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2024 Autumn Budget: A Call to Action for Health Services – What's Next?

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Of the big Budget bet made by the government, one-third (c.£26bn) has been staked in turning around the NHS. While welcome, there is now a weight of expectation for the NHS to deliver. And if the NHS cannot deliver by March 2026, there is a risk that its next settlement might not be so generous.

The Budget provides certainty until March 2026, and compared to the previous Government's Spring Budget, it includes £20 billion in additional revenue spending and £1bn in additional capital investment this year and next. This includes delivering Labour's manifesto commitments to £1.5bn for elective and diagnostic capacity and £2 billion for digital productivity.

The expected return on this investment is high. The government expects 2% productivity improvements (equivalent to c.£3.8bn a year), over 40,000 more elective appointments, 1.2 million diagnostic tests, and the start of a return to constitutional standards, including waiting time targets, all from next year. The Secretary of State wants big shifts in care from analogue to digital, hospitals to communities, and sickness to prevention.

But, over 95% of this money is revenue – creating a risk that the historical pattern of high spending and low investment will be maintained. While there is more money, much of it risks finding its way to the same places.

Before the Budget, the NHS revenue budget for 2024/25 had already been revised to £179bn, which increased to £181bn in the Budget. Pay settlements, agreed earlier in the year, and national insurance changes, announced in the Budget, will likely add a further c. £4.5 billion to revenue costs this year. And this relies on delivering £9.3bn of efficiencies this year (6.9%), of which only £2bn (21%) had been delivered by August 2024.

Next year looks likely to bring similar pressures. Even if cost pressures are held to c.3.1% (the OBR's projection of long-run pressures), the sector will face c.£5.6bn additional costs in 2025/26.

Take all this together, and the generous settlement appears to have been largely committed.

This means productivity is critical. Without improvement, we are on course to spend one-fifth of GDP on healthcare in the longer term. Avoiding this will need a step change in technology and facilities to help a limited workforce treat more people, more quickly.

At the same time, we have a capital crisis. Crumbling concrete (RAAC) continues to put buildings at risk and backlog maintenance increased by £2.2 billion last year compared with £13.8 billion in 2023/24. Whilst c. £2 billion is budgeted for remedial work, this is less than the c. £3-4 billion needed each year to clear the backlog this Parliament, and it does not fully address RAAC issues. Meanwhile, capital underspends in 2023/24 and 2024/25 (totalling £1.3 billion) continue the long habit of the Department of Health converting its capital to revenue.

So what to do?

First, deliver financial performance. Cost improvement programmes need to accelerate in the next four months to achieve the remainder of this year's efficiencies and contain further cost increases next year. This requires both short-term financial grip and control and medium-term

transformation and recovery initiatives, such as workforce redesign.

This needs to be combined with reform to the NHS's capital delivery capabilities so that investments deliver value for patients. This needs to go beyond the New Hospital Programme (about which the Budget was largely silent) to deploy world-class infrastructure on all major capital projects, enhancing local Trust and ICS teams.

Funding and investment need to focus on productivity. Digital is central to this, and the £2 billion investment committed in Labour's manifesto is welcome. However, the expectation should be that capital investment and digital spending should increase as a percentage of spending year-on-year. And systems should be able to convert revenue budgets to capital to support productivity-enhancing investments.

The shift towards community settings is likely to be focused on elective and diagnostic volume. Investment can deliver significant capacity, but local plans will need to be agreed upon in the next six months to make a difference by March 2026. And to realise the full benefits, systems should direct at least 10-20% of any infrastructure investment to digitising new facilities.

A broader challenge lies in changing the trajectory of acute spending as a proportion of overall NHS spending. This can be addressed in two ways: embedding the shift in budgets over a rolling three-year period and changing payment mechanisms to bias towards community and primary care on a volume basis.

There appears to be no significant additional funding to support the shift from sickness to prevention, which is a missed opportunity. However, there is an opportunity for ICSs to start to direct resources to high-impact interventions to increase healthy life expectancy, with the Better Care Fund, which will spend c. £8.7 billion in 2024/25, brought in scope for this. The priority should be interventions offering above-average return on investment within 12-18 months. To create additional incentives, ICSs should be allowed to retain any consequent surpluses to reinvest.

Finally, the transformation will result in stranded costs and fragile services as treatment is provided in different ways. So the NHS should start planning a big national debate in 2026 about how services are organised and delivered to prepare the ground for strategic reconfiguration and service changes.

With focus, the NHS can start to bring about the improvements the government wants to see over the coming 18 months. This can create a platform for more ambitious reforms in 2026–2029 to truly transform patient services.

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