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]

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

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.

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

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

Chapter footnotes

iv.

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

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