20] These were used for flat roof construction and span between steel beams or on masonry walls.[21] This type of precast concrete was expected to have a lifespan of around 30 years, but some trusts have used these materials for over 50 years. To mitigate the risk of sudden collapse, organisations may replace the planks with alternative structural roofs or introduce secondary supports such as scaffolding.

There are currently 14 hospitals with RAAC planks which will require extensive building work to prevent their closure.[22] Of the 14 hospitals, seven are at a critical level of risk and only two of these are currently included in the government's New Hospital Programme. The government has committed to remove RAAC from the NHS estate by 2035 and has allocated £685m mitigate the risks.[23] However, it is currently unclear how much additional capital will be made available for trusts impacted by RAAC planks, whether the government will implement a separate funding stream to deal with the issue, and if the remaining places on the NHP will be taken by RAAC-affected trusts.

19 Public Accounts Committee, 'Introducing Integrated Care Systems', January 2023, p.7.

20 Defence Infrastructure Organisation, 'Safety alert: failure of reinforced autoclaved aerated concrete (RAAC planks)', May 2019.

21 New Civil Engineer, 'NHS trusts need hundreds of millions to stop hospitals' roofs collapsing', October 2022.

22 NHS England, 'Video of the NHS England board meeting – 6 October 2022', October 2022.

23 UK Parliament, 'Hospitals: buildings – question for Department of Health and Social Care', December 2022.

5 RECOVERING PERFORMANCE AND IMPROVING PRODUCTIVITY

The operational ask of the NHS cannot be delivered without adequate capital investment. Following the Autumn Statement and the publication of the operational planning guidance, there is now a national drive to recover core NHS services across elective and urgent and emergency care (UEC) and improve productivity. The planning guidance sets a range of national NHS objectives for 2023/24, including improving A&E waiting times so at least 76% of patients wait no more than four hours, reducing general and acute bed occupancy to 92% or below, improving patient flow to ease UEC pressures, and reducing category two ambulance response times to an average of 30 minutes.[24]

The recently published UEC recovery plan recognises that performance recovery is not confined to ambulance services and emergency departments.[25] Wider system collaboration is required between providers across the acute, community, ambulance, mental health, primary care and social care sectors.

This section highlights the role of strategic capital spending in enabling trusts to improve productivity, operational performance and patient care across all sectors. Not only is capital investment critical to maintaining efficient and modern equipment, technology and estates within the NHS, it can also enable a transformative, whole system approach to improving patient flow. This requires full consideration of the capital needs across the acute, ambulance, mental health and community sectors.

Enhancing diagnostic capacity

Replacing and investing in new equipment to increase activity

Enhanced diagnostic capacity has a major impact on health outcomes and improves access to planned care and is therefore a key enabler to delivering on the ambitions of the elective recovery plan. However, the UK has a relatively small diagnostic capital stock compared to similar OECD countries. This means a lower number of CT scanners, MRI units and positron emission tomography (PET) scanners per million people than most OECD countries, and a lower than average spend per person on in vitro diagnostics.[26]

As well as a need for new diagnostic equipment, there is a significant backlog of diagnostic infrastructure more than 10 years old which needs replacing – including unreliable mobile X-ray machines and old CT scanners.[27] The replacement of old equipment and investment in new diagnostic infrastructure is therefore vital.

24 NHS England, '2023/24 priorities and operational planning guidance', December 2022.

25 Department of Health and Social Care and NHS England, 'Delivery plan for recovering urgent and emergency care services', January 2023.

26 The King's Fund, 'Why do diagnostics matter? Maximising the potential of diagnostics services', October 2022, pp.23-25.

27 The King's Fund, 'Why do diagnostics matter? Maximising the potential of diagnostics services', October 2022, p.23.

Community diagnostic centres can ramp up activity beyond acute sites

The provision of community diagnostic centres (CDCs), which are separate from urgent scan facilities, enables patients to access planned diagnostic care more locally. The establishment of CDCs were recommended following Professor Sir Mike Richards' independent review of NHS diagnostics capacity.[28] The SR apportioned £2.3bn for CDCs.

They provide a single point of access in the community and enable trusts to increase diagnostic capacity. NHSE's ambition is to roll out a network of 160 centres across England, freeing up capacity in acute sites and providing MRI, CT and other diagnostic services closer to patients' homes, thereby also helping to reduce regional inequalities in access.[29]

However, the need to fund the 2022/23 NHS pay award without additional money from the government meant NHSE has had to slow the pace of its transformation programmes and scale back revenue funding due to wider pressures on the national budget, including national technology programmes and diagnostic capacity.[30] It is unclear at this point what the impact will be on delivering the ambitions of these programmes. It is vital however that the government make a long-term commitment to invest in diagnostics.

Estates reconfigurations and surgical hubs to separate elective and emergency care

£1.5 billion was allocated at the SR to create surgical hubs and increase bed capacity. Separating elective and emergency care enables trusts to better deal with Covid-19 waves and winter pressures which disrupt planned elective activity to transform outpatient services. The hubs take different forms on trust sites – integrated, stand-alone and specialist – to enable surgeons to deliver both low and high-complexity surgery. They provide an opportunity to improve and expand surgical training, create a positive working environment for staff, ringfence planned treatment, and avoid excessive cancellations due to wider demand pressures.[31] However, the Royal College of Surgeons notes that workforce requirements can challenge the feasibility of staffing hubs, and that independent evaluation of the units is required to ensure there are no adverse impacts on staffing levels or health inequalities.[32]

Estates reconfigurations can also help reduce infection and prevention control (IPC) risks across inpatient settings, improve patient experience and increase productivity.

28 NHS England, 'Diagnostics: recovery and renewal – report of the independent review of diagnostic services for NHS England', November 2020.

29 NHS England, 'One million checks delivered by NHS 'one stop shops'', June 2022.

30 NHS England, 'Board meeting: financial performance update', December 2022.

31 Tim Briggs, Peter Kay, Stella Vig, Alvin Magallanes, Haroon Rehman, Mary Fleming, Isobel Clough, 'Optimising surgical hubs for staff: case studies on training, wellbeing and retention', British Journal of Healthcare Management, vol 28, no 12, November 2022.

32 Royal College of Surgeons, 'The case for surgical hubs', July 2022.

For example, capital projects which increase the number of bathroom facilities on wards, or investment in respiratory ward infrastructure to support patients requiring non-invasive ventilation (NIV) and high-flow care, thereby reducing patient time in intensive care.

The need to expand bed capacity across the system

Meeting growing demand pressures

Having sufficient capacity to meet demand has always been a critical factor in the NHS' ability to deliver high-quality care. Limited bed capacity and historic underfunding of the NHS estate can go some way to explaining underperformance against some activity targets. For example, evidence shows how admissions delays are directly related to numbers of available beds – a 1% increase in bed occupancy is associated with a 9.5% fall in trusts' probability of meeting the four-hour waiting time target to admit, transfer or discharge patients.[33]

Between 2010/11 and 2018/19, the number of available beds fell by 5% while admissions rose by 5%, and The Health Foundation forecasts that the NHS may need up to 39,000 more beds by 2030 to deliver 2018/19 rates of care.[34] As the Institute for Fiscal Studies notes, while the total number of beds has increased by 1% against pre-pandemic levels, the number of beds available to non-Covid patients in the final quarter of 2022 was still lower than prior to the pandemic.[35]

Expanding trusts' estate and bed capacity will be essential in helping the NHS meet growing demand. This is particularly important given the current impact of ambulance handover delays. NHSE recently confirmed the profile of the additional money announced at the Autumn Statement – £1bn of revenue funding will help NHSE afford additional capacity, including 5,000 additional beds to ramp up the permanent bed base ahead of next winter.[36] It is unclear what the balance between physical and virtual beds will be.

Ensuring the right combination of beds across systems and the use of virtual wards

Trusts require the right bed capacity in different parts of the country including general and acute beds, but also intermediate care, rehabilitation beds and step-down mental health support. It is vital that capital investment beyond the current SR period underpin sustainable solutions to expand physical bed capacity, and that additional revenue requirements for staffing these beds be met.

33 Rocco Friebel and Rosa M. Juarez, 'Spill over effects of inpatient bed capacity on accident and emergency performance in England', Health Policy, vol 124, no 11, pp.1182-1191, November 2020.

34 The Health Foundation, 'Projections general and acute hospital beds in England (2018-30)', July 2022.

35 Institute for Fiscal Studies, 'NHS funding, resources and treatment volumes', December 2022.

36 Department of Health and Social Care and NHS England, 'Delivery plan for recovering urgent and emergency care services', January 2023.

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National investment in virtual wards has the potential to deliver tangible improvement in patient experience and outcomes, and in systems' performance, by reducing the length of stay in hospital and preventing avoidable admissions.[37] The importance of this approach is underlined in the recent UEC recovery plan. However, there are challenges in scaling up and workforce shortages remain the rate limiting factor, as additional investment in digital capacity will ultimately require a significant boost to staff numbers and the right skill mix for delivery.

Investing in the estate to improve staff wellbeing

Unsurprisingly estates which are not fit for purpose have an impact on the staff who work in them. Repurposed buildings and rooms can make the delivery of services more challenging – for instance, working in cramped conditions where spaces were previously allocated to staff, or in corridors which have been adapted to create more capacity for patient care. This issue was particularly prevalent during the height of the pandemic, when social distancing requirements placed additional strain on physical spaces for care delivery.

Not only are such environments often unpleasant for patients and difficult to work in, but this process takes away spaces which previously enabled staff to rest, eat, or undertake administrative work. The absence of investment in NHS estates has made such practices increasingly common. Staff and trust leaders alike have repeatedly raised the issue of a lack of staff-only spaces in the NHS, and the BMA's recent report highlights the impact this has on staff morale and physical wellbeing.[38]

The physical working environment in the NHS also impacts productivity. The BMA's report notes that 83% of doctors who responded to their survey find the condition of NHS workplaces limits their ability to use technology when delivering care.[39] The most frequently cited issues were matters of basic infrastructure, such as cracked plug sockets, unreliable internet access, outdated computers and lack of office space for clinical staff to undertake administrative work.

While funding for staff-only spaces can be – and often is – taken from budgets set aside for staffing costs, investment in the estate more widely is necessary to ensure that these spaces are functional, remain protected for staff-only use, and improve staff productivity and wellbeing across the board.

37 NHS Providers, 'Provides deliver: trusts in systems', November 2022.

38 British Medical Association, 'Brick by brick: the case for urgent investment in safe, modern, and sustainable healthcare estates', December 2022, pp.16-25.

39 British Medical Association, 'Brick by brick: the case for urgent investment in safe, modern, and sustainable healthcare estates', December 2022, p.29.

5

Reducing the mental health care backlog and drive long overdue improvements in patient care

Spending Review uplift welcome but there remains a need to improve the mental health estate

In October 2020, the government expanded the funding available to replace outdated mental health dormitories, committing more than £400m up to 2023/24.[40] By March 2022, £220m had already been allocated, with 16 schemes completed and another 22 awaiting construction.[41] The government has also recently confirmed £150m of capital funding initially announced in the SR to upgrade mental health crisis response infrastructure and to procure up to 150 specialised mental health ambulances.[42]

While the Spending Review uplift was welcome, national capital allocations have largely been prioritised towards acute settings. Many trust leaders are concerned that the national priority for elective recovery means there is a corresponding underinvestment in mental health and community services. National capital for mental health and learning disability trusts appears to be limited. This is a particular issue for those mental health trusts aiming to redevelop their estates to improve the quality of care offered to patients, reduce the mental health backlog and improve their efficiency.

The need to improve the therapeutic environment and create low stimulus settings for mental health inpatients

The need to improve the therapeutic environment and create 'low stimulus' settings for mental health inpatients is pressing. In November 2021, the Health and Social Care Committee's Expert Panel noted that service users had highlighted how the therapeutic offer was limited and, crucially, that capital funding had been insufficient to transform the physical estate.[43] The committee noted that significant work is still required to enable adults with severe mental illness to access services in both safe and therapeutic environments.[44]

Mental health inpatient units require significant investment to improve the quality of patient care. Worryingly, the capital maintenance backlog across mental health trusts increased significantly from £425m in 2019/20 to £677m in 2021/22 in cash terms.

40 Department of Health and Social Care, 'Over £400m pledged to remove dormitories from mental health facilities', 10 October 2020.

41 Department of Health and Social Care, 'Annual report and accounts 2021-22', January 2023.

42 Department of Health and Social Care, 'Press release – mental health services boosted by £150 million government funding', January 2023.

43 House of Commons: Health and Social Care Committee, 'Evaluation of the Government's progress against its policy commitments in the area of mental health services in England: Second Special Report of the Session 2021-22' 2021-22, December 2021, p.15.

44 House of Commons: Health and Social Care Committee, 'Evaluation of the Government's progress against its policy commitments in the area of mental health services in England: Second Special Report of the Session 2021-22' 2021-22, December 2021, p.59.

There are some particularly outdated mental health hospitals designed in the 1950s which are still in operation. Some units include multiple wards shared by many patients, and male rooms which overlook recreation facilities for female patients, thereby failing to adequately meet dignity and privacy requirements.

Mental health trusts must be given appropriate prioritisation in capital funding decisions at the national and system level, and their role in improving productivity and supporting the delivery of the government's recovery plans better understood.

Expanding step-down care capacity to relieve system-wide pressures

As already highlighted, national capital allocations following the SR have been largely directed at acute settings with more recent focus on elective restoration, cancer and frontline digitalisation. However, there has been a relative lack of prioritisation for community and intermediate services.

In the context of system capital planning, community providers can find it difficult to access capital. They often must resort to expensive rental arrangements with third party organisations to provide accommodation and expand the community bed base. Given the pressures on emergency care and discharge, additional national funding for community and intermediate services can improve much needed capacity and reduce operating costs.

The process for accessing funding for community trusts can often be more complex given their ties with primary care providers. For example, community providers may lease premises from NHS Property Services and share facilities with a GP practice. Ensuring high-quality integrated care at local level requires clear ownership models and routes for funding to support community providers and GPs to run the primary care estate collaboratively.

STRATEGIC INVESTMENT TO TRANSFORM THE NHS ESTATE

6

There are major opportunities to transform the NHS estate to become more sustainable, efficient and digitised. Trust sites designed to support new models of care, digital transformation and clinical research have the potential to lead to measurable improvements in key health outcomes. Indeed, the NHP has the capacity to improve patient-centred care and experience, drive long overdue improvements in patient safety, materially improve staff recruitment and enable trusts to increase productivity.

This section considers the scope of wholescale transformation of the NHS estate, how capital investment can underpin major changes to service delivery, and with the right support from government, can enable trusts to maximise economic and social value from its estate and use it more efficiently.

Capital investment vital to enable NHS to deliver on net zero ambitions

The NHS plans to become the world's first net zero carbon national health system. As part of its strategy, the carbon footprint of emissions it controls should be net zero by 2040.[45] Systems are therefore expected to consider the impact of capital spending on trusts' carbon footprint, local air pollution, and the health of staff and patients.[46]

As well as reducing the carbon impact of major infrastructure projects like building new hospitals, there are sustainable day-to-day changes that can reduce the NHS' carbon footprint. However, major investment is required to improve energy efficiency across the NHS estate and enable trusts to reduce their carbon footprint.

Significant funding was announced at the SR to decarbonise the NHS. Like other public sector bodies, NHS trusts and foundation trusts may apply for funding via the Public Sector Decarbonisation Scheme operated by the Department of Business, Energy and Industrial Strategy (BEIS). The scheme takes a 'whole building approach' to decarbonising heat. Current projects include the installation of air and ground source heat pumps; improving energy efficiency through double glazing, loft and cavity wall installation; installing LED lighting, and setting up solar panels to produce renewable electricity.[47]

This financial support has enabled some trusts to materially progress their net zero strategies. As NHS Providers noted in our report on trusts' efforts to reach net zero emissions, as well as transforming supply chains and enabling more sustainable procurement strategies, the route to large-scale decarbonisation will also require significant capital investment.[48] For example, enabling the NHS to transition to a fully zero emission ambulance fleet will require investment in the wider NHS estate to provide electric vehicle charging stations.

45 NHS England, 'Delivering a 'net zero' National Health Service', October 2020.

46 NHS England, 'Capital guidance 2022 – 2025', April 2022.

47 Department for Business, Energy and Industrial Strategy, 'Phase 3a Public Sector Decarbonisation Scheme: project summaries', November 2022.

48 NHS Providers, 'Climate change is a public health emergency', April 2022.

However, the financial case for transformative 'green plans' can be challenging when annual capital charges exceed cost savings. In addition, given the limited headroom across the NHS capital budget, it is unclear whether the main source of funding going forward will be via BEIS rather than DHSC.

Delivering fully digitally connected estates

Capital investment to improve interoperability

Frontline digitisation via electronic patient records (EPRs) has long been identified as a key enabler in transforming services to improve outcomes, tackle inequalities, enhance productivity and contribute to broader social and economic development. This is relevant for both new builds and estate refurbishments.

Trusts require the 'basics' to be right first, ensuring they have a strong foundation to grow their digital maturity – including reliable Wi-Fi coverage, strong technical infrastructure, and EPRs – before moving ahead to any more advanced digital health technologies. Digital needs must therefore be considered at the outset when designing new hospitals.

As NHS Providers' Digital Boards programme has evidenced, EPRs can enhance patient safety by enabling synchronous data entry at the point of care; improve staff satisfaction by transforming the usability of software; increase productivity by reducing the time spent by staff entering and searching for data, and help inform service transformation to improve population health management.[49]

Interoperability and the ability of technical systems to exchange information across organisations and systems is vital. As the BMA highlights, improving the level of coordination between primary and secondary care is vital to reducing the care backlog by helping to speed up clinical and administrative processes, and ensuring patient pathways are completed as quickly as possible.[50]

49 NHS Providers, 'Making the most out of your electronic patient record system', January 2023, p.21.

50 British Medical Association, 'Getting IT right: the case for urgent investment in safe, modern technology and data sharing in the UK's health services', December 2022.

6

The need for a long-term view of benefits realisation from digital investment

Trust leaders welcomed the £2.1bn of capital funding allocated at the SR to improve NHS technology and digital assets. However, the current level of digital investment is not enough to support trust leaders to meet the ambitious digital transformation goals set out in DHSC's digital strategy for health and social care.[51] There remain concerns that digital investment will be scaled back at a time when trusts and systems require these enablers to deliver long-term transformation of the estate. It is also important for policy makers to explore a rebalance of the funding model for digital, which requires both revenue and capital investment.

The government must take a long-term view on digital funding. It can take 5-10 years for the benefits of digital transformation to be fully realised. For this reason, constantly changing, short-term national digital priorities hamper trust leaders' ability to build digital foundations for the long term.

New Hospitals Programme

In September 2019 the government launched the Health Infrastructure Plan (HIP), which announced funding for six new hospitals and seed funding for an additional 21 trusts to develop business cases for proposals.[52] The Conservative Party's 2019 manifesto committed to building 40 new hospitals by 2030. In October 2020, the then prime minister announced the trusts that comprise the New Hospital Programme (NHP).[53] This included the initial six HIP1 trusts. Some of these projects were already in flight. There are currently 40 separate projects across 35 trusts in the programme, and their business cases are at different stages of development.[54]

In July 2021 the government announced it planned to fund an additional eight hospitals.[55] Trusts which applied to be included in the final cohort are still awaiting the outcome of the selection process.

51 Department of Health and Social Care, 'A plan for digital and social care', June 2022.

52 Department of Health and Social Care, 'Health infrastructure plan', September 2019.

53 Department of Health and Social Care, 'PM confirms £3.7 billion for 40 hospitals in biggest hospital building programme in a generation', October 2020.

54 NHS England, 'Board paper: New Hospital Programme update', October 2022.

55 Department of Health and Social Care, 'Eight new hospitals to be built in England', 15 July 2021.

Trusts and foundation trusts currently in the New Hospital Programme

Cohort 1 (in-flight)	Cohort 2 (in-flight or construction starts by 2024)
Brighton and Sussex University Hospitals NHS Trust Redevelopment of Royal Sussex County Hospital to deliver a regional centre for teaching, trauma and tertiary care	**Cambridge University Hospitals NHS Foundation Trust** New cancer hospital at Addenbrookes
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Rebuild of Northgate Hospital	**County Durham and Darlington NHS Foundation Trust** New build to place Shotley Bridge Hospital
Liverpool University Hospitals NHS Foundation Trust New hospital to replace Royal Liverpool University Hospital	**Dorset HealthCare University NHS Foundation Trust** (five schemes) New build of St Ann's Hospital, rebuild of Poole Community Hospital, rebuild of Bournemouth Community Hospital, rebuild of Christchurch Community Hospital, rebuild of Dorset County Hospital
Moorfields Eye Hospital NHS Foundation Trust A new eye care and education facility at Moorfields Eye Hospital	**Nottingham University Hospitals NHS Trust** New national rehabilitation centre at the Stanford Hall
North Cumbria Integrated Care NHS Foundation Trust New oncology hospital	**Royal Cornwall Hospitals NHS Trust** New women and children's hospital
Royal United Hospital Bath NHS Foundation Trust New cancer hospital and improving the Combe Park estate	**University Plymouth Hospitals NHS Trust** New integrated emergency care hospital
Salford Royal NHS Foundation Trust New non-elective, high acuity hospital	
Sandwell and West Birmingham Hospitals NHS Trust New Midland Metropolitan Hospital	

Cohort 3 (planned start date tbd)	Cohort 4 (planned start date tbd)
Barts Health NHS Trust New hospital at Whipps Cross	**East Sussex Healthcare NHS Trust** New hospital at Eastbourne, new clinical building at Bexhill and refurbishment at Conquest
Epsom and St Helier University Hospitals NHS Trust New major hospital at Epsom and St Helier	**Hampshire Hospitals NHS Foundation Trust** New Basingstoke and North Hampshire Hospital and major refurbishment at Royal Hampshire Hospital
Hillingdon Hospitals NHS Foundation Trust Rebuild of Hillingdon Hospital	**Imperial College Healthcare NHS Trust** (two schemes) Rebuild of St Mary's Paddington and Hammersmith Hospital and major refurbishment of Charing Cross
Leeds Teaching Hospitals NHS Trust New hospital for adult healthcare and new build for Leeds Children's Hospital	**James Paget University Hospitals NHS Foundation Trust** Rebuild of James Paget Hospital
Manchester University Hospitals NHS Foundation Trust Rebuild of North Manchester General Hospital	**Kettering General Hospital NHS Foundation Trust** Rebuild of Kettering general Hospital
Princess Alexandra Hospital NHS Trust A new integrated healthcare campus to replace Princess Alexandra Hospital	**Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust** Rebuild of Royal Preston Hospital and Royal Lancaster Infirmary
University Hospitals of Leicester NHS Trust Rebuild at Leicester Royal Infirmary and Glenfield Hospital	**Milton Keynes University Hospital NHS Foundation Trust** New women and children's hospital at Milton Keynes Hospital
West Hertfordshire Hospitals NHS Trust New buildings at Watford General Hospital	**Nottingham University Hospitals NHS Trust** Rebuild of Queen's Medical Centre and City Hospital
	Royal Berkshire NHS Foundation Trust Rebuild of Royal Berkshire Hospital
	Royal Devon University Healthcare NHS Trust Rebuild of North Devon District Hospital
	Somerset NHS Foundation Trust Rebuild of Musgrove Park Hospital
	Torbay and South Devon NHS Foundation Trust Rebuild of Torbay Hospital
	West Suffolk NHS Foundation Trust Rebuild of West Suffolk Hospital

6

Is there enough funding to meet the ambitions of the programme?

Given that many parts of the NHS estate are in extremely poor condition, in some cases, demolition and rebuild is the only viable way forward. As highlighted in section four, some trusts' critical infrastructure risk can become increasingly costly and operationally challenging to mitigate. New builds can therefore enable trusts to significantly reduce their maintenance backlog by repurposing, refitting or replacing outdated facilities.

In October 2020 the prime minister announced that £3.7bn would be made available for trusts to make progress on the 40 hospitals across all cohorts, and at the SR the government confirmed this funding for 2022/23 to 2024/25. The current envelope therefore does not cover the life cycles of all the projects. Additional funding was also made available for upgrades at trusts outside of the NHP.

While the initial £3.7bn of investment between 2022/23 and 2024/25 was welcome, it is unclear how far this notional capital envelope will enable trusts to deliver at their preferred scale – particularly as demands on this budget for those trusts currently in the programme continue to grow. Trusts have identified the financial cost of delays given inflationary pressures across the construction sector and material inputs. It is unclear whether there are any plans to announce a revised budget for the NHP beyond the spending review period.

The challenge in aligning local plans and business cases with a national programme

The NHP has also highlighted the tension in delivering a national programme driven by the government with individual trusts which remain accountable to and close to their local populations. The programme ultimately requires co-design between national government and local and regional health systems.

The NHP has been delayed as central government seeks to agree a programmatic approach to delivery, and because the projects were all at different stages of business case development when the NHP was announced. Some are still at the first stage (strategic outline case) which assesses the initial scope of the project; others have moved on to the second stage (outline business case) which sets out the preferred option and determines affordability and funding requirements.

There is buy-in to the programmatic approach given its economic and social value, and its potential to benefit all constituent trusts currently part of the NHP, as well as trusts that will utilise the capability and capacity of the NHP in the future. However, trusts are still waiting to proceed pending funding approval.

What is the value of design standardisation and what are the costs?

The NHP is expected to transform the procurement and design strategy for manufacturing material inputs for new hospitals. A standardised approach means it should become cheaper in the longer term to build hospitals and enable more efficient use of trusts' estates. Modern methods of construction (MMC) is a now a key policy of the government and the NHS, with a national target for NHS capital projects over £25m to deliver MMC for 70% of new builds and 50% for refurbishments.[56]

It is unclear at this point how many trusts currently part of the NHP will be expected to employ MMC. Trusts recognise the value of MMC in reducing long-term delivery costs and how design standardisation can improve clinical outcomes. There may be however major cost implications to implementing full standardisation in the short term.

Strategic use of the NHS estate: partnerships with communities, research and industry

The government should continue to explore how the NHS can maximise values from land disposal and use the wider estate more efficiently for the benefit of staff, patients and communities.

The value of land and buildings owned by NHS providers stood at £38.2bn at the end of 2020/21.[57] The Naylor review explored the value in releasing inefficient or unused land that was no longer needed for the delivery of healthcare. The commission estimated that land disposal across the acute and non-acute sectors could release risk-adjusted capital receipts with a value of £2.7bn – this figure could be higher if the NHS were able to secure more cost-effective housing quotas and develop a more commercially orientated approach to estate management, and if planning regulations were more amenable.[58]

Anchor capital strategies to benefit communities

Trusts play a key role in creating economic and social value for their communities – as a major employer, a provider of key services and advice and often as a supporter of local businesses and voluntary sector organisations. This is particularly important for rural providers where there are few other public service institutions which have the capacity to play a similar role.

The Naylor review identified opportunities to develop affordable housing models for NHS staff in collaboration with housing associations and developers.

56 NHS England, 'Capital guidance update 2023/24', January 2023, p.9.

57 Department of Health and Social Care, 'Annual report and accounts 2021-22', January 2023.

58 NHS Property and Estates, 'Why the estate matters for patients: an independent report by Sir Robert Naylor for the Secretary of State for Health', March 2017.

The Health Foundation has also outlined how 'anchor capital strategies' can operate in practice, expanding community access to the NHS estate, converting land using capital receipts for the benefit of local communities, and improving staff wellbeing and retention by developing more affordable housing.[59]

Land disposal and partnership with the life sciences industry

Some trusts have been developing bids for clinical and research facilities for additional bed capacity, as well as life science clusters, which are developed (and funded) through partnerships with industry. Policy makers should explore the scope for further partnerships between NHS organisations with the life sciences industries to enable trusts to improve their estate and patient care, while also investing in vital research and development.

Trusts are now able to generate 'CDEL 'credits' through land disposal, which means the credit from land and property does not have to be used in the same year, and could help enable greater flexibility over their multi-year capital spending profile.[60] However, there are limitations on any sales from land disposal, as any profits above the net book value of assets must remain affordable within system envelopes.

Primary care estate

While the focus of this report has centred on secondary care, it is also vital to consider the recommendations of the Fuller stocktake of primary care. The report noted that GP owner-occupied models can limit cross-system working and estate management, and that ICSs should ensure system estate transformation plans take due consideration of population health, access and inequalities.[61]

59 The Health Foundation, 'Building healthier communities: the role of the NHS as an anchor institution', August 2019, pp.36-37.

60 NHS England, 'Capital guidance update 2023/24', January 2023, pp.6-7.

61 NHS England, 'Next steps for integrating primary care: Fuller Stocktake report', May 2022, p.23.

CAPITAL ALLOCATIONS: PROCESS AND CONSTRAINTS

7

The way in which capital is allocated across the NHS has changed over recent years. At the start of 2020/21, DHSC and NHSE introduced changes to the NHS capital regime, including setting capital spending limits at integrated care system (ICS) level in anticipation of ICSs being placed on a statutory footing. At the same time there has been fierce competition to access national capital funding pots to fund strategic transformation and investment.

In this section we cover the role of systems in capital planning, how the national public spending framework constrains capital spending across the NHS, and how trusts make the case for their capital bids at both the system and national level.

Operational capital and system prioritisation

What is the role of systems in allocating capital?

Capital envelopes are held at 'system' level by ICSs and managed through integrated care boards (ICBs). The system approach to capital allocations represents a significant change to planning processes. ICBs now play a key role in operational capital planning and prioritisation across the system, whereas clinical commissioning groups (CCGs) did not take on this function.[62]

Operational capital allocations are informed by the value and depreciation costs across the NHS estate. As a result, there is limited headroom for strategic capital investment across systems beyond existing national priorities, constraining the scope for vital transformation of the estate and limiting the role of ICSs in targeting investment to where they agree it's most needed. As the role of systems in capital allocation is refined, there would be value in exploring how they might play a more integral role in managing strategic capital investments in future.

62 HFMA, 'Developing an effective integrated care board finance team', September 2022.

7

Capital limits and restrictions on capital spending

Capital departmental expenditure limits

In 1998 a new fiscal framework was introduced by HM Treasury to separate capital and resource budgets, to counter a concern that a lack of distinction between revenue and capital spending had enabled a bias against investment, given that net capital spending across the public sector had fallen from 3% of GDP in 1978-79 to 0.75% in 1998/99.[63] Departments have since been given firm multi-year limits set in cash terms to incentivise them to improve spending control and promote long-term financial planning.[64]

Providers' ability to invest in capital schemes is limited by DHSC's capital departmental expenditure limit (CDEL). Regardless of the source of cash, capital spend by NHS organisations in aggregate must not exceed the national CDEL.[65]

Foundation trust freedoms and constraints

Previously, foundation trusts were free to spend their surpluses on capital investment (or carry the surplus over into the next financial year). However, following the passage of the Health and Care Act 2022, NHSE can use powers to impose capital limits on foundation trusts where they are at risk of breaching their system's capital envelopes.[66] This proposal arises from the need for DHSC and NHSE to ensure the national CDEL is not breached. The rationale is that without mechanisms to set capital spending for foundation trusts, there may be instances where it is necessary to constrain or delay capital spending by non-foundation trusts (which may be more urgent or address higher priority needs than foundation trust plans).

System capital limits put a constraint on foundation trusts' ability to invest in their estates, despite having cash available which would previously have been earmarked for capital investments. This does however ensure more of a level playing field in the context of system capital planning. The balance sheet position is mixed across the country, but there are some providers are sitting on historical surpluses which they cannot invest in the wider estate due to system CDEL restrictions.

63 HM Treasury, 'Economic and fiscal strategy report 1998', June 1998.

64 Institute for Fiscal Studies, 'The planning and control of UK public expenditure, 1993-2015', p. 31.

65 Office for Statistics Regulation, 'Response on NHS funding', October 2019. Cash that is held in reserves by public sector bodies will not be scored against CDEL unless it is spent.

66 NHS England, 'Foundation trust capital resource limits statutory guidance', January 2023.

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The role of retained surpluses and the value of needs-based capital planning at the system level

The current capital framework is underpinned by a system-level approach to financial planning, which does challenge the historical foundation trust model and role of organisation-level financial incentives. As The King's Fund noted in its review of system capital allocations, there is a wider question about the role of retained surpluses for capital investment within the current financial architecture, and in particular the freedom to spend surpluses as an incentive for financial delivery.[67]

Systems can now access additional capital funding on a weighted population basis dependent on the previous year's revenue performance.[68] For example, systems' ICB allocations may be uplifted on a fair share basis against a £300m fund, should systems deliver surplus and breakeven positions or if they hit nationally set targets in the previous financial year. Therefore, while financial incentive levers remain within the allocation framework, historical surpluses (i.e. before the previous financial year) are not included in the current methodology.

It is still unclear the extent to which trusts retained surpluses can in future be reinvested in their estates. However, if there is a materially higher level of operational capital available in future, allocations need to be weighted to reflect organisations' needs.

Limited capacity for commercial growth

All trusts recognise the need to avoid breaching nationally set capital limits. However, the current system also means that trusts are often restricted in investing in projects beyond maintenance renewal, including opportunities for commercial growth. The need to ensure operational capital is allocated to business-as-usual activity and maintenance repairs limits the scope for more innovative commercially driven investment.

There are trusts providing specialised services which are hubs for clinical innovation and are capital intensive. However, given the demands on limited capital budgets, commercial development opportunities are less likely to be prioritised.

67 The King's Fund, 'Review of the current capital allocation methodology for system envelope', March 2022, pp.12-13.

68 NHS England, 'Capital guidance update 2023/24', January 2023, pp.3-4.

7

Business case approvals and releasing funding at the local and national level

Capital bids must be underpinned by robust business cases. When additional capital spend is required, trusts will put together business cases to assess the strategic fit of a project or programme, evaluate the commercial and management approaches to delivery, quantify the lifetime costs and benefits, and ensure projects and programmes align with the five-case model to deliver public value.[69] This is a recommended methodology and assurance framework underpinning business case development, ensuring that bids demonstrate the strategic, economic, commercial, financial and management case for investment.[70] Depending on the scale of investment, business cases will be subject to oversight and assurance from NHSE, DHSC and HMT.[71]

However, the business case approval process for access to national funding pots can be beset by delays, regionally and nationally. The Nuffield Trust has challenged the extent to which the approvals process is entirely proportionate for capital bids of relatively small value.[72] Given there are well established processes for business case oversight, it is important for government and NHSE to ensure the approval process at the national and regional level is expedited as quickly as possible.

Trusts note how delays in releasing funding can hamper their ability to manage year-to-year capital spend. Limits on the capacity of trusts and systems to reprofile spend, and the need to use capital funds within annual limits, means money is not necessarily spent on the original priorities set out in initial capital plans. Delays to major national programmes are also increasing the cost of capital projects given inflationary pressures, thereby challenging trusts' initial cost estimates.

There is also often a "hockey stick" effect whereby capital spending is backloaded to the final quarter of the financial year and spent in haste to avoid underspends. This can lead to a last-minute bidding culture. Late notification of available funding means some trusts might advance their projects at risk, without certainty of funding by year-end.

69 HM Treasury, 'The Green Book: central government guidance on appraisal and evaluation', 2022.

70 HM Treasury: 'Guide to developing the programme business case', 2018; 'Guide to developing the project business case', 2018.

71 NHS England, 'Capital investment and property business case approval guidance for NHS trusts and foundation trusts', February 2023.

72 The Nuffield Trust, 'NHS capital and infrastructure: delivering the manifesto and unlocking potential', November 2022.

8 CONCLUSION

This report has highlighted the significant and wide-ranging benefits of investment in health infrastructure. However, many parts of the NHS estate are in extremely poor condition. Trusts need major operational capital investment to drive substantial and long overdue improvements to service capacity, increase productivity, improve the safety and experience of patients and staff, and to prevent the further deterioration of the NHS estate.

Strategic investment is also needed to transform the delivery of healthcare and modernise the estate. Giving trusts access to adequate strategic capital will deliver the transformation needed to improve patient flow and deliver integrated, high-quality care across the whole system. This requires full consideration of the needs across the acute, ambulance, mental health and community sectors.

As the Public Accounts Committee has recently recommended, the Department of Health and Social Care must publish a long-term capital strategy to meet the needs of a 21st century health and care estate. The government should outline how systems are expected to sustainably reduce the capital maintenance backlog, and map out routes for trusts to access capital for strategic transformation of their estate outside of the New Hospitals Programme.

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