10 Year Health Plan working group: physical infrastructure

Co-chairs' report

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Chair's foreword by Simon Linett and Emily Curtis

The future infrastructure needs of the NHS are difficult to predict. Future innovations and policy choices could have radical implications for long term infrastructure demand, through advances like artificial intelligence (AI), improved prevention, scientific progress, better use of incentives such as payment by results, virtual wards and shifting more care to community or social care settings. Accordingly, the working group commissioned a capacity model designed to help policymakers adapt to evolving advancements, but it has proved extremely difficult to coalesce around well-evidenced demand assumptions that build in left shift at scale. What is clear, however, is that the NHS is starting from an extremely difficult place. As Lord Darzi highlighted, the NHS estate is in disrepair and has suffered from capital starvation and political short-sightedness for decades (Darzi, 2024). The NHS in England has fewer beds per capita than any Organisation for Economic Co-operation and Development (OECD) peer nation (British Medical Association, 2025). As such, our group has reached the conclusion that inevitably, successful delivery of the 10 Year Health Plan will require significant investment in infrastructure in the short and medium term.

As suggested by vision working groups, new developments should incorporate as much flexibility as possible to accommodate changing demands throughout their lifetimes. The estate of the future must be more dynamic and responsive than in the past as we expect an acceleration in technology adoption, new treatments, demographic changes and changing pathways, such as the rapid rise in caesarean sections (Roberts, M., 2024). Physical infrastructure will need to enable priority new treatments of the future (genomic medicine, CAR-T therapies and mRNA vaccine manufacture), as well as accommodating the basics of functioning digital infrastructure.

Our working group strongly supports shifting capital investment leftward, as primary and community care offer better value for money. Moving services from hospitals enables innovative pathway redesign, not just relocation. Elective outpatient, diagnostic and day surgery procedures can be faster, one-stop where possible, with fewer unnecessary follow-ups. Community urgent treatment centres (UTCs), especially when co-located with diagnostics, reduce costly hospital visits (NHS England, 2024a). This approach delivers both elective and urgent care faster, at lower cost, closer to home and with higher patient satisfaction. By investing more in this space, acute hospital admissions and length of stay could also be reduced. Neighbourhood health models, and models which integrate healthcare with well-being, employment, housing and third-sector services, can reduce infrastructure needs while better serving deprived communities and tackling health inequalities.

There are clearly trade-offs involved with making this shift happen in practice. It would require ongoing political appetite, especially given the significant backlog in the acute NHS estate and the demographic and morbidity trends in the general population. Maximising the size of the total pot through alternative financing models could mean that this trade-off is felt less acutely. Public-private partnerships, real estate investment trusts (REITs), Local Improvement Finance Trusts (LIFT), mutual investment models and joint ventures could leverage private capital without repeating past mistakes. Now is the time to explore this fully with His Majesty's Treasury (HMT).

The NHS's acute estate faces an intimidating maintenance backlog, with a growing proportion categorised as high or significant risk, including around 47 hospitals that contain reinforced autoclaved aerated concrete (RAAC) (GOV.UK, 2023). This poses safety concerns for patients and staff, disrupts services and hampers productivity. The National Audit Office (NAO) reported 5,400 clinical service incidents occurred in the NHS every year due to property and infrastructure failures between 2019 to 2020 and 2023 to 2024 (National Audit Office, 2025). Addressing this backlog is essential, but given the constraints on public capital, we must make choices about priorities. Our working group has chosen to recommend a long-term shift towards primary and community care investment. This is something successive strategies have aspired to but never fully delivered. This shift will require major system-wide transformation, which comes at a cost. Realistically, meeting future infrastructure needs will require both increased funding, whether through greater public spending or alternative financing mechanisms, and difficult trade-offs. Over time, this may necessitate the consolidation of acute services, and in the long term, even the closure of some hospital sites or wards. While these are challenging decisions, they are essential if we are to build a sustainable NHS estate that supports the delivery of modern, efficient and patient-centred care.

Alongside this, we should aggressively incentivise better utilisation of existing health infrastructure, including disposing of and repurposing estate, and prioritise a One Public Estate approach, co-locating services with other public sector and third-sector organisations. Consolidating primary care into large units, and expanding community diagnostic centres should be encouraged, as recommended by vision working groups. The current capital regime is too centralised, bureaucratic, slow and costly. Approval layers should generally be streamlined to 3 layers: provider, system and national (Department of Health and Social Care and NHS England), with only the very largest schemes requiring ratification by HMT and or Cabinet Office. High performance should be rewarded with greater autonomy, while underperformance should be subject to enhanced scrutiny, alongside additional incentives to encourage strong delivery. The future role in the infrastructure ecosystem of government's 2 property companies - Community Health Partnerships and NHS Property Services - needs focused attention. The highest priority is significant reform of NHS Property Services if we are serious about left shift to improve estate condition, tenant satisfaction and patient care. Such reform could involve

constitutional changes to place NHS property services, like the primary care it serves, in the private sector and enable it to operate more commercially and have greater access to capital. One future need that is certain is the shift to a decarbonised, more climate resilient estate. Addressing the NHS's net zero targets within the next 3 to 5 years will require national coordination and cross-government funding agreements. Greater emphasis must also be placed on climate resilience and adaptation, with a national governance mechanism recommended to oversee these efforts.

We would like to thank our working group members, international experts, and NHS, government, and local government leaders for working with us on this endeavour and welcoming us to sites across England. Despite the challenges, we remain cautiously optimistic that by continuing this work and embracing bold proposals the NHS can build a more effective health estate to meet the evolving needs of the population.

Introduction

Physical infrastructure is a crucial enabler of health system performance and improvement. Without the right estate, in the right location, in good condition, world class care is not possible.

In that context, Lord Darzi's findings paint a stark picture. We have systematically underinvested in capital since 2010. If we had matched peer countries' investment growth, we would have spent an extra £37 billion over the period (Darzi, 2024).

The impacts of this prolonged funding squeeze are clear and have been strongly felt by both the public and staff, as highlighted in the widespread Change NHS public engagement programme. The hospital backlog maintenance bill has soared to £13.8 billion - more than doubling since 2014 to 2015 - while the proportion of high and significant risk issues has risen from 34% to 55% (Fozzard,K., 2024; Kirk-Wade, E., 2024). This compromises safety, forces ward closures, cancels operations and hampers productivity. In primary care, 20% of the estate predates the NHS, with many facilities still housed in sometimes unsuitable residential properties (Darzi, 2024). We lag behind international peers on equipment and scanners and the pathway to the NHS' net zero commitments is steep, with the NHS estate still responsible for 30% of public sector carbon emissions (Darzi, 2024).

The challenges here extend beyond funding levels. The current NHS capital regime is notoriously complex and difficult to navigate and has been described by Lord Darzi as "byzantine" and "dysfunctional" (Darzi, 2024). This complexity often hinders progress. Additionally, the system is still adapting to the structural reforms that established integrated care systems (ICSs) and their role in setting local health infrastructure strategies. Capability across ICSs varies. These issues combined would challenge even a well-functioning and mature system. Addressing these issues is essential to achieving the level of estates transformation required to deliver the 10 Year Health Plan.

Despite these challenges, there is reason for optimism. Throughout this process, our working group has engaged with stakeholders across the health system and beyond, drawing on diverse perspectives and considering bold proposals, which we have set out even where these require further definition. This report also outlines straightforward changes to the capital regime that could have a significant impact, alongside opportunities for better utilisation of the NHS's large estate.

We have structured this report around 4 priority themes. The first 2 focus on getting the basics right and maximising what we already have. These are the essential foundations the system needs to be built upon. We then move to how infrastructure needs to support and drive the government's reform agenda, by enabling the left shift. Finally, and with that strategic direction set, we consider how best to empower the system over the long term,

ensuring the right capability and frameworks are in place to deliver consistently excellent outcomes by the end of the 10 Year Health Plan and beyond.

Priority theme 1: getting the basics right

Headline recommendations:

- give immediate certainty to the system through a multi-year capital allocation to the NHS following the conclusion of the Spending Review in June
- beyond that move to 10-year planning horizons for capital
- make the capital funding regime much more flexible to aid effective financial management of infrastructure schemes, through fewer ringfences and more flexibility between financial years
- introduce a national estates survey to significantly improve the data and evidence we hold on physical infrastructure
- radically streamline the capital approvals process, removing duplication and 'layers' to foster dynamism and delivery

We should start with addressing the fundamentals of the NHS capital system as it stands today. A clear and consistent message from public and staff engagement is that failures in these fundamental elements slow delivery, reduce value for money, stifle innovation and ultimately worsen patient outcomes. As one Change NHS participant put it, healthcare facilities are "old, too small, have leaking roofs, and are generally not really fit for purpose… years of underinvestment has exacerbated the problems". As such, the 10 Year Health Plan must include clear, common-sense recommendations to reform capital planning and investment.

Long term capital funding settlements

Long term certainty is consistently cited as one of the biggest barriers to unlocking better value from infrastructure investment. This is a longstanding challenge with capital settlements for government departments, and one of the obvious constraints is the government's overall fiscal cycle.

Recent years have been particularly challenging here. The change in government, high inflation environment, capital to revenue switches at a national level, and the one-year funding settlement at spending review 2024 all combined to undermine the system's ability to plan. England's short-term approach to capital planning is not shared by other health systems, in some of which an outlook, if not detailed spending plans, of between 10 and 30 years is possible.

The reforms announced by the Chancellor at the Autumn Budget will help. Firstly, by moving to 5-yearly capital funding settlements updated every 2 years through a spending review; secondly, through the new fiscal rule that effectively prohibits capital to revenue switches. Spending review 2025 will confirm departmental budgets in June to 2029 to 2030; the next round of NHS planning guidance should build on this by confirming indicative multi-year capital allocations to systems, to enable them to properly plan their forward investment strategy. This returns to the approach taken following spending review 2021. This will support development of a much clearer pipeline of capital and infrastructure investment projects across the system, aligned with integrated care strategy (ICS) long term infrastructure strategies, in turn, clearly signalling demand and improving partnership to, and with, the construction sector, and in turn generating improved value for money.

Alongside this, the department should continue to make the case to HMT for even longer-term 10-year capital settlements for health. This could be approached in different ways. For example, 5 years of fixed budgets followed by a 5-year indicative settlement, or a minimum planned investment level. In any case, giving more certainty to the sector and extending planning horizons should lead to better investment outcomes.

Increased capital flexibility

In addition to greater certainty, we should introduce greater flexibility to capital funding pots. This has been cited as barrier to effective financial management and infrastructure delivery.

There are 2 main opportunities here. This includes a move towards fewer ringfences around individual capital funding pots, to allow funding to be spent more coherently and strategically in line with local infrastructure strategies and plans. Also, considering mechanisms to provide greater flexibility across financial years. This could support more efficient use of capital and end poor practice where money is rushed out of the door before financial year end. This aligns with the direction of travel being established for overall NHS funding through the finance and contracting 10 Year Health Plan working group. Calls for cross-year budget flexibility are not new. With that in mind, it is recommended that the Department of Health and Social Care (DHSC) and HMT work to develop a short note on where cross-year flexibility is already possible within existing budget guidance and identify where that guidance might need to change so that others can take advantage of it.

Radically improved estates data

Good long-term planning starts with having a strong understanding of the existing estate and asset base. However, the information held on the state and composition of health infrastructure is fragmented and generally poor. Although we generally support more local

decision making, there will always be a need to make some decisions nationally, and a standardised, high equality, approach is necessary to inform this.

At national level, data on the secondary care estate is gathered through the Estates Returns Information Collection (NHS England, 2025a). This is self-reported by trusts, with inconsistencies in how data is gathered and reported. Data on the primary care estate is held on NHS England's SHAPE platform, although this is not routinely collected in the same way and the ownership model means information is not necessarily consistent or up to date (Department of Health and Social Care, 2025). Some integrated care boards (ICBs) do not have a full picture of all health assets in their geographies.

This makes it challenging to ensure resources are effectively targeted at the most pressing need. High quality, independently audited data is an important tool for holding owners of public assets to account for how they are maintained and managed. Other departments do this better than health. The Department for Education's 'Condition Data Collection' for schools provides an independent assessment of building condition to help inform long term capital and infrastructure strategy both nationally and locally (Department for Education, 2024). While recognising that health buildings are generally more complex and diverse than schools, adopting a similar approach for the NHS could bring huge benefits. The government and NHS England should therefore introduce a national health estate survey, operationalised and conducting surveys on sites by 2027 to 2028.

This should cover both the secondary care estate and primary or community buildings. Its data collection objectives should align with our core policy aims, from improving estate quality to mitigating carbon emissions and adapting to climate change. This will generate a much stronger evidence base on infrastructure need nationally and enable resources to be targeted much more closely at genuine need - delivering significantly improved value for money. The department and NHS England should also use this to develop a system-level model of future capital investment required for infrastructure, building on NHS England's Long Term Infrastructure Strategy modelling. This is not a one-off exercise, regularly repeating the survey will allow us to see accurately the deterioration in the estate and hold ourselves to account on whether our maintenance investments have been sufficient in the intervening periods.

Further streamlining of the capital approvals process

Another area that requires attention is the capital approvals process. Lord Darzi describes it as 'so byzantine that it is hard to find an NHS senior manager that understands it' (Darzi, A., 2024). The NHS Confederation say 'there are too many layers in making decisions on too many business cases', and that 'a process meant to ensure sensible spending… ends up paradoxically adding expense as ongoing approvals and inflation drive up costs' (Barron, J., 2025).

This can introduce perverse incentives into the system. We have heard from stakeholders that cheaper schemes that may not represent the optimum long term infrastructure solution are sometimes prioritised over alternatives by virtue of the fact they would represent a more straightforward approvals route. Innovation is stifled; there is limited appetite among already stretched providers to embark on a drawn-out, attritional process if, at the end of it, the outcome for a potentially novel scheme is uncertain. This disincentivises creative solutions.

We of course need to be mindful of the arguments the other way here. It is clearly right that large amounts of public spending are properly scrutinised to ensure investments genuinely represent value for taxpayer's money. DHSC and NHS England have already taken steps to reduce friction. A joint investment committee has been established and the approval process for smaller schemes has been fast tracked (NHS England, 2025b). Nevertheless, the working group's view is there remains scope to go further.

The NHS capital approvals process therefore needs further streamlining. As a starting point, this should include:

- a maximum of 3 levels of approval for any capital scheme (for example, locally by the trust; system-level from the ICB; and one unified national approval from the government, with only the most major schemes requiring HMT approval

- an increase to the thresholds at which individual business cases require central government approval from £50 million to £100 million, with more delegation to the frontline so that for example NHS England might only consider schemes above around £50 million (rising from £25 million)

- DHSC and NHS England considering whether earlier stages of business case approval (for example, strategic outline case) can be streamlined further, for example, requiring local approval only, and whether further 'tiering' can be built into approvals process (for example, based on project complexity)

Our ambition here is to turbocharge the capital allocations process, create a more dynamic system that supports rather than bears down on new thinking, and drive improved value and delivery. It also reads across to roles and responsibilities of different actors in the infrastructure regime, which we think need clarifying and cover in section 4.

Driving better value for money

Alongside restoring good practice to the capital regime, the 10 Year Health Plan also represents an opportunity to assess how to maximise value for money from spending on infrastructure. This should include continuing to drive standardisation of building design and components to reduce cost and speed up delivery. These principles are generally

already well-embedded in nationally led capital programmes, and these should be reflected in locally delivered projects as well.

In a similar vein, there are areas where centralised procurement may deliver clear benefits. For example, the UK has fewer diagnostic scanners per capita than comparable nations and often pays a premium when purchasing them individually at a local level (Darzi, 2024). A more co-ordinated and centralised approach to procuring high-cost equipment such as MRI and CT scanners could secure better value for money, ensuring greater affordability and wider access across the system. By leveraging national purchasing power, the NHS could negotiate lower prices, standardise equipment where appropriate, and streamline maintenance and support contracts.

The working group has also heard that the NHS Health Building Notes can sometimes lead to additional costs and are difficult to meet in full. There is clearly a balance to strike here with ensuring sufficient safeguards are in place to ensure health facilities are suitably designed and meet modern safety standards. NHS England has been working on reducing the number of notes and streamlining the guidance. We are supportive of this ongoing work and recommend NHS England continues to build on that approach with a view to streamlining and introducing pragmatic flexibility where possible to do so.

Priority theme 2: maximising what we already have - utilisation, growth and productivity

Headline recommendations

- prioritise a One Public Estate approach for health infrastructure, removing barriers to cross-sector working to identify and deliver colocation opportunities

- drive and incentivise much better utilisation of existing health buildings by taking a more muscular approach to addressing unused space, disposing of or making alternative use of excess land, and designing financial incentives to support efficiency and productivity

- better alternative use of NHS land to support government growth and housing objectives, including promoting a new off-balance sheet delivery model to build homes for NHS staff

- develop a target capital model for decarbonising the NHS estate that prioritises high-return interventions and includes a clear incentives framework for decision-makers, and explore new funding options for climate adaptation R&D

Better use of existing buildings can help drive and enable our health priorities, in particular left shift, while also realising wider government growth and productivity goals. NHS infrastructure has the potential to be the engine of this change, and we have considered how the 10 Year Health Plan can best help to drive this.

Co-location

First and foremost, we should be driving better use out of public buildings, land and space - both within health and beyond. Co-location offers huge opportunities - efficiency and productivity, but more importantly through fostering integration and redesign across public services to benefit users and improve outcomes. As recognised by Vision Working Group 1, this could also support both the community and prevention shifts the 10 Year Health Plan is seeking to deliver. There needs to be a sharpening of the ambition to collaborate with other local government services as well as the third and private sectors.

We have seen powerful examples. The Reginald Centre in Leeds brings together primary care services with housing advice, employment services and a library to provide a ‘one stop shop’ for the local community (Leeds City Council). The third sector is often highly effective in managing costs and maximising utilisation (sweating the asset). These venues are often located in areas of high health inequity and where traditional NHS funded estate is lacking, poorly accessible or not trusted. The third sector can, with support from NHS

partners and their communities exploit their community anchor status in a neighbourhood which connects and holds a network of hyper-local initiatives building community powered health. The Leeds Community Anchor Network (LCAN) is one such example with local relationships with primary care, the local authority, and often with businesses (Doing Good Deeds, 2025).

In Whitstable GP owned estate has been used to provide a left shift model of community integrated healthcare. GP services are co-located with services normally requiring a trip to hospital. These include a range of outpatient services, diagnostics, day surgery (cataract, hand and wrist, dermatology, hysteroscopy and cystoscopy) and a busy UTC with a deep vein thrombosis service and fracture clinics. The collective of consultants, GPs and allied health professions provides an innovative model of left shift healthcare which is both clinically and financially efficient. Primary and secondary care clinicians combine to support patients by working together. Consequently, patient satisfaction is very high. This model also subcontracts from secondary care to help reduce waiting lists.

We therefore recommend using the 10 Year Health Plan to further drive and prioritise co-location opportunities with the wider public and community estate. Currently these tend to be the result of especially effective local join-up across health and local government, or through specific schemes from the Cabinet Office's One Public Estate programme. We should be working to make this a much more systematic across England and the NHS.

Government's role should be to identify and address the barriers that prevent this from happening. In practice these are myriad and there are no silver bullets. Ideas include:

- development of a playbook of best practice examples, which sets out the benefits of different approaches and the factors required to make them happen, to support and mobilise the system

- introduce a duty to co-operate with partners across health, local government and other public sector bodies to work collaboratively to deliver health infrastructure, through the development of long-term ICS infrastructure strategies, and also in other areas (for example, section 106 or communities infrastructure levy funding from new housing)

- a renewed drive from the centre of government (Cabinet Office) to expand the One Public Estate agenda, properly resourcing and empowering the central team to work across departments to facilitate for example joint funding models, streamline approvals and align national estates strategies

- allowing rent-free periods for GPs or other health services and wider community services to occupy space at zero overall net cost to the taxpayer, where vacant space exists and is already paid for by the NHS

- setting expectations that co-location opportunities are fully explored and demonstrated through the capital approvals process, ICS infrastructure strategies, and other appropriate checkpoints

Embedding a One Public Estate approach requires proactive co-ordination and commitment. Through this process, we have already initiated productive conversations with several public and third-sector partners, including Ministry of Housing, Communities and Local Government, local government, Department for Work and Pensions, and Citizens Advice. The department should build on this momentum beyond the 10 Year Health Plan process to unlock further opportunities for collaboration, ensuring co-location becomes a core principle of public estate planning.

Optimising utilisation of buildings

We also need to take a much more muscular approach to confronting underutilised estate, bearing down on vacant and void space where this exists. It is not acceptable that these act as a continual drain on NHS resources, while other parts of the system struggle desperately for additional capacity.

There are a mixture of barriers here - in some instances small amounts of capital investment to refurbish and repurpose space (for example, from office and other non-clinical purposes) can bring it back into clinical use. This enables much improved productivity for relatively little cost. Where buildings are genuinely unneeded tail estate and unsuitable for future health use, they should be disposed of. We should also think boldly about how to maximise benefits from core, well-functioning estate - for example, extended opening hours.

The policy question then becomes how best to drive and incentivise this. As a minimum we should expect all ICSs and asset owners to have a strong grip of how space in their domain is currently used. ICS infrastructure strategies must set out a clear plan for better utilising their estate, potentially with consequences for capital allocations if they don’t. Technology can assist and enable this (for example the NHS OpenSpace platform for room bookings), and government could consider mandating space utilisation studies. As a matter of course national and local capital schemes should consider options to repurpose existing estate before new builds. There have been highly effective examples of this through the Community Diagnostic Centre programme, including using existing LIFT buildings.

In addition, government should ensure the right incentives are in place through the capital regime to reward efficient and productive use of estate. This ultimately is at the core of effective health service delivery and many effective incentives extend beyond the capital regime itself. In dialogue with the finance and contracting group we have explored incentives to improve current infrastructure usage through a payment by results

mechanism for elective activity alongside the ability to spend generated surpluses. This has been successful in past contexts, and some initial progress has been made here with NHS England this year proposing to reintroduce some ability for providers to spend generated surpluses as capital in the following 2 years. In the right management hands, tools such as PBR and spend what you earn have represented a strong motivational force in securing greatest output from the existing estate; local caps have muted this. These ideas should be explored fully, to maximise productive use of existing infrastructure. This work should also encompass reform of the public dividend capital charge, which was originally established to incentivise productive use and disposal of assets but there is limited evidence it is still functioning as an effective mechanism.

Better use of NHS land to support government housing objectives

The NHS estate and infrastructure should do more to support wider government housing objectives, a core part of its growth mission. In the past, the NHS' contribution has principally been the provision of sites for housing through disposal of estate, in particular through previous iterations of the Public Sector Land Programme (Ministry of Housing, Communities and Local Government, and others, 2022). Most of the low-hanging fruit has now gone (and often the remaining sites are unviable for housing due to de-risking requirements).

There is still large redevelopment potential across the NHS estate, particularly building up on surface car parking and which could be used for key worker accommodation and homes for NHS staff. We know there is extensive and growing demand here across the country in the context of wider housing market conditions. The key barrier has been finding the necessary capital departmental expenditure limit (CDEL) to build accommodation on NHS land. The department has developed an off-balance sheet concession model that will enable housing with discounted rent for NHS staff to be built on NHS land - funded and built by third party developers and compatible even within current HMT private finance rules.

This will significantly benefit staff recruitment and retention, drive improved productivity of NHS land and contribute directly to the government's wider housing mission. While this is not a one size fits all solution and other viable models should also be explored (especially in the context of wider reform to private finance rules), an initial programme with pathfinder Trusts should be established to take forward delivery.

Net zero and adaptation

Darzi was clear that "the NHS must stick to its net zero ambitions" (Darzi, 2024). The Change NHS public engagement programme also found public support for ensuring the NHS becomes more energy efficient. In the long run a greener estate will drive improved

productivity through lower running costs and more resilient buildings. However, we need to be clear that the current fragmented approach to capital investment in net zero will not be sufficient to achieve the NHS's 2040 target. Delivering this commitment will ultimately require significant amounts of capital investment. Whilst much of this investment can also support backlog maintenance reduction and boost efficiency, the group notes that many of the of most critical technologies, such as heat pumps, do not currently offer attractive returns to NHS budgets.

We therefore recommend formally setting a target capital model for decarbonising the NHS estate as part of the 10 Year Health Plan - a model that properly balances interests across the system and government, and which sets clear funding expectations and responsibilities across DHSC, Department for Energy Security and Net Zero and potential private finance sources (focusing health capital on measures that have the highest return to trusts). This must be underpinned by more specific targets and regular monitoring for such high-return measures (like LED lighting) - potentially incorporating a new, stronger incentives framework for decision-makers at trusts and ICBs. Furthermore, a level of green space should be protected, where practical to do so, within the NHS estate as this offers wider health benefits.

In addition, climate adaptation issues must receive far greater attention within estates planning and risk management, rather than being viewed as a subset of net zero initiatives (though there are clear synergies and conflicts between the areas that need careful management). This must start by developing a dedicated NHS governance mechanism - with effective and integrated monitoring processes for vital issues like flooding and overheating and potentially doing more to understand and map risk through dedicated research and development - linking more effectively to the National Adaptation Programme.

Priority theme 3: enabling left shift

Headline recommendations

- rebalance infrastructure investment towards primary and community care, to facilitate and enable left shift over the course of the 10 Year Health Plan

- adopt a 4-fold strategy to invest in neighbourhood health infrastructure - utilise, repair, replace and innovate

- work with HMT to explore changes to current rules on private finance to help fund new primary care infrastructure, through new public-private partnerships, mutual investment models or a REIT structure

- wider reform of the GP payment regime to address some of the barriers preventing integration of care services in hub infrastructure models

The ambition to move to a neighbourhood health service has been reinforced by the conclusions from the vision working groups which recommend care outside of hospital where possible.

New models of care prioritising lower cost interventions in the community can improve outcomes, improve patient experiences and reduce long term demand on acute services. There is more work to do on the core service offer of the future, and this will determine precisely how infrastructure will need to respond in different parts of the country. In any scenario, there are decisive steps we should be taking now on our approach to infrastructure to enable and drive left shift of care.

Shifting infrastructure investment leftwards by prioritising primary and community care could also help to address and reduce healthcare inequalities. Care delivered closer to home can be more accessible to individuals with low incomes, who may face barriers such as travel costs and time constraints when seeking hospital-based services.

Macro infrastructure investment strategy

The system is undercapitalised overall, which Darzi has drawn out sharply (Darzi, 2024). Within that, primary care has fared especially poorly since 2010, particularly in comparison to acute settings - and already faces significant challenges in terms of age (20% constructed pre-1948), suitability (with many premises still located in residential properties, some of which are unfit for delivering modern standards of care) and capacity (Darzi, 2024). Unless we confront these challenges, and the barriers that underpin them, the

government's ambition to left shift and create a neighbourhood health service will not be achieved.

We are therefore recommending government should prioritise rebalancing infrastructure investment towards primary and community care - thereby making a physical reality of left shift. This should be achieved through a combination of funding for national primary care capital programmes and incrementally increasing the primary care ringfence for operational capital spending.

Again system-wide evidence in England to support this recommendation is currently difficult to come by but we have seen examples and local areas where this works and is demonstrably better and better value. The left shift of services previously delivered in hospital settings allows for innovative redesign of clinical pathways and not merely relocation. Elective outpatient, diagnostic and day surgery procedures can be delivered faster, one stop where possible, and with less unnecessary follow ups. Community UTCs can reduce more expensive acute hospital attendances especially if collocated with diagnostic services (NHS England, 2024a). Thus, both elective and urgent care can be delivered faster, at less cost, closer to home and with improved patient satisfaction.

This is a choice - one that we believe will bring significant benefits in the longer term. Our modelling shows that a left shifted system where a greater proportion of activity takes place out of acute settings will mean the level of capital required to sustainably maintain and replace the estate overall will be lower. We have modelled a scenario that assumes 60% of maximum ICS left shift being achieved in 10 years (7% elective, 6% non-elective, 16% A&E, 13% outpatient shift). Across the 10-year period to 2034 to 2035, this leads to an average annual net saving of £1.6 billion. This is an average of £4.0 billion gross saving offset by a £2.4 billion additional cost to build and maintain new infrastructure in primary and community settings (see annex 2).

We asked other health systems how they have used physical infrastructure to enable the left shift. Prioritisation was crucial. For example, picking candidate specialties that could benefit from the treatment-to-community shift with an associated physical infrastructure strategy. A Californian healthcare provider delivered the shift to community specialty-by-speciality and broadly looked for specialities with a high volume of procedures and conditions where there are fewer multi-disciplinary concerns. We would recommend a similar approach where clinicians guide which services and procedures can be moved first. However, this would be a fundamental design choice in the implementation of the 10 Year Health Plan, and it would challenge a model where either 1) all specialties experience all shifts at the same time across all 42 ICBs; or 2) trailblazers are considered on a purely geographical basis, so that all specialties within say 21 of the 42 ICBs should trail the shifts.

Prioritisation involves trade-offs, particularly in fiscally constrained contexts - and in this case we are recommending prioritising investment in primary care settings over acute. There is of course nuance to this (we do not, for example, recommend ignoring high risk infrastructure need in hospitals), and it will require political will to see through. In some instances, additional space will still be required in acute settings to meet immediate demand - where this is the case, building in flexibility is crucial to adapt to future changes in care trends. Alternative financing models could help us to maximise the size of the total pot and therefore mean that this trade-off is felt less acutely.

There are, however, good reasons to believe that policy interventions over the coming decade may help manage some of the demand for acute space - in particular advancements in AI and technology, virtual wards, alongside any potential improvements in discharge and long stays (which will ultimately require solutions in social care, beyond the direct remit of this group). The risks of not taking bold choices now are potentially greater, albeit less visible, than the maintaining the status quo. Our recommended approach here uses capital investment as a tool to actively drive the system transformation we want to see.

Setting a left shift investment ‘target’

Our group debated whether to propose a specific target for investment in primary and community care estate, similar to the Mental Health Investment Standard, or recommending a gradual increase over 10 years, for example 1% per year until reaching a defined level of 10% by 2035. There was consensus on the need to increase spending on primary care infrastructure, but no agreement on a specific target. Most of the group favoured avoiding a fixed target, citing risks such as perverse incentives, misalignment with other targets set elsewhere in the system and the need for flexibility in adapting to evolving service models.

However, there was also recognition that without a target there remains a real risk of inertia in channelling investment leftwards. If a target were to be developed, it should align to defined service models and pathways that are prioritised for shifting into primary and community, rather than setting a blanket percentage. Without clarity on these service models and pathways, we cannot recommend a fixed target, but further work could take place to develop a target that aligns to the overarching recommendations of the 10 Year Health Plan. In any case and as a minimum, we should ensure that ICSs demonstrate how they are maximising shift over time in their infrastructure strategies, including One Public Estate but also other mechanisms.

Investing in neighbourhood health infrastructure

Moving beyond headline prioritisation of investment, we propose a 4-fold approach to delivering the neighbourhood health infrastructure needed to enable the 10 Year Health Plan vision:

Utilise

Some estate is unused, underutilised or in limited cases being upgraded; these offer quick and value for money options to deliver additional capacity. This should also focus on co-location and partnership opportunities with the wider public estate and community assets (we discuss this further in section 4).

Repair

Previous underinvestment has stored up maintenance issues; Spending Review 2024 provided £102 million for a modernisation and integration fund targeting premises where refurbishment and reconfiguration could unlock improved productivity (His Majesty's Treasury, 2024).

Replace

Not all health infrastructure is suitable for modernisation; 20% of the primary care estate predates 1948 and many of these properties are in unsuitable residential properties (Darzi 2024). These facilities ultimately need to be replaced, and disposals opportunities realised where appropriate.

Innovate

Going further to supercharge left shift through new investment models, a new approach to commissioning and contracting community and primary care services that better delivers supporting infrastructure and integrating community services as part of purpose-built neighbourhood health centres - with support to ICSs through a playbook on possible approaches to neighbourhood health infrastructure and integrated centre models.

Adopting this approach

The department should reflect these within its Spending Review 2025 capital proposals to HMT. In particular, given the wider fiscal context, there is a strong case for government to revisit current private finance rules to allow new investment models which offer value for money and suitably transfer risk away from the public sector. We have identified models that we think would meet these criteria, specifically the Mutual Investment Model being used in Wales to deliver infrastructure and REIT structures. Ultimately this is not within the direct remit of DHSC and will require HMT agreement; however, the realistic counterfactual is that we will lack the capital required to truly accelerate left shift and the

government's vision for neighbourhood health. We have begun dialogue and HMT colleagues seem much more open to revisiting this than several years ago. We recommend that NHS England and DHSC and HMT assemble a cross-organisation committee to expediate reform here and provide a joint submission to ministers setting out options ahead of the 10 Year Health Plan publication.

If we secured agreement from HMT, we would need to develop a detailed plan to operationalise a new investment model. This could involve developing a national pipeline to attract private investment, with a standard building specification for example on neighbourhood health centres. We'd also need to be clear on how revenue costs for these new premises would be funded otherwise we may find local areas reluctant to participate.

There are other avenues to crowd in investment that the NHS can make better use of. For example, neighbourhood centres could attract co-funding by bringing together multiple services both in local government and the neighbourhood health service to support multi-disciplinary teams and better integrated care, including through little-used Section 2 arrangements with local authorities. Communities infrastructure levy or section 106 contributions should be better leveraged to deliver new neighbourhood health facilities alongside the government's 1.5 million homes target and new towns commitment – where robust and considered long term local infrastructure strategies can significantly strengthen health's hand.

Wider GP payment regime

Beyond direct capital investment, we have also heard how the current GP contract does not adequately incentivise and support working in modern, multidisciplinary facilities. It restricts a wider service offer by only providing rent reimbursement for core general medical services. More broadly we know there is diminishing appetite for GP investment in existing GP owned estate with its associated liabilities. This represents a major delivery risk and has undermined previous initiatives to drive left shift; and we have heard equally disheartening examples of new facilities standing empty with GPs unwilling to occupy them.

We therefore recommend that reform of the wider GP payment regime is considered, potentially through development of a new neighbourhood contract. We understand the people and workforce group are considering a similar proposition - as that contracting mechanism is designed, and the wider service model defined, provision needs to be made for financing estate requirements. From an infrastructure perspective, this should support the reimagining of local health services and remove the barriers that the current GP contract and ownership model present. The usage of new infrastructure could be mandated over time as old contracts end and GPs retire, triggering change without unrest and destabilisation of existing services. Depending on design and overall direction of travel

on GP reform, it could also remove premises liabilities and open-up further opportunities in terms of employment models.

Taken together, this would represent a bold package of reforms representing a genuine step change in the government's approach to delivering the infrastructure required to enable the neighbourhood health service and realising left shift of care out of hospitals and into the community.

Priority theme 4: empowering the system

Headline recommendations

- clarify national, system and local roles within the capital regime to ensure clear accountability and effective decision-making at all levels

- review the capital allocation methodology to ensure capital flows to the right place, enabling local decision-makers to drive change in the estate

- establish a new centralised property and estates capability function to drive improved strategic planning and capital delivery

- renew efforts to elevate the status of the property profession within the NHS, to properly shape and inform decision-making on infrastructure

This section outlines how to establish a system that can lead the necessary change. Having the right capability and authority in the right places is crucial to delivering the previous 3 priority themes. The infrastructure landscape is complex, with many actors and layers, leading to unclear decision-making. The introduction of ICBs has created some turbulence as the NHS adjusts to its new operating model. Capability, particularly in strategic infrastructure planning and delivery, is inconsistent and often misplaced.

These issues must be addressed in the 10 Year Health Plan, enabling the system to become a more dynamic planner, commissioner and builder of health infrastructure.

Roles and responsibilities

The roles of national, system, and local bodies need to be clarified to ensure effective management and planning of capital and infrastructure. While it is not within our remit to propose an alternative structure for the NHS, we have focused on making the current system work as efficiently and coherently as possible.

We start from the recognition that our current capital system has evolved to become exceptionally centralised with a rather artificial split between strategic and nationally led capital and operational capital allocated by formula to ICSs. We believe that decisions should be taken, and accountability should sit as close to the front line and operators of the assets as it makes sense to do so. This implies a significant devolution of infrastructure planning and allocative decisions down from the national level. However, it will always make sense to plan and allocate some things nationally. For instance, where there are significant programmes that local areas could not manage them within their portfolios, where national spending will supercharge transformation, or where there is benefit in

making use of national buying power. This might suggest the following rough split of responsibilities.

NHS trusts should manage core estates activities, including maintenance and equipment replacement, with a local estate plan aligned to their ICS's long-term infrastructure strategy. If new or transformed provider organisations emerge as part of the left shift, they should take ownership and responsibility for their estates.

ICSs should co-ordinate capital and infrastructure plans, develop a long-term estates strategy that balances national priorities with local needs, and distribute capital across maintenance, improvement, and transformation schemes. They may also take on the delivery and ownership of out-of-hospital capital schemes, such as GP or primary care buildings.

At the national level, DHSC and NHS England should set long-term strategic priorities, fund a small set of things centrally where there is clear benefit in doing so either because they are such major programmes (for example, new hospitals), or to supercharge them to guarantee they happen, and they should allocate capital to ICSs based on a needs-based formula. Both organisations should work closely to streamline approvals for local projects.

We hold that this approach strikes the right balance between granting appropriate local autonomy and flexibility to develop and implement infrastructure plans, while maintaining proportionate national oversight and direction-setting. We recommend that this be agreed centrally and published by NHS England to provide clarity to the system.

As part of this we need to consider the future role and remit of NHS Property Services - which faces significant challenges from its property portfolio including high levels of backlog maintenance and operational difficulties with tenants and rent arrears (Comptroller and others, 2019). It is at a significant disadvantage in serving its private sector clients (in other words, GPs) with being in the public sector, without the ability to truly drive the hardest bargains, pay for the best people and raise more capital. A radical option could be to try and shift it or re-form it in the private sector. We have not had time to explore this at length with HMT, who tell us it is harder than it was historically to mutualise companies and get them off the public balance sheet. We also think there is potentially a key role for them to play in supporting improved asset management and strategic planning capability across the system more consistently - which we explore further in the next section.

Building capacity and capability

It is critical that this overall structure is equipped with the appropriate capability to work effectively. We have identified 2 key aspects to focus on here: infrastructure delivery (including commercial and contracting expertise) and strategic planning.

Currently the latter of these bites particularly hard at ICS level. To operate effectively at the strategic co-ordinator level, ICS infrastructure teams need to be adept at understanding their current asset base, its constraints and opportunities, interpreting infrastructure requirements of their clinical strategies navigating complex relationships with local councils and other local public sector bodies, understanding the intricacies of planning processes, and having deep insight into neighbourhood health models.

At present, ICSs are overall not equipped to do this well. We have seen through the first wave of NHS England's ICS infrastructure strategies programme that strategic planning capacity is generally immature, often due to a lack of dedicated resource (NHS England, 2024b). We have heard that capital delivery is impaired by a range of issues including overly bureaucratic processes, uncertain capital availability and pipeline, and a lack of requisite skills, experience and leadership in the system.

Meanwhile the capability we do have is housed elsewhere the system. For example, NHS Property Services has a significant amount of asset management and planning expertise focused on managing their own estate. NHS trusts (especially large ones) typically have strong operational expertise, but this is not easily transferable across the system. NHS England regional teams support providers in their geographies with infrastructure projects.

We have considered the best way to address these challenges. Our broad conclusion is that it will be highly challenging to sufficiently build this capability embedded within every ICS and across the entire system over the duration of the 10 Year Health Plan. The workforce supply is not there, and it would not be an efficient operating model to build for example strong delivery capability at a level where systems may only have a small number of major capital projects over that timeframe.

Instead, we recommend establishing a new centralised NHS property and estates capability function. This recommendation echoes recommendations from the 2017 Naylor review into NHS Property and Estates but these were not fully met (Naylor, R., 2017). This could be designed in several ways depending on the objective but ultimately would draw in expertise from the system and operate as an accessible resource for systems to support with development of their long-term estates strategies. This could potentially be set up in a regional cluster model to share best practice across geographies and providing direct support (rather than oversight). In this context, we should also consider the role of the existing NHS England Estates central function (as well as NHS Property Services and Community Health Partnerships) which holds estates resources at both national and regional levels, and these could be reconfigured to provide more hands-on support to ICSs in estate planning and project execution.

An alternative approach could be to establish a central delivery function that directly supports ICSs in delivering capital projects (addressing the first of our identified capability challenges). This function would bring together commercial and project management

expertise, providing hands-on support rather than just oversight. ICSs could commission it to lead the delivery of capital schemes within their infrastructure strategies, reducing reliance on external consultants and addressing gaps in local capacity. Careful consideration is needed to determine the best organisational structure to attract and retain the necessary expertise while ensuring flexibility to meet local needs. Regardless of the precise model, the principle remains the same: a central capability function should strengthen, not replace, local decision-making. This will enable ICSs to plan and deliver capital investment more effectively.

This should be backed up with a renewed drive to elevate the status of the property profession within and across the NHS more widely. In doing so, we should build on recent successes such as the launch of the NHS Estates Graduate Training Programme and apprenticeship programmes (Pathways 2 Estates, 2024). The profession should be properly represented in NHS board structures so that strategic decisions on capital and infrastructure planning are fully informed by property and asset management expertise.

Ownership of non-acute assets

The group held differing views on the question of who should own new primary care estate when it is funded through public capital. This is very linked with questions about the future of the GP ownership model more generally. There was no clear consensus on whether ICSs are the right bodies to both deliver and own out-of-hospital schemes, or whether this should depend on the scale and complexity of the project. Some members raised concerns about whether ICSs currently have the capability to effectively manage and maintain estate, arguing that ownership could become a significant distraction from their strategic role. This highlights the importance of investing in capacity and capability to support infrastructure management at a system level.

One perspective was that ICSs should focus on setting the strategic direction and developing collaborative estate plans, rather than taking on ownership responsibilities in the short to medium term. Others suggested that infrastructure should be owned and operated by those who use it, NHS Property Services, another estate-holding body, or a provider organisation under a contractual arrangement. However, given that ICSs are being given increasing decision-making responsibilities, it was argued that they should logically also have ownership of the buildings that support service delivery. The challenge remains whether sufficient expertise could be developed across all 42 ICSs to manage this effectively.

Some members also highlighted the benefits of the GP ownership model giving a stronger incentive to invest in improvements, optimise the use of space, and tailor facilities to better meet patient needs. ICSs sometimes lack meaningful clinical input, particularly from general practice, which could limit their ability to make effective decisions on estate

ownership and management. Given the complexity of these issues, further consideration is needed to determine the most effective ownership models that balance financial sustainability, operational efficiency and local service needs.

Capital allocation

Local decisions should influence the direction and deployment of a greater proportion of capital spend than they do currently. This means we should also consider how the funding flows and is distributed to local level, to enable the change we want to see.

Currently operational capital funding is allocated predominantly based on depreciation and gross asset value. In effect this will always bake in the status quo; systems are funded based on composition of the estate they have today, not the estate they want to transition to in the future. That becomes problematic when we are trying to re-envision models of care, and the supporting infrastructure required to support that.

Developing an alternative methodology will require detailed and careful work. Accordingly, we recommend that over the coming months DHSC and NHS England conduct a review of the capital allocation methodology to explore alternative approaches that better support our strategic priorities and vision.

Conclusion and next steps

The government's reform agenda offers an opportunity to reshape health and care provision in the NHS over the next decade, in line with the Secretary of State's 3 shifts. Physical infrastructure is a key enabler of system transformation and reform. Without the right estate in the right locations, high-quality care and a positive patient experience cannot be achieved.

Failure to act on the recommendations in this report will exacerbate existing challenges, compromising safety, service quality and accessibility. Continued deterioration of NHS infrastructure risks making the service unsustainable, with significant political and operational consequences. Decisive action is needed now to avoid irreversible damage.

The full estates implications of the 3 major shifts - analogue to digital, treatment to prevention, and hospital to community - remain uncertain. Further work will be required once the 10 Year Health Plan has set out preferred new models of care, particularly for neighbourhood health and digital approaches. Only then can we fully assess infrastructure needs and determine the best support mechanisms.

Fundamental reform of infrastructure planning and delivery is only possible with a capital regime that streamlines approvals and aligns incentives across local, system and national levels. Infrastructure must support the left shift and neighbourhood health models, enhancing experiences for both staff and patients. Effective cross-departmental collaboration, including with Ministry of Housing, Communities and Local Government and Department for Work and Pensions, will be essential to maximising the benefits of the One Public Estate. Given the challenges of predicting future needs, the NHS estate must remain as adaptable as possible, as recommended by vision working group 2.

Some of our most transformative policy proposals challenge the NHS's historical spending patterns. Shifting investment towards primary and community care would be a radical departure from the longstanding focus on hospitals. Reforming private finance rules to support primary care infrastructure could unlock substantial new funding for under-invested estates.

However, several key questions remain:

- defining the ambition for left shift and neighbourhood health over a 10-year period and setting investment targets for primary and community care

- clarifying the role of ICSs in property infrastructure management, particularly for primary and community assets, ensuring they have appropriate asset management capabilities and devolved capital allocation

- working with HMT to develop a value-for-money private finance model for primary care infrastructure

- establishing the government's risk appetite in a constrained financial environment

- assessing the willingness of other government departments to streamline regulations affecting health infrastructure, particularly in procurement and planning, which increase costs and delay delivery

While shifting capital resources towards primary and community care is necessary, it entails trade-offs. Acute care estate challenges will persist and further serious safety threats, may arise, as happened historically with RAAC. Without addressing the acute sector's maintenance backlog, ICSs will be understandably reluctant to reallocate investment. Finding a solution is essential to enabling transformation.

Political action is required to address these challenges, including securing a substantial uplift in capital funding from HM Treasury and exploring alternative financing mechanisms. Without such measures, the NHS risks being unable to deliver high-quality, universal care in a decade's time.

There is strong enthusiasm across the country to drive these fundamental changes. If we fail to seize this opportunity to reshape NHS infrastructure, we risk losing it altogether.

Annex 1: physical infrastructure working group

The physical infrastructure working group has met 6 times between November 24 and February 25. This report is structured around 4 key themes:

- getting the basics right
- maximising what we already have - utilisation, growth and productivity
- enabling left shift
- empowering the system

The group has put forward recommendations for government to take forward. Where consensus among the group was not possible on individual elements, we have attempted to draw that out faithfully in this document. It has been formally approved by the co-chairs, Emily Curtis and Simon Linnett.

The group also established a ‘sub-group’ structure early on, tasking smaller subsets of the main group to consider and make recommendations on detailed areas of priority policy. The findings of these subgroups have been synthesised and informed the overall recommendations in this report. These subgroups covered:

- what others do
- alternative financing models
- primary care capital
- value for money analysis
- working with MHCLG
- net zero and adaptation
- decision making structures

Subgroup reports are available on the request of the central 10 Year Health Plan team.

In forming the recommendations in this report, we have also considered and discussed at the working group relevant findings and insights from the Change NHS public engagement exercise as far as they relate to the remit of our group, staff engagement exercises, as well as submissions from external organisations. Public sector equalities duties have been considered in drafting.

We have also been acutely conscious throughout the process and while writing this report, that physical infrastructure is arguably more reliant than any other on recommendations being put forward by other working groups - particularly on finance, accountability and structures, digital, and workforce. We have attempted as far as possible to align our recommendations with what we understand is being concluded in those groups.

The members of the group were:

- Andrew Hunter, Bracknell Forest Council
- James Brent, University Hospitals Plymouth NHS Trust
- Dr John Ribchester MBE, Whitstable Medical Practice
- Professor Michael Davies, UCL Institute for Environmental Design and Engineering
- Michelle Bateman, Derbyshire Community Health Services NHS Foundation Trust
- Michelle Humphreys, Manchester University NHS Foundation Trust
- Mike Green, Defence Infrastructure Organisation
- Oliver Clarke, NHS England
- Phill Wells, NHS North Central London Integrated Care Board
- Richard Douglas, NHS South East London Integrated Care Board
- Siva Anandaciva, The King’s Fund
- Steve Beechey, Wates Group
- Tim Irish, King’s Health Partner (KHP) ventures
- Wendy Farrington-Chadd, Community Health Partnerships

Annex 2: modelling summary and outputs - left shift of infrastructure

The purpose of the model is to forecast physical infrastructure needs and estimate the capital cost of delivering these under different scenarios.

Calculations: the basic sum

- step 1: maintenance or replacement cost of existing estate, plus
- step 2: investment to control backlog maintenance, plus
- step 3: “As is” investment to grow estate to meet activity, minus
- step 4: activity left shifted, to out of hospital, to digital or through prevention, plus
- step 5: the investment in extra infrastructure outside hospital to facilitate the shift

Description of calculations

Step 1 applies cost per square metre maintenance and replacement costs per square metre to the current size of estate. Step 2 uses a trend model to calculate funding needed to stabilise backlog. Step 3 calculates the space and cost to deliver current activity then grows based on activity projections and efficiencies that are being used for the Spending Review. Step 4 “left shift” assumptions are drawn from an example ICS strategy work: suggests maximum “left shift” over 15 years of 27.5% of A and E attendances, 10% for non-elective spells, 12% for elective spells and 21% for outpatient contacts. Scenarios assume different proportions of these savings are achievable phased over 10 years, with a small initial shift in 2025 to 2026, one-third by 2029 to 2030 and two-thirds in the final 5 years. Step 5 uses a basic assumption on substitution of activity into primary and community using DHSC evidence - 12 primary or community contacts for every acute admission; further adjusts based on the delivery mechanisms assumed for the ICS (significant proportion of self-care so no infrastructure implications).

Results

Table 1: scenario showing overall costs in 24/25 nominal prices assuming 60% of example ICS maximum shift achieved in 10 years (7% elective, 6% non-elective, 16% A and E, 13% outpatient shift)

Overall costs in 2024 to 2025 nominal prices

Costs	**25/ 26**	**26/ 27**	**27/ 28**	**28/ 29**	**29/ 30**	**30/ 31**	**31/ 32**	**32/ 33**	**33/ 34**	**34/ 35**	**Mean**
Maintenance costs	7.9	7.9	7.9	7.9	7.9	7.9	7.9	8	8	8	7.9
Costs to tackle backlog	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
Costs for extra capacity	5.4	5.5	5.7	5.8	6	6.1	6.3	6.4	6.6	6.8	6.0
Total savings	-0.6	-1.1	-2.2	-3.4	-4.1	-4.5	-5.1	-5.6	-6.2	-7	-4.0
Additional infrastructure cost	0.4	0.7	1.5	2.1	2.4	2.7	3	3.3	3.7	4.1	2.4
Total costs	**15.4**	**15.4**	**15.2**	**14.7**	**14.6**	**14.6**	**14.5**	**14.6**	**14.5**	**14.3**	**14.8**

NB. The £1.6 billion average net saving referred to in paragraph 48: an average of £4.0 billion gross saving offset by a £2.4 billion additional cost.

Next Steps

Refine the theory of change to more accurately estimate implications for primary or community infrastructure costs; further socialise and debate assumptions on delivery mechanisms (primary care, community care and self-care); and draw on assumptions used by digital, prevention and workforce subgroups.

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