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 (short version)**

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

Summary

This summary draws on the arguments and recommendations set out in the full paper of the same name. The complete research, case studies and references are available here. NHS Shared Business Services (NHS SBS) provides shared operational services to the NHS, and the thinking in this paper is informed by that day-to-day experience, alongside independent research and evidence.

Our thanks go to the participants in these roundtables 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.

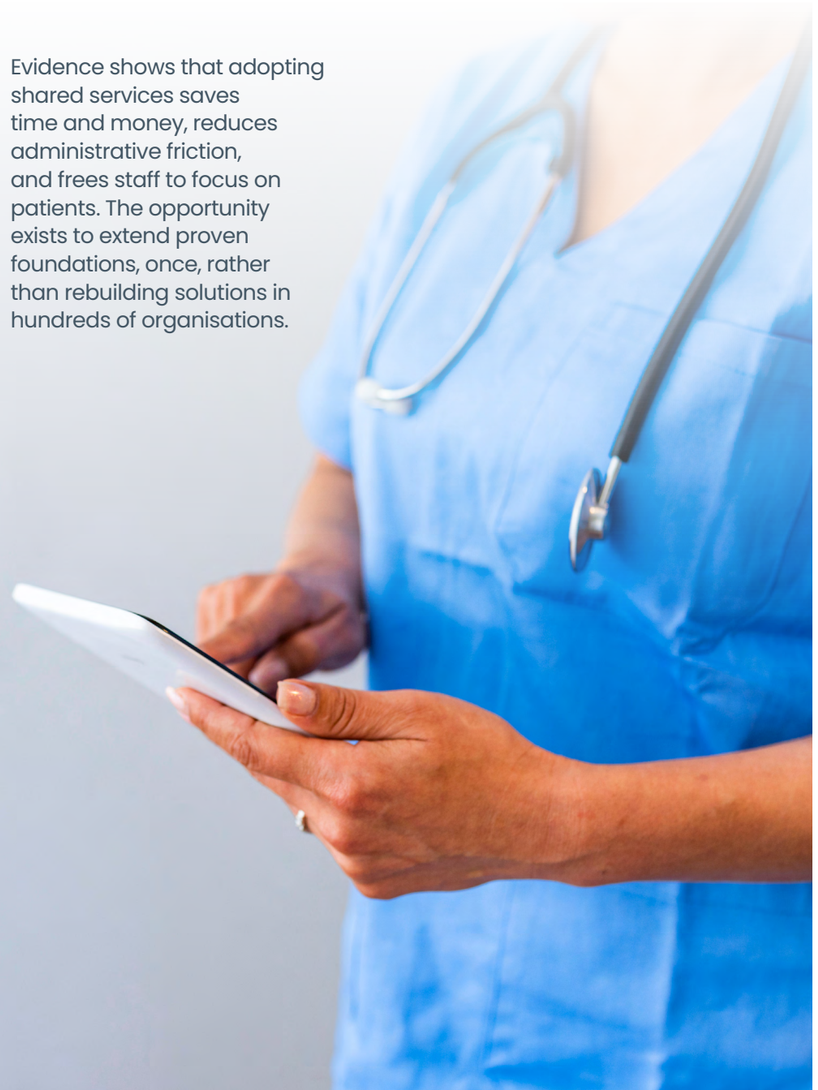
The case for shared corporate services

The government's three shifts need operational foundations that work across the system, not just within organisations.

The government's 10 Year Health Plan sets out an ambitious programme of reform built around three shifts: hospital-to-community, analogue-to-digital and sickness-to-prevention. Delivering each of them depends on care being coordinated across organisational boundaries, and on a set of back- and middle-office systems that function reliably across the whole NHS. In reality, that means finance, procurement and payroll systems run alongside clinical care and keep it working.

This paper argues that a shared operational infrastructure, deliberately designed, built and used across the health service, is needed to deliver the Plan's ambitions. There are examples of this already being used in parts of the system.

Evidence shows that adopting shared services saves time and money, reduces administrative friction, and frees staff to focus on patients. The opportunity exists to extend proven foundations, once, rather than rebuilding solutions in hundreds of organisations.



Why shared foundations matter

Corporate costs have risen while productivity has stalled. Inconsistent operational infrastructures are an understudied part of the explanation.

The productivity gap

Corporate costs across the NHS have risen by £1.85 billion (40%) since 2018, yet productivity remains below pre-pandemic levels. Between January and July 2024, the NHS had significantly more staff than in 2019, but was treating only marginally more patients.[1]

Productivity in healthcare is influenced by a complex set of factors, but evidence suggests that inconsistent operational systems limit the NHS's ability to translate investment into lasting improvement, an area that has received less attention than clinical and workforce factors in previous reform efforts.

The Spending Review 2025 committed up to £10 billion in NHS digital and technology transformation funding by 2028/29.[2] The Health Foundation argues that making change stick requires not just one-off capital investment but sustained funding for implementation and the organisational capacity to deliver it.[3]

The cost of inconsistency

Inconsistent operational infrastructure costs the NHS in different ways. Patients experience delays at critical moments in their care, staff lose time to workarounds and administrative tasks that don't help patients, and the NHS loses purchasing power because buying decisions are made by hundreds of organisations independently rather than collectively.

For example, on any day in the winter of early 2025, on average 13,740 medically fit patients were waiting to be discharged from hospital[4] – the equivalent of 23 hospitals' worth of capacity. Re:State, which made these calculations, noted the problems resulted from "a complex landscape of accountability, funding and inefficient processes".[5]

Operational systems are one part of that picture that shared services reform can directly address.

£10bn

Committed in The Spending Review for Digital and Technology transformation funding

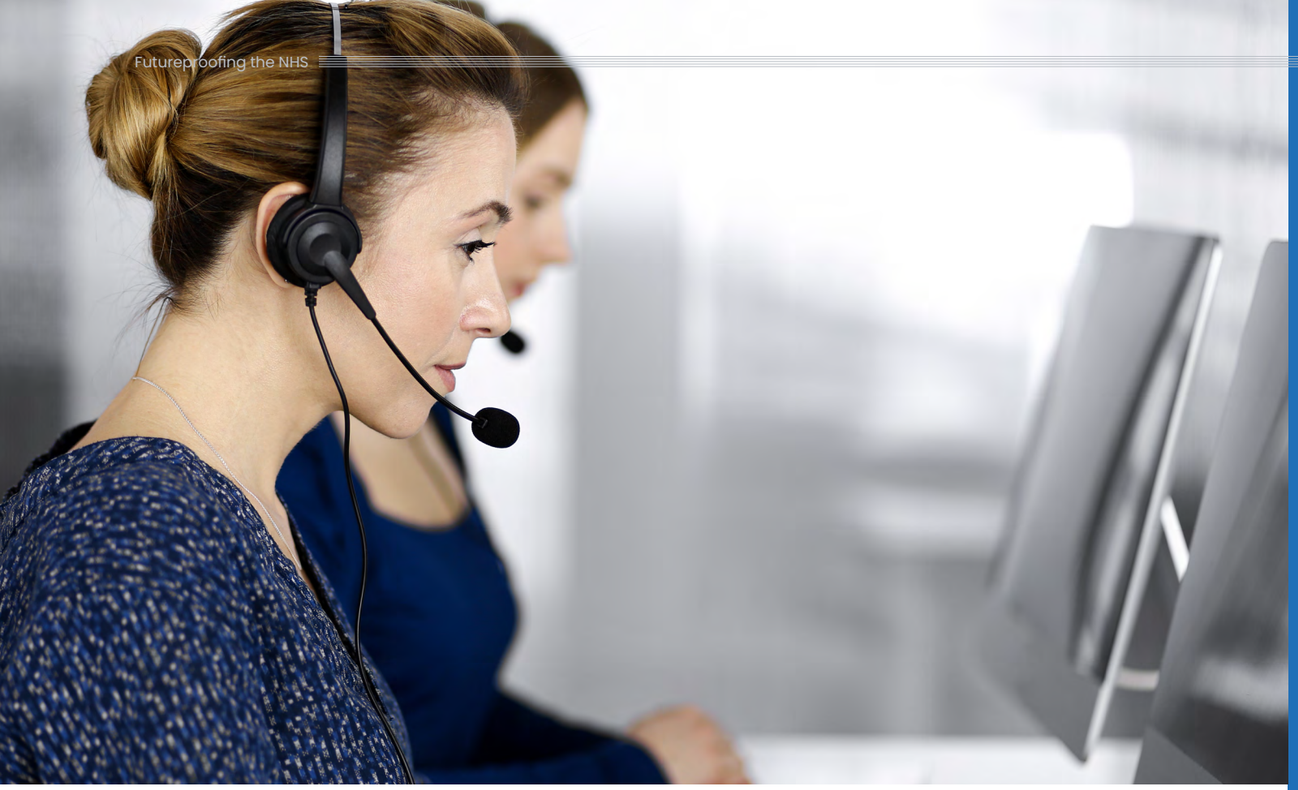
1. NHS England, Board Minutes, Item 5: NHS productivity, December 2024.

2. HM Government, Spending Review 2025, June 2025.

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

4. NHS England, Acute discharge situation report, 2025.

5. Re:State, Hospital of the Future: Ending the patient gridlock, October 2025.



"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."

David Furness
Managing Director, the Shelford Group

This impacts staff too, as David Furness, Managing Director of the Shelford Group, has explained: "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. 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."[6]

At the market level, the NHS spends more than £60 billion a year on goods and services, excluding staff pay, but that purchasing power is spread across hundreds of organisations buying independently rather than together.[7] The Public Accounts Committee (PAC) has warned that this inconsistency costs the NHS tens of millions of pounds in preventable waste a year. Experience from other sectors shows that collective buying and shared supply chains typically deliver around 60% of the total financial gains from working together. The NHS is not yet capturing those gains.[8]

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

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

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

Why variation persists

The problem is structural, not a failure of will.

The variation in operational systems across the NHS is the by-product of various structural changes. Since 1974, the health system has undergone significant organisational reconfiguration, often resetting accountability without establishing a shared operational foundation. Organisations have invested independently in their own systems, embedding bespoke local practices into technical infrastructure. As systems are added to, and patched, without addressing and standardising the underlying infrastructure, the problem becomes harder and more costly to solve over time.

Making the shift to shared services asks local leaders to absorb the costs and disruption of change now, in return for benefits that are larger but arrive later, and often flow to the system rather than back to the organisation that made the investment. That tension is one reason why well-intentioned collaboration sometimes stalls. Boards are accountable to their own organisations, not to the system, and governance arrangements that do not address this directly can leave partnering organisations pulling in different directions even when they agree on the ultimate goal. A National Audit Office (NAO) review of government shared services confirms that even with committed investment and formal obligations, delivery cannot be secured without clear collaborative governance in place.[9]

Richard Stubbs, Chief Executive of Health Innovation Yorkshire & Humber and an expert advisor to the The Health Foundation's NHS Productivity Commission, frames this as a question of loyalty akin to 'club versus country', calling on leaders to move from allegiance to their own organisations toward a more collective vision.[10]

9. National Audit Office (NAO), Update on government shared services, HC 1718, March 2026.

10. NHS SBS, Webinar: The NHS of tomorrow – embedding shared services for lasting transformation, January 2026.

What ‘good’ looks like – freedom within a framework

Shared operational infrastructure enables local autonomy rather than constraining it.

The principle of ‘freedom within a framework’ distinguishes between what must stay local and what works better when shared. Core operational platforms, common data standards, and repeatable transactional processes are well-suited to shared solutions, while clinical decision-making, service configuration and community partnerships should remain local, because they depend on contextual knowledge and relationships.

Drawing that deliberate boundary is what makes the approach work. When the operational foundations are shared, local leaders gain the time, data and capacity to focus on what genuinely requires their judgement. Adoption must be a logical choice for leaders, grounded in demonstrable value and involvement in how services evolve.

What changes in practice

Operational improvements have a direct and measurable effect on the time available for patient care.

Time returned to staff and patient care

The clearest sign that operational systems are working is that people stop noticing them. In contrast, when they do not work, time and energy are absorbed by workarounds, corrections and administration that add no clinical value.

The British Medical Association (BMA) estimates that inadequate and poorly integrated IT costs NHS doctors more than 13.5 million working hours each year, a consequence of systems that fail to support clinical and operational workflows. [11]

When those systems are improved or replaced, the difference is immediate and measurable. At Central and North West London NHS Foundation Trust, automating a paper-based consent process (the kind of manual administrative task that had been absorbing nurses’ time) saved 56 clinical hours every day. Those are hours returned directly to patient care.[12]

13.5m

Estimated working hours lost by NHS doctors in England every year to delays caused by inadequate or malfunctioning IT systems and equipment. (BMA, 2022)

“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.”

Fiz Yazdi
Managing Director, Sopra Steria Next[13]

11. British Medical Association, Millions of hours of doctors’ time lost each year to ‘inadequate’ IT systems, December 2022

12. UiPath, Automation saves time for clinicians in North West London (Central and North West London NHS Foundation Trust case study).

13. NHS SBS, Webinar: Digital transformation under pressure: sustaining momentum amidst NHS reorganisation, October 2025.

Process before technology

Before updating and/or consolidating technologies or automating practices, there needs to be a clear understanding of the role and purpose of the task - how it works, where errors happen, and what causes rework. Without this, problems can become worse.

At Lewisham and Greenwich NHS Trust, automation designed around a specific manual pharmacy invoice workflow reduced task time from around an hour to a few minutes, but the outcome depended on understanding the process before choosing the technology.[14]

Across the NHS and in other sectors, the evidence consistently shows that the organisations that realise lasting value from technology investment are those that treat implementation - process redesign, staff engagement, and sustained support - as seriously as the procurement decision itself.

From local gains to system returns

The gains from operational improvement compound when organisations work together. 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. In Ireland, the Health Service Executive (HSE) deployed automation across corporate services and restored 800,000 hours of capacity valued at more than €30 million.[15]

14. NHS SBS, New pharmacy robot 'Steve' frees up resource (Lewisham and Greenwich NHS Trust case study).

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

Data as shared infrastructure

The NHS generates operational data that could help predict problems and improve decisions.

The NHS generates vast volumes of operational data every day, covering workforce, finance, procurement and estates across hundreds of organisations. However, this data often does not reach the right people, in a form they can use, at the point when it would make the biggest difference. Clinical teams routinely use evidence to inform treatment decisions, but the same discipline has yet to be applied systematically to operational management.

Workforce, finance and procurement information can reveal system pressures months before they appear in clinical metrics.

For example, in one NHS organisation, workforce analytics predicted with 95% accuracy which staff were at risk of leaving, enabling managers to take preventative action before the problem affected waiting lists.[16] In Norfolk and Waveney, meanwhile, a unified data catalogue across five trusts revealed the potential for millions of pounds in previously invisible savings. Identical items had been purchased at different prices across organisations, but the data had never been standardised to enable comparison. [17]

The NAO has noted that data convergence makes it "much easier to integrate systems and use new technology like artificial intelligence (AI)".[18] However, governance for operational data does not require a separate compliance infrastructure; it needs the same operational rigour already demanded of high-stakes transactional services like payroll or invoice processing, where accuracy and consistency are built into processes as a matter of course rather than bolted on afterwards.

Good enough, soon enough

Data needs to match the purpose for which it will be used, rather than trying to standardise everything by default. 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 will become necessary.

16. NHS SBS, Improving Staff Retention with Workforce Analytics.

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

18. NAO, Update on government shared services, March 2026

The delivery model

Delivery models that operate at scale can invest, implement and improve in ways that individual trusts cannot.

Building shared operational foundations requires delivery models that can invest over the long term, operate reliably at volume, and implement change repeatedly without bespoke reinvention. Many individual NHS organisations currently lack the financial headroom to make sustained investments in back- and middle-office services, with capital budgets routinely diverted to cover day-to-day pressures.

Delivery models that operate at scale have a capacity, capability and resilience that individual organisations do not. For example, the new Procurement Act 2023 requires organisations to follow complex procurement, reporting and governance processes, which very few trusts can maintain alongside day-to-day service delivery. Shared procurement services can meet these requirements once, and well, across multiple organisations.

Existing examples show what is achievable. In Norfolk and Waveney, unified procurement cut requisition-to-order processing from days to minutes, and NHS England has since recognised the system as a reference site for consistent reporting and reduced unwarranted variation across an integrated care system. These remain pockets of progress, and the task now is deliberate and sustained extension.[19]

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

Seven recommendations

The structural changes within the NHS as it works to deliver the 10 Year Health Plan create a genuine window for deliberate choices about the operational foundations on which it runs. The Health Foundation's analysis of NHS group models notes that 'economies of scale from creating central corporate service functions' are among the most commonly cited benefits of collaboration.[20] The following seven recommendations could deliver the change needed to achieve both efficiency and clear benefits to patients and staff.

1. Focus leadership attention on operational infrastructure - it is where the efficiency gains are.

Payroll, invoice processing, procurement and most HR administration work essentially the same way in every trust. These functions need to work reliably and efficiently. The practical test is whether a function genuinely requires local knowledge to perform well.

20. Health Foundation, Leading NHS groups, August 2025.

2. Create the conditions for long-term investment in the systems that keep the NHS running.

Shared operational foundations require sustained capital, multi-year planning horizons, and governance that allows costs and benefits to be shared fairly across participating organisations. Operational infrastructure must be treated as a system asset.

3. Invest in understanding problems, not just buying technology.

Procurement that occurs before a workflow is properly understood yields the wrong solution, or the right solution in the wrong form. Shared services add value here by investing in defining problems before specifying solutions, bringing in procurement expertise early, and pooling implementation capabilities that learn from each deployment.

4. Extend proven shared platforms deliberately, rather than allowing uncoordinated variation to continue through inattention.

Where shared operational infrastructure has demonstrated value, national and regional leaders should prioritise extending it rather than defaulting to continued duplication.

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

Delivery models operating at scale can identify, test and embed emerging best practices in ways that individual organisations cannot. Leaders commissioning or governing shared services should expect continuous improvement, not just reliable transaction processing.

6. Use operational data as an early warning infrastructure.

Workforce, finance and procurement data can reveal system pressures before they appear 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.

7. Design governance that makes collaboration easy.

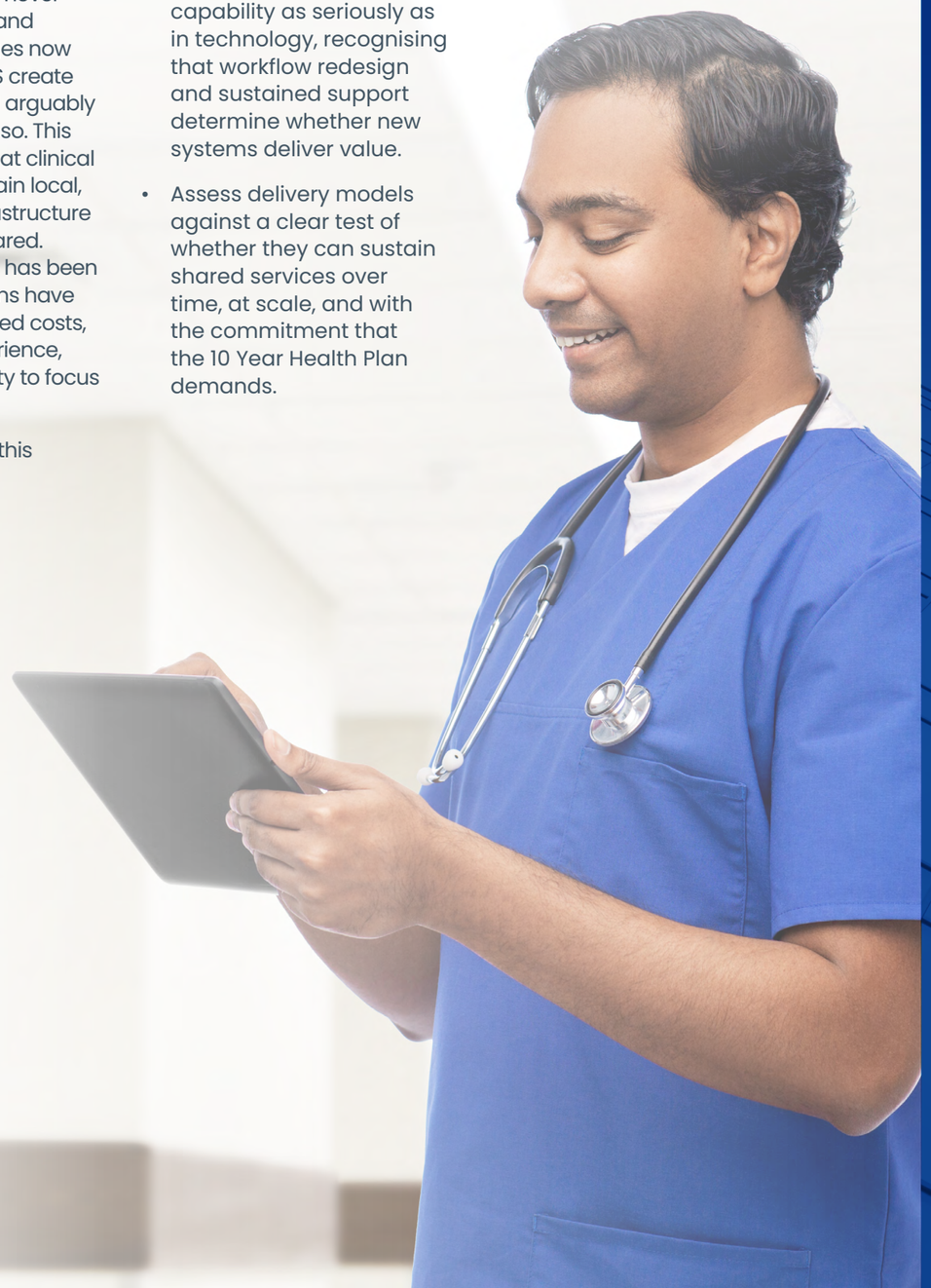
Shared foundations succeed when local leaders have genuine influence over how services evolve, performance is visible, and the benefits of participation are clear and demonstrable.

Conclusion

The 10 Year Health Plan's three shifts require a system to have an operational layer that works consistently across organisational boundaries. That foundation has never been properly built, and the structural changes now underway in the NHS create the opportunity, and arguably the obligation, to do so. This analysis suggests that clinical decisions must remain local, but operational infrastructure works best when shared. Where that principle has been applied, organisations have freed up time, reduced costs, improved staff experience, and created capacity to focus on care.

Leaders who act on this analysis will:

- Treat operational infrastructure as a system asset that benefits from being shared.
- Invest in implementation capability as seriously as in technology, recognising that workflow redesign and sustained support determine whether new systems deliver value.
- Assess delivery models against a clear test of whether they can sustain shared services over time, at scale, and with the commitment that the 10 Year Health Plan demands.



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