Shared vision.
Better together

NHS
Shared Business Services

Futureproofing the NHS

The case for transforming corporate services for innovation and productivity
- an evidence-based analysis

Contents

Acknowledgements

The contents of this paper were partially drawn from a series of online round tables held publicly in 2025 and early 2026.

Our thanks go to the participants in these round tables and others who have generously shared their insights and expertise: **Jake Arnold-Forster**, Chief Executive, Carradale Futures; **Erika Bannerman**, Managing Director, NHS Shared Business Services; **Heather Barton-Jones,** Area VP, Strategic Transformation Office, UiPath; **Alex Curling,** Head of PR, NHS Shared Business Services; **Laura Devine,** Senior Delivery Lead for the New Hospital Programme at NHS Shared Business Services, **Alice Donovan-Hart**, Director of Consulting, NHS Shared Business Services; **David Furness**, Managing Director, Shelford Group; **Pam Garside**, Co-Chair, Cambridge Health Network; **Paddy Howlin**, Procurement Solutions Director, NHS Shared Business Services; **Mark Jennings**, Chief Solutions and Services Officer, Strasys; **Justin Jewitt**, Non-executive Director, NHS SBS; **Pritesh Mistry**, Digital Technologies Fellow, The King's Fund; **Danny Mortimer**, (at time of writing) Chief Executive, NHS Employers; **Raine Pell**, Director of Marketing and Communications, NHS Shared Business Services; **Cassie Smith**, Director of Legal, Trust and Ethics, Health Data Research UK; **Richard Stubbs**, Chief Executive, Health Innovation Yorkshire & Humber; **Stephen Sutcliffe**, Director of Finance and Accounting, NHS SBS; **Robert Walker**, Head of Health & Social Care, techUK; **Fiz Yazdi**, Managing Director, Sopra Steria Next.

The opinions in this paper are informed by the amalgamated views of these experts and are not necessarily representative of the views of each individual.

Foreword

The NHS has an extraordinary capacity for innovation. This is something that has been consistently evidenced throughout our 78-year history. It shows up in the quality of thinking, the genuine will to do things differently, and the sheer dedication of the people working within the health service. Innovation is a team sport, and in my opinion, as CEO of Health Innovation Yorkshire & Humber for the past ten years working with the NHS, industry, academia and local government, that collaborative instinct has never been stronger.

Our challenge is not invention; it is enabling and supporting these great innovations to be spread and adopted in every corner of the NHS, so that they truly benefit all our patients and all our staff. It is often said that the NHS has more pilots than British Airways. We are extraordinarily good at discovering and testing ideas, but we struggle to implement them at scale. The reasons are complex, but they rarely come from a shortage of ideas or ambition. The conditions in which people work shape what is possible just as much as the ideas they bring. When data cannot flow where it needs to, when staff spend time working around processes rather than delivering care, the space for genuine transformation shrinks, regardless of how good the ideas are.

You cannot compensate for that by simply adding technology on top. The lesson I keep returning to from years of working on this is that **you cannot digitise your way to a better health service; you have to start from what good actually looks like and build towards it.** Transformation is about redesigning the whole system, not layering solutions onto the one that already exists.

What is striking, and what this paper captures well, is where some of the most significant gains are being made. These are not always in clinical care, where the complexity and risk are greatest and the change is hardest to embed, but in the operational layer: tackling inefficiency, improving the patient experience, and providing the workforce with systems that function well and make their lives easier.

The 10 Year Health Plan sets out an ambitious vision. We need to ensure the right conditions are created to enable us to deliver that ambition. **Shared data, aligned systems, and operational foundations that connect rather than compete: these are some of the vital building blocks that will allow us to deliver tangible improvements in the nation's health.** Organisational collaborations are key. Sharing services, functions and processes does not mean a loss of local identity or local control; it creates the time and the headroom to prioritise resources to where they can make the biggest difference to patient care.

That is the argument this paper makes, and it is one I find both urgent and convincing.

Richard Stubbs

Chief Executive, Health Innovation Yorkshire & Humber.
Expert Advisor, Health Foundation Productivity Commission.

Executive summary

The NHS in England is being restructured toward local, place-based care, but delivering that ambition will depend on consistent operational foundations across the system. This paper argues that shared operational infrastructure enables local autonomy rather than constraining it.

The 10 Year Health Plan's three shifts - hospital to community, analogue to digital, sickness to prevention - each require care to be coordinated across providers and places.

However, no comprehensive mechanism for aligning the operational layer of the health service has ever existed. NHS restructures have focused primarily on clinical and organisational design, while the compatibility of underlying operational systems (finance, workforce, procurement, and the data that underpins them) has received less systematic attention. The result is an NHS in which local autonomy over clinical provision is often combined with variation in how corporate functions are run. This adds cost, impacts the time frontline staff can spend delivering patient care, and makes transformation harder than it needs to be.

This paper sets out the case for core operational utilities - payroll, finance platforms, procurement frameworks, and corporate data - to be shared across the NHS, and describes the steps required to achieve this.

Section 1 examines why local care depends on shared operational foundations. Since the pandemic, productivity has not kept pace with staffing increases. This gap cannot be solely attributed to insufficient effort by the workforce. Productivity in healthcare depends on many factors, but fragmented operational systems mean that staff often spend time on navigating workarounds rather than delivering care. Shared operational services enable local control by standardising processes, freeing leaders and their teams to focus on clinical priorities. They deliver value for money by reducing costs without compromising quality. Investment alone will not close the gap; new resources layered onto inefficient structures produce diminishing returns.

Section 2 explains why fragmentation persists despite its known negative effects, such as sunk costs and institutionalised (and often setting-specific) expertise. Operational infrastructure remains weakly coordinated, and the high cost of changing systems makes fragmentation progressively harder to unwind.

Section 3 sets out the principle that should guide reform: freedom within a framework. This separates what must remain local from what would benefit from being shared. Core operational platforms, common data standards, and repeatable transactional processes are well suited to shared solutions. Operational decision-making and community partnerships should remain local. The NHS has the scale and buying power to build a shared operational infrastructure if it chooses to do so.

Section 4 shows how reducing the operational burden impacts staff and patients. The clearest sign that internal systems and services are working is that people stop noticing them. Routine tasks fade into the background and attention shifts to care.

They can be completed faster, reducing time spent on administration and freeing staff to focus on patients. However, since technology only enables improvement when the underlying processes are sound, design must come first. Trust in systems is built through repeated, reliable experience; when staff see improvements delivered as promised, they extend their confidence to the next change.

Section 5 makes the case for operational data as shared infrastructure. Workforce, finance and procurement data can reveal system pressures before they appear in clinical metrics, but only if it flows across organisational boundaries with consistent standards in place.

Section 6 describes the delivery model required to build shared operational foundations at scale. This means a shift from organisation-by-organisation transactional processing to shared operational platforms that underpin the system, which requires sustained investment, credibility and governance structures to enable collaboration. Wider adoption of shared operational platforms has the potential to generate significant system-level value over time. Realising those gains would depend on sustained collaboration, disciplined implementation, and consistent adoption across participating organisations.

Where shared operational infrastructure has been extended deliberately, evidence shows reductions in cost and administrative burdens have improved productivity and given leaders greater capacity to focus on care.

This paper concludes with seven recommendations for policymakers and health service leaders, each of which is explored more fully in **Section 7**:

1. Focus leadership attention on operational foundations as a source of efficiency and capacity for patient care.
2. Create the conditions for long-term investment in operational infrastructure and treat it as a system asset, with sustained capital, multi-year horizons, and fair cost-sharing across organisations.
3. Invest in understanding problems and designing workflows, not solely in technology.
4. Deliberately extend proven shared platforms rather than solving common problems separately.
5. Use shared services to drive innovation, not just efficiency.
6. Use operational data to spot system pressures early.
7. Design governance that makes collaboration easy.

Key facts

£1.85bn
or 40% rise in corporate costs since 2018/19

£37bn
capital investment shortfall (Darzi)

£11.6bn
backlog maintenance

£1.7bn
savings already delivered through centralised procurement

13,740
patients medically fit for discharge daily, February 2025

Introduction

This paper is about the operational foundations of the health service – the finance, workforce and procurement systems, processes, and related corporate data – that sit alongside clinical care and enable it to function. These systems are rarely discussed in policy debates about the future of health and social care. They should be.

The NHS is entering a period of significant structural change. The government's impact statement for its 10 Year Health Plan for England confirms its ambition to devolve power, 'putting decision-making closer to patients and local communities, where their needs are best understood'. Structural reforms will give providers greater freedom to innovate, with local clinical leadership at the heart of a new three-tier NHS operating model.[1]

Achieving that ambition depends on something that has never been systematically addressed: a fully coordinated, modern, shared operational infrastructure. For clinical decisions to be genuinely local, they must be supported by a consistent operational layer that works seamlessly across organisational boundaries. Without this, devolution risks compounding the variation in operational systems that eats away at the NHS budget and takes frontline staff away from delivering patient care.

In the following sections, we examine the consequences of fragmentation in today's NHS, why it has persisted (despite widespread awareness), what it costs, and how proven models for shared operational foundations can be extended.

The **Secretary of State for Health and Social Care,** recently remarked, ***"Investment is important, but so is modernisation."***[2] This paper sets out how a new delivery model for corporate services goes hand-in-hand with changes to clinical care, for achieving the NHS's 10 year ambition.

> *"Investment is important, but so is modernisation."*
>
> **– Secretary of State for Health and Social Care**

1 Department for Health and Social Care, Impact statement: the 10 Year Health Plan for England, January 2026

2 BBC Radio Four, Today Programme, January 2026 [link expired]

Section 1

Why local care needs shared operational foundations

The government's 10 Year Health Plan for England[3] sets out a fundamental reorientation of health and social care, built around three shifts – from hospital to community, analogue to digital, and sickness to prevention. The goals are clear: care closer to home, built around people rather than institutions, delivered across traditional organisational boundaries, and supported by modern digital infrastructure. Each of these shifts increases dependence on operational foundations that work consistently across the system.

The structural machinery to deliver this is already in motion. NHS England (created less than 15 years ago) is to merge with the Department of Health and Social Care (DHSC), with the central headcount expected to reduce significantly. This reflects a move toward a leaner centre with greater responsibility devolved to systems and places.

The current 42 integrated care boards (ICBs) in England will be consolidated into clusters or merged entities. In total, there will be 'six new ICBs established across England through the abolition of 12 existing ICBs'[4]. Commissioning Support Units (CSUs) will close, and new integrated health organisations (IHOs) will hold whole-population budgets.[5]

The scale of the NHS's operational challenge is clear. Corporate costs have risen by £1.85bn.

Together, these changes are intended to reduce duplication and support strategic commissioning with greater local accountability.

This shift toward local, place-based services can seem paradoxical. The more distributed the system becomes, the more it depends on a consistent operational infrastructure to function. For example, where integrated care systems (ICSs) commission services across a geography, they need common procurement approaches to avoid duplication. The rewards for getting this right can be significant. In one case, where buying Negative Pressure Wound Therapy (NPWT) products was standardised across an ICS, it saved hundreds of thousands of pounds and improved training and service quality.[6]

Local leaders seeking to redesign pathways need clear and reliable spend and workforce data information so they can plan capacity and see where fragmented procurement and contracting has created inconsistency. Otherwise, the ambition for local care risks being undermined by the friction of incompatible systems and opaque spending patterns that make coordination and value for money harder to achieve.

The productivity gap

The scale of the NHS's operational challenge is clear. **Corporate costs have risen by £1.85bn (40% excluding pay and pensions) since 2018/19[7], yet productivity remains below pre-pandemic levels.** Between January and July 2024, the NHS employed significantly more staff than in 2019, yet delivered only modest increases in elective admissions (+9.1%) and outpatient appointments (+12.1%), highlighting the pressure to achieve more with constrained resources.[8]

This disparity should not be interpreted as a failure of staff effort. Productivity in healthcare is influenced by a complex set of factors, including case mix, patient acuity, policy constraints, funding flows and, critically, the system's capacity to absorb investment and translate it into sustained operational improvement.

3 HM Government, 10 Year Health Plan for England: fit for the future, July 2025

4 NHS England, Integrated care, 2025

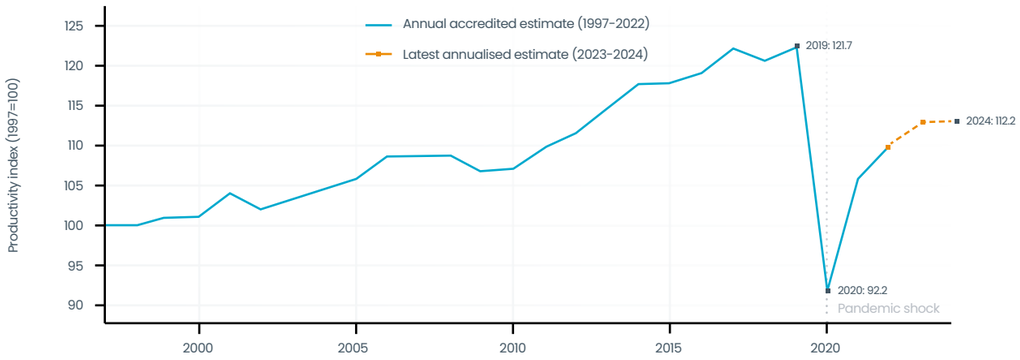
5 HM Government, 10 Year Health Plan for England: fit for the future, July 2025

6 Example cited in an interview with NHS SBS procurement team representative, January 2026

7 Healthcare Financial Management Association (HFMA), Working together in 2025/26 to lay the foundations of reform, April 2025

8 House of Commons Library, NHS productivity - Research Briefing CBP-10313, July 2025

NHS productivity over time (ONS public-service healthcare productivity proxy)



Source: ONS UK public-service healthcare productivity. 1997-2022 are annual accredited official statistics; 2023-2024 are annualised estimates from the ONS quarterly bulletin and are official statistics in development.

Recent policy commitments signal strong intent to address this challenge with technology. The 2025 Spending Review announced up to £10 billion in funding for NHS digital and technology transformation by 2028/29, a significant increase compared with recent years.[9] However, evidence suggests that one-off investment alone is insufficient. **Health Foundation analysis highlights that digitising healthcare at scale requires not only capital funding, but sustained revenue investment and the organisational capacity to implement and embed change over time.**[10]

Nor does investment in technology alone guarantee productivity gains. The NHS Confederation highlights persistent constraints in digital, data and technology capabilities, including a lower proportion of digital and data professionals relative to other sectors, and unfilled Digital, Data and Technology (DDaT) roles in some areas. These capacity gaps make it harder to deliver and embed change at pace, even where funding is available.[11]

Poorly-designed or fragmented technology can actively undermine productivity. Lord Darzi's independent investigation into the NHS found that staff often experience IT systems as an additional burden, particularly where they are outdated, poorly integrated, or misaligned with clinical and operational workflows. In these circumstances, technology intended to save time can instead introduce additional friction and inefficiency.[12]

Workforce churn further compounds these challenges. A House of Commons Library briefing summarises Institute for Government and Public First research showing that the loss of experienced staff, and declining retention rates, are eroding institutional knowledge across the NHS.[13]

Taken together, these findings point to a direct relationship between operational infrastructure and productivity. Where management capacity is limited, placing responsibility for bespoke or poorly integrated operational systems on already stretched leaders diverts time from service delivery, compounding the productivity gap the system is trying to close.

Where staff retention is a priority, systems that generate daily workarounds and frustration work against it. And where institutional knowledge is being lost through churn, consistent and well-designed operational infrastructure becomes more important, not less, as it reduces the reliance on tacit knowledge held by individuals and strengthens the system's capacity to translate investment into lasting productivity gains.

"If we want people to be energised, to be encouraged and innovative, then you've got to give them a working environment that enables them to do that. Not one where it feels like you're wading through treacle just to get the simple things done."

- David Furness, Managing Director, Shelford Group

The impact of fragmented systems

The consequences of fragmented operational infrastructure are most visible at points where care delivery depends on coordination across teams, organisations and sectors. Where systems and processes do not align, routine operational activity generates friction, including delays, duplication, manual workarounds, and decisions made with only partial information. Over time, this friction constrains system performance and absorbs capacity that could otherwise be directed toward care.

Hospital discharge illustrates this dynamic. According to the Re:State think tank, **in February 2025, on average 13,740 patients were medically fit for discharge but remained in hospital each day, equivalent to nearly 23 hospitals' worth of capacity.** Because discharges were around 40 per cent lower on weekends than weekdays, patient flow typically faced a Monday morning surge.[14]

The clinical and social care drivers of delayed discharge are well documented. However, operational infrastructure also plays a part in shaping how efficiently systems respond when patients are ready to move on. Fragmented workforce data can make it difficult to understand staff availability across providers and plan discharge activity accordingly.

Differences in financial systems between health and social care can slow agreement on the responsibility for funding care packages. Incompatible contracting and administrative processes mean that even where community capacity exists, arranging it can take longer than necessary. These factors introduce avoidable friction at a critical transition point in care.

The same variation in operational systems affects decision-making outside hospital walls. When finance, workforce and outcomes data cannot be consistently accessed or analysed across providers, commissioners and system leaders must rely on partial, lagging or proxy information. This limits their ability to assess the true cost and impact of care delivered outside hospital settings, or to confidently shift resources upstream. As a result, existing patterns of provision are reinforced, not because they are optimal, but because the operational infrastructure does not support timely, system-wide insight.

These infrastructure constraints also have a cumulative human cost. In an August 2025 webinar on the resilience of corporate functions, David Furness, Managing Director of the Shelford Group, described the day-to-day experience of staff working within fragmented systems:

"I suspect the experience of everybody across the NHS is of multiple frictions in your daily life that take up your bandwidth and are slightly frustrating because they take a bit of time to overcome. They feel like small things, but they're not, because if we want people to be energised, to be encouraged and innovative, then you've got to give them a working environment that enables them to do that. Not one where it feels like you're wading through treacle just to get the simple things done." [15]

9 HM Government, Spending Review 2025, NHS section, June 2025

10 Health Foundation, Digitising the NHS and adult social care: what could it cost?, May 2025; England extrapolation: NHS Confederation, Digital transformation in the NHS: a reference guide, December 2025

11 NHS Confederation, Digital transformation in the NHS: a reference guide, December 2025

12 Lord Darzi, Independent Investigation of the National Health Service in England, September 2024

13 Institute for Government and Public First, The NHS productivity puzzle, June 2023 (cited in HoC Library CBP-10313)

14 Re:State, Hospital of the Future: Ending the Patient Gridlock, October 2025

15 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

When operational systems require constant and complex navigation and workarounds, they erode energy and make already demanding roles harder.

Taken together, this evidence suggests that fragmentation in operational infrastructure is not a peripheral issue, but a structural constraint on performance. It slows coordination, weakens decision-making, and increases the cognitive and administrative burden on staff. Discharge delays represent just one visible outcome of many.

Shared foundations enable local control

Local leaders are closest to their communities and best placed to understand what they need. They are also closest to their staff, and any shift to shared infrastructure or services must address legitimate workforce concerns. People sometimes worry what standardisation means for their roles, their teams, and their professional autonomy. Shared foundations succeed when they use this local knowledge to demonstrably improve working conditions, not when they are imposed without sufficient regard for the people affected.

They also deliver value for money. Aggregating demand across organisations creates purchasing power that no single trust can achieve alone, reducing costs while maintaining or improving quality. The 2016 Carter Report found wide variation in how much trusts pay for identical products and identified aggregated purchasing power as a key route to efficiency.[16] **NHS Supply Chain has since reported savings of more than £1.7 billion through centralised procurement of medical equipment and consumables.**[17]

For example, when five NHS trusts in Norfolk and Waveney moved to a unified procurement and finance platform, local control teams gained time and headroom to focus on service improvement rather than duplicating basic transactional processes that added no value to patients. Requisition-to-order processing fell from two days to ten minutes. Automatic purchase order generation reached 94%.[18]

16 Carter of Coles, Lord P., Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (commissioned by the Department of Health), 2016

17 National Audit Office, NHS Supply Chain and efficiencies in procurement, January 2024

18 Health Service Journal, Shared procurement system cuts purchase order time by 99 per cent, June 2025

Investment alone will not close the gap

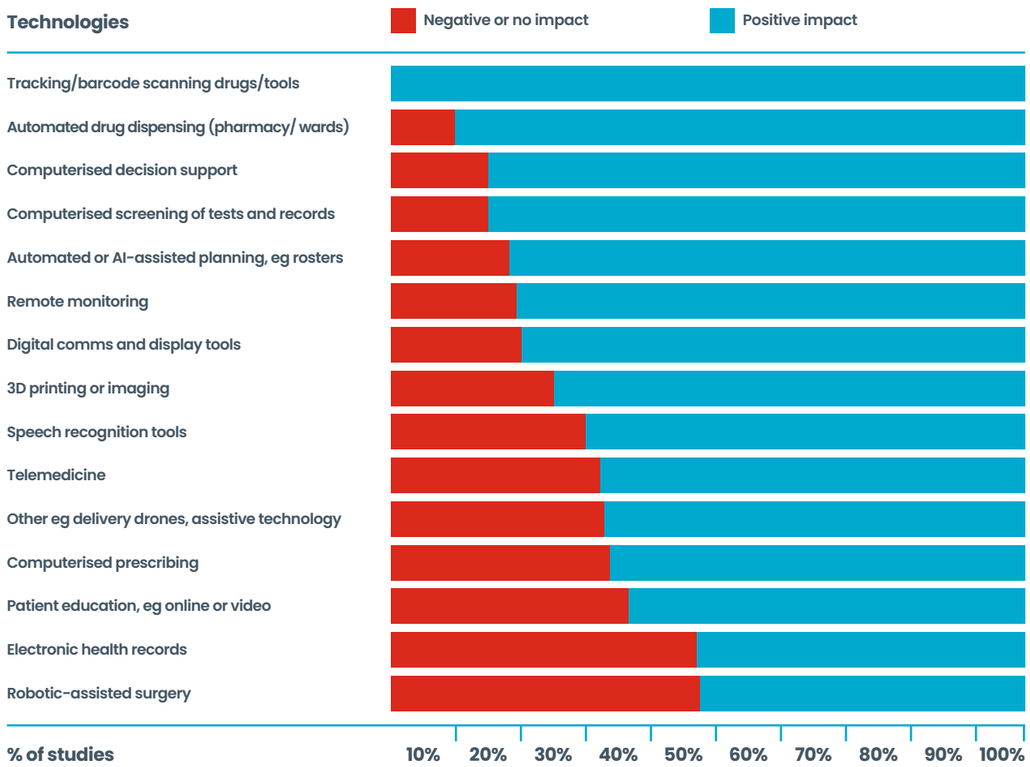
Norfolk and Waveney's shared finance and procurement contract worked not just because they'd invested in it, but because five trusts genuinely collaborated. They committed to collaborative procurement, workflow redesign, training, and sustained change management. The technology mattered, but the partnership made it effective.

The Health Foundation's February 2025 analysis of 467 studies on health technology implementation found the same pattern at scale. Successful outcomes depended less on the technology itself than on how it was embedded into practice. Regarding workflow redesign, staff engagement, training, and ongoing support, the foundation concluded that policymakers and system leaders must "fund the change, not just the tech".[19]

19 Health Foundation, Tech to save time: how the NHS can realise the benefits, February 2025

Most technologies reviewed showed a mixed impact on staff time

The proportion of studies, by technology category, that found a positive impact on staff time vs no or negative impact.



Source: Health Foundation analysis of 467 studies on technology and staff time, February 2025.

NHS operational leaders suggest the challenge of building systems with both the workforce and workflow in mind often begins with procurement. Rather than a transactional function that starts at the point of purchase, procurement is better characterised as 'a change programme with a contract attached'. Procurement teams that are embedded early, understand the service a provider is trying to design, and work with them to set priorities, achieve better outcomes than those brought in later on when the scope is already fixed. As Alice Donovan-Hart of NHS SBS has observed, procurement teams **"tend not to be embedded early enough in strategic priority setting…they end up coming in too late and getting caught in [the] rules-based bit".**[20]

This is not a counsel of despair; it clarifies where effort needs to go. Simply digitising an analogue process is rarely enough.

Successful implementation requires a deep and detailed understanding of the workflow and the integration of automations in a way that improves delivery and reduces friction. For example, at Lewisham and Greenwich NHS Trust, automation designed around a specific manual pharmacy invoice workflow reduced task time from around an hour to just a few minutes, freeing staff from repetitive work and enabling them to focus on higher-value tasks.[21]

20 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

21. NHS Shared Business Services, New pharmacy robot "Steve" frees up resource

The same principle applies to the staff who will use new systems. A House of Commons inquiry into NHS digital transformation found that without wider staff engagement, digital initiatives risk being ***"perceived as an unwelcome, time-consuming imposition on an already over-stretched workforce"***.

With any change, it is essential to involve staff - not just clinicians, but administrative and operational teams - to ensure that systems address real problems rather than create new ones.[22]

When new systems are layered onto existing ones over time, rather than replacing or integrating them coherently, infrastructure becomes operationally fragile and increasingly difficult to change. Workarounds can then consume time that was supposed to be saved.

Danny Mortimer, Chief Executive of NHS Employers, says: ***"Some of our systems are really old and can't support the kind of experience that [staff need]. Secondly, people have tried to find workarounds... their solution to the fact we have a very old core system is to buy lots of other bolt-ons, which isn't ideal."*** [23]

But this is not inevitable. The evidence suggests that technology can deliver when it is implemented well.

Success depends not just on effective, user-friendly tools, but also on organisations' willingness and capacity to embed the operational changes required to support the technological changes. That often depends on operational foundations that work consistently across the system. The question is whether the NHS is ready to implement those foundations at scale, and whether investment can be organised to enable proper implementation, or if it stops at procurement.

The NHS has increased staffing substantially since 2019, yet productivity has not kept pace. This reflects what happens when additional resources flow into fragmented structures. Complexity grows, workarounds multiply, and the returns on each pound invested reduce. Without changing the system's operational foundations, future investment risks perpetuating this pattern, adding cost and pressure on local leaders while delivering limited improvement in access or outcomes.

The path to sustainable improvement runs through shared operational foundations. The next section examines why these foundations have remained fragmented despite the known consequences, and why local reform efforts repeatedly encounter the same structural barriers.

"Some of our systems are really old and can't support the kind of experience that [staff need]. Secondly, people have tried to find workarounds... their solution to the fact we have a very old core system is to buy lots of other bolt-ons, which isn't ideal."

- Danny Mortimer, Chief Executive of NHS Employers

22 House of Commons, Health and Social Care Committee, Digital Transformation in the NHS, June 2023

23 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

Section 1 - Why local care needs shared operational foundations - Key takeaways

- The 10 Year Health Plan for England's three shifts - hospital to community, analogue to digital, sickness to prevention - all depend on shared operational infrastructure. None can be delivered by individual organisations working alone.
- Major structural reform is underway. The NHS England-DHSC merger, ICB consolidation, and new IHOs, will redistribute accountability, but local leaders will still need common operational foundations to deliver.
- Productivity has not kept pace with staffing increases. Operational friction, fragmented systems and insufficient management capacity could explain the gap.
- Shared foundations enable local control by standardising operational processes, freeing local leaders to focus on clinical priorities.
- Shared services deliver value for money. Aggregating demand creates purchasing power that individual organisations cannot achieve alone, reducing costs while maintaining quality.
- Procurement teams need to be brought in early, so they can be involved in designing purchases that meet the needs of staff, and 'real life' workflows (rather than a disconnected set of IT specifications).
- Investment alone will not close the gap. New resources flowing into fragmented structures will produce diminishing returns without the operational foundations to absorb them.

Section 2

Why fragmentation persists

The consequences of operational fragmentation, set out in Section 1, are well understood. The question is why variations in operational systems persist despite repeated reform, widespread recognition of its costs, and sustained efforts to encourage collaboration. The answer lies not in a lack of intent or leadership, but in a set of structural dynamics that repeatedly reproduce fragmentation over time, even when organisations are motivated to work together.

Reorganisation without a coordinating operational layer

Since 1974, the NHS has undergone almost constant organisational reconfiguration. Each reform has reset organisational boundaries, leadership teams, governance, and accountability arrangements.

Yet successive changes have not established a single, empowered coordinating mechanism for the operational infrastructure that underpins clinical delivery.

Responsibility for operational infrastructure has historically been distributed across organisations, with coordination relying more on guidance and voluntary collaboration than on a single end-to-end mandate.

Reorganisation did not create these variations in operational systems, but by repeatedly resetting accountability without addressing the operational layer, it allowed different parts of the system to drift further apart, making it harder and more costly to bring them into alignment over time. Each cycle increased the number of systems in play, extended the lifespan of local technology choices, and made subsequent coordination more complex and expensive.

Misaligned financial incentives

Fragmentation also persists because, under current financial and accountability arrangements, collaboration is often a rationally difficult choice for individual organisations. Budgets, financial risk, and performance accountability sit locally, whereas the benefits of shared approaches are often distributed across systems, or realised over longer time horizons.

The costs of collaboration, including change effort, system transition and temporary disruption, are immediate and visible to individual organisations. The benefits, including efficiency gains, reduced duplication or improved resilience, may accrue elsewhere or later. In this context, fragmentation is not the result of resistance to collaboration, but the product of incentives that reward local optimisation over shared solutions.

The problem is not simply that collaboration goes unrewarded; current structures actually (if unintentionally) incentivise variations in operational systems. Every trust is assessed on its own performance, creating an operating environment in which organisations are effectively pitted against each other. Leadership decisions are shaped by local pressures and, at times, by institutional pride and a reluctance to adopt approaches perceived as 'not invented here'. These dynamics are cultural as much as structural, and they compound the financial barriers to working together.

Richard Stubbs, Chief Executive of Health Innovation Yorkshire & Humber and expert advisor to the Health Foundation's Productivity Commission, frames the challenge as a question of loyalty. The shift required is akin to 'club versus country', he says, asking people to move from long-standing allegiance to individual organisations toward a more collective sense of purpose. When leaders are *"pulling up the drawbridge, protecting what they've got, whether it's their own job, their own resources, sometimes their own power and control"*, he observes, *"you can talk the talk, but you're not really going to walk the walk".*[24]

24 NHS SBS, Webinar: The NHS of tomorrow - embedding shared services for lasting transformation, January 2026

These dynamics play out against a backdrop of chronic underinvestment. The 10 Year Health Plan impact statement notes that the UK spends less than many OECD countries on capital investment in healthcare; Lord Darzi's independent investigation estimates a historic shortfall of £37 billion between 2011 and 2020. Backlog maintenance stood at £11.6 billion in 2024, and money earmarked for capital spending was repeatedly diverted to cover day-to-day costs.[25]

Organisations often prioritise shorter-term decisions about immediate service pressures over longer-term ones that require upfront commitment for downstream returns.

Governance

Governance[26] arrangements can work against collaboration, even where there is positive intent. Laura Devine, Senior Delivery Lead for the New Hospital Programme at NHS SBS, describes a common pattern: organisations want to partner, but have not established joint governance structures, so often find their priorities 'different facing'.

Where each board or committee is accountable to its own organisation rather than to the group, collaboration stalls.

Those in governance roles become cautious if they lack the knowledge or confidence to act.

Paradoxically, rushing to collaborate by launching too many initiatives at once can create confusion rather than momentum, particularly where governance has not been designed to coordinate effort. What works, Devine argues, is formalised but genuinely collaborative governance, with representation from all organisations, clear decision-making frameworks, defined accountability, and agreed shared objectives. These steps sound obvious but are often skipped, and act against collaborative efforts.[27]

A recent National Audit Office (NAO) report on government shared services substatiates the point, noting that even with committed, multi-billion pound investments, and formal departmental obligations, delivery cannot be secured without clear governance in place.[28]

Incompatible data and limited system-wide visibility

How operational data is produced and used further reinforces fragmentation. Data on workforce, finance and procurement is primarily generated to meet reporting and compliance requirements, but often uses differing standards, definitions and systems. This limits the ability to compare performance, identify effective practices, or build a shared evidence base for change across organisational boundaries.

Where data cannot be accessed or compared easily, fragmentation becomes self-reinforcing. Operational practices that reduce friction or duplication tend to remain local rather than spreading across the system.

Differences between organisations are harder to interpret, making it difficult to distinguish between variations that reflect genuine local need and ones that arise from fragmented systems. Without that clarity, the case for alignment or shared approaches is harder to make and harder to sustain over time. These effects, and the opportunities that can be unlocked through better stewardship of operational data, are considered in greater detail in Section 5.

Technology debt and constrained digital change

Digital investment patterns also compound variation in operational systems. Over time, organisations have invested in systems independently, embedding local processes and assumptions into technical infrastructure.

As systems age and integrations accumulate, switching costs rise, making shared approaches progressively harder and more expensive to adopt, even when better options exist.

The Innovation Ecosystem Programme found that NHS staff felt it "took too long or was too difficult to try something new in a way that worked for them."[29] Technology debt is therefore not simply a technical issue but a structural factor that constrains collaboration, as each investment cycle raises the cost of subsequent alignment.

Complex procurement and contracting

Procurement and contracting arrangements illustrate how variations in operational systems can become embedded in practice. Across a single integrated care system, the same category of goods or services may be sourced in dozens of different ways, each reflecting local specifications, approval processes and supplier relationships. This variation rarely reflects genuine clinical need; more often, it reflects the absence of any coordinating mechanism.

Several factors contribute to this pattern. Procurement cycles, contract lengths and compliance requirements are typically managed locally, reflecting local accountability and risk-management priorities. As previously discussed, governance arrangements differ between organisations. Schemes of delegation, standing financial instructions, and approval thresholds often vary, making joint procurement slower and legally harder to establish, even where collaboration is lawful and encouraged.

Price variation table for selected products (2022/23 data)

Product	Lowest price paid (£)	Highest price paid (£)	NHS Supply Chain price (£)
Replacement hip stem part	258	490	258
Portable touchscreen bladder scanner	6,591	12,760	7,005
Insulin delivery devices	196	285	235

Source: National Audit Office, NHS Supply Chain and efficiencies in procurement, January 2024.

£4.5bn

through NHS Supply Chain annually

£3.4bn

spent outside NHS Supply Chain annually

99.5% of trusts use NHS Supply Chain at least sometimes, but still divert £3.4bn each year.

25 Department for Health and Social Care, Impact statement: the 10 Year Health Plan for England, January 2026

26 "Governance" in this context refers to decision-making, funding, procurement and accountability, not board structures

27 NHS SBS, Webinar: The NHS of tomorrow - embedding shared services for lasting transformation, January 2026

28 National Audit Office (NAO), Update on government shared services, March 2026

29 NHS England, The Innovation Ecosystem Programme – how the UK can lead the way globally in health gains and life sciences powered growth, November 2024

Procurement teams are also frequently involved too late in the process. By the time they are engaged, the scope has already been defined and the preferred solution identified. In this context, as discussed in Section 1 above, procurement professionals' expertise in market dynamics, supplier management and commercial design can go largely unused.

These dynamics are compounded by procurement's limited representation at senior levels. In many organisations, procurement reports through finance rather than holding a direct line to the board.

This structural position makes it harder to influence strategic decisions early, and reinforces the perception that procurement is transactional rather than strategic. The result is a profession under pressure, with high attrition and limited capacity to shape the decisions that determine value.

The 10 Year Health Plan impact statement recognises the value of addressing procurement fragmentation, noting that: "From April 2026, several integrated care boards (ICBs) will be trialling new financial flows through a test and learn approach that will enable them to receive some of the resources they will save."[30] Achieving that efficiency dividend will require the kind of coordinated operational infrastructure described in Section 6 of this paper.

30 Ibid

The coordination challenge

Taken together, these factors explain why fragmentation persists despite repeated reform and clear evidence of its costs. What has been missing is a consistent operational layer capable of aligning these elements across organisational boundaries, rather than leaving each organisation to resolve them independently.

International experience underlines the effectiveness of such an approach. **Health systems in Ireland[31], Norway[32] and Denmark[33] have taken different routes to shared operational services, through mandated consolidation, voluntary collaboration, or jointly-owned delivery bodies.**

While none of these models is directly transferable, they demonstrate that fragmentation is not inevitable, and that shared operational infrastructure can coexist with local accountability when governance and incentives are deliberately designed.

31 In Ireland, the health system is pursuing a centrally mandated approach to shared operational services. The Health Service Executive (HSE) is actively implementing national programmes to standardise and consolidate HR, payroll and finance systems on common platforms, with the objective of reducing fragmentation in back-office functions. While delivery remains phased and incomplete, the direction of travel is toward nationally standardised operational foundations alongside continued local accountability for care delivery

32 In Norway, the specialist health service's hospital medicines procurement is conducted through a nationally coordinated framework under the Norwegian Hospital Procurement Trust (Sykehusinnkjøp HF), which was established to provide strategic and operational responsibility for national procurement of pharmaceuticals on behalf of the four Regional Health Authorities. This framework underpins a national approach to tendering and contracting for hospital medicines.

33 In Denmark, the five regional health authorities jointly own and govern Amgros, a centralised procurement agency responsible for procuring nearly all hospital medicines and selected medical devices for public hospitals, creating economies of scale and supporting more consistent access across regions.

What this means for local innovation

The argument here is not against local leadership nor local innovation; rather, for both to succeed, they depend on foundations that fragmented infrastructure cannot provide. When leaders must build or maintain operational foundations before they can focus on service transformation, innovation is constrained by infrastructure rather than enabled by it.

As Heather Barton-Jones, Area VP in UiPath's Strategic Transformation Office, has noted, automation and shared approaches should be understood not as a drain on budgets, but as mechanisms for making resources more usable.[34] Shared operational foundations are therefore not an obstacle to local freedom, but a precondition for it.

An NAO report on government shared services notes that even with committed, multi-billion pound investments, and formal departmental obligations, delivery cannot be secured without clear governance in place.

34 NHS SBS, Webinar: Digital transformation under pressure: Sustaining momentum amidst NHS reorganisation, October 2025

Section 2 – Why fragmentation persists - Key takeaways

- Fragmentation persists not because of poor intent or weak leadership, but because a set of structural dynamics repeatedly reproduces it over time, even when organisations want to collaborate.
- Repeated organisational change has reset accountability without establishing a coordinating operational layer, increasing divergence and raising the cost of alignment with each reform cycle.
- Financial and wider leadership arrangements often make collaboration a rationally difficult choice for individual organisations, as the costs of change are immediate and local while benefits are distributed or delayed.
- Incompatible data standards and limited system-wide visibility reinforce variation in operational systems by preventing learning, comparison and the accumulation of shared evidence for change.
- Digital investment and procurement decisions made organisation-by-organisation embed local processes and assumptions, creating dependencies that constrain subsequent sharing.

Section 3

What ‘good’ looks like – shared foundations with local freedom

The preceding sections examined what fragmentation in corporate services costs the NHS and why it persists. The question now is what to do about it, not through another reorganisation, but through a clearer strategy that distinguishes operational infrastructure (which benefits from being shared) from clinical and strategic decisions (which should remain local).

Freedom within a shared framework

‘Freedom within a framework’ is not a new idea in public services.[35] It aims to make large systems consistent and efficient while ensuring local organisations and professionals exercise judgement in how services are delivered. The approach combines centrally-defined standards and shared infrastructure with local autonomy over decisions that require contextual knowledge.

The principle applies here in a specific and practical sense. The ‘framework’ applies to the operational foundations of the health service; the systems and processes that are fundamentally the same across organisations.

‘Freedom’ applies to care, and professional judgement, where variation is both inevitable and desirable.

Mark Jennings, Chief Solutions and Services Officer at Strasys, has observed that **most organisations are ‘20% special and 80% standard’**[36]. He says: ***“Every silo thinks they’re special; in medicine many are special, but 80% commonality is too easily overlooked for 20% variance and that massively impacts automation and consistency of customer service.”***[37]

There is no reason why specifications for basic infrastructure should differ fundamentally between trusts when the core requirements are the same. Standardising the pattern, as any successful franchise operation demonstrates, enables economies of scale without sacrificing local relevance.

When it comes to collaboration, people must ***“meet in the middle and understand the give and the get”***, says Richard Stubbs, Chief Executive of Health Innovation Yorkshire & Humber.

He describes the underlying proposition as “devolved sovereignty on the basis that you’re going to get more than you have to relinquish”.

When operational foundations are shared, local leaders gain the time, data and headroom to focus on what genuinely requires local judgement.[38]

Functions well suited to shared solutions include core operational platforms such as finance, payroll and procurement systems; common data standards and definitions; repeatable transactional processes; bulk purchasing of commonly used commodities; and system-wide operational reporting.

Functions best kept local include clinical decision-making; service configuration and delivery models shaped by local context; and relationships with community, local government, and voluntary sector partners.

From principle to practice

This way of organising the operational layer has several practical implications.

First, it requires investment in shared platforms designed for interoperability and a better experience from the outset. Bolting systems together after the fact is expensive and fragile. Building for connection creates infrastructure that can evolve as needs change.

35 The phrase ‘freedom within a framework’ has been used in UK public service reform since 2005 to describe an approach combining nationally set standards with local autonomy in delivery (Higher standards, better schools for all: more choice for parents and pupils (DfES White Paper, 2005)). Via DERA - access to paper requires registration. While the terminology is not used directly by the OECD, the underlying governance logic - centrally defined frameworks and shared infrastructure combined with discretion in implementation - is consistent with established OECD public governance principles (OECD, 2020).

36 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

37 Ibid

38 NHS SBS, Webinar: The NHS of tomorrow - embedding shared services for lasting transformation, January 2026

Second, genuine collaboration matters more than mandated compliance - though increasingly, the DHSC expects both. The NHS Oversight Framework requires ICBs to pursue agreed ways of working through joint plans and partnership agreements.[39]

Third, it demands a different approach to data. Operational data - covering workforce, finance and procurement - should function as a shared resource that enables system-wide visibility and decision-making. It should not be a by-product locked inside organisational silos, or conversely an endless pipeline of figures produced to 'feed' a voracious central machine that wants to audit every paperclip and penny. When data works well, leaders can see patterns beyond their own boundaries, act earlier, plan better, and learn from what works elsewhere.

Fourth, it assumes that the NHS's position as a single national system is an advantage, not an obstacle. Few health systems have the scale and coherence to build genuinely shared operational infrastructure. The NHS does. The question is whether it chooses to use that advantage or opts to continue to solve common problems separately, many times over.

The next section examines how improving design in corporate functions through shared services can deliver benefits to staff and patients, and how an extension of the 'freedom within a framework' principle could multiply these benefits across the health service.

"Every silo thinks they're special; in medicine many are special, but 80% commonality is too easily overlooked for 20% variance and that massively impacts automation and consistency of customer service."

- Mark Jennings, Chief Solutions and Services Officer, Strasys

"[People must] meet in the middle and understand the give and the get."

- Richard Stubbs, Chief Executive of Health Innovation Yorkshire & Humber.

39 NHS England, NHS Oversight Framework 2025/26, June 2025

Section 3 - What 'good' looks like - shared foundations with local freedom - Key takeaways

- 'Freedom within a shared framework' means standardising the operational foundations so that decisions about care can remain local - easier to implement, compare, and learn from.
- The boundary matters. Most organisations are 20% special and 80% standard. The special part deserves protection while the standard part benefits from common solutions. Drawing that boundary deliberately is what makes the approach work.
- Core operational platforms, common data standards, and repeatable transactional processes are well suited to shared solutions. Clinical decision-making, service configuration and community partnerships should remain local.
- Shared operational foundations depend on collaboration. Adoption must be the logical choice, based on demonstrated value and genuine involvement in how services evolve.
- The NHS's scale is an advantage. Few health systems have the coherence to build shared operational infrastructure.

Section 4

Reducing operational burden so that local teams can focus on care

The impact of shared operational foundations is evident in how staff and leaders across the health service experience their work. When operational systems are reliable and well-designed, routine tasks fade into the background, allowing attention to focus on care, improvement and leadership. When they are not, time and energy are consumed by administration, coordination and workarounds. This section focuses on the changes that happen in practice when the operational burden is reduced, how staff experience their work differently, how trust in systems is built, and why these matter as much as formal structures or strategies.

Evidence from NHS corporate functions shows that Robotic Process Automation (RPA) can complete routine tasks five to ten times faster than manual effort, operate continuously, and reduce time spent on administration, freeing up staff to focus on direct patient care.[40] In practice, **automation has been shown to cut operational costs by 20-30% and deliver returns of £30-£50 for every £100 invested,** while improving accuracy and providing full audit trails for governance and compliance.[41]

Improved operational design creates the conditions for digital transformation to benefit all stakeholders in the system, including staff and patients, as well as improving organisational performance. Indeed, Heather Barton-Jones, Area VP in UiPath's Strategic Transformation Office has noted that sustaining digital progress amid organisational pressures depends on making services more accessible, efficient and convenient for staff.[42]

Emerging digital technologies, such as responsibly adopted forms of Artificial Intelligence (AI), can also deliver very practical productivity gains when they are built on sound operational foundations. As the Royal College of Radiologists has concluded: *"AI will add the greatest value to the NHS by augmenting or replacing existing administrative and organisational tasks, thereby improving patient pathways."*[43] National NHS guidance frames AI as a means of empowering NHS staff, reducing routine administrative burden and supporting judgement-rich work, rather than replacing people or automating decisions in isolation.[44]

Writing in *Health Service Journal*, Matthew Swindells, then Chair of the North West London hospital group, said: *"The potential for the massive productivity improvements in the NHS is enormous. This includes automating repetitive back-office tasks like recruitment or onboarding, improving data completeness with 24/7 'bots', thereby enhancing patient experience, and relieving our skilled valued staff from mundane admin tasks. Major, complex organisations are achieving a 30-50 per cent productivity boost through transformation and automation – why not us? There's no technology barrier, just a need for priority, investment and willingness to rethink workflows."*[45]

Example - recruitment

› NHS recruitment teams using RPA to support pre-employment checks have reported significant reductions in manual processing time, allowing staff to focus on candidate engagement and complex decision-making rather than repetitive administrative tasks. In one NHS recruitment programme, automation supported the completion of more than 24,000 hours of work, contributing to faster offer turnaround and reduced backlogs in routine checks.

Source: NHS Employers, The value of robotic process automation in NHS recruitment

40 NHS Shared Business Services, Robotic Process Automation
41 British Computer Society (BCS), How automation is driving NHS efficiency and innovation, August 2025
42 NHS SBS, Webinar: Unlocking the potential of digital transformation in the NHS, October 2025
43 Royal College of Radiologists, AI Deployment in the NHS: reviewing progress made and defining future action, April 2025
44 NHS England, AI Knowledge Repository
45 HSJ, The NHS is holding the economy back by failing to share its data, January 2025

What staff notice when systems work

The clearest sign that operational systems are working is that people stop noticing them. Payroll runs accurately and on time. Orders placed arrive when expected. Information entered once flows where it needs to go without re-keying. These are not dramatic improvements, but they are the quiet indicators of a system functioning as it should. The alternative comes at a high price to the workforce. A 2025 industry survey found that NHS workers spend on average five additional hours every week on tasks created by process inefficiencies, equivalent to an estimated 7.5 million hours of avoidable work across the NHS workforce.[46] That is time that could be spent with patients or delivering service improvements.

Mark Jennings of Strasys says: ***"Corporate functions have a really tough job because they can't make the frontline love their work, but they absolutely can make them hate it."***[47] When operational systems fail, frustration is immediate and personal. When they work, staff may not consciously register the improvement, but they have more time, and more capacity, to focus on what they came into the health service to do.

Taken together, these kinds of improvements reflect what Lord Darzi has described as the need for a 'major tilt toward technology' to boost productivity, particularly for frontline staff; not through major system implementations alone, but through changes that remove friction from everyday work.[48]

Where operational improvements are implemented, their impact is felt across a range of settings. Nurses at Central and North West London NHS Foundation Trust had been struggling with consent forms - a process that consumed significant clinical time. Heather Barton-Jones, Area VP in UiPath's Strategic Transformation Office, explains: ***"Nurses were drowning in paper forms; we digitised and automated them, and freed 56 clinical hours per day. That's time back for care."*** [edited for clarity][49] Those 56 hours could mean the difference between a team that ends every shift behind and one that has more time for patients.

"Nurses were drowning in paper forms; we digitised and automated them, and freed 56 clinical hours per day. That's time back for care."

- Heather Barton-Jones, Area VP Strategic Transformation, UiPath

Richard Stubbs from Health Innovation Yorkshire & Humber argues that when properly implemented, technology should not be seen as a threat to the workforce: ***"Technology isn't necessarily going to erode the workforce base. It's actually about freeing people up to go and put their expertise where it can work and be most impactful."***[50]

Alice Donovan-Hart, Director of Consulting at NHS SBS, says: ***"Improving onboarding is not just about making it quicker or less error prone...it also has a direct correlation with your retention rates, so you're hitting some of your key strategic priorities, which is a much bigger win."***[51] Faster onboarding is good, but onboarding that leaves new staff feeling welcome and prepared, because HR teams have time to spend with them rather than processing paperwork, affects whether they stay.

Elsewhere, when an NHS Trust in the East of England redesigned and automated four distinct manual finance processes - each with different workflows, high error rates and limited audit trails - processing time fell by half and error rates declined from 5% to 1%. Staff who had been stretched and demoralised found themselves able to focus on higher-value work.

Crucially, the project was led collaboratively and 'done with them, rather than to them', as the trust described it.

Meanwhile, an evaluation of ambient voice technology across nine London sites showed a 23.5% increase in patient interaction alongside an 8.2% overall reduction in appointment length. Results in A&E were particularly strong, with a 13.4% increase in patients seen per shift.. Economic modelling indicated that, if deployed across all emergency departments in England, this could create capacity to see more than 9,000 additional patients per day, and clinicians reported greater presence with patients when not burdened by documentation.[52]

These examples share a common thread. The goal in each case was not to make staff work harder or faster, but to remove the friction that had been making routine work unnecessarily difficult. Time returned to staff is time available for patients, for colleagues, and the small acts of attention that can make excellent care the norm.

The moments that matter

Fiz Yazdi, Managing Director of Sopra Steria Next, has a very clear way of thinking about the real purpose of operational improvement: ***"People really value efficiency, but they don't get out of bed in the morning for it alone, and it's the tender moments of care that they remember. That's what transformation should aim for."***[53]

Operational improvement is sometimes discussed in purely transactional terms (minutes saved, errors avoided, costs reduced). These metrics matter, of course: digital services like the **NHS App delivered an estimated £249 million in benefits in 2023/24 and freed up around two million hours of staff time.**[54] But these numbers are only part of the picture. What really matters is what becomes possible when the administrative burden is lifted. A nurse who is not chasing paperwork has time to sit with a patient. A manager who is not reconciling spreadsheets has space to notice that a colleague is struggling. These moments cannot be mandated or measured, but they are made possible by reliable operational systems.

Example - payroll services (fewer queries, faster resolution)

› NHS organisations that use redesigned payroll services and digital self-service tools have reduced routine payslip queries and shortened resolution times, thereby freeing payroll teams to focus on complex cases rather than repetitive corrections and enquiries.

Source: NHS Shared Business Services, The future of NHS payroll: innovation, agility and empowerment

"Technology isn't necessarily going to erode the workforce base. It's actually about freeing people up to go and put their expertise where it can work and be most impactful."

- Richard Stubbs, CEO, Health Innovation Yorkshire & Humber

46 Appian, New Data Shows NHS Burdened with 7.5 Million Hours of Extra Work Every Week, February 2025. The five-hour figure and 7.5 million hours estimate do not appear in the published survey report; they are cited in Appian's press release, which states that the survey included 242 NHS respondents and extrapolates the weekly figure across the NHS's 1.5 million workforce.

47 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

48 British Computer Society, How automation is driving NHS efficiency and innovation, August 2025

49 British Computer Society, How automation is driving NHS efficiency and innovation, August 2025

50 NHS SBS, Webinar: The NHS of tomorrow - embedding shared services for lasting transformation, January 2026

51 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

52 Mahdi, A., et al., Unlocking Clinical Time in Emergency Departments with Ambient Voice Technology: A Scientific Evaluation and Economic Impact Assessment of Ai Emergency Care Productivity and Capacity, August 2025

53 NHS SBS, Webinar: Digital transformation under pressure - Sustaining momentum amidst NHS reorganisation, October 2025

54 NHS England, Board Minutes, Item 5 - NHS productivity, December 2024

In 2022, the British Medical Association estimated that NHS doctors in England lose more than 13.5 million working hours each year from delays and workarounds caused by inadequate or malfunctioning IT.

Redesign before technology

Technology plays a role in many of these improvements, but it is rarely sufficient on its own. More important is understanding how tasks actually flow, where errors accumulate, and what causes rework. Digitising a broken process embeds the friction in code rather than fixing it. The scale of this problem is reflected in clinicians' experience of poorly designed or inadequately integrated systems.

In 2022, the British Medical Association estimated that NHS doctors in England lose more than 13.5 million working hours each year from delays and workarounds caused by inadequate or malfunctioning IT.

This lost time is not the result of insufficient digital ambition, but of systems that fail to support clinical workflows effectively.[55]

Pritesh Mistry, Digital Technologies Fellow at The King's Fund, has warned against replicating analogue processes in digital form:

"What's needed is fundamental transformation, not simply doing what we currently do with additional digital technologies bolted on."[56]

UiPath's Heather Barton-Jones has cited evidence that 92 per cent of AI projects fail to deliver value, not because the technology doesn't work, but because it generates insights without changing how work is actually done.[57]

Trust built through experience

When staff encounter systems that work reliably, they begin to trust that improvement is possible.

"Corporate services are often overlooked, but they hold huge potential," says Mistry. Because they're not clinically facing, the risk level is lower, allowing you to implement improvements faster and show people the benefits sooner. That builds confidence and helps staff experience technology as an enabler rather than a burden. And once people experience the benefits, they are more likely to embrace more."[58]

In contrast, unreliable systems create defensiveness in the workforce. Staff who have been let down repeatedly become cautious. They hedge against failure by maintaining their own records, avoiding new tools, and assuming that promised improvements will not materialise. Each new initiative must overcome not only the specific problem it addresses but also (potentially) the accumulated scepticism of people who have had a poor experience in the past. Reliable systems can reverse this dynamic. **In one NHS organisation, workforce data was used to predict, with 95% accuracy, which staff were at risk of leaving.**[59]

As Raine Pell, Director of Marketing and Communications at NHS SBS, describes it: *"The organisation was able to put preventative steps in to ensure they were supporting their workforce. That data was used as an early warning system, to help with the retention issue before it started to impact clinic and wait times."* [60]

55 BMA, Millions of hours of doctors' time lost each year to 'inadequate' IT systems, December 2022

56 NHS SBS, Webinar: Digital transformation under pressure - Sustaining momentum amidst NHS reorganisation, October 2025

57 IBid

58 IBid

59 NHS SBS, Improving staff retention with workforce analytics

60 NHS SBS, Webinar: Data as infrastructure - the foundation for NHS transformation, December 2025

The value lay not in the prediction alone, but in the ability to act before problems became evident in waiting lists or vacancy rates.

"Corporate services are often overlooked, but they hold huge potential. Because they're not clinically facing, the risk level is lower, allowing you to implement improvements faster and show people the benefits sooner."

- Pritesh Mistry, Digital Technologies Fellow at The King's Fund

From better working lives to system-wide returns

The improvements described beforehand - **time returned to staff, friction removed from routine work, trust rebuilt through reliable systems** - are powerful within individual organisations but at system-wide level, they can produce returns at scale. Individual gains become collective ones, and the institutional confidence that comes from seeing improvement delivered locally makes further collaboration across the system easier to sustain.

In Greater Manchester, nine NHS trusts, each with distinct procurement systems, are developing a shared approach. The aim is not only millions of pounds of savings, but also something harder to quantify: an ability to work together on operational foundations to make further collaboration easier.

These local returns point to a much larger opportunity across the health service. Deloitte estimates that **the NHS collectively spends more than £60 billion a year on goods and services (excluding staff pay) - purchasing power that is currently dispersed across hundreds of organisations rather than systematically coordinated.**[61]

The Public Accounts Committee recently warned that **inconsistent procurement practices are costing the NHS tens of millions of pounds in potential savings,** even within narrow categories such as medical equipment and consumables.[62] In sectors outside public healthcare, experience shows that **the largest financial gains from organisations working together usually come from buying goods and services collectively and running shared supply chains, often accounting for around 60% of the total cost reductions achieved.**[63]

The same pattern is visible internationally. **Ireland's Health Service Executive has deployed automation across corporate services, restoring 800,000 hours of capacity to the system, valued at more than €30 million.**[64] Those hours represent exactly the kind of time returned to staff described earlier in this section. But the system-level effect matters just as much: demonstrated success at this scale builds the institutional confidence that makes further collaboration more feasible and less risky.

Reducing operational burdens is not separate from the clinical and strategic priorities set out in the 10 Year Health Plan; it is a precondition for delivering them. The next section examines how operational data can function as shared infrastructure, enabling decisions at the place and system level.

Ireland's Health Service Executive has deployed automation across corporate services, restoring 800,000 hours of capacity to the system, valued at more than €30 million.

61 Deloitte, NHS Procurement and Supply Chain: Extracting value from Shared Services

62 House of Commons Committee of Public Accounts, NHS Supply Chain and efficiencies in procurement, March 2024

63 Deloitte, NHS Procurement and Supply Chain: Extracting value from Shared Services

64 UiPath, How the HSE transformed healthcare by saving over 800,000 hours of manual work

Section 4 - Reducing operational burden so that local teams can focus on care - Key takeaways

- The clearest sign that operational systems are working is that people stop noticing them. Routine tasks fade into the background and attention shifts to care, improvement and leadership.
- Reliable systems remove friction; unreliable ones create frustration that compounds over time.
- Time returned to staff is time available for patients and colleagues - for the 'tender moments of care' that depend on presence and attention, not speed.
- Technology enables improvement only when the underlying process is sound. Redesign must come first; digitising a broken process only further embeds the problem.
- Trust in systems is built through repeated, reliable experience. When staff see improvements delivered as promised, they extend their confidence to the next change.
- Value compounds when organisations collaborate on operational infrastructure. Savings and efficiency matter, but so does the institutional confidence that comes from seeing improvement delivered, which in turn makes further collaboration easier.
- Reducing operational burden is not a distraction from the 10 Year Health Plan's ambitions, but a precondition for delivering them.

Section 5

Data

Service improvement depends on the ability to see what is happening across organisational boundaries, and act on that information in time to make a difference.

The Sudlow Review, an independent assessment of the UK health data landscape, calls for a shift towards a health data ecosystem that supports the use of data for workforce, patient and public benefit and incentivises organisations to share and generate value from it.[65] This underscores that operational data must not only be visible, but actively used to improve care and outcomes at a place and system level.

From collection to use

Alongside its clinical records, the NHS generates vast volumes of operational data every day covering finance, workforce, procurement and estates across hundreds of organisations. This data is highly transactional, long-lived and repeatedly aggregated at local, regional and national levels. Over time, this amounts to many petabytes of information that underpin how the health service is funded, staffed and run. Yet too often, this data does not reach the people who need it, in a form they can use, at the point when it would make a difference.

The problem is not primarily one of collection but of whether data is designed for decision-making or treated as a by-product of administrative processes. Mark Jennings of Strasys identifies a paradox: ***"It's really strange to me that in health care, you have, on the clinician side, the absolute belief in the scientific method, in using data to guide diagnosis and to drive better care decisions. And yet, corporately, there is incredibly little of that."***[66]

Clinical teams routinely use evidence to inform treatment decisions, but for operational questions (where staff shortages will emerge, which suppliers offer best value, how capacity is distributed across a system), they often rely on incomplete information, lagging indicators, or local knowledge that cannot be shared.

The 10 Year Health Plan signals a shift in emphasis. From April 2026, the NHS started publishing quarterly employer-level data on compliance with minimum staff standards for modern NHS employment. Employer-level data on recruitment and workforce composition will enable monitoring of progress in workforce diversity. These commitments reflect a move towards using operational data to drive improvement rather than simply satisfying reporting requirements.

This shift is consistent with the Sudlow Review, which identifies high-quality operational and workforce data as critical to service improvement, but notes that such data has historically been used in isolation and largely for reporting rather than for evaluating impact. The review argues that linking operational data to outcomes and workforce metrics is essential for understanding performance, costs and inequalities, reframing operational data as an improvement tool rather than an administrative by-product.[67]

Beyond workforce reporting, **the 10 Year Health Plan does not articulate a detailed operational data strategy for corporate services. It does, however, emphasise digital transformation and the use of data and AI to reduce administrative burden and support productivity, which implicitly recognises that operational data has value as infrastructure, not just as a reporting requirement.**

Why operational data remains fragmented

Effective operational management depends on the ability to see across organisational boundaries, to understand workforce deployment, spending patterns and service delivery in ways that are consistent and comparable. That requires data interoperability, not just within individual organisations, but across technologies, systems and institutions. Without it, there is no single source of truth.

Almost all progress in clinical care has come from careful and accurate collection and analysis of data, right the way back to the invention of vaccines. We now need to apply the same rigour to corporate services to see an equivalent level of transformation.

The NHS has made progress in some areas. The Electronic Staff Record (ESR) and new procurement systems are beginning to create more consistent foundations. But these are not yet connected in ways that enable system-wide insight. Analytics capability to bring operational data together, to make it usable for planning and decision-making, remains limited.

Indeed, the NAO reported in 2024 that NHS workforce modelling relied on limited integration across parts of the data pipeline and extensive manual processing. Documentation and manual adjustments constrained independent replication of results, undermining transparency and reproducibility.[68]

Research into integrated care systems shows that variation in local data standards and governance continues to limit effective system-wide use of operational information.[69]

Procurement and spend data shows a similar pattern. Without a single, consistent view of what is being purchased across the system, variations in price, specification, and supplier choice remain invisible. Avoidable costs can go unnoticed, hidden behind what appear to be routine local decisions. NHS England's Spend Comparison Service[70], which now requires providers to submit detailed purchasing data, exists precisely because this fragmentation persists. The Procurement Act 2023[71] add further pressure by stipulating that organisations must now publish more information about their contracts, track whether they are delivering value, and report against clear performance measures. All of this is significantly harder when the underlying data is inconsistent or incomplete. These regulatory demands strengthen the case for shared data infrastructure, but also expose how far the system still has to go.

Flaws in data governance structures contribute to the problem, often making sharing data across systems and sites especially challenging. Progress depends less on creating additional systems, and more on having consistent standards and interoperable approaches that reduce duplication and make data comparable.

Good enough, soon enough

Jake Arnold-Forster, Chief Executive of Carradale Futures, says: ***"If you want transformation, you first have to make processes consistent. Once processes are consistent and transparent, they can be improved. Unwarranted variation is, by far, the biggest cause of avoidable harm and waste in healthcare."***[72]

The pursuit of perfection can become an obstacle to providing useful data. To make better decisions, leaders do not always need information to be complete, but to be good enough, consistent enough, and available soon enough, to inform the choices in front of them. This principle recognises that not every field needs to be standardised, nor every dataset linked.

For many operational decisions, core definitions, basic interoperability and common logic are sufficient to make patterns visible and actionable. Where more advanced capabilities are required, including automation or AI-enabled decision support, higher levels of consistency and standards for datasets become necessary to enable them to be used, for example, for model training.

A recent NAO review of government shared services reached the same conclusion, noting that data convergence is what makes it "much easier to integrate systems [and] use new technology like artificial intelligence".[73]

65 HDR UK, The Sudlow Review, Uniting the UK's Health Data: A Huge Opportunity for Society, November 2024

66 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

67 HDR UK, The Sudlow Review, Uniting the UK's Health Data: A Huge Opportunity for Society, November 2024

68 National Audit Office (NAO), NHS England's modelling for the Long-Term Workforce Plan, March 2024

69 Understanding Patient Data, The use of data in Integrated Care Systems, June 2024

70 NHS England, NHS Spend Comparison Service

71 Legislation.gov.uk, Procurement Act 2023

72 NHS SBS, Webinar: Digital transformation under pressure: Sustaining momentum amidst NHS reorganisation, October 2025

73 National Audit Office (NAO), Update on government shared services, March 2026

The discipline lies in matching data maturity to the purpose at hand, rather than imposing the highest standard everywhere by default.

Where this approach has been applied, the practical difference is evident. In Norfolk and Waveney, an Insight Diagnostic solution provides system-wide data and intelligence across five trusts. A unified catalogue of more than one million frequently purchased items revealed the potential for millions of pounds in previously invisible savings. The same items had been purchased at different prices across organisations; no one could see it because the data was not standardised. The problem was not a lack of data, but that the data could not be compared.[74]

"If you want transformation, you first have to make processes consistent. Once processes are consistent and transparent, they can be improved. Unwarranted variation is, by far, the biggest cause of avoidable harm and waste in healthcare."

- Jake Arnold-Forster, Chief Executive of Carradale Futures

74 NHS SBS, Norfolk and Waveney Integrated Care System Insight Diagnostic, 2024

The role of agentic AI and emerging operational capability

AI is advancing at an extraordinary pace, with implications for productivity, skills, and the operation of large systems. In public services, the question is not whether AI will be used, but how, and under what conditions.

This paper does not assume that new technologies automatically deliver value. Experience suggests otherwise - AI amplifies existing systems, data and governance. Where foundations are weak, it creates risk; where they are strong, it can release capacity and improve work.

In operational and corporate services, emerging approaches such as agentic AI are best understood as tools for coordinating workflows and supporting people, rather than replacing judgement or redesigning services in isolation. Their usefulness depends on stable processes, high-quality data, clear accountability, and human oversight.

Organisational experience outside the NHS reinforces this. One study found that companies with an enterprise-wide strategy for intelligent automation reduced costs by an average of 24% and increased revenue by 8%, whereas organisations without an enterprise-wide strategy achieved only 14% cost reduction and 3% revenue gain on average.[75]

The challenge for health and social care is therefore not to chase AI adoption, but to build the operational discipline and shared infrastructure that allows new technologies to be used safely, consistently, and in the public interest.

75 Summary of findings drawn from industry survey interpreted from Deloitte intelligence on automation strategy performance: Mercurial Minds, Intelligent Back-Office Automation: A Practical Guide, October 2024, noting that companies with enterprise-wide intelligent automation strategies show enlarged cost and revenue impacts compared with those without.

Governance as operational discipline

Data quality does not typically emerge from lengthy theoretical frameworks written in advance of use, but from the operational discipline and processes that produce reliable information as a matter of routine, clear accountability for maintaining that reliability, and the skills to interpret and act on what the data shows.

For example, NHS Shared Business Services processes 658,000 payslips monthly at more than 99% accuracy and processes £395 billion in NHS client cash annually. This level of reliability is achieved through processes designed to embed accuracy, not through a standalone data governance function. This is, in effect, 'lived' governance where the same systems and processes that are in place to deliver accurate reliable services also produce accurate, reliable data.

Governance that exists only to satisfy external requirements tends to produce defensiveness and delay. Governance understood as an operational discipline rather than a compliance exercise produces faster, more confident decisions. As Cassie Smith, Director of Legal, Trust and Ethics at Health Data Research UK, has said: ***"We know what good governance is. But we need to do it once."***[76]

76 NHS SBS, Webinar: Data as infrastructure - the foundation for NHS transformation, December 2025

Operational data - a view from NHS SBS

Much of the public debate around health data focuses on clinical and personal information - patient records, research access, and the safeguards needed to maintain trust. These are undoubtedly important.

But operational data is different. Information on workforce deployment, financial flows, procurement activity and organisational capacity does not raise the same privacy concerns as clinical records. It is already being collected across the system. The question is whether it can be made consistent, comparable and usable for cross-service decision-making.

The position we advance in this paper is that operational data infrastructure should be recognised as a system-wide asset, and that mechanisms for sharing it safely should be deliberately extended, rather than left to emerge unevenly through local efforts. Governance for operational data does not require new frameworks; it requires the operational discipline that high-stakes transactional services already demand.

The NHS does not need to wait for consensus on clinical and patient data governance before improving how operational data supports decisions. These are parallel challenges, not sequential ones.

"If we're talking about a reimagined NHS, we should be talking about one that's reimagined around what the patients need, how they behave, what motivates them, and what outcomes we need to achieve for them. And that is largely in the operational data. Putting that with the clinical data, I think that is where the real unlock comes for what's next for the NHS."

- Mark Jennings, Chief Solutions and Services Officer, Strasys

Value across boundaries

Operational data is most valuable when it enables visibility across the boundaries that currently fragment decision-making. Workforce data that shows pressures in one organisation but not another limits the ability to respond at system level. Financial information that cannot be compared across providers makes it harder to identify where efficiency is being achieved or might be improved. Capacity and activity data locked within individual organisations prevents the coordinated planning required for integrated care.

The Norfolk and Waveney integrated care system illustrates what becomes possible when operational data infrastructure is deliberately aligned.

Before moving to shared services, the five provider trusts operated five different finance platforms, three e-sourcing platforms and two purchasing platforms, each with separate charts of accounts and incompatible data structures.

Consistent system-wide reporting was effectively impossible; variation between organisations was invisible because the data could not be compared.

Moving to a single platform with an aligned chart of accounts did not simply improve efficiency, but created conditions for system-wide visibility that had not previously existed. NHS England has since recognised Norfolk and Waveney as a reference site for how provider organisations can achieve a consistent reporting platform and reduce unwarranted variation across an ICS.

Laura Devine, Senior Delivery Lead for the New Hospital Programme at NHS SBS, draws out the implication: *"That's one ICS. Imagine what we could do if we pull that together at a national level,"* she says. The opportunity is not simply to replicate Norfolk and Waveney's approach, but to extend the same logic across the system, creating the visibility that enables the NHS to use its collective power strategically, rather than leaving value hidden in fragmented datasets.[77]

In describing the potential that could be unlocked through system-wide integration, Mark Jennings from Strasys argues for a core triad of clinical, operational and workforce data: *"You understand patient needs and behaviours more from operational data than you do from clinical data. Yes, every treatment has to be grounded in clinical data. But if we're talking about a reimagined NHS, we should be talking about one that's reimagined around what the patients need, how they behave, what motivates them, and what outcomes we need to achieve for them. And that is largely in the operational data. Putting that with the clinical data, I think that is where the real unlock comes for what's next for the NHS."*[78]

Put simply, data on, for example, workforce turnover, procurement spend and financial pressures can reveal system strain before it manifests in clinical metrics. When trusts begin to lose experienced staff, the pattern shows in workforce data months before it appears in waiting times. Operational data, when it flows across organisational boundaries, functions as an early warning system.

Without this visibility, decisions may default to historical patterns, potentially at the expense of the wider system. The structural changes underway in the NHS assume that leaders can see and act across traditional organisational boundaries. That assumption depends on data infrastructure that makes such visibility possible.

77 NHS SBS, Webinar: The NHS of tomorrow - embedding shared services for lasting transformation, January 2026

78 NHS SBS, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025

Building incrementally

The history of large-scale data programmes in the public sector offers a cautionary lesson. Ambitious initiatives that promise comprehensive solutions often stall, consume resources without delivering proportionate benefit, or arrive too late to address the problems they were designed to solve.

The Chief Data and Analytical Officers Network, which represents NHS data leaders, published an open letter in February 2025 supporting the principle of shared data infrastructure but warning against 'one-size-fits-all' approaches that do not account for local circumstances and existing investments.[79] Their concern reflects a broader lesson that mandated uniformity often produces resistance, while demonstrated value builds adoption.

The alternative is to build incrementally, starting where better data would make the most immediate difference to decisions, and extending from there. This approach allows for learning as the work progresses, builds confidence through demonstrated value, and avoids waiting for perfect infrastructure before any improvement is possible. Data quality improves through use because when information is actively used to inform decisions, errors become visible and get corrected.

79 Digital Health, Data chiefs raise concern about NHS federated data platform, March 2025

What this makes possible

When operational data serves as shared infrastructure, leaders can see patterns that cross organisational boundaries, act before pressures become crises, and make trade-offs with a clearer understanding of their consequences.

The practical foundation of this is consistent, trusted data that enables evidence-informed decisions across the system. It does not exist everywhere, but it can be built incrementally by organisations that recognise its value and have the operational discipline to sustain it.

Section 5 - Data - Key takeaways

- Data is valuable only when it informs decisions. The shift from data for reporting to data for decision-use is fundamental.
- Minimum viable consistency is the priority, not comprehensive standardisation. Core definitions, basic interoperability, and common logic are enough for most operational decisions. This changes when the goal is to implement AI-based systems.
- Governance is an operational discipline, not a compliance exercise.
- Visibility across organisational boundaries enables better decision-making.
- Operational data can signal system pressures before they appear in clinical metrics, but only if it flows across organisations.
- Incremental progress is more likely to succeed than comprehensive programmes.
- Demonstrated value builds adoption, while mandated uniformity produces resistance.

Section 6

A suggested delivery model

The preceding sections have established why shared operational foundations are necessary in the NHS, what they look like when well-designed, and how they change the day-to-day experience of staff and leaders. What remains is a practical question: how can these foundations be built and sustained at scale, across a system as large and diverse as the NHS, without undermining local accountability for care?

The answer lies in the characteristics of the delivery model. Shared operational infrastructure cannot be built piecemeal or sustained through short-term funding.

It requires consistent investment, the credibility to engage providers as partners, and governance arrangements that make collaboration rational rather than burdensome.

When these conditions are met and sustained at scale, the evidence suggests significant returns. Deloitte analysis of mature shared services models, for example, benchmarks returns on investment of up to 10:1.[80]

What a scalable delivery model must be able to do

Scale is achieved through collaboration. Operational processes and data increasingly need to flow across organisational boundaries, particularly as care is delivered between places and pathways rather than within individual institutions. Successful delivery models are those that make collaboration practical and achievable by providing shared platforms, standards, and implementation support, while giving local leaders a meaningful role in shaping how services evolve.

A delivery model capable of operating across multiple organisations must also be able to invest over the long term. Shared operational foundations tend not to be one-off projects; they involve renewing core platforms, developing common data standards, redesigning workflows, and continuously improving services that millions of staff depend on every month.

Many individual NHS organisations lack the financial headroom or specialist capability to make these investments repeatedly and independently.

This is a challenge reinforced by sector analysis that highlights constrained in-house digital, data and transformation capacity across NHS organisations.

As the NHS Alliance (formerly NHS Confederation) has noted, *"many staff still perceive IT systems as outdated, slow and disruptive to workflows. Leaders can address this by promoting interoperability, supporting the DDaT workforce and ensuring all staff are equipped with the right tools and training to use digital systems confidently and effectively".*[81]

A scalable model must be able to commit capital to this over multiple years and remain accountable for public value over time.

Operational credibility matters just as much as investment capacity. Shared data and governance only work when the services that generate them or depend on them are reliable at volume. Accurate payroll runs, consistent procurement processes, effective workforce modelling and dependable transaction-handling are not peripheral details, but the foundation on which trust is built. Leaders are far more likely to adopt shared solutions when they can see that the underlying service is resilient and already operating at scale.

This makes collaboration feel safer rather than more complex. In one example, a group of hospitals in England moved collectively to aligned finance, accounting and procurement services, establishing a Design Authority to govern ICS-wide decisions, standardising Standing Financial Instructions (SFIs) across all organisations, and implementing a shared Target Operating Model (TOM).

While the implementation was not without challenges, the partnership approach meant that problems were addressed jointly rather than becoming grounds for retreat.

The result is an ICS where finance and accounting services are now operating to contract across all the hospitals, with a multi-year roadmap for further integrations.

A truly scalable model must absorb regulatory and technical complexity that most individual organisations cannot sustain. The requirements introduced under the Procurement Act 2023 (detailed transparency notices, KPI reporting, supplier due diligence) demand specialist expertise in procurement law, data standards and commercial design.[82]

Few trusts can maintain this capability in-house alongside the pressures of day-to-day service delivery. Shared procurement services, operating across multiple organisations with common platforms and pooled category expertise, can meet these requirements once and well, rather than expecting each trust to build the capability independently.

Equally important is the ability to implement change continuously without resorting to bespoke system design. This paper has already shown that technology alone does not deliver improvement. Indeed, it is often workflow redesign, staff engagement, and sustained support that make new systems usable. A scalable delivery model must include a repeatable implementation approach that respects local context while avoiding unnecessary divergence. Learning must travel from one deployment to the next, so that each implementation becomes faster and less disruptive.

Evidence from shared corporate service programmes shows that once common processes and implementation approaches are established, subsequent deployments can be delivered more quickly and with reduced disruption to local teams.[83]

This is reinforced by workforce models that pool specialist operational, digital and change capability, providing continuity and expertise that many organisations cannot sustain independently.[84]

Standardisation with discipline, not uniformity

Discipline around standardisation is central to this. Successful delivery models are clear about what should be shared and what must remain local, and they hold that line consistently.

Shared platforms and operational blueprints work when they standardise the underlying utilities - finance, payroll, procurement processes, and core data logic - while leaving judgement-based decision-making in local hands. Standardising the wrong things erodes trust, but failing to standardise what is common adds cost and friction without delivering value. This discipline is increasingly reinforced by national expectations around productivity measurement. The NHS has set out its intention to agree a standard set of productivity metrics for executive teams and boards, alongside service delivery measures. This ambition depends on shared definitions, comparable data and consistent operational foundations.[85]

Data capability reinforces this point. As set out in Section 5, many human-led operational decisions can be supported by "good enough" data. Introducing automation or AI-enabled decision support requires higher data standards. A scalable delivery model must both support raising data maturity, where advanced capabilities are deployed, and avoid imposing maximum standardisation everywhere by default. This tiered approach is essential to match ambition with practicality.

A scalable delivery model must also stay ahead of operational practice, not simply codify what exists. Shared services that track emerging standards and proven approaches (and embed them once, and well, across the system) raise the baseline for every organisation that adopts them.

80 Deloitte, Introduction to Shared Services at Scale within the NHS, April 2024

81 NHS Confederation, Digital transformation in the NHS: a reference guide, December 2025

82 Legislation.gov.uk, Procurement Act 2023

83 Arden and Greater East Midlands CSU, Delivering Efficiencies Through Corporate and Shared Services Webinar, January 2025

84 NHS Confederation, Digital transformation in the NHS: a reference guide, December 2025

85 NHS England, Update on planning for 2024/25, December 2023

This is one of the clearest advantages of operating at scale: the capacity to invest in identifying and implementing best practice, rather than expecting each organisation to do so independently.

Governance, legitimacy and contestability

Shared operational infrastructure fails when it is perceived as imposed or opaque. It succeeds when those who use shared services have genuine influence over how they evolve, when performance is visible, and when accountability is clear. Participation becomes rational when the benefits are demonstrable financially, operationally, and in terms of staff experience.

A case for shared operational foundations is not a case for a monopoly. Choice matters, and different parts of the system will adopt different approaches depending on existing capability and investment. The relevant question is whether the models in use can deliver the characteristics required to sustain shared foundations over time.

Existing shared operational infrastructure in the NHS has demonstrated tangible benefits. **In Sussex, an 'anytime' payroll model has improved accuracy and staff experience.**[86] **In Norfolk and Waveney, unified procurement has reduced requisition-to-order processing from days to minutes.**[87] **In Cambridgeshire, automated referral processing has substantially reduced administrative handling time.**[88]

These examples illustrate what becomes possible when operational foundations are shared rather than repeatedly rebuilt in isolation, but they remain pockets of progress rather than a system norm.

Delivery models

A range of delivery models already exist within the NHS to support shared operational services. These include in-house consolidation within provider groups, jointly governed shared service organisations, and public–private partnerships. Each approach has different strengths depending on local circumstances, existing infrastructure, and investment capacity. The key question for system leaders is not which institutional form is preferred, but whether a model can provide long-term investment, operate reliably at scale, and support the consistent operational foundations that modern health systems require.

86 NHS SBS, Innovative "anytime" payroll service increases staff satisfaction whilst generating savings

87 NHS SBS, Pioneering ICS-wide corporate services for huge savings, 2025

88 NHS SBS: "Ada" automates Bedfordshire and Luton referrals

Example: NHS Shared Business Services

› NHS Shared Business Services (NHS SBS) is one example of a shared operational provider operating at national scale within the NHS. Through this model, shared operational platforms, implementation capability, and governance can be established once and extended across the system, rather than rebuilt repeatedly through local effort. At place and system level, the value lies in longer-term operational partnerships, where shared foundations are co-governed and evolve with local priorities, rather than procured episodically.

This model supports several steps that the NHS increasingly needs to take. It enables wider adoption of shared services, avoiding duplication that adds cost without creating local value. It supports a shift from transactional processing to shared digital platforms that provide a consistent operational backbone. It enables cost savings by enabling the bulk-buying of commodities and the sharing of procurement expertise. It provides access to change and transformation capability alongside core services, recognising that implementation determines outcomes. And it enables deeper place- and system-level partnerships, where shared foundations are co-designed and governed with local leaders rather than delivered at arm's length.

The joint venture structure also addresses the capital investment challenge that constrains many NHS organisations. As previously mentioned, individual trusts often lack the financial headroom to make sustained investments in operational infrastructure, and capital budgets are routinely raided to cover day-to-day pressures. NHS SBS can commit capital over multiple years, fund platform renewal and continuous improvement, and absorb the upfront costs of transformation that deliver downstream returns, without competing against immediate service demands for limited NHS resources. This makes it possible to invest in shared infrastructure at a pace and scale that any single organisation would struggle to sustain alone.

Internal NHS SBS modelling suggests that wider adoption of shared operational platforms could generate significant system-level value over time. Realising such gains would depend on sustained collaboration, disciplined implementation, and consistent adoption across participating organisations. These figures are not automatic savings; they depend on disciplined adoption, workflow redesign, and sustained support. When shared foundations are extended deliberately rather than left to emerge unevenly, the cumulative opportunity for efficiency and service improvement is substantial.

What this means for health leaders and policymakers

If the NHS is serious about delivering local care, higher productivity and better workforce experience at scale, it must judge delivery models against a clear test: can they invest for the long term, operate reliably at volume, implement repeatedly without bespoke reinvention, balance standardisation with local flexibility, and enable collaboration in a way that builds trust?

Where models meet this test, they can help the NHS move from pockets of operational excellence to system-wide capability.

The following section sets out recommendations for how national and local leaders can act on this insight.

The delivery model characteristics set out in this section - long-term investment capacity, operational credibility, repeatable implementation, disciplined standardisation and legitimate governance - align directly with the three shifts at the heart of the 10 Year Health Plan.

Moving care from hospital to community requires operational infrastructure that works across organisational boundaries. Moving from analogue to digital demands investment in shared platforms, not funding the same digitisation work repeatedly across hundreds of organisations. Moving from sickness to prevention requires data that flows and systems that support early interventions with 'early warning signals'.

Without shared operational foundations, each shift will be harder, slower, and more expensive than necessary.

Section 6 - A suggested delivery model - Key takeaways

- Shared operational infrastructure cannot be built piecemeal. Scalable delivery models require sustained capital investment, reliable performance at volume, and repeatable implementation across organisations. These are characteristics that most individual NHS trusts cannot maintain independently.
- Standardisation must be applied with discipline. Shared platforms work when they standardise underlying utilities while leaving judgement-based decisions in local hands. Standardising the wrong things erodes trust; failing to standardise what is genuinely common adds cost without value.
- Governance and legitimacy matter. Shared services fail when they are perceived as imposed or opaque. Participation becomes rational when users have genuine influence over how services evolve, performance is visible, and accountability is clear.
- Shared operational foundations are a precondition for the 10 Year Health Plan's three shifts, not a separate concern. Each shift depends on infrastructure that works across organisational boundaries, data that flows, and investment that is not repeatedly duplicated across hundreds of organisations.

Section 7

Recommendations – enabling the next phase of reform

The structural changes now underway in the health service create a window for deliberate choices about operational infrastructure.

For too long, reform efforts have focused on clinical pathways and organisational boundaries while leaving back- and middle-office functions to fragment. The Health Foundation's analysis of NHS group models notes that "economies of scale from creating central corporate service functions" are among the most cited benefits of collaboration.[89]

Yet the evidence reviewed for this paper suggests these gains remain harder to realise in practice than the ambition implies.

The following recommendations are intended to help policymakers and health service leaders focus on the operational foundations that underpin everything else.

1. Focus leadership on operational infrastructure – it's where the efficiency gains are

Payroll works essentially the same way in every trust. So does invoice processing, procurement, and most HR administration. These functions don't need local variation; they need to work reliably and efficiently.

However, organisations routinely rebuild them independently, duplicating cost and effort that could be spent on care.

Clinical decisions and service design require local knowledge but back-office operations do not. The practical test is whether a function genuinely needs local knowledge to work well.

2. Create the conditions for long-term investment in operational infrastructure

Shared operational foundations require sustained capital investment, multi-year planning horizons, and governance arrangements that allow costs and benefits to be shared fairly across participating organisations. Leaders should advocate for funding mechanisms that recognise operational infrastructure as a system asset, and enable investment decisions to be taken at the appropriate scale.

3. Invest in understanding problems, not just buying technology

Too often, procurement happens before anyone has properly understood the workflow or the problem they're trying to solve. Technology is bought to fix the wrong thing, or the right thing in the wrong way. Every trust knows that new systems need training, support and workflow redesign to succeed, but few can afford dedicated teams to do the upfront work properly or support implementation afterwards.

This is where shared services add value beyond transaction processing: they can invest in understanding problems before specifying solutions, bring procurement teams in early enough to shape requirements, and pool implementation expertise that learns from each deployment. Buying technology without investing in the whole journey, from problem definition to adoption, is money wasted.

4. Extend proven shared platforms deliberately, rather than solving common problems separately

Where shared operational infrastructure has been adopted, it has delivered measurable improvements in efficiency, accuracy, and staff experience. These remain pockets of progress rather than a system norm. National and regional leaders should prioritise deliberately extending platforms that have already demonstrated value, rather than permitting continued fragmentation through inattention.

5. Use shared services to drive innovation, not just efficiency

Shared operational infrastructure should not simply standardise current practices; it should raise the bar.

Delivery models that operate at scale have the capacity to identify, test and embed emerging best practices in ways that individual organisations cannot. They can also pilot new approaches

89 The Health Foundation, Leading NHS groups, August 2025

- for example, testing automation, AI, and other emerging technologies in controlled conditions before rolling them out widely. Leaders commissioning or governing shared services should expect continuous improvement and innovation, not just reliable processing of transactions.

6. Use operational data as early warning infrastructure

Workforce, finance and procurement data can reveal system pressures before they show up in clinical metrics.

This requires consistent definitions, interoperability across organisational boundaries, and for governance to be treated as an operational discipline rather than a compliance exercise.

Leaders should invest in data capability proportionate to the decisions it supports, as more sophisticated data standards are needed when deploying automation or AI-enabled decision-making.

7. Make collaboration easy

Shared foundations fail when they are perceived as imposed. They succeed when local leaders have genuine influence over how services evolve, when performance is visible, and when the benefits of participation are clear.

Leaders assessing delivery arrangements should ask whether they enable long-term investment, have a track record of operating reliably at scale, allow implementation to build on proven approaches rather than starting from scratch, and ensure transparent accountability. Where these conditions are met, collaboration becomes the best choice rather than an additional burden.

Section 8

Conclusion

Over the years, NHS reorganisations have reshaped clinical structures and organisational boundaries, while the compatibility of the operational systems that underpin them has received less attention. The 10 Year Health Plan's three shifts now provide both the vision and the opportunity to address that gap.

This paper has argued for a simple distinction: clinical decisions must remain local, but operational infrastructure works best when shared. Where that principle has been applied, organisations have saved time and money, reduced friction, and freed staff to focus on care. The opportunity now is to extend these proven foundations more deliberately, rather than continuing to solve common operational challenges separately across multiple organisations.

As automation and AI evolve, the NHS will need operational infrastructure capable of implementing them safely and at scale. Delivery models that combine platform capability, collaboration and workforce development will be best placed to support the system as it develops these foundations.

Leaders who act on this analysis will do three things differently. First, they will distinguish operational infrastructure from clinical decision-making. Second, they will invest in implementation capability as seriously as technology. Third, they will assess delivery models against a clear test of whether they can sustain shared services over time. The foundations already exist in parts of the system; what matters now is deliberate extension and sustained implementation.

- NHS Shared Business Services - June 2026

Section 9

Sources and references

1. Appian, New Data Shows NHS Burdened with 7.5 Million Hours of Extra Work Every Week, 27 February 2025.

2. Arden and Greater East Midlands CSU, Delivering Efficiencies Through Corporate and Shared Services Webinar, January 2025.

3. BBC Radio Four, Today Programme, January 2026 [link expired]

4. British Computer Society, How automation is driving NHS efficiency and innovation, August 2025.

5. British Medical Association, Millions of hours of doctors' time lost each year to 'inadequate' IT systems, December 2022.

6. Carter of Coles, Lord P., Operational productivity and performance in English NHS acute hospitals (commissioned by the Department of Health), 2016.

7. Darzi, Lord A., Independent investigation of the National Health Service in England, September 2024.

8. Deloitte, NHS Procurement and Supply Chain: Extracting value from Shared Services, nd.

9. Deloitte, Introduction to Shared Services at Scale within the NHS, April 2024.

10. Department for Education and Skills, Higher standards, better schools for all: more choice for parents and pupils, 2005.

11. Department of Health and Social Care, Impact statement: the 10 Year Health Plan for England, January 2026.

12. Digital Health, Data chiefs raise concern about NHS federated data platform, March 2025.

13. HDR UK, The Sudlow Review, Uniting the UK's Health Data: A Huge Opportunity for Society, November 2024.

14. Health Foundation, Leading NHS groups, 2025.

15. Health Foundation, Tech to save time: how the NHS can realise the benefits, February 2025.

16. Health Foundation, Digitising the NHS and adult social care: what could it cost?, May 2025.

17. Health Service Journal, The NHS is holding the economy back by failing to share its data, January 2025.

18. Health Service Journal, Norfolk and Waveney trusts unify procurement with cloud-based EP2P platform, automating 94 per cent of orders, June 2025.

19. Healthcare Financial Management Association, Working together in 2025/26 to lay the foundations of reform, April 2025.

20. HM Government, Spending Review 2025, NHS section, June 2025.

21. HM Government, 10 Year Health Plan for England: fit for the future, July 2025.

22. House of Commons Committee of Public Accounts, NHS Supply Chain and efficiencies in procurement, March 2024.

23. House of Commons Health and Social Care Committee, Digital transformation in the NHS, July 2023.

24. House of Commons Library, NHS productivity - Research Briefing CBP-10313, July 2025.

25. Institute for Government and Public First, The NHS productivity puzzle, June 2023.

26. Legislation.gov.uk, Procurement Act 2023.

27. Mahdi, A. et al. (2025), Unlocking clinical time in emergency departments with ambient voice technology: a scientific evaluation and economic impact assessment. SSRN Working Paper.

28. Mercurial Minds, Intelligent Back-Office Automation: A Practical Guide, October 2024.

29. National Audit Office, NHS Supply Chain and efficiencies in procurement, January 2024.

30. National Audit Office, NHS England's modelling for the Long-Term Workforce Plan, March 2024.

31. National Audit Office, Update on government shared services, March 2026.

32. NHS Confederation, Digital transformation in the NHS: a reference guide, December 2025.

33. NHS England, AI Knowledge Repository, n.d.

34. NHS England, NHS Spend Comparison Service, nd.

35. NHS England, Update on planning for 2024/25, December 2023.

36. NHS England, The Innovation Ecosystem Programme – how the UK can lead the way globally in health gains and life sciences powered growth, November 2024.

37. NHS England, Board minutes, Item 5 - NHS productivity, December 2024.

38. NHS England, Integrated care systems, 2025.

39. NHS England, NHS Oversight Framework 2025/26, June 2025.

40. NHS Shared Business Services, Improving staff retention with workforce analytics.

41. NHS Shared Business Services, Innovative 'Anytime' Payroll Service.

42. NHS Shared Business Services, New pharmacy robot 'Steve' frees up resources.

43. NHS Shared Business Services, Norfolk and Waveney Integrated Care System Insight Diagnostic, 2024.

44. NHS Shared Business Services, 'Ada' automates Bedfordshire and Luton referrals, 2025.

45. NHS Shared Business Services, Pioneering ICS-wide corporate services for huge savings, 2025.

46. NHS Shared Business Services, Robotic Process Automation.

47. NHS Shared Business Services, Webinar: Surviving the squeeze – delivering excellence in corporate functions with diminishing resources, August 2025.

48. NHS Shared Business Services, Webinar: Unlocking the potential of digital transformation in the NHS, October 2025.

49. NHS Shared Business Services, Webinar: Digital transformation under pressure – sustaining momentum amidst NHS reorganisation, October 2025.

50. NHS Shared Business Services, Webinar: Data as infrastructure – the foundation for NHS transformation, December 2025.

51. NHS Shared Business Services, Webinar: The NHS of tomorrow - embedding shared services for lasting transformation, January 2026.

52. OECD, Public governance principles, 2020.

53. Re:State, Ending the patient gridlock: Hospital of the future, October 2025.

54. Royal College of Radiologists, AI Deployment in the NHS: Reviewing Progress Made and Defining Future Action, April 2025.

55. UiPath, How the HSE transformed healthcare by saving over 800,000 hours of manual work, 2025.

56. Understanding Patient Data, The use of data in Integrated Care Systems, June 2024.

Shared vision.
Better together

NHS
Shared Business Services

For more information

please visit www.sbs.nhs.uk

Or contact us at **sbs.hello@nhs.net**

MAR075