



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health & Social Care**

# Review of capital expenditure in the NHS

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National Audit Office

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Department of Health & Social Care

# Review of capital expenditure in the NHS

Report by the Comptroller and Auditor General

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National Audit Act 1983 for presentation to the House of  
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Gareth Davies  
Comptroller and Auditor General  
National Audit Office

28 January 2020

This report sets out the facts on capital investment in the NHS. It draws on and expands on issues we cover in our annual report on NHS financial sustainability.

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# Contents

**Key facts** 4

**Summary** 5

**Part One**

The age of the NHS estate and rising maintenance costs 9

**Part Two**

The allocation of the capital investment budget 16

**Part Three**

Sources of capital funding 26

**Part Four**

Challenges to planning and delivering an effective capital strategy 30

**Appendix One**

Our investigative approach 34

**Appendix Two**

Recent capital funding announcements 35

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## Key facts

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**£4.3bn**

transferred from the capital budget to revenue budget between 2014-15 and 2018-19

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**£6.5bn**

estimated total backlog maintenance as reported at October 2019

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**£1.7bn**

difference between NHS foundation trusts' and NHS trusts' (NHS providers') capital spending plans and the available providers' capital budget at the start of 2019-20

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**20%** minimum reduction requested by NHS England and NHS Improvement in the revised capital spending plans of NHS providers in July 2019, before additional capital funds were announced in August 2019

**£1.1 billion** of high-risk backlog maintenance reported at October 2019, putting patients at risk of harm

**99%** increase in the funds raised from the sale of assets between 2016-17 and 2018-19

**£600 million** remaining gap between NHS providers' original capital spending plans and their capital budget for 2019-20, following the announcement of additional funding

# Summary

**1** The Department of Health & Social Care (the Department) sets the overall strategic direction of the health system in England. It is accountable to Parliament for ensuring that its annual spending, including spending by NHS England and NHS Improvement (NHSE&I), other arm's-length bodies; and local NHS bodies, is contained within the overall budget proposed by the government and authorised by Parliament. This budget, termed a spending limit, is for day-to-day spending (the revenue budget) and capital investment (the capital budget).

**2** The NHS capital budget is for the construction of new buildings and the replacement of medical and other equipment. It is also used to enhance existing assets and to develop the infrastructure for transforming services. Capital investment is essential for modernising and improving the quality of care and for achieving the changes that will make the NHS sustainable in the longer term. The Department sets an annual NHS capital budget based on local spending trends and central initiatives.

**3** Many organisations share responsibility for the planning, allocation, approval and management of NHS capital. Overall, the Department is responsible for ensuring that the capital limit is not exceeded, and NHSE&I work with NHS trusts and NHS foundation trusts (NHS providers), who set out their capital needs in business plans. The rules around setting local capital spending limits are different for different types of NHS provider. NHS foundation trusts have greater freedom over their capital spending decisions compared with NHS trusts and those NHS foundation trusts in financial distress. Increasingly, individual capital plans of local NHS providers are being prepared within sustainability and transformation partnerships (STPs). STPs comprise local NHS providers, commissioners, local government and other stakeholders.

**4** This report sets out the facts on capital investment in the NHS. It draws on and expands on issues we cover in our annual report on NHS financial sustainability. It includes:

- the age of the NHS estate and rising maintenance costs (Part One);
- the allocation of the capital investment budget (Part Two);
- sources of capital funding (Part Three); and
- challenges to planning and delivering an effective capital strategy (Part Four).

**5** The primary care estate (for example, General Practice) is excluded from our scope as most capital investment in this area does not count towards the Department's capital budget. We also exclude capital expenditure on research and development since our focus is mainly on physical assets within NHS providers.

**6** We set out our audit approach and evidence base in Appendix One. Appendix Two contains a list of the 20 projects that the government announced in August 2019 would receive additional capital funding investment, as well as the schemes and seed funding announced in the *Health Infrastructure Plan*.

## **Key findings**

The age of the NHS estate and rising maintenance costs

**7 Parts of the NHS estate do not meet the demands of a modern health service.** NHS hospitals include Victorian-era buildings, and 14% of the NHS estate predates the formation of the NHS (1948). *The NHS Long Term Plan* acknowledges that elements of the estate do not meet the demands of a modern health service (paragraphs 1.2, 1.3 and Figure 1).

**8 The growth in backlog maintenance indicates that there is an increased risk of harm to patients.** In October 2019 NHS Digital reported that the backlog of maintenance work to restore buildings to an appropriate standard was around £6.5 billion. An appropriate standard includes the physical condition of the estate, as well as compliance with fire safety and health and safety standards. High-risk backlog maintenance currently stands at £1.1 billion, and grew by 139% between 2014-15 and 2018-19, indicating an increased risk of harm to patients. Individual NHS providers told us about specific risks from failing operating theatres and dangerous ligature points<sup>1</sup> (paragraphs 1.4 to 1.9).

Recent issues with allocating the capital budget

**9 NHS providers' assessment of their need for capital funding has been consistently greater than the funding available.** NHS providers' annual assessment of their need for capital investment has been, on average, £1.1 billion higher than their spending limit in each year from 2016-17 to 2018-19. The Department prioritised demands given that the total of NHS providers' plans exceeded the capital limit available for the Department (paragraph 2.7).

<sup>1</sup> A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Care Quality Commission, *Brief Guide: Ligature Points*, 2015.



**10 Since 2014-15 the Department has transferred £4.3 billion from capital to revenue spending.** The Department began transferring from its capital budget to its revenue budget in 2014-15. From 2016 it was given special flexibility by HM Treasury to transfer up to a maximum amount from capital to revenue in each year between 2016-17 and 2019-20. The Department has used all of this flexibility. It has transferred a total of £4.3 billion in the five years from 2014-15 to 2018-19. The Department was thus able to prioritise support for day-to-day spending on current services at the cost of foregoing longer-term investment in buildings and other long-term assets. In March 2019 the Department was unable to give a definitive measure of the impact on patients' services of repeatedly making these transfers (paragraphs 2.8 to 2.11 and Figures 8 and 9).

**11 Capital investment budgets have not been fully used.** There have been particular years where noticeable underspends have occurred. Between 2010-11 and 2012-13, there was an average underspend of £677 million (12%) against the capital spending limit. In 2017-18, £360 million (6%) was unspent. These underspends have occurred at a time when the UK has had lower levels of medical equipment per population than other countries, for example, 26th out of the EU28 countries for magnetic resonance imaging (MRI), and 27th out of the EU28 for computed tomography (CT) scanners (paragraph 2.12).

### Sources of capital funding

**12 Some NHS providers are in surplus and some NHS providers are in deficit and have had to borrow to fund capital plans.** In 2018-19, 124 out of 230 NHS providers (54%) delivered a surplus, which improves providers' cash balances. The current capital regime means that the availability of cash, and ability to spend capital without approval from the Department (for example, in those trusts delivering surpluses and foundation trusts), does not necessarily match where there are the most urgent capital needs. Therefore, unlike providers with healthy cash balances, NHS providers in deficit are likely to resort to borrowing funds to meet their revenue and capital spending plans (paragraph 3.3).

**13 NHS providers have increasingly sold their assets to fund day-to-day activities.** Government policy encourages public sector entities to sell assets where they no longer serve a public purpose. NHS providers can sell assets such as land to finance capital investment, and profits made can fund day-to-day spending. The overall proceeds from asset sales rose by 99% (from £222 million to £441 million) between 2016-17 and 2018-19. During this time the proportion of profit made on these sales also increased, which assists the revenue position, and meant that not all of these asset proceeds have been available to reinvest into capital (paragraph 3.4).

**14 NHS providers owe the government £10.9 billion in interim revenue and capital debt.** Cash shortages affect the ability of NHS providers to invest in new capital assets. Another source of funding is loans from the government. In 2018-19, the total outstanding debt from interim loans reached £10.9 billion (paragraph 3.6).

## Challenges to planning and delivering an effective capital strategy

**15 The capital allocation process for 2019-20 was particularly challenging for the Department.** At the start of 2019-20, NHS providers' capital spending plans exceeded the budget by around £1.7 billion. NHSE&I approached NHS providers twice in the following months requesting them to reduce their capital spending plans. However, in August 2019, the government announced a further £1.8 billion (£1.1 billion for 2019-20) for capital investment to include 20 specific capital projects. Effectively, this left a gap of £600 million between the NHS provider capital spending plans and their limit for 2019-20 (paragraphs 4.4 to 4.6 and Appendix Two).

**16 Political events have delayed the announcement of a long-term capital strategy.** The Department had intended to announce its capital strategy for 2020-21 to 2024-25 in the (now postponed) 2019 Spending Review. The original plan expected this five-year settlement to support the strategic direction of *The NHS Long Term Plan* and the revenue settlement for NHS England, agreed to 2023-24. Instead, a one-year spending round was delivered in September 2019 to allow government to focus on exiting the EU, with a full spending review postponed to 2020 (paragraphs 4.10 and 4.11).

**17 Proposed legislative changes to improve capital planning by NHS England may disincentivise some NHS providers.** There are proposals to limit the amount of capital spend of some individually named NHS foundation trusts, similar to the limits placed on NHS trusts. This may ease some of the challenges in managing the national capital budget and, in turn, improve the capital planning process. The individually named NHS foundation trusts would change each year, upon review from NHSE&I. However, some NHS foundation trusts have benefited from the greater freedom and autonomy in their capital planning since they have been able to generate surpluses and invest in service and facilities improvement. This was intended to act as one of the incentives for NHS providers to seek efficiencies and reinvest budget surpluses in current and new services. The Department aims to ensure there continues to be a benefit for those systems that have delivered and maintained overall financial balance (paragraphs 2.7 and 4.14).

# Part One

## The age of the NHS estate and rising maintenance costs

**1.1** This part provides an overview of the NHS estate. It briefly describes: the age of the NHS estate; the rising backlog maintenance costs; individual examples of estates issues; and the variation in backlog maintenance costs.

### The age of the NHS Estate

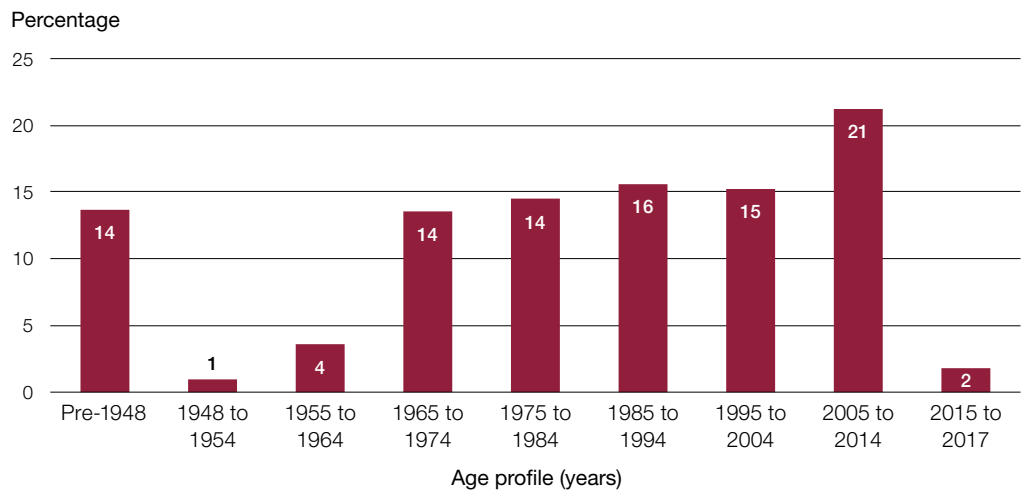
**1.2** Capital assets in the NHS include physical assets (for example, buildings and medical equipment) and non-physical assets (for example, software). The capital assets used to provide NHS services includes hospitals and equipment owned by NHS trusts and NHS foundation trusts (NHS providers) as well as private sector companies (through the Private Finance Initiative). It also includes hospitals and equipment leased through arrangements with the public sector (through NHS Property Services Limited).

**1.3** Parts of the NHS estate predate the formation of the NHS (1948) and include Victorian-era hospitals. *The NHS Long Term Plan* acknowledges that “some of our estate is old, in parts significantly older than the NHS itself, and would not meet the demands of a modern health service”. A building’s age does not necessarily indicate a problem, as it can be upgraded to meet modern standards of care, but the upkeep of any facility depends on the availability and efficient use of capital funds. **Figure 1** overleaf shows that, at 2016-17, 46% of the NHS estate by gross internal area was more than 33 years old.

**Figure 1**

Age of the NHS estate by gross internal area

14% of the estate dates from before the formation of the NHS and 46% was more than 33 years old



**Notes**

- 1 Totals may not sum due to rounding.
- 2 Age of the estate data last reported for 2016-17.

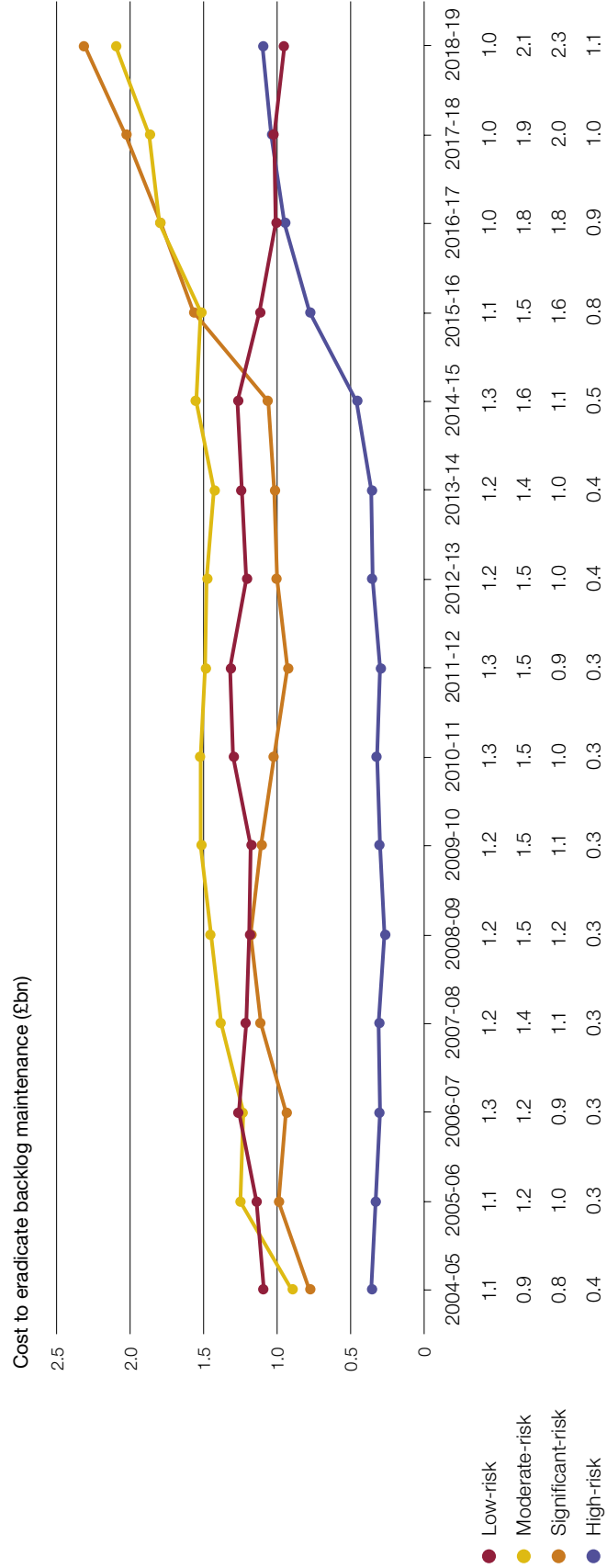
Source: National Audit Office analysis of NHS Digital Estates Return Information Collection (ERIC) data 2016-17

**Rising cost of backlog maintenance**

**1.4** Backlog maintenance is a measure of how much spending is needed to restore NHS buildings to an appropriate standard. An appropriate standard includes the physical condition of the estate, as well as compliance with fire safety and health and safety standards. Backlog maintenance is classified into four categories: low-, moderate-, significant- and high-risk (**Figure 2**). The total cost of backlog maintenance estimated in 2018-19 is £6.5 billion. This comprises: £1.0 billion for low-risk maintenance; £2.1 billion for moderate-risk maintenance; £2.3 billion for significant-risk maintenance; and £1.1 billion for high-risk maintenance.

**1.5** High-risk backlog maintenance grew by 139% between 2014-15 and 2018-19. High-risk is defined as “where repairs/replacement must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution”.

**Figure 2**  
 Cost to eradicate backlog maintenance 2004-05 to 2018-19, by risk category  
 Significant-risk and high-risk backlog maintenance has increased by 118% and 139% respectively since 2014-15



**Notes**

- 1 Definitions of high-risk, significant-risk, moderate-risk and low-risk are reproduced below from NHS Improvement's Estates Returns Information Collection (ERIC) 2017-18, Data Fields and Definitions; available at: <https://files.digital.nhs.uk/8D/8DF512/ERIC-201718-Data%20Definitions%20v2.pdf>
- 2 High-risk is defined as where repairs/replacement must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.
- 3 Significant-risk is defined as where repairs/replacement require priority management and expenditure in the short term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- 4 Moderate-risk is defined as where repairs/replacement require effective management and expenditure in the medium term through close monitoring so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- 5 Low-risk is defined as where repairs/replacement require to be addressed through agreed maintenance programmes or included in the later years of an Estates Strategy.

Source: National Audit Office analysis of NHS Digital's Estates Return Information Collection (ERIC) data 2004-05 to 2018-19

## Examples of estate issues

**1.6** Trusts we spoke to gave examples of the difficulties they experience with estates and backlog maintenance:

- A large NHS trust with an ageing estate told us it had to temporarily relocate a maternity suite as it could not source the parts to repair a lift. The trust said: “Our capital issues do impact on our productivity, through downtime of the machinery and clinical space not being set up for modern care and so requiring a greater number of staff.”
- A mental health trust gave an example of high-risk maintenance to remove the threat to health from ligature points (features which could support a noose or strangulation device). It had been unable to resolve all these potential threats and so had to employ more staff to observe patients to keep them safe. These extra staff were usually employed through an agency.
- An acute trust told us: “Capital is deferred year-on-year, which means a gradual accumulation of risk. We are forced into under-investing in medical equipment, increasing the likelihood of a major loss of service which will impact on patient safety.”

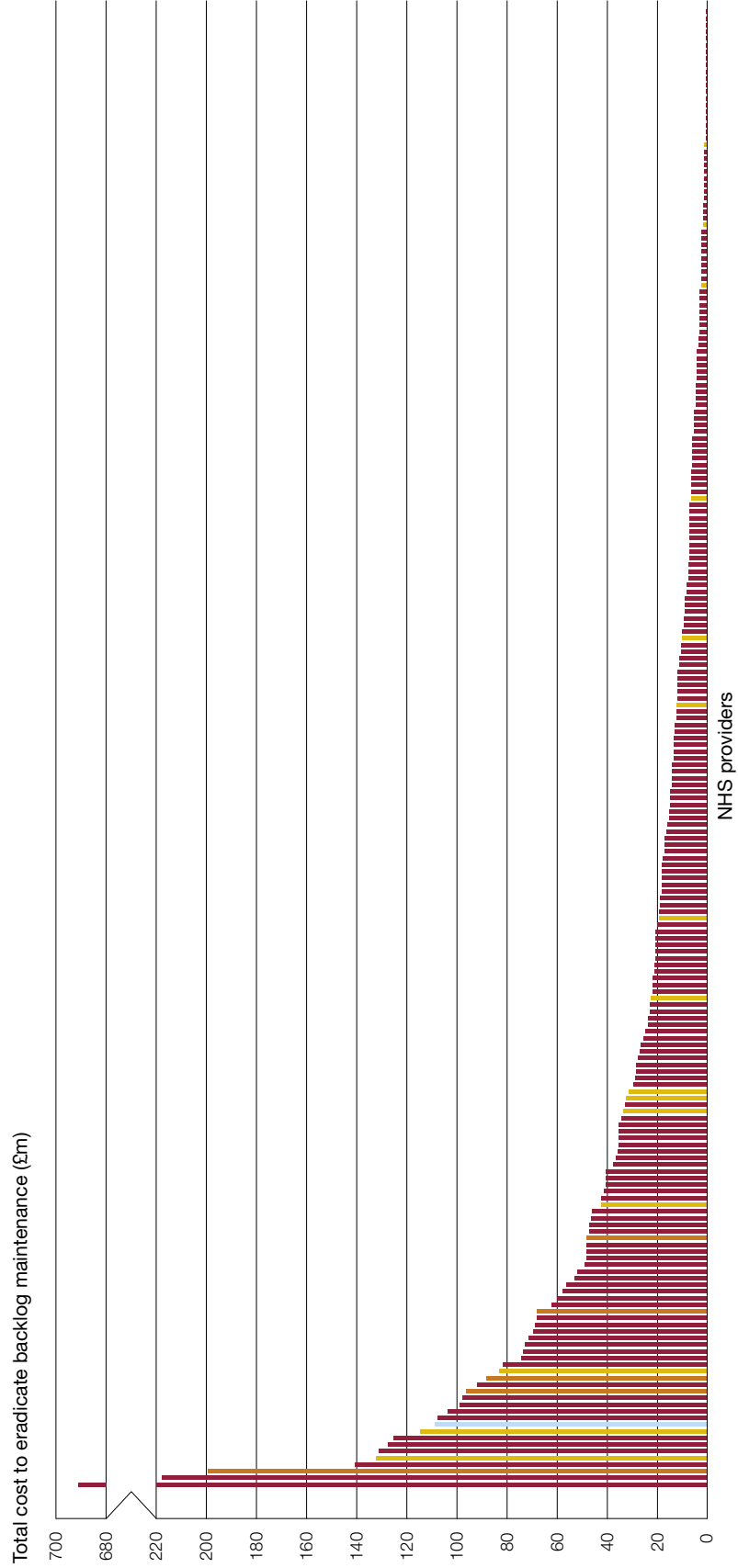
## Variation between providers in the cost to eradicate the backlog maintenance

**1.7** The cost to eradicate backlog maintenance varies between the 227 NHS providers reporting as at October 2019 (**Figure 3**). The top 20 NHS providers account for 45% of all backlog maintenance. These 20 providers are all acute hospitals, and 12 of them are also teaching hospitals.

**1.8** An investment of £850 million over five years for new capital schemes was announced in August 2019 and are listed in Figure 15 in Appendix Two. Those NHS providers receiving assistance from the scheme have been highlighted in yellow and blue in Figure 3. There is no clear relationship between those NHS providers with high levels of backlog maintenance, and these new schemes announced.

- Those six NHS providers who will develop hospitals under the *Health Infrastructure Plan* (HIP1, 2020–2025) with £2.7 billion of funding are highlighted in orange and blue in Figure 3 and are listed in Figure 16 in Appendix Two. They range from the third to the 38th highest backlog maintenance.
- For the period 2025–2030, 21 NHS providers have been given £100 million of seed funding to develop hospitals under phase two (HIP2). The chosen NHS providers are listed in Figure 17 in Appendix Two, alongside their rank for backlog maintenance in 2018-19. The level of high- and significant-risk backlog maintenance was included as a criterion in selecting these 21 NHS providers.

**Figure 3**  
 Variation in the total cost to eradicate backlog maintenance in NHS trusts and NHS foundation trusts (NHS providers) as at 2018-19  
 NHS providers receiving funds from the new capital scheme are distributed across all providers



- NHS providers who are receiving assistance from the £850 million capital investment scheme, August 2019
- NHS providers who are receiving assistance from the *Health Infrastructure Plan* (HIP1, 2020–2025), September 2019
- Leeds Teaching Hospitals NHS Trust is receiving funding under both the August 2019 and September 2019 announcements
- All other NHS providers

**Notes**

- 1 An investment of £850 million over five years for new capital schemes was announced in August 2019 and are listed in Figure 15 in Appendix Two.
- 2 The six NHS providers who will develop hospitals under the *Health Infrastructure Plan* (HIP1, 2020–2025) with £2.7 billion of funding are listed in Figure 16 in Appendix Two.
- 3 The y-axis is broken at £220 million to fit all NHS providers on the same figure.

Source: National Audit Office analysis of NHS Digital's Estates Return Information Collection (ERIC) data 2018-19

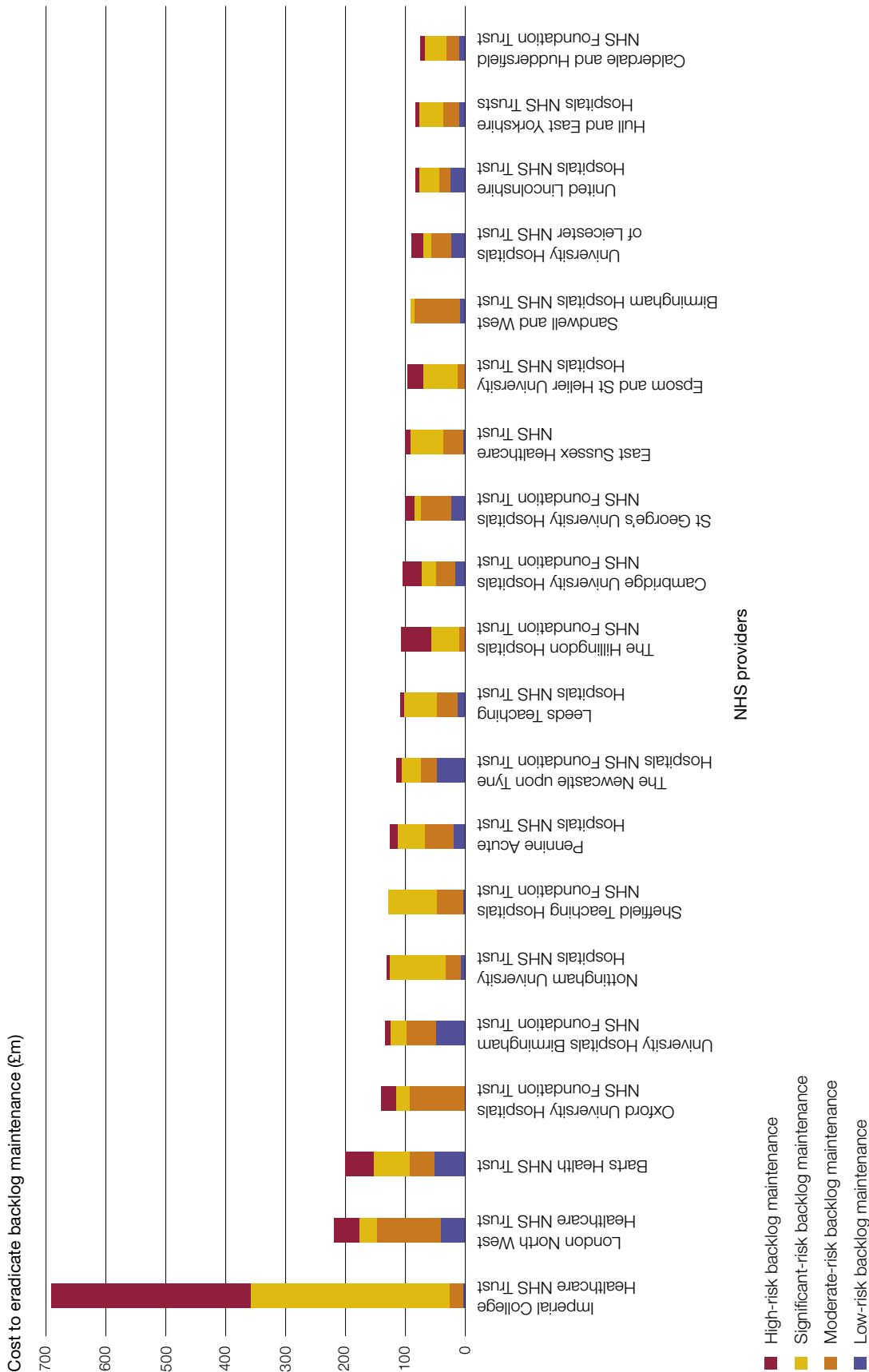
**1.9** The 20 NHS providers with the highest costs to eradicate backlog maintenance are shown in **Figure 4**. Imperial College Healthcare NHS Trust has £691 million total backlog maintenance, of which £334 million is high-risk and accounts for 31% of NHS high-risk backlog maintenance; this may be partially explained by the fact that a quarter of its buildings are more than 70 years old.

**1.10** NHS providers are responsible for measuring their own costs of addressing backlog maintenance, but their reporting may not be accurate. In 2017 the Naylor Review set out to develop a new estates strategy and stated that it believed the backlog maintenance figure was a “substantial underestimate”, because there has been no real incentive to report the situation accurately.<sup>2</sup>

<sup>2</sup> Sir Robert Naylor, *NHS Property and Estates*, 2017.



**Figure 4**  
 The 20 NHS trusts and NHS foundation trusts (NHS providers) with the highest-value backlog maintenance  
 Imperial College Healthcare NHS Trust has around £700 million of backlog maintenance



Source: National Audit Office analysis of NHS Digital's Estates Return Information Collection (ERIC) data 2018-19

## Part Two

### The allocation of the capital investment budget

**2.1** This part of the report provides an overview of the government capital planning and NHS budget-setting process, and the challenges in allocating the NHS's capital budget. It also covers the reallocation of capital funding to revenue budgets by the Department of Health & Social Care (the Department), and a comparison of the United Kingdom's capital investment in health relative to other countries.

#### Capital spending plans

**2.2** Spending reviews set out the government's plans for spending over several years. The allocation of funding then follows a process where the government sets out, and Parliament authorises, the maximum amount each department can spend annually. This is known as the Departmental Expenditure Limit (DEL) and cannot be exceeded without further approval from Parliament. The DEL is split between revenue and capital spending. Revenue spending is for day-to-day activities, for example staffing, while capital spending is for investment, for example land, buildings and equipment.

**2.3** In 2018-19 Parliament authorised a DEL for the Department of £132 billion (**Figure 5**). Of this, £126 billion was for revenue spending and £6 billion for capital spending. A further £13 billion was allocated for demand-led spending that is mostly outside of the Department's control – this is known as Annually Managed Expenditure (AME). AME includes items for which the timing and amount are difficult to predict, for example clinical negligence claims.

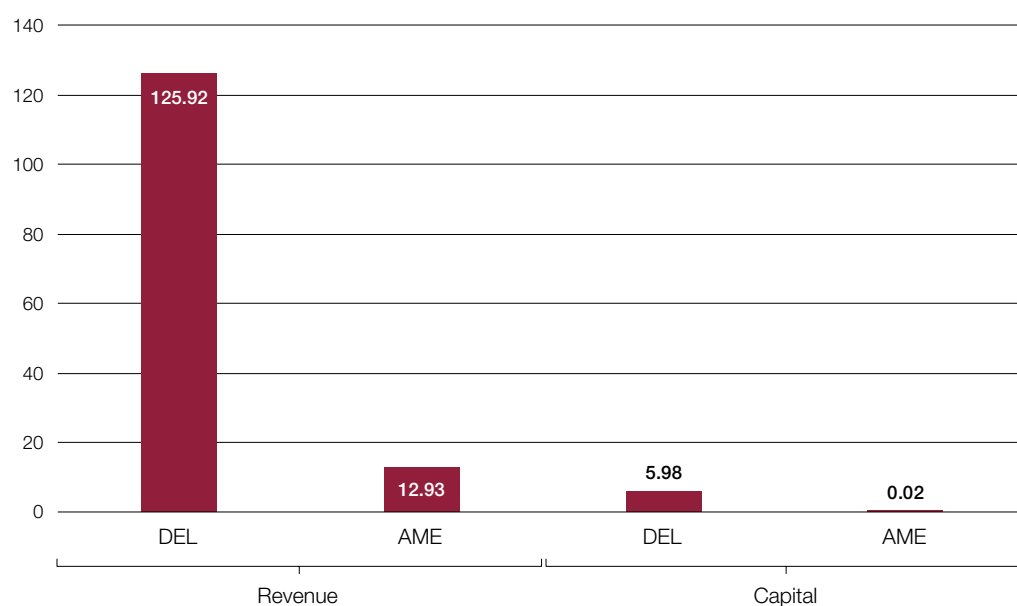
**2.4** Of the Department's £6 billion capital spending limit in 2018-19, £3.6 billion was for NHS trusts and NHS foundation trusts (NHS providers) as shown in **Figure 6** on page 18. The Department retains the accountability for the overall capital limit while NHS England and NHS Improvement (NHSE&I) are involved in the planning, coordination and authorisation of capital. In 2019-20 NHSE&I also involved sustainability and transformation partnerships (STPs) in the planning of NHS capital on a regional basis for the first time. STPs are non-statutory bodies comprising clinical commissioning groups, NHS providers, local authorities, the voluntary sector and other bodies brought together to plan and deliver services across 42 geographical footprints in England. The more advanced STPs have become integrated care systems, defined by closer collaboration between organisations with greater freedoms to manage the operational and financial performance of services.

**Figure 5**

Departmental expenditure limits (DEL) and annually managed expenditure (AME) for revenue and capital, 2018-19 (£ billion)

**Capital is a relatively small but strategically important part of the Department of Health & Social Care's spending**

Expenditure budgets (£bn)



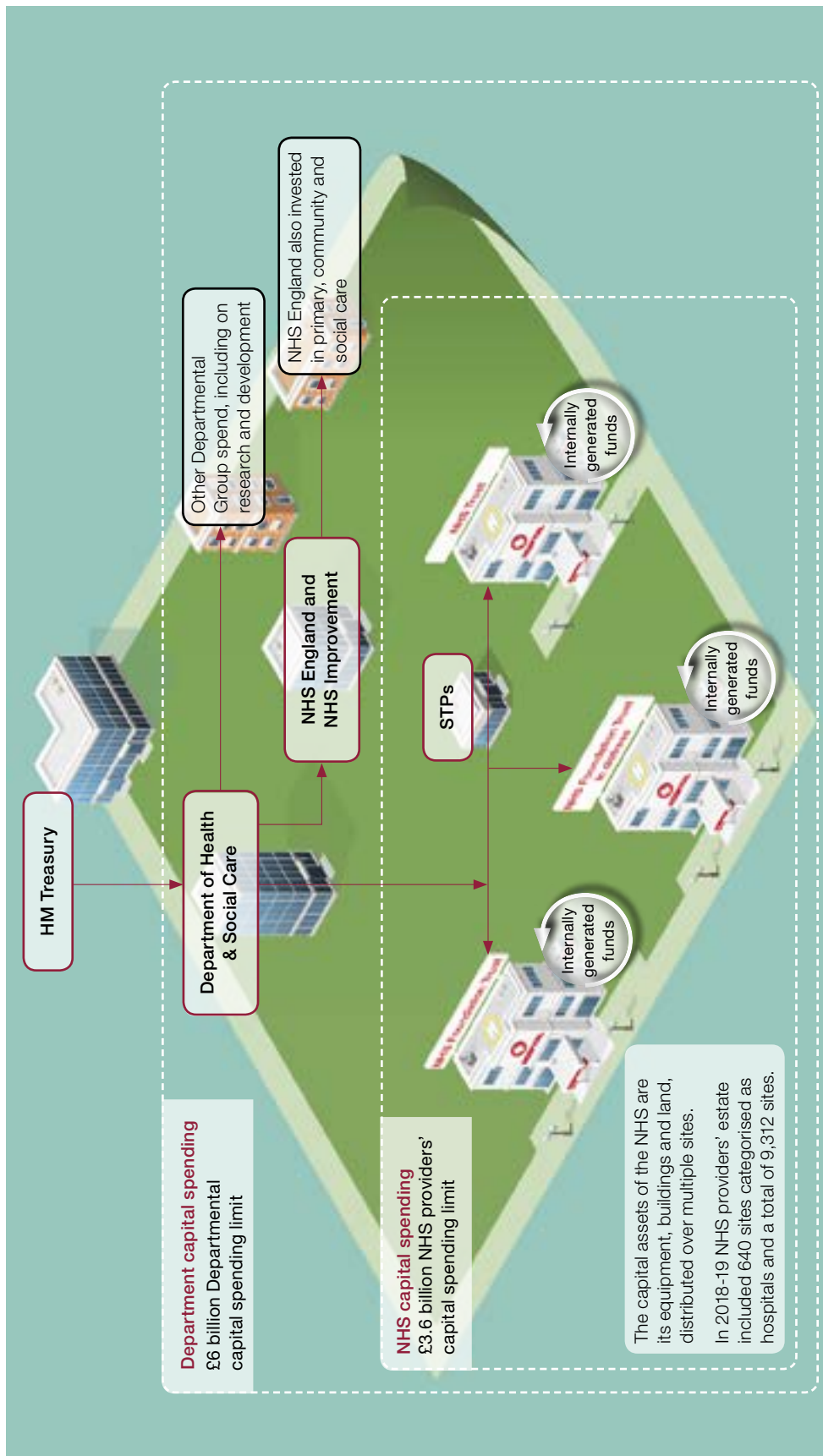
Source: National Audit Office analysis of the Department of Health & Social Care *Annual Report and Accounts*, 2018-19

**2.5** Figure 6 shows the three categories of NHS provider in the capital planning system, which includes NHS foundation trusts, NHS foundation trusts in financial distress and NHS trusts. Organisations in these last two categories must seek approval from NHSE&I for different levels of capital spending and have different freedoms for generating and spending capital.

**2.6** Many organisations share some of the responsibility for the planning, allocation and management of NHS capital (**Figure 7** on page 19). The capital arrangements contrast with the more straightforward revenue side of NHS funding, where NHS England is responsible for both transparently allocating revenue funding to the NHS through clinical commissioning groups and ensuring overall NHS financial balance. The stated reason that NHS England is in charge of allocating revenue funding is that “this prevents any perception of political interference in the way that money is distributed between different parts of the country”.

**Figure 6**  
Capital spending flows and limits

Of the Department of Health & Social Care's (the Department's) £6 billion capital spending limit in 2018-19, £3.6 billion was for NHS trusts and NHS foundation trusts (NHS providers)



**Note**

1 Sustainability and transformation partnerships (STPs) are non-statutory regional bodies, included as they have been given responsibility for regional control totals in 2019-20.

Source: National Audit Office analysis of Department of Health & Social Care, *Annual Report and Accounts 2018-19*; NHS Improvement Capital Regime and NHS Digital's 2018-19 ERIC data

**Figure 7**  
2019-20 process for planning, allocating, approving, managing and monitoring NHS capital

Multiple organisations have some responsibility for planning, allocating, approving, managing and monitoring NHS capital



Source: National Audit Office analysis of 2019-20 NHS capital regime

## Challenges in the capital allocation process

**2.7** The Department faces challenges in managing the capital funding process to ensure the capital limit is not breached. These challenges include:

- NHS foundation trusts not in financial distress only need to report significant capital spending (for example, more than 10% of income) to NHSE&I and the Department. Therefore, the absence of a limit for capital spending by NHS foundation trusts can result in delays in approvals for NHS trusts (and NHS foundation trusts in financial distress), as the Department balances capital spending to ensure the limit is not breached.
- The Department needs to prioritise competing demands for capital when NHS provider plans exceed the limit. NHS providers have, from 2016-17, consistently assessed their need for capital funding as greater than the funding available. The total capital investment requested by providers has been, on average, £1.1 billion more than the limit set in each year from 2016-17 to 2018-19. In 2019-20, it was £1.7 billion higher (paragraph 4.4).

## Reallocation of capital

**2.8** The Department began reallocating capital spending to revenue spending in 2014-15. It transferred £640 million in 2014-15, £950 million in 2015-16, £1.2 billion in 2016-17, £1 billion in 2017-18 and £500 million in 2018-19 (**Figure 8**). Since 2014-15, the Department has transferred in total £4.3 billion from capital spending to revenue spending. The Department plans to transfer £0.5 billion in 2019-20.

**2.9** HM Treasury guidance clearly states, “Departments may not switch provision from capital budgets to resource budgets; such switches would mean that money that had been earmarked for investment was used for current spending”. The £640 million transferred in 2014-15 and the £950 million transferred in 2015-16 were agreed in-year through the Supplementary Estimates process.<sup>3</sup> The 2015-16 transfer of £950 million followed a November 2015 Spending Review announcement of £4.8 billion of capital investment every year from 2015-16 to 2020-21. Three months later, in February 2016’s Supplementary Estimate, the £950 million was transferred and £3.7 billion was available for capital for 2015-16. In February 2016, HM Treasury gave its approval for special flexibility to allow the Department to make multi-year transfers from capital to revenue spending, up to a maximum amount in each year between 2016-17 and 2019-20. The Department has used all of this flexibility. In 2019-20, the Department plans to transfer £471 million, although this will exceed the agreed special flexibility for that year by £221 million. This process of switching from capital to revenue budgets is not unique to the Department of Health & Social Care.

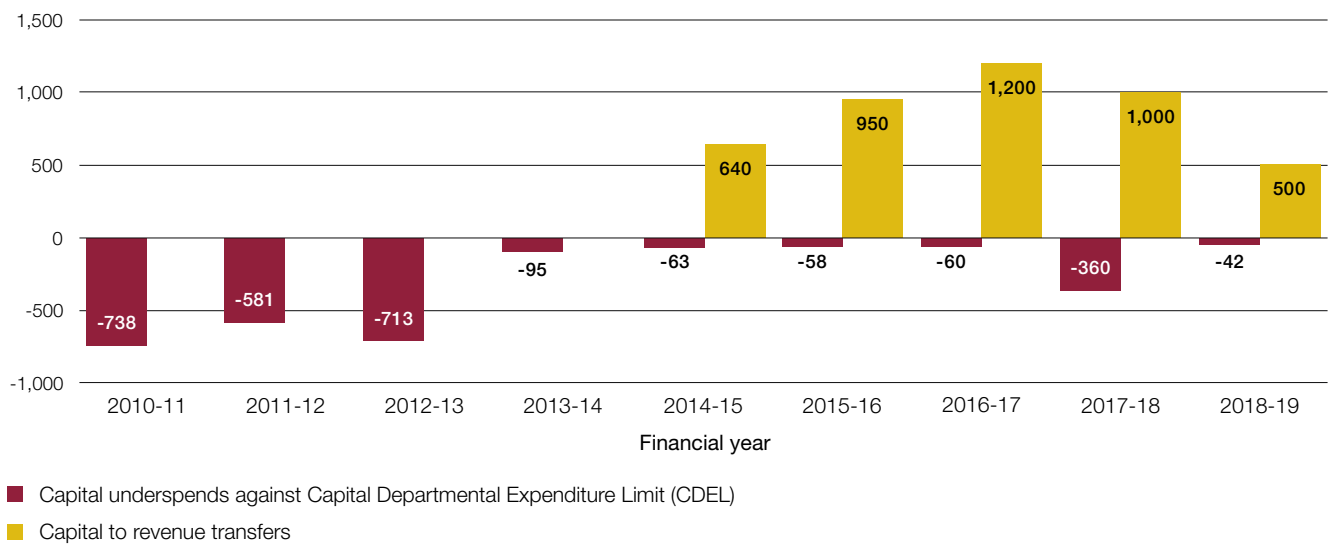
<sup>3</sup> Supplementary estimates are the means of obtaining from Parliament the legal authority to consume resources. HM Treasury, *Central Government Supply Estimates 2015-16, Supplementary Estimates*, HC 747, February 2016.

**Figure 8**

Annual transfers from capital spending to revenue spending, and underspends against the capital limit, 2010-11 to 2018-19 (£ millions)

Large transfers from capital spending to revenue spending occurred between 2014-15 and 2018-19

Capital underspends and transfers to revenue (£m)



Source: National Audit Office analysis of Department of Health and Department of Health & Social Care *Annual Report and Accounts*, 2014-15 to 2018-19

**2.10** The actual amounts spent by the Department and NHS providers on capital in each year up to and including 2018-19 is shown in **Figure 9** overleaf. The 2019-20 column shows the estimated limit for capital spending by NHS providers in 2019-20 together with the Department's total capital limit and planned transfer of resources from the capital budget into revenue. Transfers from capital to revenue are expressed at a Departmental level and other outturn refers to capital spending in other parts of the Departmental group (see Figure 6).

**Figure 9**

The Department and NHS providers' capital spending 2010-11 to 2018-19, and limits 2019-20 (£ millions)

The Department began transferring from its capital budget to its revenue budget in 2014-15

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20 <sup>1</sup>
<b>Total Department of Health &amp; Social Care capital outturn</b>	<b>4,202</b>	<b>3,786</b>	<b>3,783</b>	<b>4,349</b>	<b>3,951</b>	<b>3,632</b>	<b>4,556</b>	<b>5,238</b>	<b>5,941</b>	<b>7,020</b>
Of which:										
Research and Development (R&D) outturn <sup>2</sup>							1,024	1,100	1,100	Note 1
Other outturn	742	922	619	1,118	644	690	667	1,092	913	Note 1
NHS providers' outturn	3,460	2,864	3,164	3,231	3,307	2,942	2,865	3,046	3,928	4,800
<b>Total capital to revenue transfers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>640</b>	<b>950</b>	<b>1,200</b>	<b>1,000</b>	<b>500</b>	<b>471</b>

**Notes**

- 1 2010-11 to 2018-19 are outturns. 2019-20 are estimated limits and the planned capital to revenue transfer provided by the Department.
- 2 R&D outturn is included as it has scored, and will continue to score, as capital expenditure from 2016-17 onwards due to a classification change under European System of Accounts 10 moving Research and Development to Capital DEL (CDEL).

Sources: Figures from 2010-11 to 2018-19 are those reported in and for each year's corresponding Department of Health; and from 2017-18, Department of Health & Social Care, *Annual Report and Accounts*, 2010-11 to 2018-19. The 2019-20 planned NHS provider limit, total CDEL estimate and 2019-20 planned capital to revenue transfer are estimates provided to the National Audit Office by the Department

**2.11** The transfers from capital to revenue spending occurred at a time when the financial position of some NHS providers was deteriorating (**Figure 10**). The Department was thus able to prioritise support for day-to-day spending on current services at the cost of foregoing longer-term investment in buildings and other long-term assets. This increases the risk that assets deteriorate, and that future capital spending is needed to bring assets back up to an adequate standard, rather than making investments in new technology or premises. The Committee of Public Accounts (the Committee) said in March 2018, "despite our earlier warnings, the Department has not yet assessed the impact on patient services of repeatedly raiding its capital budget to fund short-term needs of the NHS".<sup>4</sup> In March 2019, the Committee found that the Department was again unable to give a measure of the impact on healthcare services from these transfers.<sup>5</sup> The Department acknowledges that transferring money from capital to revenue spending is not an ideal solution but judged it to be in the best interests of patients while the NHS got to grips with its financial problems.

4 HC Committee of Public Accounts, *Sustainability and transformation in the NHS*, Twenty-ninth Report of Session 2017–2019, HC 793, March 2018.

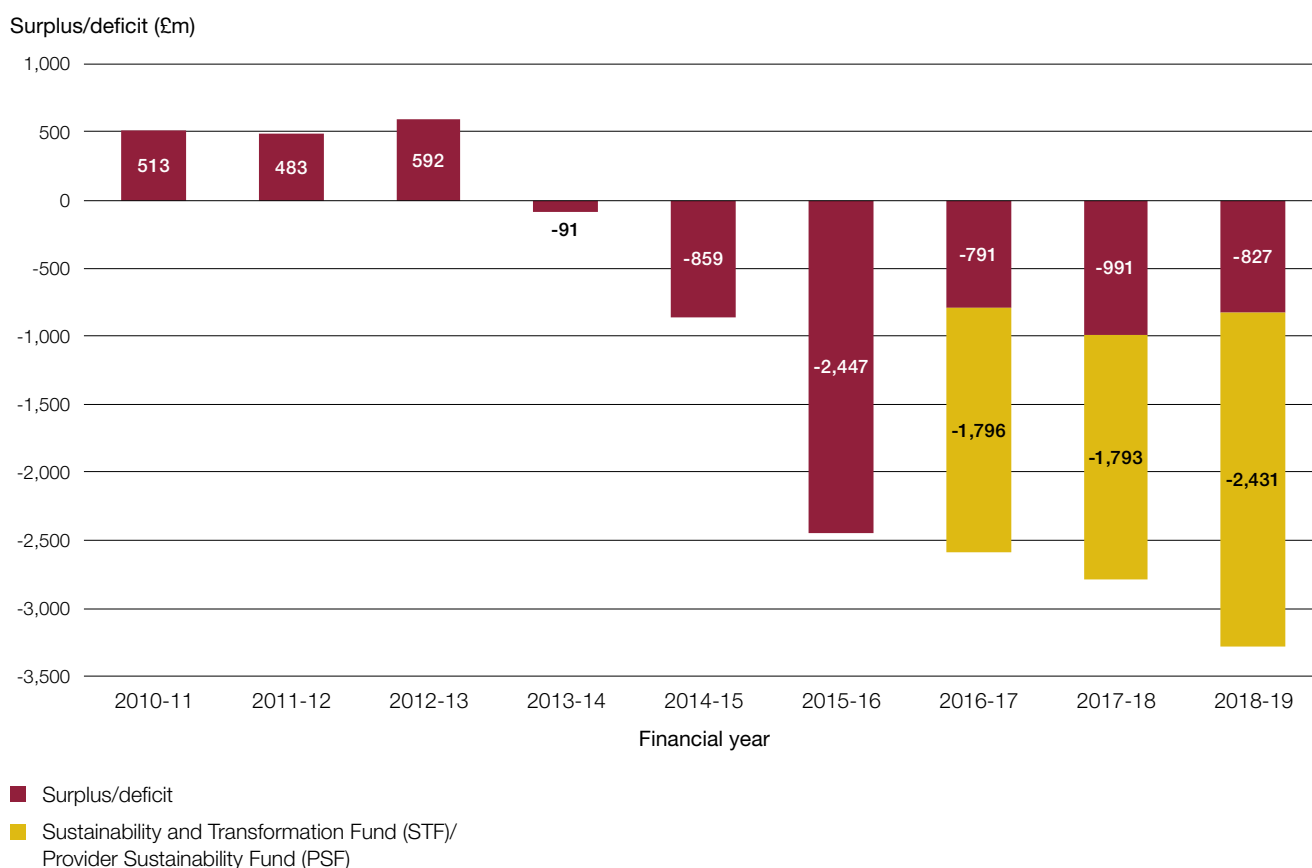
5 HC Committee of Public Accounts, *NHS financial sustainability*, Ninety-first Report of Session 2017–2019, HC 1867, March 2019.



**Figure 10**

The combined surplus/deficit of trusts in England between 2010-11 and 2018-19

From 2013-14 NHS providers have been in overall deficit even with the help of the Sustainability and Transformation Fund and the Provider Sustainability Fund (from 2018-19)

**Notes**

- 1 In April 2016, the Sustainability and Transformation Fund was introduced to support the financial recovery of NHS trusts. It originally committed funding of £1.8 billion each year until 2018-19, but in February 2018, NHS England and NHS Improvement committed an additional £650 million to the fund to create a larger £2.45 billion Provider Sustainability Fund for 2018-19. The graph highlights that the deficits reported from 2016-17 would have been greater but for this STF/PSF funding.
- 2 The figure for 2018-19 excludes adjustments due to the accounting treatment of Carillion's Private Finance Initiative assets.

Source: Comptroller and Auditor General, HM Treasury, *NHS financial sustainability*, Session 2017–2019, HC 1867, National Audit Office, January 2019. Updated with 2018-19 NHS trusts and NHS foundation trusts accounts information

**2.12** Any delay in the approval of capital projects creates a risk that the overall national budget is not fully spent. NHS providers told us that when central funding decision announcements were delayed, this reduced the time they had to implement their capital plans for that year. Unused capital money, whether from central funding or internally generated by NHS providers (see paragraph 3.2), cannot be easily redistributed within the NHS. Capital budgets have not been fully utilised in each of the financial years between 2010-11 and 2018-19 (Figure 8). Between 2010-11 and 2012-13 there was an average underspend of £677 million (12%) in capital spending. In 2017-18 the capital underspend was £360 million (6%), and the total capital underspend since 2010-11 is £2.7 billion. This cumulative underspend has occurred at a time when the UK has had lower levels of medical equipment (for example, 26th out of the EU28 countries for magnetic resonance imaging (MRI) and 27th out of the EU28 for computed tomography (CT) scanners per population)<sup>6</sup> and there was growing significant- and high-risk backlog maintenance (paragraphs 1.4 to 1.9).

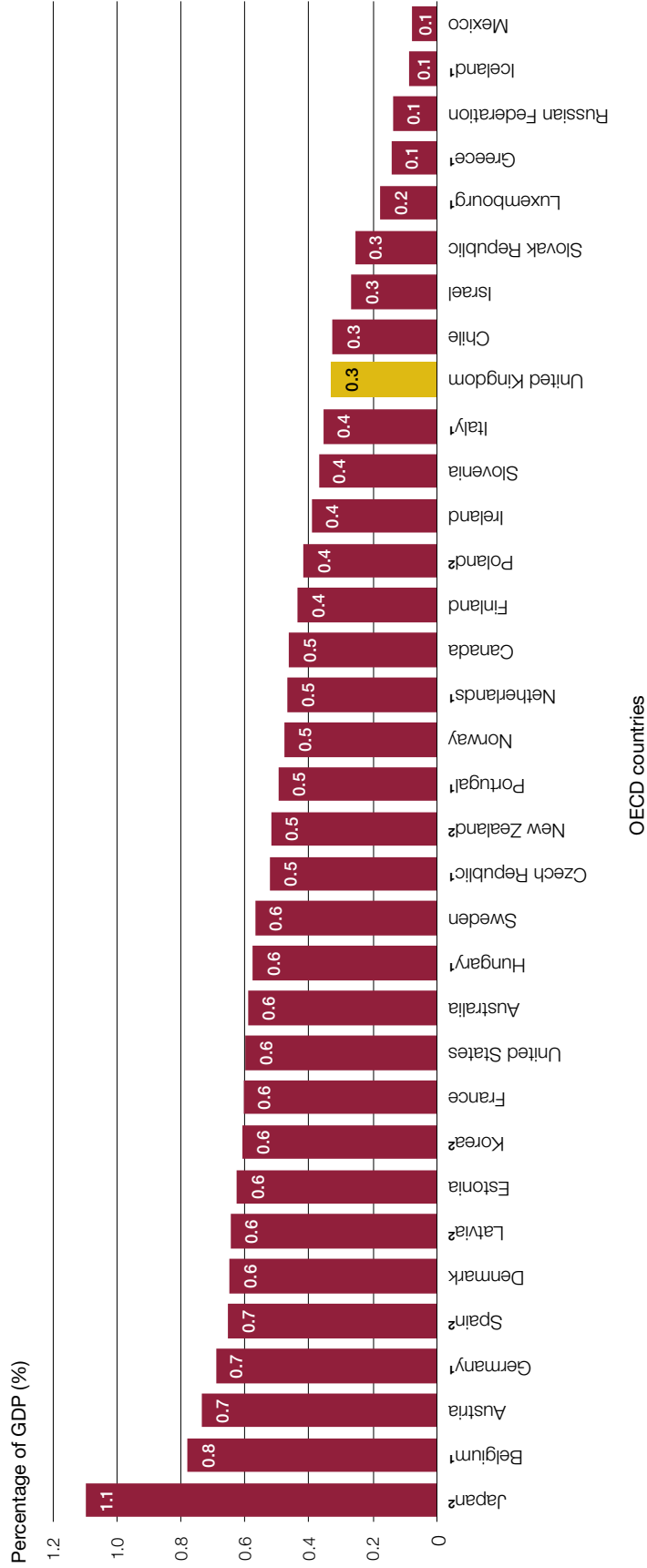
### **Comparisons with OECD countries**

**2.13** In recent years, the UK invested less capital in its healthcare services than other Organisation for Economic Co-operation and Development (OECD) countries. The OECD compares countries' net capital spend on healthcare assets as a percentage of GDP and places the UK 26th out of 34 OECD countries in 2015 (**Figure 11**). NHS England considers that the NHS already uses its capital assets and infrastructure more intensively than most other Western countries.

<sup>6</sup> Organisation for Economic Co-operation and Development, *Health at a Glance Europe 2016*, figures 7.17 and 7.18 (2014 or nearest year). Figures are for the United Kingdom, for which they are an estimate and only include scanners in the public sector.

**Figure 11**  
 Capital investment in healthcare as a percentage of gross domestic product (GDP), 2015 or nearest year (Organisation for Economic Co-operation and Development (OECD))

**UK is 26 out of 34 OECD countries for capital investment in healthcare as a proportion of GDP**



**Notes**

- 1 Refers to gross fixed capital formation in International Standard Industrial Classification (ISIC) 86: Human health activities (ISIC Rev. 4).
- 2 Refers to gross fixed capital formation in ISIC Q: Human health and social work activities (ISIC Rev. 4).
- 3 Gross fixed capital formation is defined as "resident producers' acquisitions, less disposals, of fixed assets during a given period plus certain additions to the value of non-produced assets realised by the productive activity of producer or institutional units. Fixed assets are produced assets used in production for more than one year" (European System of Accounts 2010).

Source: Organisation for Economic Co-operation and Development (OECD) Health Statistics 2017; OECD National Accounts

# Part Three

## Sources of capital funding

**3.1** This part of the report considers how NHS trusts and NHS foundation trusts (NHS providers) acquire funding to finance their capital projects. It also sets out the various means by which NHS providers can access the funding to meet their capital needs.

### Capital funding sources

**3.2** NHS providers receive payments for providing care to patients. These payments include a consideration for costs to cover the wear and tear of assets. Those providers that can, on aggregate, deliver patient care at or below the cost they receive for it can more easily use these internally generated funds for replacing and maintaining their assets. For many NHS providers, internally generated funds do not support their total capital spending plans. Consequently, they must look for additional sources of funding. Capital funding sources include the following:

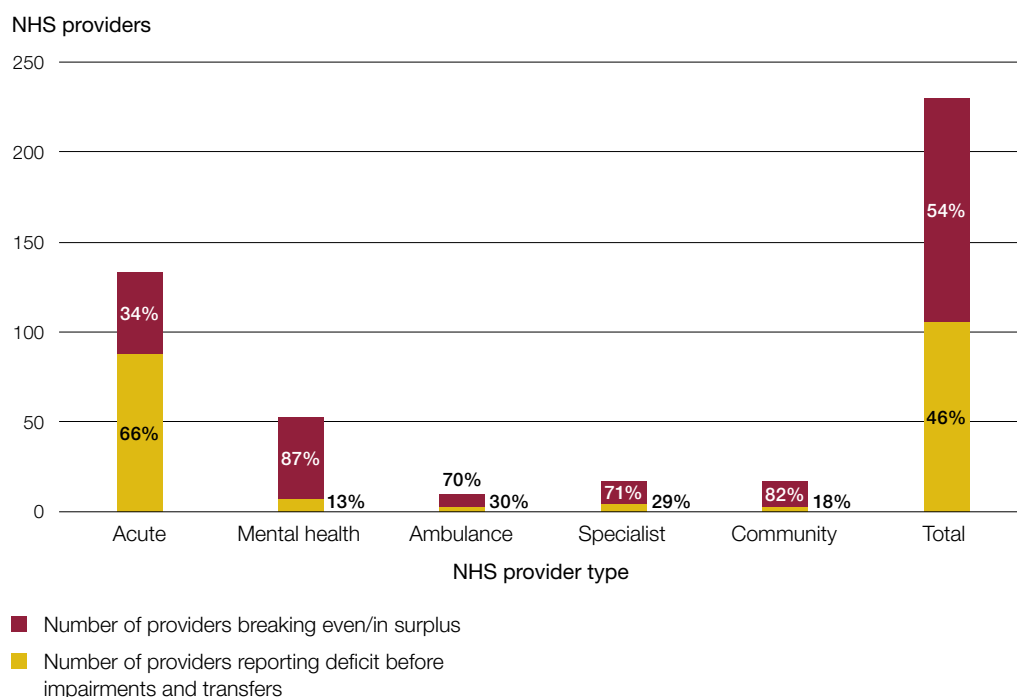
- Internally generated funds and use of surpluses (paragraphs 3.2 and 3.3).
- Selling land (paragraph 3.4).
- Loans from the government, as well as capital funding for strategic central programmes (paragraph 3.6).

**3.3** In 2018-19, 124 out of 230 (54% of NHS providers) delivered a surplus (**Figure 12**). Delivering a surplus improves the NHS providers' cash balance. Those in surplus, particularly NHS foundation trusts, have specific freedoms to use their surplus for capital spending or to let the surplus carry forward into the following year. NHS providers in deficit have scarce cash resources and have no means of accessing cash from surpluses elsewhere in the NHS, such as from within their sustainability and transformation partnership (STP), and must resort to seeking loans from the Department of Health & Social Care (the Department) to fund agreed capital spending plans. The current capital regime means that the availability of cash does not necessarily match where there are the most urgent capital needs. The greatest number and proportion of NHS providers in deficit were in the acute sector (in other words, general hospital services).

**Figure 12**

Number of NHS trusts and foundation trusts (NHS providers) producing a surplus or a deficit in 2018-19, by provider type

While 54% of all NHS providers broke even or produced a surplus in 2018-19, this falls to 34% of acute providers



Source: NHS Improvement, *Consolidated NHS provider accounts 2018-19*, HC 2376, July 2019

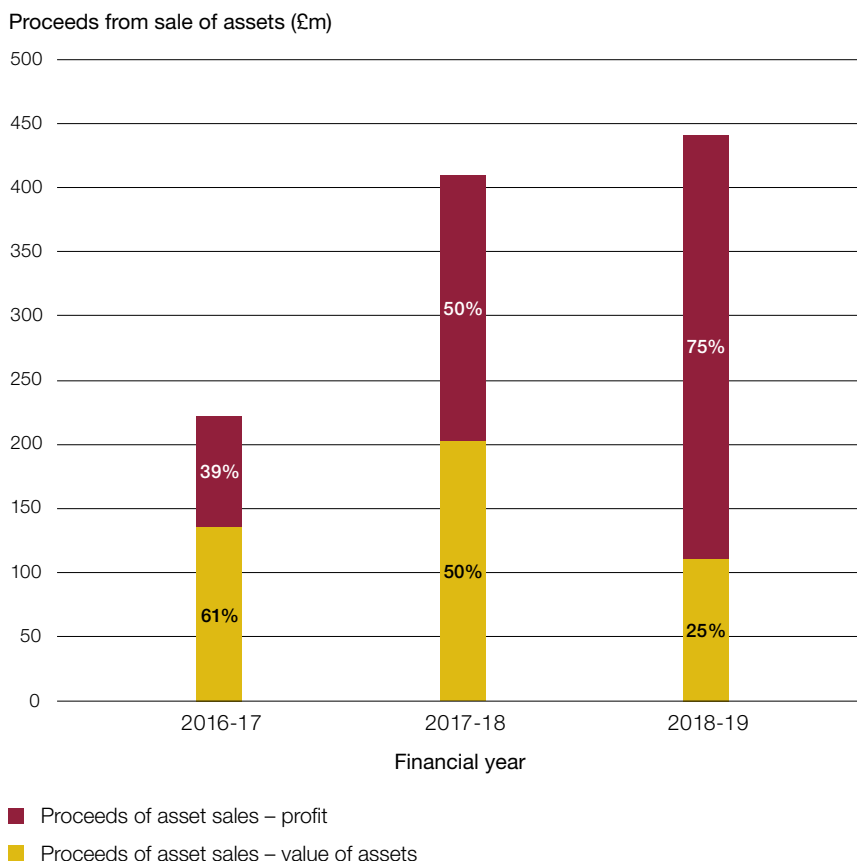
**3.4** NHS providers can sell assets to raise funds. Government policy encourages public sector entities to sell assets where they no longer serve a public purpose. HM Treasury guidance has specific rules about the use of sale proceeds, and how they should be split between capital and revenue budgets. Typically, once sold, the value of the asset in the NHS providers' accounts is available for capital investment, and profits are available for day-to-day spending, although the level of profit that benefits day-to-day spending is limited and monitored. **Figure 13** overleaf shows that the overall proceeds from asset sales increased by 99% between 2016-17 and 2018-19, from £222 million to £441 million (annual increases of 84% between 2016-17 and 2017-18, and 8% between 2017-18 and 2018-19). The proportion of profit made on asset disposal also increased from 2016-17 to 2018-19 by 36 percentage points (from 39% in 2016-17 to 75% in 2018-19). This assists the revenue position and meant that not all these asset proceeds have been available to reinvest into capital.<sup>7</sup> The high value of land in London creates a potentially large source of funding for London's NHS providers.

<sup>7</sup> The National Audit Office report on government's land disposals (Comptroller and Auditor General, *Investigation into the government's land disposals and strategy*, Session 2017–2019, HC 2138, National Audit Office, May 2019), said that: "It would be a concern if departments are selling land and property to support day-to-day running costs, rather than to invest in refurbishing existing assets or purchasing new ones."

**Figure 13**

Proceeds from asset sales, 2016-17 to 2018-19

Proportionately the profit made on sale of assets by NHS trusts and NHS foundation trusts (NHS providers) has increased by 36 percentage points



Source: National Audit Office analysis of Consolidated NHS provider accounts

**3.5** A reduction in an asset’s value due to, for example, damage sustained, a decline in market value or change in use, is known as an impairment. For the Department, which includes NHS providers, impairments stood at around £1.6 billion during the period 2013–2015. In the following two years there was a noticeable increase in impairments: £2.2 billion (2015-16) and £2.6 billion (2016-17). In January 2016, NHS providers were guided by NHS Improvement to “review all equipment and buildings asset lives given that less capital will be available for replacement in future”. This guidance encouraged NHS providers to apply an alternate method of valuation “where advantageous”, which would result in a reduction in an asset’s value, thus creating a one-off impairment, and therefore a reduction in depreciation charges. Creating the one-off impairment does not hinder the financial performance figure that is used by NHS Improvement to hold NHS providers to account, and a reduction in the depreciation charge improves the ‘bottom line’. Reducing the book value of assets can also contribute to improving a trust’s bottom line by reducing its annual dividend payment to the Department.

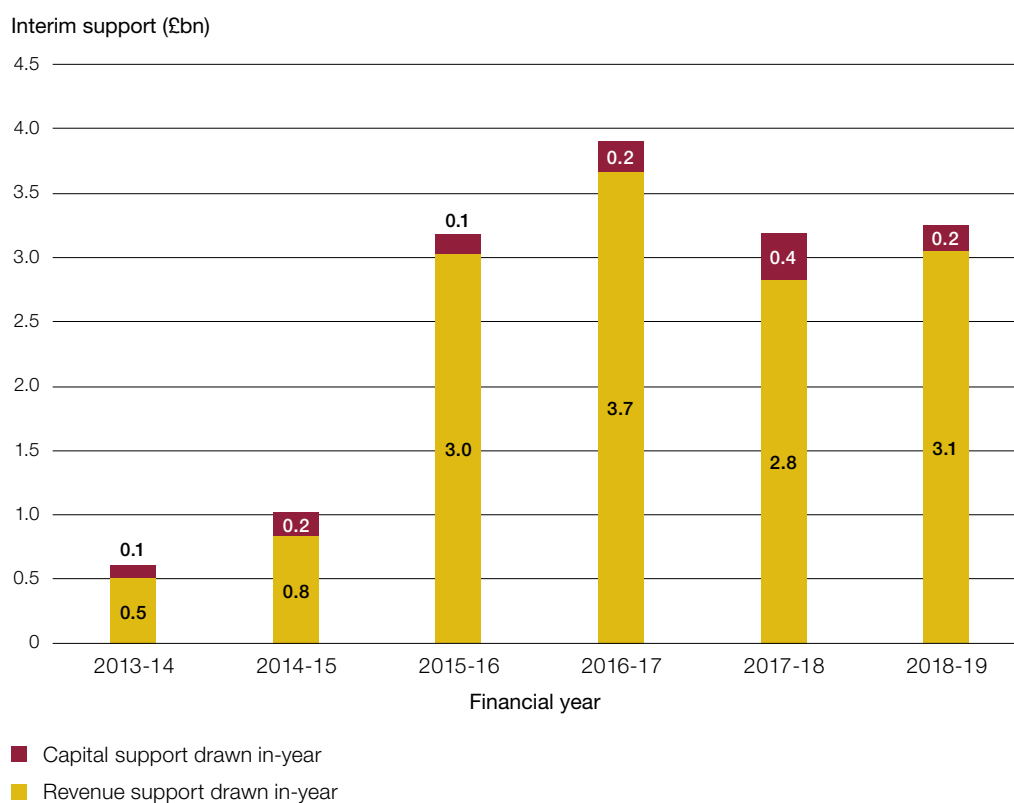
**3.6** Since the period 2013-15, there has been an increase in the interim financial support from the Department to NHS providers. This interim support is for NHS providers in financial distress to support the continued delivery of services (**Figure 14**). The number of providers receiving interim capital support has also grown, with 35 NHS providers receiving support in 2018-19 compared with 17 in 2013-14. In 2018-19, the combined debt for capital and revenue interim borrowing reached £10.9 billion.

**3.7** In 2018-19, £3.6 billion of the Department's capital limit was for NHS providers, but NHS providers spent £3.9 billion. The overspend of £377 million was balanced by underspends elsewhere in the Department. NHS providers generated 76% (£3 billion) of the total capital expenditure from internally generated funds, loans and asset disposals. The Department and NHS England and NHS Improvement (NHSE&I) provided £543 million (14% of NHS providers' capital expenditure) in the normal course of business for strategic projects, with, for example, £141 million for emergency and urgent winter preparations. The remainder is made up of other capital support (6%) and Private Finance Initiative residual interest (4%).

### Figure 14

Interim financial support from the Department of Health & Social Care to NHS trusts and NHS foundation trusts (NHS providers), 2013-14 to 2018-19

Since the period 2013–2015, NHS providers have received increased support from the Department



#### Note

1 Interim revenue and capital support drawn in-year by NHS providers as loans or public dividend capital.

Source: National Audit Office analysis of information extracted from the Department of Health & Social Care Section 40 publications

## Part Four

### Challenges to planning and delivering an effective capital strategy

**4.1** In this part of the report, we look at the challenges faced by both NHS trusts and NHS foundation trusts (NHS providers), and the Department of Health & Social Care (the Department), in delivering an effective capital strategy. These include the capital budget allocations process, *The NHS Long Term Plan* ambitions, the postponement of the 2019 Spending Review, legislative proposals and the Private Finance Initiative (PFI).

#### **Capital budget allocation process**

**4.2** The 2019 National Audit Office (NAO) report on NHS financial sustainability found that the capital funding system made it difficult to plan and acted as a barrier to investment.<sup>8</sup> As part of our interviews with NHS providers for this report a trust told us: “We need to replace our estate but there’s no clarity on how to access the funds for big projects.” Previous NAO reports have highlighted that filling in documents to access financial support can be resource-intensive and can require the same amount of effort irrespective of the level of funding.

**4.3** NHS Providers (the membership organisation representing NHS trusts and NHS foundation trusts) has said that the current NHS capital strategy, that is, the capital bidding, prioritisation, allocation and approvals process, is broken and in need of rapid reform. HM Treasury had asked the Department and NHS England and NHS Improvement (NHSE&I) to conduct a review of the current capital strategy, which was due to outline options for a new capital system in autumn 2018.

<sup>8</sup> Comptroller and Auditor General, *NHS financial sustainability*, Session 2017–2019, HC 1867, National Audit Office, January 2019.



**4.4** The capital funding process has been particularly challenging for 2019-20. At the start of 2019-20, NHS providers submitted plans for capital spending that exceeded the budget available by around £1.7 billion. In response, in May 2019, the chief financial officer of NHSE&I wrote to NHS providers asking them to reduce or defer capital expenditure plans, and to only include plans that required borrowing where there was an urgent and critical need. The letter also recognised the need for “a more planned, proactive and collaborative approach” to managing capital spending in order to avoid “continuous, unnecessary resubmission of planning spreadsheets requiring significant work”. As a result of the difference between providers’ plans and the available budget, NHS providers were asked by NHSE&I to reduce their capital spending plans and to resubmit them.

**4.5** In July 2019, following the resubmission by NHS providers of their capital spending plans, the chief financial officer of NHSE&I wrote again to providers saying that their resubmissions had only reduced the total by 3% and that a 20% reduction was required. The letter also asked NHS providers to work together on a sustainability and transformation partnership (STP)/integrated care system (ICS) footprint to prioritise capital spending to meet the limit set by the Department.

**4.6** In August 2019, the government announced an additional £1.8 billion for capital investment. Of that, £850 million was specifically for 20 new capital investment projects over five years (Figure 15 in Appendix Two), with £100 million of this available for these projects in 2019-20. NHS providers can therefore spend up to a maximum of £1.1 billion more on their capital plans in 2019-20 than the limit at the start of the financial year, to address in-year pressures. However, this still leaves a gap of £600 million between the original NHS providers’ capital spending plans and their capital budget for 2019-20. The Department expects the £600 million gap to reduce based on previous years’ forecast of capital spending against actual outturn.

**4.7** In October 2019, the Department published the *Health Infrastructure Plan*. The plan acknowledges the “piecemeal and uncoordinated approach to NHS buildings and infrastructure” taken by the Department and outlines the proposed new capital regime. This includes changes to an “overly bureaucratic” approvals process. The proposed new capital regime aims to provide the right incentives for providers to invest in their infrastructure, and a clearer set of capital controls. The plan also announced six new schemes to be delivered by 2025 (Figure 16 in Appendix Two), with seed funding for a further 21 schemes to develop plans for 2025 to 2030 (Figure 17 in Appendix Two).

## **The ambitions in *The NHS Long Term Plan***

**4.8** One of the five tests in *The NHS Long Term Plan* is: “the NHS will make better use of capital investment and its existing assets to drive transformation”. *The NHS Long Term Plan* explains that in order to achieve this transformation it will consider a number of reforms to the NHS’s capital strategy to prioritise and allocate capital funding efficiently. The Department had planned to set out these reforms at the (now postponed) 2019 Spending Review.

**4.9** *The NHS Long Term Plan* has set out new ambitions for the NHS such as digitally enabled care and local partnerships, with estate plans to include a pipeline of possible capital investments. It gives no information on the cost of delivering digitally enabled care or how it will assess these “possible capital investments”.

## **The postponement of the 2019 Spending Review**

**4.10** The fast-tracked one-year Spending Round in September 2019 allowed government to focus on exiting the EU, with a full spending review postponed to 2020. The postponement of the 2019 Spending Review created some uncertainty regarding future announcements by the Department on capital planning. For example, the Department is currently undertaking a review of capital as requested by HM Treasury and had planned to announce its capital strategy from 2020-21 to 2024-25 to support *The NHS Long Term Plan* (and the revenue settlement for NHS England, agreed to 2023-24), in the autumn 2019 Spending Review. Instead the Department’s *Health Infrastructure Plan*, published in October 2019, provides an overview of their capital strategy.

**4.11** The 2019 Spending Review had also been an opportunity to explore alternative views about how to remedy the lack of available capital in the NHS, for example, the Chair of NHS England Lord Prior’s proposal to raise a £50 billion government bond for infrastructure spending. In June 2019, HM Treasury closed its consultation on the broader government approach to the role of private finance in infrastructure projects, after ending the use of the Private Finance Initiative (PFI)/Private Finance 2 but is yet to set out whether it will make a mechanism to enable private investment in capital projects available to the NHS.

## **The current NHS landscape restructuring**

**4.12** Although the responsibility for managing the capital spending limit lies with the Department, there was an increased role in 2019-20 for mature STPs and ICSs in managing capital expenditure across their system. These are non-statutory bodies and in some cases are newly formed. It may be difficult for them to gain the knowledge and skills to manage a complex process in such a short time.

## Short-term capital planning

**4.13** Managing capital spending on an annual basis reduces capital planning flexibility. Some capital investments are likely to be long term with spending over several years to improve the capacity and productivity of health services. However, the Department manages capital spending on an annual basis without the ability to carry forward unspent resources. This reduces the flexibility of the Department to manage capital investment on a long-term basis. The NAO's report *Improving government's planning and spending framework* provided recommendations on integrating planning and spending to deliver long-term value for money for taxpayers and on realistic medium-term planning and prioritisation by departments.<sup>9</sup>

## Plans for legislative changes

**4.14** NHS foundation trusts were established in 2004. It was expected that all NHS trusts would eventually apply for foundation trust status and therefore benefit from the incentives of a greater level of financial autonomy, including the ability to retain surpluses. At 31 March 2019, there were 227 NHS providers, of which 77 (34%) retained non-foundation trust status. These 77 non-foundation trusts will continue to have their capital limits determined centrally. For the 150 NHS foundation trusts (66% of NHS providers), NHSE&I has proposed that NHS Improvement should have the power to set annual capital spending limits for these providers, with each use of the power applying to a single named foundation trust individually and which automatically ceases at the end of the financial year, with the reasons for the use of the power published. This is intended to improve the Department's ability to plan its capital spending within its spending limit. If implemented, this may limit the ability of foundation trusts to draw on any surplus they have earmarked for capital investment. This greater autonomy was also seen as an incentive for achieving fiscal balance.

## Existing facilities built under PFI

**4.15** Access to capital funding under PFI is no longer an option for NHS providers. The Chancellor confirmed at the October 2018 Budget that no further PFI projects could be entered into, but existing projects would be honoured. There are 156 existing PFI and Local Improvement and Finance Trust schemes with a total future commitment of £52.4 billion. Of these, 26 schemes each have a total future commitment greater than £500 million.

**4.16** Two PFI hospital projects, for Sandwell and West Birmingham Hospitals NHS Trust and Royal Liverpool and Broadgreen University Hospitals NHS Trust, were being built when the construction company Carillion collapsed and required government support. We examined the costs of these projects in a separate report on the rescue of the two PFI hospitals, published on 17 January 2020.<sup>10</sup>

<sup>9</sup> Comptroller and Auditor General, *Improving government's planning and spending framework*, Session 2017–2019, HC 1679, National Audit Office, November 2018.

<sup>10</sup> Comptroller and Auditor General, *Investigation into the rescue of Carillion's PFI hospital contracts*, Session 2019–20, HC 23, National Audit Office, January 2020.

# Appendix One

## Our investigative approach

### Scope

- 1 This report is an introduction to capital expenditure in the NHS. We reviewed:
  - trends in capital spending and the age of the NHS estate;
  - access to capital funding and the funding process; and
  - challenges to delivering an effective capital strategy.

### Methods

- 2 In reviewing these issues, we interviewed senior staff from four NHS trusts and NHS foundation trusts (NHS providers) in May and June 2019 (a mental health trust, two acute providers and a community health provider) in varying financial positions and with different levels of backlog maintenance. We used semi-structured questions to ask about their most significant capital-related issues facing their trusts. We interviewed senior staff from the Department of Health & Social Care (the Department) and NHS England and NHS Improvement and we also interviewed stakeholders such as NHS Providers, the Kings Fund, the Health Foundation and the Healthcare Financial Management Association.

- 3 We reviewed various documents such as the *NHS Property and Estates* report by Sir Robert Naylor, NHS providers' accounts and various research documents such as the Organisation for Economic Co-operation and Development's *Health at a Glance*. We examined NHS Digital's Estates Return Information Collection data, NHS providers' financial data, OECD data and the Department's accounts.

- 4 Cash figures are given in nominal prices, unless stated otherwise.

- 5 We excluded GP practices from our scope because, as private businesses, their own investment in capital does not count towards the Department's capital spending limit. Since our focus is predominantly on physical assets in NHS providers, we also excluded discussion of capital expenditure on research and development.

# Appendix Two

## Recent capital funding announcements

**1** **Figure 15** on pages 36 and 37, **Figure 16** on page 38 and **Figure 17** on pages 39 and 40.

**Figure 15**

The 20 projects that the government announced in August 2019 would receive £850 million additional capital funding investment

The projects are ranked according to their total estimate of cost to eradicate backlog maintenance in 2018-19

Organisation	Funding (£m)	Purpose of funding	NHS trust rank for total backlog maintenance in 2018-19 (227 = lowest, 1 = highest) <sup>1</sup>
University Hospitals Birmingham	97.1	to provide a new hospital facility, replacing outdated outpatient, treatment and diagnostic accommodation.	5
The Newcastle upon Tyne Hospitals NHS Foundation Trust	41.7	to improve paediatric cardiac services.	9
Leeds Teaching Hospitals NHS Trust	12	to provide a laboratory information management system.	10
United Lincolnshire Hospitals NHS Trust	21.3	to improve patient flow in Boston by developing urgent and emergency care zones in A&E.	18
Stockport NHS Foundation Trust	30.6	to provide a new emergency care campus development, incorporating an urgent treatment centre, GP assessment unit and planned investigation unit.	43
Luton and Dunstable University Hospital NHS Foundation Trust	99.5	a new block to provide critical and intensive care, as well as a delivery suite and operating theatres.	57
Royal Cornwall Hospitals NHS Trust	99.9	to build a new Women's and Children's Hospital.	59
Croydon Health Services NHS Trust	12.7	to extend and refurbish critical care units at the Croydon University Hospital, Croydon.	60
University Hospitals of North Midlands NHS Trust	17.6	to create three new modern wards in Stoke.	74
Wye Valley NHS Trust	23.6	to provide new hospital wards in Hereford, providing 72 beds.	86
Greater Manchester Mental Health NHS Foundation Trust	72.3	to build a new adult mental health inpatient unit.	118
Tameside and Glossop Integrated Care NHS Foundation Trust	16.3	to provide emergency and urgent care facilities.	128
Isle of Wight NHS Trust	48	to redesign acute services.	149
Mersey Care NHS Foundation Trust	33	to provide a new 40 bed low secure unit for people with learning disabilities.	181
Norfolk and Suffolk NHS Foundation Trust	40	to build four new hospital wards in Norwich, providing 80 beds.	190

**Figure 15 continued**

The 20 projects that the government announced in August 2019 would receive £850 million additional capital funding investment

Organisation	Funding (£m)	Purpose of funding	NHS trust rank for total backlog maintenance in 2018-19 (227 = lowest, 1 = highest) <sup>1</sup>
Norfolk and Norwich University Hospitals NHS Foundation Trust	69.7	to provide diagnostic and assessment centres to aid rapid diagnosis and assessment of cancer and non-cancerous disease.	202
Barking, Havering and Redbridge Clinical Commissioning Group and North East London NHS Foundation Trust	17.0	to develop a new health and well-being hub in north-east London.	Backlog maintenance not applicable as it is a clinical commissioning group (CCG).
South Yorkshire and Bassetlaw Integrated Care System	57.5	for primary care investment.	Backlog maintenance not applicable as it is an integrated care system.
NHS South Norfolk Clinical Commissioning Group	25.2	to develop and improve primary care services in South Norfolk.	Backlog maintenance not applicable as it is a CCG.
NHS Wirral Clinical Commissioning Group	18.0	to improve patient flow in Wirral by improving access via the Urgent Treatment Centre.	Backlog maintenance not applicable as it is a CCG.

**Notes**

- 1 NHS organisations have been ranked according to their total estimate of cost to eradicate backlog maintenance in 2018-19, where 1 = the highest estimate of backlog and 227 = lowest estimate of backlog.
- 2 Backlog maintenance costs may be addressed through a combination of capital and revenue funding.

Source: Funding announcement is from Government Press Release, *PM announces extra £1.8 billion for NHS frontline services*, August 2019, [www.gov.uk/government/news/pm-announces-extra-18-billion-for-nhs-frontline-services](http://www.gov.uk/government/news/pm-announces-extra-18-billion-for-nhs-frontline-services). Ranking is from National Audit Office analysis of NHS Digital's Estates Return Information Collection 2019

**Figure 16**

Six NHS providers are to develop schemes under the *Health Infrastructure Plan* (HIP1, 2020–2025), with £2.7 billion of funding, announced in September 2019

The projects are ranked according to their total estimate of cost to eradicate backlog maintenance in 2018-19

NHS provider	Proposed sites	NHS trust rank for total backlog maintenance in 2018-19 (227 = lowest, 1 = highest)
Barts Health NHS Trust	Whipps Cross University Hospital	3
Leeds Teaching Hospitals NHS Trust	Leeds General Infirmary	10
Epsom and St Helier University Hospitals NHS Trust	Epsom, St Helier and Sutton Hospitals	15
University Hospitals of Leicester NHS Trust	Leicester General, Leicester Royal, Glenfield	17
West Hertfordshire Hospitals NHS Trust	Watford General	27
The Princess Alexandra Hospital NHS Trust	Princess Alexandra Hospital	38

**Notes**

- 1 NHS organisations have been ranked according to their total estimate of cost to eradicate backlog maintenance in 2018-19, where 1 = the highest estimate of backlog and 227 = lowest estimate of backlog.
- 2 Backlog maintenance costs may be addressed through a combination of capital and revenue funding.

Source: Provider and site information is from Department of Health & Social Care's *Health Infrastructure Plan 2019*, and ranking is from National Audit Office analysis of NHS Digital's Estates Return Information Collection 2019



**Figure 17**

21 NHS providers are being given seed funding of £100 million to develop their plans under the *Health Infrastructure Plan (HIP2, 2025–2030)*, announced in September 2019

The projects are ranked according to their total estimate of cost to eradicate backlog maintenance in 2018-19

NHS provider	Proposed sites	NHS trust rank for total backlog maintenance in 2018-19 (227 = lowest, 1 = highest)
Imperial College Healthcare NHS Trust	Charing Cross, St Mary's and Hammersmith hospitals	1
Nottingham University Hospitals NHS Trust	Queen's Medical Centre, Nottingham City Hospital	6
Pennine Acute Hospitals NHS Trust	North Manchester General Hospital	8
Hillingdon Hospitals NHS Foundation Trust	The Hillingdon Hospital	11
Cambridge University Hospitals NHS Foundation Trust	Addenbrookes	12
East Sussex Healthcare NHS Trust	Conquest, Eastbourne District Hospitals	14
Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital, Basingstoke and North Hampshire Hospital	22
University Hospitals of Morecambe Bay NHS Foundation Trust	Royal Lancaster Infirmary and Furness General Hospital	26
Royal Berkshire NHS Foundation Trust	Royal Berkshire Hospital	35
Royal United Bath NHS Foundation Trust	Royal United Bath Hospital	41
Plymouth Hospitals NHS Trust	Derriford Hospital	44
Kettering General Hospital NHS Foundation Trust	Kettering General Hospital	46
Lancashire Teaching Hospitals NHS Foundation Trust	Royal Preston Hospital	53
Torbay and South Devon Health Care NHS Foundation Trust	Torbay District General	56
Royal Cornwall NHS Foundation Trust	Royal Cornwall Hospital	59

**Figure 17** *continued*

21 NHS providers are being given seed funding of £100 million to develop their plans under the *Health Infrastructure Plan* (HIP2, 2025–2030), announced in September 2019

NHS provider	Proposed sites	NHS trust rank for total backlog maintenance in 2018-19 (227 = lowest, 1 = highest)
Taunton and Somerset NHS Foundation Trust	Musgrove Park Hospital	62
West Suffolk NHS Foundation Trust	West Suffolk Hospital	69
James Paget University Hospitals NHS Foundation Trust	James Paget Hospital	93
Dorset Healthcare NHS Foundation Trust	Various (potentially 12) community hospitals	106
North Devon Healthcare NHS Trust	North Devon District Hospital	115
Milton Keynes NHS Foundation Trust	Milton Keynes Hospital	137

**Notes**

- 1 NHS organisations have been ranked according to their total estimate of cost to eradicate backlog maintenance in 2018-19, where 1 = the highest estimate of backlog and 227 = lowest estimate of backlog.
- 2 Backlog maintenance costs may be addressed through a combination of capital and revenue funding.

Source: Provider and site information is from Department of Health & Social Care's, *Health Infrastructure Plan 2019* and ranking is from National Audit Office analysis of NHS Digital's Estates Return Information Collection 2019

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