NHS Confederation

Capital efficiency

February 2025

How to reform healthcare capital spending

About us

NHS Confederation

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Integrated Care Systems (ICS) Network

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Key points

- The NHS capital regime is broken. It does not support most efficient spending of the limited healthcare capital spending available. Improving efficiency of capital investment can boost NHS productivity and support economic growth.

- Drawing on engagement with NHS Confederation members, this report makes proposals for how the NHS capital regime can be improved to deliver on the government's missions for health and economic growth. It sets out 16 practical recommendations across five areas to make the system work better.

    1. **Streamline approvals and devolve more decision-making to system level**. The capital approval process moves too slowly and involves too many overlapping actors. Interpretation and application of approval criteria often varies at different layers in the process and stops investment from funding the most pressing local needs. Combined, this adds cost and unnecessary complexity, and, at its most extreme, makes otherwise viable schemes unworkable.

    2. **Deliver longer-term funding and planning cycles with more flexibility on capital spending limits**. In recent years capital allocations have been as short as one year. Too often, national funding is allocated late in the year, delivering poor taxpayer value for money. Short-term allocation of planning cycles hampers leaders' ability to plan strategically and have certainty over what they can deliver, particularly when it comes to long-term, complex and costly projects.

    3. **Devolve capacity and capability to local systems to manage budgets and existing assets and greater control over the assets in their footprint**. Local systems need sufficient management capacity (whether this sits in ICB or providers) to identify assets for recycling and then to go through the process of closing and selling them. The current set up does not allow this.

4. **Improve cross-boundary capital flows to allow better and more efficient capital movement across ICS boundaries**. Ensuring capital investment follows patient flows across system boundaries is a longstanding challenge. While not an easy issue to fix, there are changes that could be made that would begin to make cross-capital flows work better.

5. **Enable systems to raise private investment to meet the 2 per cent annual productivity challenge set out in NHS England's long-term workforce plan**. For decades we have consistently invested less than half as much as our OECD peers. Changing national policy and guidance to allow new routes for private investment and supporting an attractive investment market can help meet the productivity challenge and fill the existing gap in capital funding.

- The 16 recommendations in this report should be incorporated into the Department of Health and Social Care's ten-year health plan and the Treasury's forthcoming ten-year infrastructure strategy.

Introduction: Fixing a broken regime

The NHS capital regime is broken. Capital investment in estate, digital and equipment is essential to improving the quality of NHS services and long-term financial sustainability. However, what little money is available is all too often tied up in red tape, undermining people's care, their experience of services and taxpayers' value for money.

The Darzi review stressed the importance of 'capital investment in modern buildings and equipment' to improve productivity, ensuring more patients are seen sooner and at lower cost. Capital investment will be crucial to delivering the government's health mission of shifting care from hospitals to communities and from analogue to digital. This will require spending a greater share of capital funding on primary care, community care and mental healthcare.

However, for over a decade the 'NHS has been starved of capital, so the service has too few scanners, too little investment in digital automation in laboratories and pharmacy, and too little digital technology to support its workforce.' Local NHS financial leads have consistently said that insufficient capital investment is their greatest challenge. As the Darzi review noted, a 'desperate shortage of capital prevents hospitals being productive.' Patients and staff expect better than sewage leaking on to cancer wards, maternity units and A&E departments.

Based on the estimates of local NHS leaders, the NHS Confederation calculated that £6.4 billion per year additional capital investment is needed across England over phase two of the government's Spending Review (2025–28) to help increase annual productivity growth to 2 per cent per year. This investment is crucial not just in acute hospitals but for improving estate, equipment and digital technology in primary, community and mental healthcare, which are central to the government's vision of earlier intervention and prevention.

The NHS Confederation has already set out options for raising the scale of investment required. The government's £3.1 billion capital increase at the October 2024 Budget is a step towards this.

Yet while the overall quantity of investment is important, there are also problems with how the existing £10.5 billion of public money – rising to £13.6 billion in 2025/26 – is spent and how productively it is used.[1] Fixing these could, to some extent, help improve services and boost productivity within existing budgets. NHS England's guidance on capital investment and business case approval states that 'we must ensure taxpayers' investment is used to maximum effect, and the NHS makes best use of capital investment and its existing assets to drive transformation.' However, too often this is not the case. Despite the best of intentions, the complex approval processes, through multiple layers of government, lead to existing NHS capital budgets being inefficiently used and not delivering best value for patients and taxpayers.

The Darzi review describes how:

> From HM Treasury to NHS provider trusts, the capital regime is widely recognised to be dysfunctional... Capital expenditure limits are imposed on NHS trusts by HM Treasury that cannot be exceeded, even if the funds to make such investments are available. And the capital approvals process is so byzantine that it is hard to find an NHS senior manager who understands it. It has left much of the NHS estate crumbling, notably in primary care, with a backlog of maintenance across the service that amounted to £11.6 billion in 2022.

The National Audit Office's analysis concludes that 'the [NHS] capital funding system [has] made it difficult to plan and acted as a barrier to investment.' The challenges causing additional cost – and their solutions – will apply more widely than just the NHS. For example, construction of the Elizabeth Line in London cost four times that of a comparable underground in Copenhagen per mile and 20 times that of Madrid.

[1] Total Department of Health and Social Care CDEL, of which NHS England's capital budget will be a subset.

The Hewitt Review previously made proposals of how to improve use of existing capital budgets, highlighting a convoluted and slow sign-off process and inefficient and ineffective allocation to projects. It stated that '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'. Although Richard Murray conducted a review of the NHS capital allocation process in 2021, this primarily considered the formula through which NHS England distributes capital funding between systems, not the speed and flow of capital reaching systems nor the sign off process and criteria for distribution that enables allocation within systems.

The Hewitt Review proposed 'a cross-government review of the entire NHS capital regime, working with systems'. Recognising this problem, Labour's Health Mission (2024) committed to 'make an assessment of all NHS capital projects to make sure money is getting allocated efficiently, that we are eliminating waste, and that we are prioritising the projects that will get the patients the care they deserve faster.' The Hewitt Review proposed specific consideration of:

- how government could move towards a ten-year NHS capital plan, with initial freedoms over larger sums for, say, five years tested and developed within more mature systems

- reviewing delegated limits and approval processes across HM Treasury Cabinet Office, DHSC, and NHS England with a view to having a simpler more streamlined approval process and giving more mature systems greater responsibility for prioritising and managing capital expenditure

- how to allow greater year-on-year flexibility to support more efficient use of capital and support invest to save or save to invest

- clarifying the government position in use of private finance and government involvement in primary care capital

- how to enable providers working across systems (particularly mental health, specialised and ambulance providers) to access capital to support population need rather than just in their headquartered integrated care system (ICS)

- incentives for more efficient system-wide property management and considering reform of capital departmental limits (CDEL) to enable void space to be filled and co-location across the NHS and local authorities.

This report takes its cue from the Lord Darzi and Patricia Hewitt's reports, to review the NHS capital regime. Based on engagement with NHS leaders in integrated care boards (ICBs), trusts/foundation trusts and primary care, as well as government and policy experts, it sets out 16 specific recommendations across five themes to make better use of existing healthcare capital spending. We hope these can be adopted through HM Treasury's forthcoming ten-year infrastructure strategy and the Department of Health and Social Care's ten-year health plan. The NHS Confederation would like to thank all those colleagues in the NHS and beyond who have contributed to the development of this report.

Summary of recommendations

1: Streamline approvals and devolve more decision-making to system level.

Recommendations:

1. Consolidate the number of approval stages from up to seven down to a maximum of five to reduce delay and cost.

2. Implement a tiered approach that ramps up approvals depending on project value, rather than having single threshold.

3. Simplify the requirements for the SOC and abbreviate the FBC process to avoid reiterating what came before.

4. Create a joint committee that can speak for all government as part of a simplified process. Currently multiple government departments often sign-off the same stage where government could allow a tight joint committee to do this on behalf of all.

5. Publish a clear map of this simplified process. This will ensure there is common understanding between all parties.

6. Double the threshold at which local capital investments require national approval to £100 million for those not in financial distress. Doing so would better fulfil the promise of integrated care system devolved decision making.

7. Monitor and report the compliance with a new 12-week capital approval cycle directly to the Secretary of State. Performance of government, not just local systems, is essential to reform and recovery.

8. Introduce earned autonomy over spending, earned through positive regulator reviews, with a cascading amount of freedom allowed based on past performance.

9. Ensure that all national pots are allocated at the start of the financial year, allowing sufficient time for money to be spent well. Too often money is allocated late in the financial year, delivering poor taxpayer value for money.

2: Deliver longer-term funding and planning cycles with more flexibility on capital spending limits.

Recommendations:

10. Deliver five-year indicative ICB capital budgets, from the next Spring Review, expected in June 2025. Health leaders need as much certainty as soon as possible about what their capital budgets will be.

11. Continue to set the departmental and system-level spending limits over a five-year rolling period.

3: Devolve capacity and capability to local systems to manage budgets and existing assets and greater control over the assets in their footprint.

Recommendations:

12. The government should consider abolition of NHS Property Services and moving its assets to ICBs, splitting its functions and budgets between ICBs and NHS England. This would enable use of existing assets, scrapping void space costs and enhancing local ICS asset-management capacity.

4: Improve cross-boundary capital flows to allow better and more efficient capital movement across ICS boundaries.

Recommendations:

13. Enable voluntary pooling of capital funds at supra-ICB level where there is local agreement between ICSs and the right alignment between different boundaries, as proposed by the Murray review.

14. Develop an allocation advisory tool – not binding but to consider what capital funds might flow from ICBs to providers headquartered in other systems who look after patient numbers above a certain threshold.

5: Enable systems to raise private investment to meet the 2 per cent annual productivity challenge set out in NHS England's long-term workforce plan.

Recommendations:

15. Change national policy and guidance to allow new routes for private investment (such as Mutual Investment Models).

16. Support an attractive investment market through policy stability and a steady pipeline of projects.

1: Streamline approvals and devolve more decision-making to system level

Streamline decision-making structures and criteria

Capital approval processes often move too slowly and involve too many overlapping actors. Interpretation and application of approval criteria often varies at different layers in the process and stops investment from funding the most pressing local needs. Combined, this adds delay, cost and unnecessary complexity and, at its most extreme, makes otherwise viable schemes unworkable.

NHS England publishes guidance on the approval of business cases, which are subject to oversight and assurance from NHS England, the Department of Health and Social Care (DHSC) and HM Treasury (HMT) depending on the scale of investment. This process is designed to ensure best value for money.

However, both Policy Exchange and the Nuffield Trust have challenged whether the approvals process is entirely proportionate to the size of capital bids and argued that modest changes to the New Hospitals Programme (NHP) and wider capital strategy could have accelerated scheme throughput. They suggest that 'unnecessary layers of scrutiny are effectively a rationing mechanism disguised as an approval process.' The Darzi review also found that that complexity of the process meant there was a lack of transparency of how decisions were made and confusion among NHS staff in systems.

A process meant to ensure sensible spending – careful delay to ensure all parties agree – ends up paradoxically adding expense as ongoing approvals and inflation drive up costs. For example, construction material prices rose by

23 per cent in 2021 and then 11 per cent in 2022. This meant many proposed projects cost the taxpayer more or became too expensive to go ahead at all

There are too many layers in making decisions on too many business cases, including NHS trusts/foundations trusts, ICBs, NHS England regional teams, NHS England's national team, DHSC civil servants, DHSC ministers and ultimately HMT. At the same time the approvals and funding processes often do not match up, with NHS England approvals unaligned with its own allocation cycles.

A snapshot

Capital business case approval process

For projects over £25 million, HM Treasury sets **three planning approval stages**

For **each planning stage**, a trust or ICB will likely have to **undertake a series of sign-offs**

Anecdotal evidence suggests that waiting for approval can take around nine months per planning stage. **This is does not account for time taken to write business cases**. Political and project difficulties mean this usually takes longer.

The three planning approval stages

1 Strategic outline case (SOC)

Sets out the **strategic context** for the project and identifies **success factors and net present social value** for the possible options.

2 Outline business case (OBC)

Commits to **a preferred option** to allow the organisation to **proceed to the procurement phase**.

3 Full business case (FBC)

Agrees a final option and cost.

Sign-off for each planning stage

SOC (steps 1-5 only), OBC and FBC

Step 1 – **Trust board** – typically meet every month.

Step 2 – **ICB board** – to add a letter of support to the business case, these typically meet every two months.

Step 3 – **Programme investment committee** – projects funded from national programmes will require approval from the relevant committee managing the programme. Takes around two weeks.

Step 4 – **NHS England region** – relevant NHS England regional team makes a fundamental criteria review. Takes around two weeks.

Step 5 – **DHSC/NHS England investment approval** – a further financial approval looking at both capital and revenue implications. Takes around three months.

OBC and FBE planning stages only

Step 6 – **HM Treasury** – Treasury approval of spending. Takes around four weeks.

Step 7 – **Ministerial approval** – while there is no service level agreement, the process typically takes between two weeks and two months depending on political priorities.

It is not unreasonable to expect a rigorous approach to ensure that large amounts of taxpayers' money are spent well. However, delay adds costs and undermines value for money. There are several ways this process can be improved – and help projects stay on budget – while still ensuring a robust process.

NHS leaders tell us that the number of steps is excessive risk aversion. The number and the unique contribution of each to improving value – balanced against additional time undermining value – should be reviewed. The approvals process could be improved in the following ways:

- Consolidating the number of steps required for each of three approvals from up to seven to a maximum of five.

- A tiered approach that ramps up the approvals depending on project value, rather than having a single threshold. For example, a smaller capital extension to an existing hospital should require much less oversight than a massive new hospital development.

- A simplified SOC requirement that sets out the basics of the project and then an abbreviated FBC process that need not reiterate what came before.

DHSC should work with HMT and NHS England **to produce a clear map of this simplified approvals process**. This should be used as a basis to streamline and accelerate the approvals process, with stages merged or scrapped. Recent experience showed this can be done. A former special adviser at DHSC noted how 'one enterprising minister discovered that by inviting himself to the official-led DHSC investment committee, he reduced the approval time for capital projects by six weeks in a single stroke.' As part of this process, **DHSC, NHS England and HMT should agree where one or two agencies could form a joint committee to speak for all three**. This could be a joint approval between ICB, NHS England and DHSC, provided it is truly joint and not consecutive.

To further reduce the number of projects that require central approval in the first place, **DHSC and NHS England should double the approval thresholds for capital projects from £50 million (for trusts not in financial distress) to**

£100 million for non-digital, and similar for digital with approval from ICBs.[2] This would reduce in one stroke the number of cases for review and the consequent time required. It should devolve the approval responsibilities for such smaller capital schemes to local ICBs, which can ensure available funds are allocated most effectively within their local system CDEL limit and in accordance with their system infrastructure plan. While this would allow some degree of project risk, it should allow for better project value overall. As each ICS is now required to develop a local infrastructure strategy, which will be reviewed and require approval by NHS England, a greater degree of autonomy can and should be devolved for decision-making that reflects those local infrastructure strategies.

Those cases that go for departmental approval should be reviewed quicker. Currently, NHS England and DHSC work to a 12-week approval cycle for projects under £50 million, not including the initial time required for NHS England to assess that the business case meets the fundamental criteria.

Performance of national bodies is as important as local systems to NHS reform and recovery. The **12-week approval cycle should also include time assessment of fundamental criteria and reflect a higher £100 million threshold, with performance metrics on meeting the 12-week cycle given to the Secretary of State on a quarterly basis**. This will turbocharge capital

[2] Delegated spending limits – HMT and DHSC have confirmed the delegated limits for capital investment and property transactions. Delegated limits will apply to NHS trusts and foundation trusts. Delegated limits apply to all capital investment and property transactions business cases including those for property, plant or equipment, disposals, IT/digital investment, leased property, plant or equipment, managed equipment, managed services and energy service performance contract schemes. For capital builds, refurbishment, upgrades or disposals, the delegated limits apply to either the capital costs or gross disposal proceeds. For whole-life cost business cases, the delegated limits apply to:

- non-digital capital schemes – the capital cost only, excluding VAT
- self-financed digital capital schemes – the capital cost and/or the whole-life cost, excluding VAT
- centrally funded digital schemes – all business cases partly or fully funded by the Frontline Digitisation Programme (NHS England Transformation Directorate) require approval.

Central approval criteria should be consistent with where best value can be derived locally.

investment decisions, enabling more projects to be successfully delivered within a parliamentary term. DHSC should allocate requisite resources from within its existing departmental running budget to achieve this target. This should also apply to business cases for proposed disposals.

The combination of this amalgamation of committees and increasing the threshold at which national approval is required would reduce the number of business cases going to NHS England and DHSC, decrease workload and accelerate decision-making.

Central approval criteria should be consistent with where best value can be derived locally.

Capital project business case criteria should be co-designed with local NHS leaders and reviewed every other year to ensure efficacy and consistency of applications.

Case study: St. George's Health and Wellbeing Hub, North East London ICS

St. George's Health and Wellbeing Hub in Hornchurch opened in late 2024 and offers residents easy access to a range of health and care services from different providers. These include GPs, acute care, community, mental health and preventions services, community diagnostics, dialysis and social care professionals as well as hosting local voluntary and community groups, all under one roof. Residents can see a range of professionals in one visit with faster and more convenient access to blood tests, MRI, X-Ray, CT and ultrasound scans. Through a multi-sessional use of space, St George's provides a completely integrated service model which wraps around patients and improves access.

The Hub's Community Diagnostic Centre is helping to reduce the backlog of elective care. Relocation of renal dialysis services to the hub has released valuable space in the PFI hospital allowing the critical expansion of A&E, providing capacity needed to help cut waiting times.

The hub is located on the site of former RAF Hornchurch, which was used to defend London during the Blitz and was gifted to the NHS and local community in the 1960s to provide healthcare. It is now providing care closer to home for local residents.

In 2013 the site was closed and transferred from the primary care trust to NHS Property Services, where services were relocated out into space that was not fit for purpose. The 27-acre site sat empty, costing the taxpayer £1 million a year in void costs, until 2018/19 when NHS Property Services sold 85 per cent for housing creating £43 million cash, which was returned centrally to DHSC. 15 per cent of the site remained for the health and wellbeing hub but the local system was asked to bid centrally for funding. The £43 million receipt was not able to be used locally.

The project used an off-site modular build to increase construction speed and contain costs, with construction completed on 4,500 square meters in just 18 months. The North East London ICB and North East London NHS Foundation Trust (NELFT) teams worked at speed to pass Outlined Business Case (OBC) and Full Business Case (FBC) approval and secure Treasury sign off in just 14 months after the pandemic, with external support and an in-house programme team to achieve this pace. The team managed to get OBC approval from Treasury in December 2021 and FBC in November 2022 with the building going live to see the first patients on 4 November 2024.

Completing St. George's took more than seven years and was proved to be a more challenging, costly and longer process than originally expected. Over the course of the bidding period and as national priorities changed, the award funding and capital grants evolved from the New Hospitals Programme to Community Diagnostic Centre programme and other funding programmes. Additionally, the model of care had to be changed to align with the five case model approvals process, to meet technical requirements around multi-sessional use of space.

The capital award process also provided additional challenges for the programme. Although North East London ICB bid for £20 million capital funding in 2017, the final award was not made until 2022. During the

intervening seven years, the cost of the project doubled to £40 million. 50 per cent of the cost increase was due to inflation, particularly in the construction sector, and 25 per cent driven by subsequent regulatory changes, including change from BREEAM to Net Zero requirements and Greater London Authority planning regulation changes. The remaining cost increase was due to shifting further services out of the hospital and into the community, in addition to the community diagnostic centre.

In this case, the length of and changes during the approval process increased the total cost by up to £15 million. The extra cost was funded out of the ICB's ringfenced local capital budget. That meant funding this capital priority was prioritised over equally urgent estate, equipment and digital projects, as well as local repair backlogs elsewhere in North East London.

Case study: Learning from the New Hospital Programme

The New Hospitals Programme (NHP) to date has faced significant challenges. The cost of the NHP spiralled by millions of pounds, simply because of the complicated approval process and the time it has taken. While standardising some elements of hospitals construction can reduce duplication and cost, the National Audit Office report on the NHP was damning. It found that 'DHSC was unable to secure agreement from the Major Projects Review Group about NHP's approach to building future hospitals' and that government had not 'achieved good value for money with NHP so far.'

Setting up a dedicated NHP team centrally in DHSC took resources away from capital spending: nearly 10 per cent of money earmarked for capital spending during its first four years (£340 million) was redirected to resource a team of over 360 staff, including those drawn from consultancies. Committing to investment which will not now be funded or has been significantly delayed has wasted millions of pounds hiring local project

teams and developing business cases, as well as being a devastating blow to those affected. Delays to funding may mean some project teams are let go and have to be re-recruited later, losing much needed institutional memory that could in itself create further delay and cost.

In contrast, and despite some of the challenges highlighted in the case studies above, the recent Community Diagnostic Centre process worked comparatively well. This was far more streamlined and involved relatively short businesses cases. Some health leaders believe that this was partly owing to the political priority placed on quick decision-making, demonstrating what can be done when the right political will exists to get good things done quickly.

Revisit central funding pots and bidding, and devolve more decision-making to a system level

Capital allocations are currently split between a national fund and local ICB allocations. Typically, national capital funds the biggest project areas designed to improve the quality of the overall health service and major schemes need national-level management. Ringfenced national pots allow ministers to target investment at their priorities. Central pots also allow funding for projects that would be too big for any regional allocation. For example, the New Hospitals Programme, the RAAC (reinforced aerated autoclaved concrete) programme and community diagnostic hubs.

ICSs are inviting bid for national funding, often at very short notice that makes it too difficult for some ICBs or trusts to apply in time. However, as plans are developed and revised following policy announcements there are often delays, which further increases costs. In addition, funding can sometimes be withdrawn, with central capital funding being transferred to the revenue budget when times are tight. While the new Secretary of State and Chancellor of the Exchequer have both said they want this to stop, it remains a potential risk of centrally held funding.

Health leaders currently say there are too many national pots, with not enough capital available to ICBs. The Murray review stressed the need for 'simplicity in design, including minimising the number of different capital budgets that operate on different timelines and under different administration regimes'. Similarly, the Hewitt Review recommended 'delegated limits and approval processes across HM Treasury, Cabinet Office, DHSC, and NHS England with a view to having a simpler more streamlined approval process and giving more mature systems greater responsibility for prioritising and managing capital expenditure.'

Digital funding has its own specific issues. Currently all digital funding goes directly to trusts, rather than through the ICBs, but ICBs are accountable for digitisation despite having limited influence over how money is spent within their systems. Current capital funding can be overly biased towards short-term spending needs associated with large-scale digital programmes.

Case study: Targeted Investment Fund (TIF) Capital Funding for an Elective Theatres Hub in ICS4

A £27 million investment from the national Targeted Investment Fund (TIF) capital funding for a new elective theatres hub was withdrawn by NHS England halfway through the project. NHS England told the NHS trust developing the hub that the project no longer aligned with national priorities as it would not be completed within their required timeframe, even though the original stated completion date and details within the outline business cases remained unchanged from initial approval.

The decision to withdraw funding had huge implications on services, leading to growing waiting lists as well as poorer patient experience and outcomes. It also led to significant financial waste. The trust estimated that it had already spent £3 million of contractor costs, which had to be written off, in addition to 10,000 hours of NHS staff time from project, clinical, operations, estates, planning, workforce, finance and communications teams.

Create earned autonomy over spending

The Health and Care Act 2022 brought all NHS capital spending within the remit of the DHSC because it ended the ability of foundation trusts to keep their surpluses, which they could spend on capital freely. The NHS Confederation supports the changes in the Act to give ICBs necessary power to control their CDEL and ensure investment in acute care is not at the expense of primary and community. However, there should be stronger incentives for ICBs and trusts to make efficiency savings that can be turned back into capital investment.

Changes need to ensure money gets spent quickly and efficiently. Earned local autonomy over spending should be introduced, increasing ICBs' share of strategic capital. The Hewitt Review touted the idea of greater freedom for some systems that would be given a greater share of strategic finance, with increasing freedom to spend it as they see fit through earned autonomy. This could be earned through positive regulator reviews, with a cascading amount of freedom allowed based on past performance. IT and digital could be a good test case for this approach. New freedoms could include a more streamlined bidding process for national funding and higher delegated spending limits for high performing systems.

ICBs have a legal duty to prepare a joint capital resource plan with NHS trusts, setting out how they will make best use of their allocated funds each financial year. NHS England has published guidance on the development of system infrastructure strategies. This welcome approach enables systems to take a strategic view of their infrastructure and how it can support not only the four core purposes of ICSs but key ambitions around prevention, shifting care closer to home and moving from analogue to digital. After system infrastructure strategies have been submitted to and approved by NHS England, ICSs should be given the accompanying autonomy and freedom to deliver on those approved strategies.

HMT, DHSC and NHS England should only use bidding as a last resort, following proper prioritisation. Bidding for centrally held funding pots slows down allocation and creates transactional costs. Unsuccessful bidders will have wasted time putting together their allocation that could have been used more productively elsewhere. Too often, successful bidders receive their allocation

late with a short window in which to spend their new funds, which inevitably drives inefficient allocation. Where bidding is required, this should commence at the start of the financial year as much as possible to align with financial and strategic planning.

Recommendations to HM Treasury, DHSC and NHS England:

17. Consolidate the number of approval stages, from up to seven down to a maximum of five.

18. Implement a tiered approach that ramps up approvals depending on project value, rather than having single threshold.

19. Simplify the requirements for the SOC and abbreviate the FBC process to avoid reiterating what came before.

20. Create a joint committee that can speak for all government as part of a simplified process.

21. Publish a clear map of this simplified process.

22. Double the threshold at which local capital investments require national approval, to £100 million for those not in financial distress.

23. Monitor and report the compliance with a new 12-week capital approval cycle directly to the Secretary of State.

24. Introduce earned autonomy over spending, earned through positive regulator reviews, with a cascading amount of freedom allowed based on past performance.

25. Ensure that all national pots are allocated at the start of the financial year, allowing sufficient time for money to be spent well.

2: Deliver longer-term funding and planning cycles with more flexibility on capital spending limits

Longer-term financial planning

In recent years capital allocations have been relatively short term, often only one year. This hampers ICBs ability to plan strategic capital projects and contributes to the growing trust maintenance backlog.

Numerous reports in recent years have highlighted how this negatively effects the NHS, including the National Audit Office and Murray review. Most recently, the Hewitt Review recommended a 'ten-year NHS capital plan' and 'greater year-on-year flexibility to support more efficient use of capital and support invest to save or save to invest.'

This short-term process contributes to frequent underspends. This is not because capital budgets are too high, but because they are released too late in the financial year, the sign-off process is too complex, or funding is repurposed to cover shortfalls in revenue. The NAO has reported 'short deadlines... [for] applications for capital funding... made it harder to spend the investment effectively and placed additional pressure on finance teams.' Analysis by the Institute for Government finds that 'between 2010/11 and 2022/23, DHSC had a cumulative capital department expenditure limits (CDEL) underspend of £6.7 billion (7.9 per cent of its CDEL budget)'. This is money the government allocated to spend on capital but did not.

Health leaders need the certainty that longer-term capital windows allow. The Chancellor announced five-year capital spending windows in the Autumn

Budget 2024, bolstered by a commitment to separate investment debt raising from revenue. However, to have an impact, this commitment needs to be cascaded all the way down to ICBs as soon as possible. To address this, **the Department and NHS England should deliver five-year indicative ICB capital budgets, from the next Spring Spending Review, expected in June 2025**.

Capital Departmental Limits (CDEL)

From 1998, the Treasury differentiated capital and revenue spending allocations for government departments, creating a CDEL for each department. This intended to protect capital investment during periods of financial pressure in line with national fiscal rules. Overall spending limits ensure the government can control public sector spending and the public finances.

However, as the Darzi review notes, despite the differentiated allocations, DHSC capital allocations have been repeatedly raided to fill gaps in revenue spending since 2014/15. Contrary to the very purpose of its creation, CDEL has become a one-way valve that sees capital funds converted to revenue funds, but not vice versa. Changes to the government's own fiscal rules at the October 2024 Budget should prevent this going forward - a welcome move to protect capital investment.

Since 2010s, most of the overall CDEL in the Department of Health and Social Care is divided between each ICS, with each ICB receiving a capital resource limit for the financial year (their fixed share of CDEL). This aims to ensure each system is permitted a fair share of capital spending by constraining each system's ability to spend available money.

CDEL means that even trusts with available funding cannot spend it on capital projects. Examples of this abound, with Lord Darzi finding 'under the current capital rules, even if the trust concerned raised the capital from disposals of other assets, they would not have the discretion to spend it on replacing or rebuilding the unit'. Any surplus sits on the government books effectively as an 'IOU' from HMT to trusts. Money not spent is not raised by government debt, so any increase to CDEL to release provider reserves would effectively push government borrowing higher and risk breaking fiscal rules. However, ideally

any spending from recycling of existing assets – with no net change in the value of capital held through those assets – would not score against CDEL. To incentivise efficiency, local systems should be able to retain receipts without that limiting their spending.

Within the constraints of national CDEL, system-level CDEL envelopes could be withdrawn, but this would require a more interventionist approach from NHS England to ensure that overall national spending stays within the CDEL envelope – potentially a backwards step undermining devolution of decision-making. While CDEL creates ongoing frustration for local leaders, there is currently no clear solution that would enable the Treasury to retain necessary control over public spending. However, any opportunity to set spending limits over a multi-year period and to align with approval cycles should be explored to allow systems greater continuity with a longer-term investment programme.

Recommendations to HM Treasury, DHSC and NHS England:

26. Deliver five-year indicative ICB capital budgets, from the next Spring Spending Review, expected in June 2025.

27. Continue to set the departmental and system-level spending limits over a five-year rolling period.

3: Devolve capacity and capability to local systems to manage budgets and existing assets

… and greater control over the assets in their footprint

To make best use of capital, ICSs need capacity and capability to manage budgets and existing assets in their footprint. The Hewitt Review noted the need for 'more efficient system-wide property management and changes to enable [better use of] void space'.

Making better use of existing assets – disposing of them to reinvest cash where needed – is essential. The Naylor Review estimated that £2.7–5.5 billion in inefficiently used land in 2017 might reasonably be used to fund other assets. While some of these savings may already have been achieved in the seven years since Naylor's report, there undoubtedly remains an opportunity to unlock value from inefficient assets to ease pressure on new capital.

Local systems need sufficient management capacity (whether this sits in ICB or providers) to identify inefficient assets for recycling and then to go through the process of closing and selling them. The 30 per cent cut to ICBs' running cost allowance between 2023–25 have hobbled ICBs' ability to support management of assets within a system. Resource should be repurposed from elsewhere and devolved to ICBs who, working with provider teams and across different care providers, can support integration and unlock best value for money.

Alongside capacity, ICSs need greater control over system assets to recycle them. ICBs can own property, unlike clinical commissioning groups (CCGs) which were too small to effectively house estate management functions. Following the Health and Care Act 2012, this function and ownership of some primary care and community estates moved from local primary care trusts (PCTs) to NHS Property Services and Community Health Partnerships, new national arm's-length bodies. As the Darzi review describes, local managerial capacity reduced as a result. This centralised ownership and management of assets was unchanged in the 2022 Health and Care Act. As ICBs operate at a larger scale, now is the time to review where capacity sits to achieve best value from existing assets and complete the reversal of the Lansley reforms.

NHS Property Services and Community Health Partnerships own and manage unused estate ('void space'), charging ICBs for void costs to disincentivise wasted estate. Combined, they own 15 per cent of NHS estate in England, mainly community and primary care premises.

Separate ownership of the estate from the system makes it harder to recycle the assets and reinvest. The cost of void space is taking much needed funding out of local health systems. In 2023/24, NHS Property Services and Community Health Partnerships charged ICBs and trusts a total of £90 million for empty space in leased buildings, which could have gone into system capital budgets, before even considering the potential value from recycling some of the assets and management time.

For example, Devon ICB (and predecessor CCGs) has had to spent £500,000 a year paying for void costs on empty wards at Oakhampton and Seaton hospitals after services were shifted from hospital to closer to people's homes. Its spend on void costs to NHS Property Services is £2.5 million and counting – money not reinvested in Devon's desperate capital need. As ICBs move more care from hospital to communities, in line with government policy, these costs will likely increase.

To enable best use of existing assets, scrap void space costs and enhance local ICS capacity, the Secretary of State should review the role of NHS Property Services and consider its abolition. NHS Property Services was created to fill a gap after the abolition of PCTs which CCGs could not fill.

Separating off this estate ownership is no longer necessary or desirable after the Health and Care Act 2022 replaced CCGs with ICBs. Any of their functions that can only be done at a national level should be transferred to and consolidated in NHS England's Estate Team. Its remaining functions, responsibilities and running cost allocation should be transferred and devolved to ICBs, bolstering ICBs' estate management capacity and capability. Any change process must retain crucial skills and expertise that currently sits in NHS Property Services, whether at a system or national level.

This reform would help to finish reversal of the Lansley reforms, which the Darzi review identified as one of the causes of the NHS's current challenges. Moving the ownership and management functions of NHS Property Services buildings to ICBs should enable a rounded conversation about delivering additional services closer to home, allowing them to use their portfolio of premises as a lever for integration. This approach would also enable ICBs to dispose of premises and re-invest capital to deliver their local infrastructure strategies and new neighbourhood health centres. Local expertise and the key role the ICB plays a system convenor provide some advantages over a nationally managed property service.

This reform could be done without primary or secondary legislation as NHS Property Services is a limited company wholly owned by the Secretary of State. It is within the Secretary of State's existing power to dissolve the entity and set up a transfer scheme for the assets and reallocate its budgets.

This reform comes with some difficulties and would benefit from a phased approach to enable the shift towards more local control, learning from the experience of PCTs. NHS Property Services' rapid creation and inheritance of an extensive portfolio of premises meant it assumed many premises with unsigned or no lease agreements and significant arrears. It is also amid legal action to recover historical debt.

The legal process could be paused and the Department of Health and Social Care could provide a one-off national settlement on historical debt across all sites, in return for agreeing appropriate rents going forward with tenants who will pay the going rate to ICBs from day one. Removing the NHS Property Services brand as landlord would allow GPs to re-enter NHS-owned

buildings with confidence and de-toxify the current premises challenge. Estate transferred to ICBs could move across with a transparent settlement regarding rent arrears, with new lease agreements signed between the ICB and providers.

Given its role and expertise in managing NHS Local Improvement Finance Trust (LIFT) estate, Community Health Partnerships should remain and continue to operate. However, in future a joint decision-making committee between Community Health Partnerships and ICSs should assess the value for money of purchasing the LIFT estate at the end of the finance agreement. If purchased, these premises should transfer to the ICB with a new lease agreement agreed between existing NHS provider tenants and the ICB. Over time, as LIFT agreements expire and the estate transfers to ICBs, Community Health Partnerships' role could be reviewed at a later date.

Recommendation to DHSC

28. Review the role of NHS Property Services and consider abolition, moving its assets to ICBs and splitting its functions and budgets between ICBs and NHS England.

4: Improve cross boundary capital flows to allow better and more efficient capital movement across ICS boundaries

Devolution of capital budgets to ICSs is the right approach to enable decision-making closer to patients and achieve best value for money. However, it also creates challenges where there are cross-boundary patient flows. ICBs hold revenue and capital budgets on behalf of the population who live in their geography, but these patients will sometimes be treated by providers outside of that ICBs' geography. In theory, the capital budget should follow the patient, but this is challenging when ICBs' primary focus and financial responsibility is to the providers based in their system geography. This is a particular challenge for ambulance trusts and specialised providers, although this also affects other providers.

The following example from the Hewitt Review highlighted this issue:

An ICS that urgently needs Tier 4 mental health beds within its own area for patients currently sent out of area finds that its mental health partner trust is unable to develop the necessary provision simply because the trust is headquartered in a different system.

Similarly, the Murray review reported:

There was universal feedback that those trusts that operate across system boundaries face specific challenges especially when it comes to agreeing additional capital for investment/transformation rather than just asset replacement. This is most acute for ambulance trusts, but others (some mental health, community and specialist trusts) face similar issues. However, there was no consensus on an alternative to approach to that currently adopted.

For ambulance trusts, while capital investment tends to focus on their ambulance fleet, the ambulance estate in England has a growing maintenance backlog which has reached over £146 million, including a rapidly increasing proportion of high-risk repairs. As with other areas of care, transformation is impeded due to a lack of capital funding across the NHS. Poor facilities are increasing running costs, endangering staff, blocking progress to net zero and impeding the shift to an electric ambulance fleet.

Where trusts are succeeding in improving their services this is often where they are co-terminus with ICBs, which enables stronger relationships to be maintained. Significant productivity gains can be achieved by investing in the ambulance estate, including steps such as adopting the 'make ready' model set out in the Carter review and pursuing co-location. While allocations will not make up for a lack of overall capital, improving cross-boundary flows can improve efficiency.

For specialised providers, this will also become an issue following the national delegation of budgets for 70 specialised services from NHS England to ICBs from 1 April 2025. Many patients travel not just across ICS but regional boundaries for specialised services, often located in major cities. Managing financial risk, including for capital, is one of the key challenges in managing the delegation of specialised commissioning budgets. Highly specialised services – and their capital budgets – remain centralised with NHS England.

The Murray review proposed the creation of 'multi-ICS budget holders to house envelopes for cross-system trusts... include more explicit information in the planning guidance as to how cross-system providers and ICSs should work together.'

Led by local agreement between ICBs, providers and other relevant system partners, **a portion of capital budgets could be pooled at a supra-system level**, potentially hosted by a lead ICB, to simplify commissioning arrangements. This could support our recommendation for increased flexibility in system-level capital allocation and aligns with the above recommendation of the Murray review. This works well in London were the London ambulance services match the regional footprint. It can also be applied to other specialised services.

Both to inform what proportion of funds are pooled and where direct investment from ICBs is needed, NHS England should **develop a cross-border allocations tool to inform ICB capital investment to providers outside their borders, where patient flows are above a certain threshold of significance**. This should be informative only, rather than mandatory, aiding decision-making while preserving local agency. Such cross-border flows, with providers having to negotiation their position in multiple ICS infrastructure strategies, is not ideal and does create complexity. As the Murray review concludes: 'What is clear is that doing nothing is the least good option.'

Recommendations to HMT Treasury, DHSC and NHS England:

29. Enable voluntary pooling of capital funds at supra-ICB level where there is local agreement between ICSs and the right alignment between different boundaries, as proposed by the Murray review.

30. Develop an allocation advisory tool – not binding but to consider what capital funds might flow from ICBs to providers headquartered in other systems who look after patient numbers above a certain threshold.

5: Enable systems to raise private investment

… to meet the 2 per cent annual productivity challenge set out in NHS England's long-term workforce plan

Private capital investment should once again be an option available to ICSs to address the capital investment cap. While the £3.1 billion additional capital investment at the Budget 2024 is a much welcome addition, this is still £3.3 billion short of the £6.4 billion a year additional capital investment needed to help boost NHS productivity growth to 2 per cent per year. The Hewitt Review called on government to clarify 'the government position in use of private finance'. The NHS Confederation has proposed that using private investment – including Mutual Investment Models (MIM) – can help make up the difference raising capital funding, alongside making better use of existing assets (in section 3). Similarly, CIPFA has argued that 'reliance on 'traditional' capital funding is unrealistic; new models of investment should be explored including those involving public and private sector partners.'

As well as increasing the overall quantum of capital available, private investment models can streamline the investment process by transferring risk, at a cost, to the private sector. In turn, faster project initiation will help bring projects into service early and to avoid higher construction costs due to inflation. It is likely that previous private finance initiatives offered better value for money than the New Hospitals Programme (NHP), given the spiralling costs caused by lengthy delays to NHP projects.

Private investment models should only be used in appropriate circumstances. The NHS Confederation has already argued that estate projects are best suited,

at appropriate scale and ideally for mixed-used developments (with income streams that can be discounted from ongoing project costs). Additionally, the National Audit Office has proposed 12 considerations for decision-making over whether to use private investment, including robust appraisal of alternative models, a robust business case and clear understanding and allocation of risk.

Unlocking private investment in NHS capital will require policy changes and actions to ensure it is an attractive market to investors. Firstly, on policy, NHS England guidance currently states that 'schemes that involve private finance are not permitted, in line with the change in central government policy on private finance.' This position should be reversed, creating a route to new forms of private investment in England including MIM, following the approach taken in Wales and Scotland. This will require a wider change of approach from HM Treasury. It is welcome that the Treasury has committed to setting out the government's approach to private investment in a forthcoming ten-year infrastructure strategy. The NHS Confederation will make further proposals in the coming months for how new private investment models could be designed. We hope that such proposals will inform he Treasury's ten-year infrastructure strategy.

Secondly, HM Treasury, DHSC and NHS England need to **ensure that the NHS is an attractive market to patient capital in line with broader government attempts to 'cut red tape'**. The Treasury has itself acknowledged that 'Infrastructure costs have... been driven up by government failing to provide a stable policy environment'. In recent years, investors have preferred other countries such as the Republic of Ireland, which has made significant use Third Party Ownership development of healthcare estate. This is unsurprising, given the ban on NHS use of private finance (although there are routes for general practice to do this) and stringent UK development planning approval process. In addition to the government's proposed planning reform and permitting new private investment models, the following recommendations should be looked at. The government's commitment to addressing this through a ten-year infrastructure strategy, coordinated across the whole of government, is most welcome.

The market needs policy stability and a clear project pipeline to invest in capacity to deliver projects. The UK tends to have a stop-start approach

to capital projects, discouraging the market for constructing and delivering projects from upscaling. The UK can learn from other countries internationally, such as France, which have a steady infrastructure project pipeline giving the market more confidence to invest and plan for the long-term. Standardised contracts for private investment could cut the time it takes to agree deals and simplify the market. The Future Governance Forum has proposed a range of procurement approaches be set out in a new infrastructure procurement framework. This approach will also require development of infrastructure contract management skills in ICBs and NHS trusts.

These steps should enable the NHS in England to both improve the quantum of capital investment and take advantage of the benefits of private investments models where these are appropriate.

Recommendations to HM Treasury, DHSC and NHS England:

31. Change national policy and guidance to allow new routes for private investment (such as Mutual Investment Models).

32. Support an attractive investment market through policy stability and a steady pipeline of projects.

Conclusion: getting the NHS building again

Over the past year the NHS Confederation has set out how much more capital funding NHS leaders need to boost productivity and options to raise capital investment. Investment must be combined with reform to how funding is used, which enables better value for money and better services for patients. This paper has made 16 recommendations to reform capital spending, specifically focused on NHS capital investment but which will likely apply more widely across public infrastructure.

Planning reform is crucial alongside capital regime reform. The UK's inability to invest is well known. It is no surprise that problems with planning and investment hinder building large, expensive or otherwise complex health facilities. Cost effectiveness and speed will come from wider planning reforms, and we urge the government to consider the public sector estate as part of these reforms. As the Foundation paper recently argued:

> 'The most conspicuous result of this cost bloat [from excessive planning requirements] is of course that the infrastructure projects that do happen tend to be wildly expensive. But perhaps the most important effect is the projects that do not happen at all. The Treasury correctly believes that, under current conditions, public infrastructure projects in Britain will be wastefully mismanaged. Its only way of protecting public finances is thus by blocking these projects altogether. Given the means available to it, this decision is often the correct one.'

Getting Britain – and the NHS – building again will also require cutting the country's expensive energy costs as part of the transition to net zero. While there are longer-term prospects for cheaper energy, there will be sharper costs in the short term. Combined, these two things make public sector projects more expensive in the UK than peer nations.

In return, more efficient NHS capital investment will contribute to the UK's economic growth, not only by making the healthcare system more sustainable but through the socio-economic benefits for local communities of building public sector infrastructure (see St George's Community Hub case study, page 12). This is a duty of integrated care systems and the correlation between healthcare and economic growth is now well established.

Further analysis is required to consider the opportunities for the NHS to work with other public sector partners, including local government. to make best collaborative use of public sector estate and capital. In addition to this, the increased focus on house building has significant implications for health and care infrastructure. Further alignment between national planning policy and the NHS capital regime, and taking into account local context, can remove some of the barriers for system partners to ensure people receive the right care, in the right place. For our part, the NHS Confederation will consider how new private investment models could work in the coming months.

While capital investment can boost productivity, policymakers should also consider the revenue implications of capital. Rapidly changing populations in certain ICSs and the time lag between capital investments and project completion may also mean further consideration of allocations is required.

Cutting red tape can enable better value for the public pound and help to deliver the government's health mission.

The recommendations in this report should be incorporated into the Department of Health and Social Care's ten-year health plan and the Treasury's forthcoming ten-year infrastructure strategy.

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