All-Party Parliamentary Group for
Healthcare Infrastructure

Built to last:
A ten-point plan to secure NHS infrastructure for the future

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Foreword
from the Chair

Chris Green MP
Chair of the All-Party Parliamentary Group for Healthcare Infrastructure
Member of Parliament for Bolton West

In the face of unprecedented challenges, including delay to the New Hospital Programme and the ongoing complexities brought about by the COVID-19 pandemic, the importance of robust healthcare infrastructure has never been more apparent. Our nation's healthcare system relies not only on the dedication of healthcare professionals but also on the solid foundation of efficient and accessible facilities.

As Chair of the All-Party Parliamentary Group (APPG) for Healthcare Infrastructure, it is my privilege to present the final report of our work during the past year. Our mission has been clear: to navigate the healthcare infrastructure landscape, providing guidance and recommendations that will shape the future of NHS estates and technologies.

The APPG has tackled some of the most pressing challenges facing healthcare infrastructure, as well as exploring exciting opportunities and new ways of thinking that could be capable of unlocking transformative change.

This report is the culmination of collaboration and debate amongst expert sector leaders and Parliamentarians. I have found the APPG to be such a lively and constructive forum. What struck me is that, so frequently, speakers and other contributors have all agreed on the core issues facing healthcare infrastructure and the solutions which policymakers and health leaders must pursue to tackle them. In the world of policy, such uniform consensus is indeed a rarity.

This report – and the Ten-Point Plan it sets out – is intended to serve as a guide for policymakers to address these pressing issues and set a clear path for the future of healthcare infrastructure. During these sessions, contributors have put forward and debated some significant and radical proposals, some of which feature in this report. We should also remember that even minor changes can have transformative effects. The recommendations set out in this report occupy that spectrum, highlighting simple and cost-effective policy changes as well as significant revisions of existing strategies and ways of working.

Healthcare infrastructure is simply too important to get wrong. The solutions seem evident. What we need is the political will to implement these now.

Overview

This final report of the All-Party Parliamentary Group for Healthcare Infrastructure is intended to provide clarity on the future of both primary and acute estates including addressing delays to the New Hospital Programme and the impact of the roll-out of digital technologies and changes to NHS structures. It offers recommendations to ensure the delivery of high-quality healthcare infrastructure which supports the NHS to meet the demands of the future.

Over the past year, the APPG has explored some of the most pressing matters in healthcare infrastructure with experts from across the NHS, policy and Parliament contributing to timely and passionate discussions. Sessions have discussed:

- The New Hospital Programme;
- The future of the primary care estate;
- Innovation in healthcare infrastructure;
- Capital and estates within ICS structures;
- Funding arrangements to deliver healthcare infrastructure for the future.

This report draws on contributions from each of these sessions, underlining the key issues currently facing health leaders and how a number of simple, but important, policy changes could positively transform the NHS estate.

The report outlines a ten-point plan, drawn from contributions to each session, which Government and local health systems could jointly implement to improve the quality of healthcare estates, contributing to fitter and healthier communities with high quality care at their centre.

Our ten-point plan

1. Develop a comprehensive and integrated estates strategy, covering primary and secondary care.
2. Create a minister-led, NHS investment taskforce.
3. Update the Health Infrastructure Plan with a particular focus on the shift to primary and community care.
4. Review capital department expenditure limit (CDEL) rules to allow for better targeted, timely and community specific investment in health facilities.
5. Develop a centralised and coordinated strategy to maximise investment in connectivity and digital transformation.
6. Overcome barriers to underutilisation to ensure that the NHS estate is used to its full potential.
7. Ensure parity of primary and secondary care within local health systems.
8. Encourage collaboration between all organisations within ICSs, including local authorities and independent partners.
9. Streamline the approvals process to help accelerate the delivery of the New Hospital Programme.
10. Provide greater clarity regarding the future of primary care estates and continued investment commitments.

New Hospital Programme

The New Hospital Programme (NHP) was set up in 2020 to fulfil the Government's manifesto commitment. It combined eight hospital building projects that were already under construction or pending final approval with the pledge for 40 more, which were to be completed between 2021 and 2030.

In 2023, seven hospitals that needed rebuilding because they contained Reinforced Autoclave Aerated Concrete (RAAC) were also brought under the programme. RAAC hospitals were prioritised due to the safety risks posed. The Government has said that because of this reprioritisation and the rising cost of building materials, some projects will now be completed after 2030.

Since the APPG's 2022 report, progress has been slow. Of the eight projects already in planning before the NHP was launched, three have opened or part opened, and three others are scheduled to open in 2024. The first of the 40 new projects which began after the programme's launch – the Dyson Cancer Centre in Bath – is expected to open in spring 2024. This is due to be followed by Shotley Bridge Hospital in County Durham in 2025, although building work is yet to commence. Most construction work is scheduled for the later years of the programme, including many of the larger hospital projects, but specific funding allocations are yet to be announced.

The Public Accounts Committee has expressed concerns about the lack of progress made and whether the programme has sufficient funding.

Speakers accepted that there have been delays approving projects across the programme but work is being done to expedite this process. One speaker envisaged the approvals process becoming a 'simple box-ticking exercise' which would lead to years being taken off delivery times in future.

The Government says it remains committed to all projects that have already been announced as part of the programme. As implementation of the NHP progresses, it is essential to address key challenges and develop a clear strategy for the programme's long-term sustainability.

One speaker also encouraged policymakers to consider the role of the primary care estate in reducing demand on acute settings. As hospital waiting lists grow and pressure on emergency departments rise, treating patients earlier and in community settings can provide much needed capacity in a shorter timeframe.

Recommendations

Streamlined approvals process

There is an urgent need to streamline the approvals process to expedite project initiation and progress. Delays in approvals from government bodies have significantly hindered the timely execution of projects. Implementing a more efficient and transparent approval mechanism will help accelerate the delivery of the NHP.

Continuation of existing schemes alongside development of a comprehensive NHS estates strategy

While it is crucial to continue with existing schemes under the NHP, there must also be simultaneous development of a comprehensive, future-oriented estates strategy. The current backlog in secondary care estate maintenance, which exceeds £11 billion, highlights the importance of proactive planning and investment. Additionally, there is a need for parity in planning and allocation of funding between secondary and primary care estates. This approach will prevent the accumulation of future backlogs and ensure holistic healthcare infrastructure development.

Clarity on primary care estate future

Alongside the implementation of the NHP, there is a critical need for greater clarity regarding the future of the primary care estate and continued investment commitments. It is essential to develop a comprehensive understanding of the long-term strategy for the NHS, which includes investment and incentivisation to transition services from hospitals to primary care settings. This will ensure a balanced and sustainable healthcare system that meets evolving needs.

The future of the primary care estate

All major political parties have stressed the need and their desire to shift patient care from the acute sector into the community. As preventative measures take effect and care is delivered closer to home, considerations must be made as to what the associated estate needs to look like and how it will be funded.

Primary and community health care has long suffered from a lack of funding, despite increasing demand. A recent report from the Royal College of General Practitioners found that 4 in 10 GPs are working in premises that are 'not fit for purpose'. 88% of respondents noted that there was an insufficient number of consulting rooms at their practices. This view was echoed by speakers at the APPG's meeting on this subject. This shortage of capacity within the primary care estate is being exacerbated by the move to increase provision of care in community settings following the passage of the Health and Social Care Act 2022. In addition, the Additional Roles Reimbursement Scheme provided welcome resources to cover the salaries of additional multi-disciplinary roles in primary care but did not address the challenges with the estate, meaning that practices may not have the space to host the additional staff that are supported through the scheme.

If any Government, current or future, is serious about shifting care to the community, they will need to address the outstanding issues and uncertainties around the primary care estate. Primary care and, in particular, general practice are suffering from a workforce crisis. The Health and Social Care Select Committee released a report into the future of general practice in 2022. It noted that 42% of GPs and GP trainees were likely to leave general practice in the next five years. This coupled with the already low numbers of GPs currently in practice, and the lack of space available for training the next generation, should be a cause for concern.

The same report, when discussing the estate noted: "*that the Government must make additional investment available for the general practice estate to enable integrated care to be effectively delivered*". This echoes the findings of Dr Claire Fuller's 2022 report into 'the next steps for integrating primary care'. Dr Fuller found that of the 8,911 primary care premises in England, around 2,000 were deemed not fit for purpose. In fact, little progress has been made since the 2017 Naylor Report, which concluded that without investment the NHS estate will "*remain unfit for purpose and will continue to deteriorate*".

The APPG's 2022 Report recommended that the Government and NHS England should consider the option of third-party partnerships, including third party development, for the construction of GP premises and provide a targeted fund to modernise and upgrade the oldest parts of the estate. It was also recommended that rules on building utilisation must be reviewed and efforts made to ensure that financial rules for different sectors of healthcare do not pose artificial barriers to making the best use of space. For example, in some cases GP rent reimbursement rules can make co-locating with community or secondary care services difficult. The focus should be on providing a modern, fit for purpose primary care estate that meets the needs of patients that have been identified locally and the rules should be reviewed to make this easier to achieve.

Since the time of our 2022 report, little headway has been made on these recommendations and many of the same issues persist. Much more needs to be done to cement the future of the primary care estate. The Health and Social Care Act 2022 formalised the move to providing greater care in community settings and both the Government and Opposition have committed to continuing with this direction of travel. However, this policy will be impossible to implement without addressing the capacity challenges within the current primary care estate.

Recommendations

Targeted investment

Funding must be officially allocated to improve and build new primary care infrastructure. This will be one of the key factors to ensuring the NHS can facilitate the shift from acute to community care. Investment must also be made into improved digital infrastructure, safeguarding the functionality of the estate for the future.

Better utilisation

There is a need to overcome barriers to integration of care between different sectors to ensure existing high quality infrastructure can be used to its full potential. At present too many primary and community care facilities have void space that is not being utilised. We would recommend that Government review funding restrictions and rules around utilisation so that these spaces can be made available for services that will support preventative healthcare. An example of this could be by ensuring that GP rent reimbursement rules do not prevent practices providing services in partnership with their local voluntary and community sector to meet local healthcare needs, offering one-stop shops and make best use of existing, high-quality infrastructure.

Supporting the next generation of GPs

Beyond infrastructure, the retention of an adequately trained and happy workforce is one of the biggest problems facing primary care. The NHS workforce plan set out the Government's ambitions to recruit more GPs however, the Royal College of GPs recent report highlighted, amongst other things, an acute lack of space for training. As part of any estates strategy, we would recommend the Government includes provisions to increase space for doctors and other healthcare professionals to train. This should be subject to rent reimbursement and we would recommend the strategy includes the revenue implications of the creation of these spaces.

Innovation
in healthcare infrastructure

In 2023, the NHS celebrated its 75th anniversary and the UK looked back fondly on how this remarkable organisation has adapted over the years. Since 1948, the NHS has grown to become one of the largest employers in the world, providing over 1.5 million patient interactions every day. The past few years have, undoubtedly, been some of the most challenging for the health service, pushing it to its limits and challenging its ways of working. As we celebrated its 75th anniversary, the APPG sought to explore what transformation would be required to ensure it survives another 75 years (and more). As demand for NHS services expands and evolves, innovation in healthcare infrastructure must be championed to meet new and existing challenges.

The APPG's 2022 Report found that the poor and disconnected data system across the NHS was one of the biggest barriers to innovation. The report called for the creation of a single nationwide patient health and social care data platform with NHS England as the sole data controller, and some progress has since been made against this recommendation.

In November 2023, the NHS awarded US tech firm, Palantir, a £330 million contract to set up and operate the Federated Data Platform (FDP). The FDP will allow Trusts and ICSs to communicate with each other and share data that will hopefully lead to improved and more efficient care. NHS England must ensure safeguards and accountability are in place to demonstrate that it retains overall control of the data and to ensure none of the commercial partners involved in the FDP can access patient data without its consent.

The FDP will be crucial to improving communication and collaboration across the NHS. To support this and wider innovation in the NHS, there must also be sustained investment in connectivity. During the APPG's session on the topic of innovation in healthcare, the value of investing in 5G connectivity was demonstrated. New technology makes it possible to link clinicians to patient data in real time and monitor patients at home, freeing up much needed capacity and enabling better treatment for those with mobility issues. Investment in connectivity will be crucial if the NHS is to remain agile and responsive to the needs of patients and staff.

The APPG's session on innovation in healthcare infrastructure explored digital health transformation (DHT). Speakers agreed that the term is used frequently by health leaders and policymakers, but there is a need to be more precise about its meaning if it is to be considered a key driver of improved health outcomes. The importance of digital education was also raised to ensure that NHS workers are trained to operate new equipment and systems.

Perhaps most important is the need to review the UK's approach to innovation. The APPG heard that, from our powerful life sciences sector to the NHS itself, the UK has world-leading assets which are waiting to be maximised. Speakers argued that the UK has a sporadic record when it comes to innovation, excelling at providing platforms for trials and early-stage application, but struggling to adopt these innovations at pace and scale. The NHS also struggles to learn from previous projects and communicate outcomes across organisations, fuelling inefficacies and hampering progress.

Recommendations

Develop a digital transformation strategy

NHS England should develop a centralised and coordinated strategy to maximise investment in connectivity and digital transformation, ensuring pioneering technologies and systems can be used across healthcare settings. NHS England should create robust objectives and clearly define what is meant by DHT and how it can help to improve patient outcomes.

Improve effectiveness of trials

NHS England should encourage ICSs and Trusts to trial innovative technologies to create a more efficient and effective health service that is fit for the future. To complement a bolder approach to innovation, ICSs and Trusts should develop stronger reporting practices, so lessons learned are not confined to specific regions or organisations.

Capital and estate within the new ICS structure

The introduction of ICSs is an important step in shifting to an integrated approach to healthcare. While the NHS has traditionally focused on treating single conditions or illnesses, people now live longer and often present with complex, long-term conditions that require support from various services and professionals. ICSs, as the name suggests, seek to integrate services and deliver improved health outcomes.

ICSs are still in their infancy and their maturity varies greatly across England. As one speaker remarked, 'once you have seen one ICS, you have only seen one ICS'. Given this variation, it is perhaps unsurprising that the APPG's2022 Report recommendation to clearly devolve estates and property management to ICSs has not been achieved consistently across England.

During the session on capital and estates, the APPG heard that there are a series of dichotomies in capital funding. Importantly, there is more capital in the system than there has been for a long time, but there is also far greater demand than ever before. Furthermore, there are tensions in less mature ICSs when the influence of the acute sector skews budgets. Finally, the APPG also discussed the clear tension between ICSs' strategic priorities, as they try to balance budgets in the short-term but deliver long-term health and estate strategies.

It is critical that ICSs develop and deliver robust estates strategies if the NHS is to have access to high quality infrastructure to meet the growing demand for services. Strong estates teams are required to devise and deliver these strategies but some ICSs lack the necessary resources and expertise to make this a reality. We heard that lack of experience has resulted in weak strategies and a failure to take advantage of non-health funding streams such as Section 106 grants and the Community Infrastructure Levy, further compounding the squeeze on local health budgets.

Coordination and cooperation should be baked into the design of ICSs with local authorities represented through a number of bodies such as integrated care partnerships and place-based partnerships. Despite this, there is often poor communication and collaboration between local authority housing teams and ICS estates teams, leading to a shortage of healthcare facilities to meet local needs.

The APPG heard that, while there have been pockets of success, a lack of primary care facilities being built alongside large housing developments is a common issue. Speakers discussed the fact that education and recreational facilities rarely see the same shortages, singling out healthcare infrastructure as an exception. The Infrastructure Levy could be a potential solution to this issue when it comes into operation, however, it was accepted that this may have little impact on existing developments already underway.

Recommendations

Parity of primary and secondary care

To facilitate the shift to community care, ICSs should focus on parity of primary and secondary care when planning estates, ensuring there are enough high-quality facilities to deliver care closer to home. Adequate investment in primary care capacity would support the delivery of earlier and more cost-effective treatments and reduce demand on acute settings which are under immense pressure.

Utilise all estates capacity and capability within systems

ICSs should make best use of partners in local health systems who can provide much needed capacity and capability to existing estates teams. Collaboration and coordination should be baked into ICSs and health leaders should ensure that all available resources and experts within local systems are being utilised to support the development of estates strategies. A broad range of contributors with a variety of expertise, including from the voluntary sector and commercial organisations, will create more robust strategies that tap into a broader range of funding opportunities.

Closer collaboration between NHS and local authorities

ICSs should seek to improve partnership working with local authorities to ensure that their estates strategies are informed by, and also inform, local house building plans, taking advantage of the new integrated approach to care. ICSs provide effective structures for this collaboration to take place, but leaders must encourage member organisations to communicate more effectively to ensure strategies align and complement one another.

Funding arrangements to deliver healthcare infrastructure for the future

As the fiscal constraints on Government expenditure and departmental budgets grow, the case for where the NHS budget should be allocated is increasingly contested. In the Chancellor of the Exchequer's 2024 Budget, he earmarked £2.5 billion of additional day to day funding for the NHS alongside £3.4 billion towards digitisation, but competition for this will see it swiftly swallowed up. After all, capital investment in the UK is far below that of comparable countries, in some cases up to 50% less.

In estate and capital spending, there remain other competing elements. Notably, a speaker claimed there is more capital in the system than ever before yet demand remains exceedingly high. Furthermore, the compartmentalisation of budgets encourages competition between organisations. As laid out at the APPG's meeting which discussed capital and estate within the new ICS structure, a speaker noted the tensions when acute organisations try to influence budgets as well as between short- and long-term strategic priorities.

This competition is further compounded by valuable capital being taken to fund retroactive and expensive works such as the demolition and rebuilding of facilities with RAAC. The budgets for capital spending remain extremely tight yet it is clear that more building must take place to meet the significant demands being placed on the health service. The case for private finance to best support the building of healthcare infrastructure remains ever-present. The 2022 APPG report recommended that HM Treasury should undertake a review of its position on partner investment into healthcare infrastructure. The White Fraiser Report, made recommendations for improving existing public-private partnership agreements and minimising disputes, but did not consider future arrangements.

One of the frequent issues raised in meetings of the APPG focused around CDEL rules and capital allocations. The amount that can be spent on capital across NHSE in any given year is called the capital departmental expenditure limit (CDEL). DHSC is responsible for ensuring the allocation is not overspent but the current accounting rules require multi-year leases to be included on balance sheets as though the entire value of the lease is allocated in a single year. This means, although the money is not due to be spent for several years, it can appear that a trust has reached or even breached their CDEL. A speaker noted that a lot of capital is ringfenced and reporting requirements can lead to its inefficient distribution. Parliament votes on the overall CDEL envelope, which speakers suggested should be better allocated in a way that matches the needs of both patients and local systems and reflects when the money will actually be allocated.

Speakers acknowledged that capital is more likely to be allocated to the acute sector than primary care, which is at least in part due to the perception that it has greater need. Shifting the care from hospitals to community will, however, require a fairer distribution of spending and greater recognition of the role that primary care can play in meeting patient needs that are currently being met in the acute sector or avoiding the need for secondary care services at all.

The APPG also heard that GP funding models currently make it difficult to share facilities with other services and providers. Both the investment and revenue flows of the existing ownership model are conducive to smaller buildings for practices. As we look to co-locate more services and create 'one-stop-shops', funding models should be adapted to accommodate this shift.

Recommendations

NHS Investment Taskforce

The Government should appoint a taskforce to conduct a full review of NHS capital and revenue investment to set out a strategy to address the urgent needs of the estate. This should be made up of DHSC, NHS and business leaders and be overseen by a Government Health Minister. The taskforce would identify key objectives and meet several times a year to agree and monitor activity to increase and improve funding for the NHS estate, in both the acute and primary care sectors.

Update to the Health Infrastructure Plan

A core part of the Taskforce's work should include a comprehensive update to the Health Infrastructure Plan to support and complement local and regional estates strategies. This should go beyond the NHP and contain a particular focus on prevention, primary and community care and the estate required. The current five year plan expires in 2024, and so the next plan should be in development urgently to avoid a gap between plans where decisions cannot be taken.

Review of CDEL rules

The current CDEL rules are limiting the ways in which ICSs and Trusts can make meaningful spending commitments to improve, upgrade or build facilities. The NHS Investment Taskforce should have a dedicated workstream to explore how systems can best use the CDEL rules to ensure local estates needs are met. This will be increasingly important for the primary care sector, whose representatives must be brought into the discussion alongside their acute sector counterparts. While there are additional mechanisms such as the GP contract and the NHS Premises Costs Directions which could provide an alternative to the CDEL rules, GPs can have concerns about taking on long-term lease liabilities where part of the liability is linked to another organisation. Reform to enable ICBs and/or NHS Trusts to guarantee the lease would be helpful to allay these concerns which could unlock additional private investment in primary care estates.

Clarity over the use of independent partnerships

Further clarity is needed on the use of independent partners, where these provide value to support the delivery of NHS infrastructure. There have been several models that have leveraged the expertise and financial structures of independent sector partners for the benefit of local communities. In the short-term, reviewing the impact of the NHS Premises Costs Directions to ensure that they are fit for purpose and can encourage third party development could lead to significant estates improvements through private sector investment in partnership with GP practices and federations. Other models such as the NHS Local Improvement Finance Trust (LIFT) and the Mutual Investment Model (MIM) should be reviewed with a particular focus on how they could be adapted for future use.

Early decision-making and robust estates planning

A particular emphasis should be placed on long-term planning and looking at multi-year revenue spending plans. Healthcare infrastructure requires long-term planning and financing, yet the allocation of funding continues to be conducted on a short-term basis. Annual budgets remain a key focus for policymakers and there must be a step change to long-term allocations to allow for effective estates planning.

The APPG for Healthcare Infrastructure

Speakers

The APPG has been fortunate to hear from a range of expert voices over the past year. We are grateful for the insightful contributions made by each of the below speakers:

- Wayne Ashton, Eric Wright Group
- Prof James Barlow, Imperial College London
- Victoria Cave, Department of Health and Social Care
- Stephen Dance, Infrastructure and Projects Authority
- Natalie Forrest, Department of Health and Social Care
- Dr Saira Ghafur, Imperial College London
- Rob James, Assura plc
- Edward Jones, NHS Confederation
- The Lord Markham, Department of Health and Social Care
- Prof Grant Mills, UCL
- Sean Phillips, Policy Exchange
- Hugh Robinson, gbpartnerships
- Nick Smallwood, Infrastructure and Projects Authority
- Nicola Theron, North Central London ICS
- Anne-Marie Vine-Lott, Vodafone

The Chair and Officers of the All-Party Parliamentary Group for Healthcare Infrastructure are:

- Chris Green MP – Chair and Registered Contact
- The Lord Bethell – Vice Chair
- The Rt. Hon. the Lord Naseby – Vice Chair
- The Rt. Hon. Theresa Villiers MP – Vice Chair
- Peter Dowd MP – Officer
- The Rt. Hon. Philip Dunne MP – Officer
- Nick Fletcher MP – Officer
- Bell Ribeiro-Abby MP – Officer

Sincere thanks is extended to all the sponsors, who contributed to, and actively participated in the APPG sessions on health infrastructure and the future of NHS primary estates this year.

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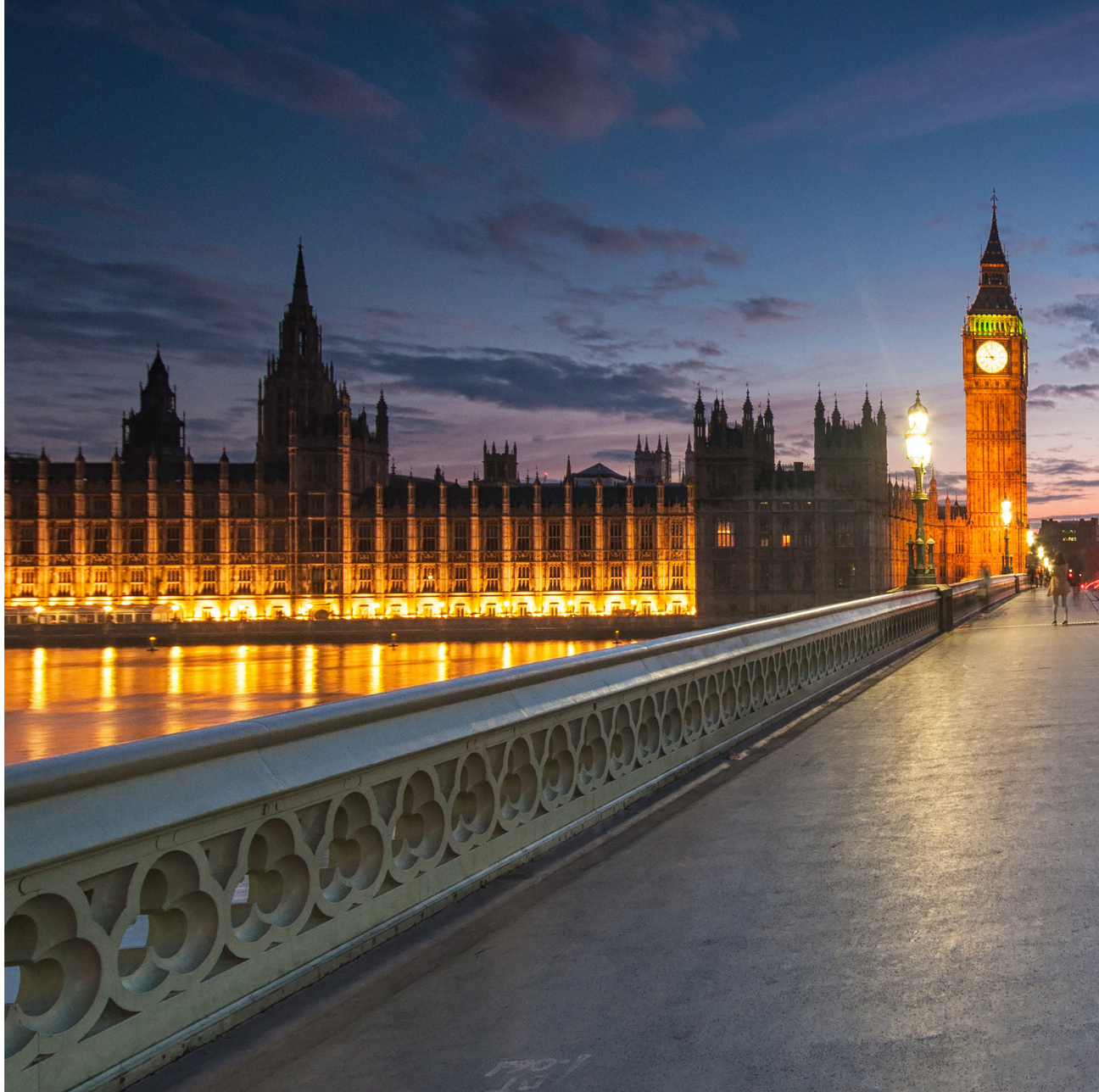

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