House of Commons

Health and Social Care Committee

Delivering the Neighbourhood Health Service: Estates

Seventh Report of Session 2026–27

HC 237

Health and Social Care Committee

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Publication

This Report, together with formal minutes relating to the Report, was Ordered by the House of Commons, on 10 November 2026, to be printed. It was published on 20 November 2026 by authority of the House of Commons. © Parliamentary Copyright House of Commons 2026.

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Summary

The government's ambition to deliver a Neighbourhood Health Service represents a significant shift in care provision. Moving many services out of hospitals and closer to local communities requires a physical estate with the space and flexibility to respond to local needs and facilitate multi-disciplinary working. This does not currently exist, with funding, governance, and regulatory arrangements presenting real barriers to creating it. The government needs to:

- **Increase funding in the NHS estate**. As the NHS capital budget is unlikely to cover the existing estate maintenance backlog, the NHS will need to be creative to unlock additional sources of funding. The government must ensure that future private sector investment learns from previous public-private partnership schemes and ensures long term value-for-money. The NHS must also get better at capturing developer contributions when new developments are built, learning lessons from sectors like education that have a stronger track record in converting these commitments into new infrastructure.
- **Improve how the NHS spends its existing capital budget**. Where funding for new buildings does exist, it can be poorly used due to unnecessarily lengthy approval processes. The government has committed to streamline such approvals–a necessary step for estate transformation. A lack of clarity on ownership of joint projects can exacerbate delays, and each project must have a dedicated lead organisation. Treasury rules on spending must also be urgently reviewed.
- **Better support the GP estate**. The Neighbourhood Health Service gives general practice a leading role, yet many GPs are finding it difficult to expand their premises. The government must develop a long-term strategy for GP estate investment that reduces reliance on personal financial risk and private borrowing and improves access to capital funding. The government must also review the role of the District Valuer, a frequent barrier to investment in new premises, and set clear targets for NHS Property Services, whose performance is currently frustrating efforts to deliver the government's model of neighbourhood health.

- **Make better use of the existing estate**. There is significant unrealised capacity within the existing NHS—and wider—estate. The government should improve the quality and consistency of utilisation data to allow local leaders to make better use of their existing spaces. The government must also review the Premises Costs Directions in GP contracts, which is preventing GP practices from hosting multidisciplinary teams. Finally, the NHS needs a clearer strategy for how to deliver healthcare service in community settings. This must ensure that rules about the delivery of healthcare in non-traditional NHS settings do not restrict innovation to deliver services nearer to where people live and work.

Introduction

1. In July 2025, Government announced that the NHS had the choice to "reform or die", setting out three major policy 'shifts' it wanted to achieve. One of these was "from hospital to community", the ambition to ease pressures on acute hospitals by providing integrated, preventative care in local communities. This was to come through the 'Neighbourhood Health Service'.[1] We launched this inquiry to examine whether the current NHS—and wider health and social care—estate could support the delivery of this ambition.

2. There is clear evidence that the current estate is insufficient, with the Government's 2024 Independent Investigation of the National Health Service in England (Darzi Review) finding that much of the NHS estate was "crumbling" and "plainly not fit for purpose", with 53% of the primary care estate being more than 30 years old.[2] We have seen how this affects practices' confidence: in the 2025 British Medical Association Premises Survey, 50% of GP practices reported their premises were unsuitable for present clinical needs, and 83% reported they were unfit for future needs.[3]

3. The government has announced investment in the NHS estate to support delivery of the Neighbourhood Health Service. This came through the creation of 'Neighbourhood Health Centres' (NHCs), alongside further capital funding to support the shift from hospital to community across the estate.[4] NHCs aim to serve as local hubs bringing together GP services, diagnostics, community health services, mental health support, rehabilitation, prevention and wider wellbeing services "under one roof", operating "12 hours a day, six days a week." In March 2026 the government announced that the first 50 NHCs would be backed by a total of £200 million investment, with the first 27 to be opened by 2027, largely focusing on repurposing existing NHS facilities.[5] The government has pledged to open

1 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, 30 July 2025; Neighbourhood health framework, 17 March 2026
2 Department of Health and Social Care, Independent Investigation of the National Health Service in England, 12 September 2024 (Darzi Review)
3 BMA, GP Premises Survey Results 2025
4 Department of Health and Social Care, 10 Year Capital Plan for Health and Social Care, 8 July 2026
5 Department of Health and Social Care and NHS England, Communities to benefit from health centres on their doorstep, 26 March 2026

120 NHCs by 2030 with a total of 250 by 2035, through a combination of refurbishments and new builds, supported by public-private partnerships (PPPs).[6]

4. In this report we consider the central question: how can the government ensure the NHS estate can deliver the Neighbourhood Health Service? We first consider current levels of capital and revenue investment and whether they are sufficient, before exploring additional options for increasing investment, such as PPPs and developer contributions. We then examine a series of technical, regulatory, and governance barriers—such as capital controls, approvals processes, accounting rules and partner fragmentation—that can prevent available funding from being used effectively. Then we consider the specific challenges facing the GP estate that prohibit neighbourhood expansion and working. Finally, we consider how existing assets across the NHS, local authorities and the community sector can be better utilised to unlock the Neighbourhood Health Service.

5. We are grateful to all those who contributed to this inquiry. We would especially like to thank our hosts on our visit to Cornwall, where we saw examples of neighbourhood health in action, alongside the difficulties that systems, settings and individuals are facing in implementing the government's aim.

6 Department of Health and Social Care, Neighbourhood Health Framework; Communities to benefit from health centres; NHS England, Neighbourhood health centre guidance for regions and integrated care boards, 16 April 2026

1 Capital investment in the NHS Estate

6. It is widely acknowledged that the NHS estate has historically received insufficient capital investment. The 2024 Independent Investigation of the NHS (Darzi Review) identified that through the 2010s, the NHS accrued a £37 billion capital shortfall compared to peer OECD countries.[7] It is estimated that fixing the current NHS maintenance backlog would cost £17.3 billion, and of this backlog, 21.4% is categorised as 'high risk' and 32.4% as 'significant risk'. This has led to an outdated, ageing and unsafe estate. There were 13,034 estates and facilities related incidents in 2025/26, an increase of 50.6% from the previous year, and 6,697 clinical service incidents caused by estates and infrastructure failure, an increase of 63.3% in the same period.[8]

7. We heard that the pressure from the maintenance backlog can prevent Trusts from investing in their future estate needs. York and Scarborough Teaching Hospitals NHS Foundation Trust highlighted that current CDEL limits across the NHS were "consumed" by basic maintenance and equipment replacement needs. Capital Departmental Expenditure Limit (CDEL) is an HM Treasury-imposed control on the amount of capital expenditure that can take place each year, which we discuss further in Chapter 2. The Trust argued that given the infrastructure risk the NHS was already carrying, investment in neighbourhood premises was likely to be constrained by CDEL limits.[9]

8. The need for more capital investment in the NHS estate is not only driven by the maintenance backlog. We also heard that the current estate was not designed to meet the demands likely to be placed on it by the government's vision for a Neighbourhood Health Service. The British Medical Association (BMA) told us that many current buildings were not designed

7 Darzi Review

8 NHS England, Estates Returns Information Collection, Summary page and dataset for ERIC 2025/26, 15 October 2026

9 York and Scarborough Teaching Hospitals NHS Foundation Trust (DNE0056)

to accommodate the multidisciplinary teams required, with other evidence also citing a lack of space preventing teams from being hosted or trained together.[10]

9. Additionally, we heard that when prioritising capital investment, a lack of overall funding had required systems to make difficult choices. Bill Shields, Executive Finance Director for the DLN cluster,[11] told us that ICBs might opt to choose a capital programme that would make immediate savings over programmes with better long-term outcomes. The "temptation" was for NHS trusts to deal with backlog and maintenance issues, and not "think bigger" in terms of pulling together capital.[12] Ruth Rankine of the NHS Alliance warned that a focus on short-term pressures, such as waiting lists, A&E performance and GP access, risked producing "the [wrong neighbourhood health] design for the longer term".[13]

10. The government's 10 Year Capital Plan for Health and Social Care stated that it was "fully embracing" the challenge of "historic and sustained capital underinvestment" and that CDEL would be the "highest" it had ever been", increasing by 16% (£1.8 billion) and reaching £15 billion by 2029–30. This includes £6.75bn for repairs and maintenance over nine years.[14] In July 2026 the BMA questioned how far this funding would stretch:

> […]to put that in context, the latest maintenance backlog is £15.9bn in England,[15] meaning [£6.75bn] won't even tackle half of it now, let alone as it continues to grow.[16]

Similarly, the British Property Foundation argued that public capital alone was insufficient to deliver the investment needed to address current maintenance needs and stimulate neighbourhood expansion.[17]

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10 Coventry and Warwickshire Integrated Care System Primary Care Team (DNE0024); OneMedical Property (DNE0025); British Medical Association (BMA) (DNE0053); Q171 [Dr Hynes]; This issue is discussed further in Chapter 4, Co-location in GP premises

11 The 'DLN' cluster refers to the ICB cluster of Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs

12 Q220

13 Q5

14 The 10 Year Capital Plan for Health and Social Care, published July 2026, denoted that CDEL will increase to £15 billion by 2029–30, though it should be noted that the Spending review settlement, published June 2025, saw CDEL rise to £14.6 billion by 2029–30; HM Treasury, Spending review 2025, 30 June 2025; Department of Health and Social Care, 10 Year Capital Plan for Health and Social Care, 8 July 2026

15 This figure has now grown to £17.3 billion; ERIC 2025/26

16 British Medical Association, Big questions remain over how far NHS capital spending plans will stretch, says BMA, 8 July 2026

17 British Property Federation (DNE0038)

11. In the 2026 Autumn Budget, it was announced that the health department's capital budget would be reduced by £1 billion over the period to 2029–30, with the four-year capital expenditure limit falling from £57.8 billion to £56.8 billion.[18] The reduction formed part of the funding package for the Defence Investment Plan. While initial plans assumed a 1% reduction in departmental capital budgets, this was increased to 2% in the later years of the spending review period to help close a residual funding gap in the Plan.[19] The Health Service Journal reported in October 2026 that several experts warned that the reduction would mean "cutting back on major capital projects in the coming years".[20] We have seen how transfers from NHS capital budgets affected infrastructure investment in the past: from 2014–15 to 2018–19, £4.3 billion was transferred from health and social care capital budgets to support day-to-day spending, with the Committee of Public Accounts concluding in 2023 that "the raiding of capital budgets in the recent past is an underlying cause of the estates crisis the NHS is now in".[21]

12. **CONCLUSION**

The NHS has long suffered from capital underinvestment. This has led to an unsustainable maintenance backlog that is constraining the delivery of care. While we welcome the ambitions set out in the 10 Year Capital Plan, we remain sceptical that levels of investment are sufficient given that the current capital budget does not cover the existing repair bill. If the government and NHS are to find the funding necessary to invest in the future of the NHS estate and support its vision for a neighbourhood health service, it will need to think creatively and consider alternative sources of funding.

13. **RECOMMENDATION**

The Committee is concerned by recent announcements that the health and social care capital budget will be reduced by £1 billion over the next four years. In the past, the raiding of NHS capital budgets directly contributed to many of the estates issues we are seeing today. In its response the government should set out the implications of this reduction on neighbourhood health estate development and the efforts to address the existing maintenance backlog.

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18 HM Treasury, Budget 2026 in full, 28 October 2026

19 Ministry of Defence and HM Treasury, The Defence Investment Plan, 30 June 2026; HM Treasury, Budget 2026, October 2026, p 31

20 Health Service Journal, Treasury takes £1bn from health capital for defence, 28 October 2026

21 Committee of Public Accounts, First Report of Session 2023–24, New Hospital Programme, HC 77, para 8; National Audit Office, Maintaining public service facilities, 22 January 2025, p 12

14. In the rest of this chapter, we consider two possible additional sources of funding: public-private partnerships and 'developer contributions'.

Public-Private Partnerships

15. A 'Public-Private Partnership' (PPP) is a long-term contractual agreement between a public sector authority and private business to design, build, finance, or operate public infrastructure and services.[22] PPPs have played a major role in past and present NHS health infrastructure—such as the Private Finance Initiative (PFI), Private Finance 2[23], and the Local Improvement Finance Trust (LIFT)—and the 2025 Autumn Budget confirmed that PPPs would be used to deliver 70 of the first 120 NHCs.[24]

16. Previous PPP arrangements, particularly PFI, have proved controversial due to their long-term costs, inflexibility and the financial pressures they placed on the public sector. PFI is a form of PPP where a private consortium (via a Special Purpose Vehicle–SPV) is responsible for designing, building, financing, and operating an asset. The public sector has strategic control through specification and service requirements, but no financial control. It makes annual unitary payments covering construction costs, financing, maintenance and sometimes soft services (such as catering and cleaning), usually over a period of 25-30 years.[25] Issues with PFI included:

- Higher long-term costs arising from private financing. Private sector borrowing is generally more expensive than government borrowing, which means that, alongside long-term maintenance and facilities management commitments, PFI projects can create greater lifetime costs.[26] The Treasury Committee found in 2011 that PFI hospitals were

22 Department of Health and Social Care and UK Trade and Investment, Healthcare: Public Private Partnerships, 18 December 2013

23 Private Finance 2, which was launched in 2012 as a "new approach" to PFI, will not be discussed further in this report. The NAO concluded in 2018 that the "fundamental characteristics of PFI" remained the same; National Audit Office, PFI and PF2, 18 January 2018, p 36

24 HM Treasury and National Infrastructure & Service Transformation Authority, UK Infrastructure: A 10 Year Strategy, 19 June 2025, p 8; Department of Health and Social Care 10 Year Health Plan; Department of Health and Social Care and HM Treasury, Chancellor to double down on drive to cut NHS waiting times and rollout of new Neighbourhood Health Centres, 24 November 2025

25 National Infrastructure and Service Transformation Authority and HM Treasury, PFI Centre of Excellence (accessed November 2026)

26 NAO PFI and PF2, pp 8-11

around 70% more expensive than publicly financed hospitals, while the Institute for Public Policy Research estimated in 2019 that £13 billion of PFI investment into the NHS cost more than £80 billion.[27]

- Additional costs from inappropriate management of risk. PFI contracts usually included "risk premiums" (the additional payment paid by the public sector to the private investors to compensate them for holding asset risks). These typically saw trusts pay 12-15% of construction costs, though some were estimated to be as high as 30%.[28] It is argued this was due to project risks being initially overstated, as well as inappropriate transfer of risks, for example 'Change in Law' risk sitting with the private sector in some contracts.[29] Additionally, when significant problems arose such as construction defects, service failures, or insolvencies, the public sector still ultimately had to step in because essential services such as hospitals could not be allowed to fail.[30]

- Smaller projects being especially poor value-for-money, as they delivered smaller returns but at the same high costs as larger projects.[31]

- Highly prescriptive contracts with high administrative fees that made it difficult or expensive to adapt buildings to changing clinical needs.[32]

- The "fiscal illusion" of PFI schemes being reported 'off-balance sheet'.[33] Prior to the 2009 adoption of International Financial Reporting Standards, most PFI projects were considered off the public sector balance sheet, as the SPV, not the Government, borrowed the money and owned the asset. This is despite the Government remaining committed to long-term payments under the contract.[34] The Public Accounts Committee stated in 2025 that this gave the "illusion of lower

27 Treasury Committee, Seventeenth Report of Session 2010–12, Private Finance Initiative, 18 July 2011, para 29; IPPR, NHS hospitals under strain over £80bn PFI bill for just £13bn of actual investment, finds IPPR, 18 September 2019

28 National Audit Office, Private finance for infrastructure, 25 March 2025, pp 24-5

29 'Change in Law risk' is the risk that new or amended laws or regulations increase costs, alter service obligations, or reduce revenue; Thomson Reuters Practical Law, Change in Law in Offtake Agreements (accessed November 2026); The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004)

30 Alliance Manchester Business School, University of Manchester (DNE0065)

31 HM Treasury, PFI: meeting the investment challenge, July 2003, p 85

32 House of Commons Library, PFI: Costs and benefits, 13 May 2025, p 7

33 The Office for Budget Responsibility described this as a "fiscal illusion" in 2019; Office for Budget Responsibility, Housing associations, classification changes and fiscal risks, July 2019

34 Treasury Committee, Seventeenth Report of Session 2010–12, Private Finance Initiative, 18 July 2011, para 2

levels of [Government] debt", creating incentives to favour private financing over public borrowing, which "detracted from delivering value for money for taxpayers".[35]

In addition to these structural criticisms, a 2023 independent review of the UK's PFI sector (the White Frasier report), commissioned by the Infrastructure and Projects Authority, noted the impact of historic weaknesses in public sector contract management, including a lack of skills, expertise and resources, alongside private sector partners not investing sufficiently in systems and resources to ensure reliable self-reporting.[36]

17. Despite the above criticisms, health infrastructure projects funded by PFI were generally built on time and within budget, delivering new buildings more quickly than publicly funded projects.[37] The Association of Infrastructure Investors in Public Private Partnerships (AIIP) highlighted that PFI built 90 hospitals in ten years, contrasting this with the 2020 publicly-funded New Hospital Programme which aimed to build 46 hospitals over 25+ years, but had only delivered five by 2025.[38]

18. The government introduced another model of PPP in 2001, the NHS Local Improvement Finance Trust (LIFT) programme. This is used mainly to deliver primary care and community assets, and sees the public sector hold a 40% stake via the Department for Health and Social Care-owned company Community Health Partnership (CHP) with the rest of the funding coming from private investors. This constitutes a company (LIFTCo) that owns the building and leases it to GPs or other tenants.[39] CHP has stated it has secured investment of over £2.5bn of private capital for £100m of

35 Public Accounts Committee, Thirty-Ninth Report of Session 2024–25, Government's use of private finance for infrastructure, HC 821, 11 July 2025, Summary

36 The White Frasier Report examined behaviours, relationships and disputes across the UK's operational PFI sector; Infrastructure and Projects Authority, White Frasier Report, 20 July 2023; NAO, Lessons learned, p 32; The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004)

37 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); Equitix Limited (DNE0033); Department of Health and Social Care (DNE0066); Qq81, 104 [Dr Hellowell, Lord Hutton]

38 The New Hospital Programme has now delivered seven hospitals; Department of Health and Social Care, New Hospital Programme annual report: 2025 to 2026, 8 July 2026; The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004)

39 CHP is the 40% shareholder on all but seven LIFT companies (out of 49) where 10 local authorities—Manchester, Salford, Trafford, Leeds, Newcastle, North Tyneside, Nottingham, Barnsley, Doncaster and Newham—are also shareholders. The LIFT estate includes over 350 healthcare facilities, including GP, primary care and community settings.; Community Health Partnerships, The NHS LIFT Estate (accessed November 2026)

public money.[40] The government is continuing to use this form of PPP to fund neighbourhood health ambitions: 16 of the first 27 NHCs are being developed by refurbishing buildings in the existing LIFT estate.[41]

19. The AIIP, the LIFT Council (the body representing the private partners in LIFT arrangements) and Equitix Limited (a PPP investor) argued that the LIFT model could help the government deliver NHCs without a lengthy procurement process, by already providing high quality, modern buildings strategically located in areas of high need. They argued that LIFT buildings were designed to be flexible and adaptable to changing clinical needs, and that lifecycle-maintenance provisions helped ensure settings remain fit for purpose over the long term. The model's "transparent" governance arrangements and joint decision-making structures were highlighted as allowing the public sector to shape outcomes and influence decisions.[42]

20. However, we also received evidence criticising the LIFT model, particularly in terms of restricting flexibility. The Darzi Review highlighted GPs' limited control over the spaces they occupied, as they were tenants leasing from the LIFTCo. The Review also stated that some GPs in LIFT buildings described "unreasonably high" charges.[43] During our visit to a LIFT NHC in Cornwall, we were told it would cost £100,000 to reconfigure a room and £300 to change a toilet roll holder.[44]

21. Alongside this, the BMA told us that 74% of its members had reported inaccurate service-charge invoices for LIFT buildings, with a third of tenants stating that service-charge disputes were affecting the sustainability of their practices. It felt this demonstrated a system that was "actively inhibiting the shift to neighbourhood-level care".[45]

22. OneMedical Property, a family-owned health and wellbeing organisation, reported that while LIFT sometimes delivered "technically compliant" buildings, they were difficult to adapt in practice, being overly constrained by contractual arrangements and poorly aligned with evolving clinical practice.[46] The NHS Alliance stated that these issues, combined with a lack of local NHS expertise, had led to the "high-quality" LIFT estates

40 Community Health Partnerships, The NHS LIFT Estate (accessed November 2026);
41 Community Health Partnerships, Neighbourhood Health in Action, April 2026
42 AIIP (DNE0004); The LIFT Council, and Fulcrum Infrastructure Group (DNE0019); Equitix Limited (DNE0033)
43 In LIFT arrangements GPs are tenants leasing spaces from the LIFTCo, who in turn make the capital decisions, with funding flows bypassing the individual practices; Darzi Review
44 The NHS Confederation and NHS Providers (DNE0030); Cornwall visit note
45 Darzi Review; Royal College of General Practitioners (DNE0010); British Medical Association (BMA) (DNE0053)
46 OneMedical Property (DNE0025)

being underutilised, and that addressing these issues and unlocking the potential of LIFT (and PFI) estates should be a "priority" for neighbourhood health.[47]

Lessons from previous models

23. Given the government's intention to continue using PPPs and the contested views on the success of previous models, much evidence to this inquiry raised the importance of learning from the past when delivering future NHCs through PPPs. Key lessons included:

- Aggregating several smaller facilities into a single regional programme, to achieve the necessary scale to draw in bidders and thus avoid the poorer value-for-money that was seen in smaller PFI projects.[48]
- We specifically saw how poor procurement in health estate development can lead to worse value-for-money. In Cornwall, a LIFT NHC was described by participants at a roundtable as "exactly what a [NHC] should look like", however attendees felt that for the money spent, two health parks could have been built. We compared this with Cober Valley Health, a GP and community centre with a Community Interest Company (CIC) partnership delivery model, as evidence told us that it was ultimately delivered at half the price of initial costing. Attendees at the roundtable argued that systems should be given the choice between PPPs and alternative sources of funding, rather than having PPPs prescribed onto them.[49]
- Ensuring that risks were held by the party best able to manage them. Evidence suggested to avoid inappropriate risk transfer resulting in higher premiums and poorer value-for-money, shared risk models could be used for highly complex NHC projects.[50]

47 The NHS Confederation and NHS Providers (DNE0030)

48 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); Fedcap (DNE0018); The LIFT Council, and Fulcrum Infrastructure Group (DNE0019); The NHS Confederation and NHS Providers (DNE0030); Equitix Limited (DNE0033)

49 Cornwall visit note

50 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); Equitix Limited (DNE0033); Archus (DNE0060)

- Avoiding building designs or contractual arrangements that lead to inflexibility in service delivery. Evidence argued that NHCs, and the PPP model that developed them, should include provisions that allowed spaces to support multidisciplinary teams and be easily adapted to changing need, without incurring high administrative charges.[51]

- Implementation of ringfenced lifecycle funding for NHC projects to avoid the maintenance backlogs often seen in the public sector estate (as discussed at the beginning of this chapter). This could be held with the private sector partner investing in the project.[52]

- Implementing a quick, proportionate and mature dispute resolution mechanism to avoid the disputes and poor contractual relationships between public and private partners.[53]

- Creating strong central oversight to solve disputes between public and private partners if or when they did arise. Barry White, co-author of the White Frasier Report,[54] and Lord Hutton, Chair of the AIIP, suggested that the National Infrastructure and Service Transformation Authority (NISTA)[55] could provide the central oversight and contract-management function for future neighbourhood health PPP schemes.[56]

24. The government told us that its new PPP model for neighbourhood health, which is being developed through NISTA and supported by DHSC, would "build on lessons from the past" in the following ways:

51 Association for Respiratory Technology and Physiology (ARTP) (DNE0008); The LIFT Council (DNE0019); OneMedical Property (DNE0025); Galliford Try Construction (DNE0047); British Medical Association (BMA) (DNE0053)

52 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); Association for Respiratory Technology and Physiology (ARTP) (DNE0008); The LIFT Council, and Fulcrum Infrastructure Group (DNE0019); Q88 [Barry White]

53 Association of Infrastructure Investors in PPPs (AIIP) (DNE0004); Q88 [Barry White]

54 The White Frasier Report was an independent review commissioned by the Infrastructure and Projects Authority in 2022 and published in July 2023. It was examined behaviours, relationships and disputes across the UK's operational PFI sector; Infrastructure and Projects Authority, White Frasier Report, 20 July 2023

55 NISTA (National Infrastructure and Service Transformation Authority) is the UK Government body responsible for overseeing major infrastructure projects and supporting the delivery of public sector transformation programmes; Government, National Infrastructure and Service Transformation Authority (accessed November 2026)

56 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); Qq107-111

- Creating "simpler, more flexible contracts with clear performance standards and robust monitoring" for NHCs. The government states it has strengthened central capability and tooling for managing long term contracts through NISTA's PFI Contract Management Programme.[57]
- Greater standardised and centrally supported procurement of projects, reducing the need for each scheme to negotiate individual contractual and commercial arrangements.
- 'Built-in flexibility' in the new PPP model to ensure estates models support, rather than lock in, service transformation, although we have not seen any detailed information on what this flexibility looks like.
- Improved data and transparency on asset condition and performance, including consideration of modern digital tools and regular condition surveys, to support better management of the PPP estate.
- Budgeting PPP models 'on balance sheet' to ensure transparent management and fiscal sustainability.[58]

25. **CONCLUSION**

Given that it is likely that external funding will be necessary to meet the government's vision to deliver Neighbourhood Health Centres, and that Public-Private Partnerships will form part of this plan, it is important that the new approach addresses the shortcomings of previous models. These include poor value-for-money, inflexible contractual arrangements, inappropriate risk allocation, weak contract management, and difficulties adapting buildings to changing service needs. While the government has stated that its new neighbourhood health Public-Private Partnership model will learn from these lessons, it has not yet demonstrated how it will address each of these issues in practice.

26. **RECOMMENDATION**

In response to this report, the government should publish a detailed statement setting out how the design of its neighbourhood health Public-Private Partnership (PPP) model reflects lessons learned from previous schemes, including the Private Finance Initiative and the Local Improvement Finance Trust. This should explain:

57 NISTA's PFI Contract Management Programme is run via NISTA's 'PFI Centre of Excellence', and aims to equip public sector authorities with the skills and operational tools to effectively manage PFI contracts; National Infrastructure and Service Transformation Authority, NISTA PFI Contract Management Guidance: Contract Strategy, 26 March 2026

58 Department of Health and Social Care (DNE0066)

- how value for money will be secured, particularly for smaller neighbourhood health projects and refurbishments, including if projects will be bundled or aggregated where appropriate;
- how risks will be allocated between public and private partners;
- how contracts and assets will be designed to provide sufficient flexibility to respond to changing clinical and community needs;
- what arrangements will be in place for contract management, performance monitoring and transparency, including how the government will ensure the public sector has the commercial capability, staffing and resources necessary to manage long-term PPP contracts effectively;
- how disputes between public and private partners will be resolved;
- whether a body such as the National Infrastructure and Service Transformation Authority will have a role in providing oversight, expertise or assurance. If not, it should explain why it has not assigned responsibility to a role with a central oversight function, and set out how it will ensure sufficient scrutiny, consistency and assurance of the PPP model across the country;
- what steps the government will take to avoid the maintenance backlogs experienced in much of the non-PPP NHS estate, including whether it will use measures such as ringfenced lifecycle funding to ensure asset maintenance; and,
- what measures will be taken to give the Department enough Capital Departmental Expenditure Limit headroom to accommodate Public-Private Partnerships, given that they will be budgeted 'on balance sheet'.

The government should also set out how it will monitor and address performance issues with the existing LIFT estate delivering NHCs. Government should also state whether its PPP arrangement will be mandated for all Neighbourhood Health Centre new builds, or whether local systems will have the opportunity to explore alternative delivery models.

Developer contributions

27. Another potential source of funding to increase investment in the NHS estate is 'developer contributions', through the Community Infrastructure Levy (CIL) and Section 106 funding (s106').[59] These see developers, through the planning system, contribute funding, infrastructure, services, or other mitigation measures to address the impacts of new developments on local communities, including increased demand for public services. They can provide an important source of capital funding for local infrastructure, although as NHS England notes they "cannot substitute for the recurrent funding needed to staff and operate services."[60]

28. In 2020 the government noted that healthcare had "not traditionally been an area that was routinely funded through developer contributions" but reported a "significant increase" in requests for healthcare-related investment. Funding within the category that included healthcare contributions increased from £55 million in 2016–17 to £187 million in 2018–19. Although healthcare spending was not separately identified in this category, the government noted that the increase might "be explained by increased demand from healthcare". Regardless, this still represented a relatively small proportion of the £7 billion in total developer contributions in 2018–19.[61]

29. We also heard that the healthcare sector was not effective at capturing or using these contributions. The Home Builders Federation reported in March 2026 that in England and Wales there was £321 million in unspent health and social care developer contributions, with £128 million held by ICBs and £193 million held by councils.[62] Our evidence gave several reasons as to why the healthcare sector failed to effectively capture contributions:

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59 'Developer contributions' is a collective term mainly used to refer to the Community Infrastructure Levy (CIL) and Planning Obligations (commonly referred to as 'Section 106' or 'S106' obligations after Section 106 of the Town and Country Planning Act 1990); Town and Country Planning Act 1990; Planning Act 2008; Community Infrastructure Levy Regulations 2010

60 NHS England (DNE0068)

61 Ministry of Housing, Communities and Local Government, The Incidence, Value and Delivery of Planning Obligations and Community Infrastructure Levy in England in 2018–19, August 2020, pp 8-10

62 It should be noted that the total value of unspent developer contributions held by local authorities is £9 billion; Home Builders Federation, Unspent developer contributions research 2026, 2 March 2026

- 'Unreasonable' NHS investment and project timescales and approval cycles, with the inability to move quick enough and authorise schemes,[63] meant that the health sector missed the window for S106 or CIL funding. This could lead to funding either remaining unspent or contributing towards another sector.[64]

- The planning system not adequately involving or accounting for the needs of the NHS.[65] One facility wrote in evidence that local planning authorities were failing to sufficiently engage with the NHS on infrastructure requirements, with consultation letters sent to regional offices rather than the specific GP practice affected by the developments.[66] NHSE told us that the different statutory, financial and geographic frameworks for health and local authority planning acted as a barrier to effective engagement, and that limited capability could mean that health impacts were only addressed once development proposals were already well advanced.[67]

- Contract complexity, limited staff resources, inconsistent templates, and complex negotiations contributing to delayed and unspent contributions.[68] Martin Steele, CEO of (NHSPS) NHS Property Services, a government-owned company that manages approximately 10% of the NHS estate, told us that local health bodies in particular lacked technical expertise, meaning that the NHS failed to get its "fair share" of contributions.[69] The NHS Alliance stated that recent requirements for ICBs to restructure and reduce headcounts had compounded this situation.[70]

30. Evidence also raised that other sectors make better use of developer contributions. Martin Steele told us that the education sector, unlike the health sector, accessed a lot of CIL and s106 funding, with a "more evolved or mature" way of approaching it.[71] This included government guidance

63 The NHS capital approvals processes are discussed further below, Chapter 2, Capital approvals process
64 Qq185, 201 [Rob James, Joe Garrod]
65 The NHS Confederation and NHS Providers (DNE0030)
66 Mereside Medical (DNE0044)
67 NHS England (DNE0068)
68 National Audit Office, Improving local areas through developer funding, 6 June 2025, pp 5, 10, 30
69 Q39
70 The NHS Confederation and NHS Providers (DNE0030)
71 Q49

detailing how the education sector could capture contributions.[72] The NHS Alliance pointed to the education sector guidance as a template that could be used for the health sector.[73]

31. The government is taking some steps to aid securing developer contributions. NHSPS supports NHS bodies within its estate with securing developer contributions through guidance, online resources, and a specialist planning expertise team.[74] NHSPS told us that its team helped those within its estate identify and capture CIL and s106 funding opportunities, and was managing around £60 million in developer contributions for projects across the NHSPS estate.[75] The government said that Health and Wellbeing Boards should "consider how to make the most of local development and regeneration opportunities" including utilising S106 monies.[76]

32. NHSE noted that health estate planning and local authority spatial planning was a "highly complex area" and that there were "challenges" in practice. It argued that ICBs should maintain evidence-based infrastructure requirements that combined population forecasts, deprivation, existing capacity, estate condition, utilisation, access and workforce assumptions, and that those requirements should inform local plans and discussions on securing developer contributions.[77]

33. **CONCLUSION**

Developer contributions could provide an important source of funding for healthcare infrastructure. However, we heard that the health sector is often less effective than other sectors, such as education, at securing and using these contributions. A lack of data, fragmented planning arrangements, limited expertise, and the absence of comprehensive national guidance mean that opportunities for developer contributions are frequently missed.

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72 Government first published guidance on planning new education infrastructure required as a result of housing growth in April 2019, with updated guidance published in August 2023; Ministry of Housing, Communities and Local Government, Department for Education, and Department for Levelling Up, Housing and Communities, Delivering schools to support housing growth, 9 August 2023

73 The NHS Confederation and NHS Providers (DNE0030); Q46 [Ruth Rankine]

74 NHS Property Services, Introduction to NHS Property Services, p 2; NHS Property Services, Property development; Funding opportunities in Town Planning: are you missing out?; Your guide to NHS Estate funding (accessed November 2026)

75 Qq38-39, 49 [Martin Steele]

76 Health and Wellbeing Boards are discussed further below, Chapter 2, Funding, planning and governance fragmentation; Department of Health and Social Care (DNE0066)

77 NHS England (DNE0068)

34. **RECOMMENDATION**
Government and the NHS should reform the way the health sector secures and uses developer contributions. This should include:

- publishing comprehensive national guidance on identifying, securing, managing and spending Section 106 and Community Infrastructure Levy funding for healthcare infrastructure. This could be based on the guidance currently available for the education sector, and should be available publicly to all NHS organisations, reviewed regularly and updated when necessary;
- supporting all NHS organisations to develop the expertise and capacity needed to engage effectively with the planning system and maximise opportunities for healthcare investment;
- improving the collection and publication of data on healthcare-related developer contributions, including funding requested, secured, held and spent;
- establishing a national performance framework for developer contributions related to the health sector, including reporting on the value of contributions requested, secured, received and used, setting clear expectations for improvement over time.

Matching capital with revenue investment

35. While capital investment is important to deliver neighbourhood health estate transformation, it is also important to consider revenue implications of new projects. We heard that investment in buildings needed to be matched by revenue funding to meet the ongoing costs of staffing, maintaining and operating new facilities.[78] Evidence stated that "insufficient revenue funding" was a common factor in neighbourhood health pilots that had struggled, and we heard that without sufficient revenue funding to staff and run facilities, new premises risked being underutilised.[79]

36. As revenue funding is usually agreed annually, this can cause uncertainty for providers committing to long-term projects. Beccy Baird, Senior Fellow at King's Fund, told us that these annual, rather than multi-year contracts, meant that "nobody" was prepared to take the revenue risk. Ruth Rankine of

78 Q47 [Ruth Rankine]
79 South Warwickshire University NHS Foundation Trust, Stratford District Council, Warwickshire District Council, Rugby Primary Care Network, and Warwickshire & Solihull Community and Voluntary Action (CAVA) (DNE0057); Qq47; 53-54 [Beccy Baird; Ruth Rankine]

the NHS Alliance explained how this could impact neighbourhood premises specifically, which would include community services which had their contracts "retendered regularly".[80]

37. In its 2025 Spending Review, the government committed to a multi-year revenue settlement to 2028/29, with an average annual real-terms growth rate of 3.0% per year in NHS day-to-day spending, equivalent to a £29 billion real-terms increase in annual resource budgets.[81] When discussing this matter during our visit to Cornwall, three-year funding cycles were described as a "good start", though we heard that "five would be better."[82]

38. **CONCLUSION**

The government's announcements for capital investment in neighbourhood health estates are welcome. However, this capital investment must be matched, where necessary, by sustainable, long-term revenue funding to meet the ongoing costs of operating, staffing and maintaining these facilities. This is particularly important where developments create additional capacity or services, rather than replacing existing premises. Without sufficient revenue support, the full benefits of neighbourhood estate investment may not be realised.

39. **RECOMMENDATION**

In response to this report, we ask the government to set out how it is ensuring that sustainable financial arrangements are in place to cover the ongoing costs of running the new neighbourhood health premises it is planning to create, including the new Neighbourhood Health Centres.

80 Q53 [Ruth Rankine, Beccy Baird]
81 HM Treasury, Spending Review 2025, 30 June 2025
82 Cornwall visit note

2 Barriers to investment

40. While we consistently heard that there was a need for more investment in the NHS estate to deliver the neighbourhood health service, we also heard that there were technical, financial and regulatory barriers that could prevent existing funding from being used effectively. As Bill Shields, Director of Finance at the 'DLN' ICB cluster,[83] said:

> It is a feature in NHS capital programming. We are not good at spending the money that we have.[84]

In this chapter we explore some of these barriers. They include rigidly imposed capital limits, delays in the capital approvals process, unintended consequences of accounting standards, and a fragmented joint-planning system.

Capital limits

41. Throughout this inquiry we heard that capital limits could constrain NHS estate development where potential funding was available, for example through land sales, developer contributions, or third-party investment. Like all departments the DHSC is subject to a Capital Departmental Expenditure Limit (CDEL), which is an HM Treasury-imposed control on the amount of capital expenditure that can take place each year. The 2024 Darzi Review noted that those limits could not be exceeded even if additional funds were available.[85] Similarly, the York and Scarborough Teaching Hospitals NHS Foundation Trust argued that the way the CDEL operated as a national cap could result in a "disconnect between local capital priorities" such as critical estate needs, and the timing of "permitted expenditure".[86]

42. Joe Garrod, Director of Place at Waltham Forest, compared DHSC CDEL with the local authority approach (the Prudential Framework) which he argued allowed greater freedom to borrow and invest.[87] The Local Government Association stated in October 2025 that the Framework was a

83 'DLN' cluster refers to NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board and NHS Nottingham and Nottinghamshire Integrated Care Board
84 Q211
85 Darzi Review
86 York and Scarborough Teaching Hospitals NHS Foundation Trust (DNE0056)
87 Qq199, 210

"major step in freeing local government from centrally imposed borrowing controls" and showed the government placing "genuine trust and reliance in local government's ability to manage its own affairs".[88] Joe Garrod described how that approach, which engendered familiarity with different funding options, contrasted with the DHSC model:

> If you are working with a range of funding streams […] your approach to delivery is to say, "How do we blend that funding to deliver the outcome?" If you are used to working in a highly governance-heavy, top-down model [it] does not facilitate that problem-solving mindset.[89]

43. Coventry and Warwickshire ICS Primary Care Team called for Integrated Care Systems to have the power to collectively allocate and approve capital allocations and encourage strategic planning by providing adequate time to develop, assess and prioritise the capital pipeline.[90]

Capital approvals process

44. We also heard that the lengthy process of NHS capital approvals could delay delivery of estate projects. Capital investment schemes typically progress from an outline business case (OBC) to a full business case (FBC), demonstrating strategic need, affordability and value for money at each stage, before receiving signoff from ICBs, NHS England (or DHSC), and for larger schemes HMT.[91] Multiple reasons were given for the significant delays in approving capital investment including:

- Excessive approval processes across several layers, with Bill Shields telling us that even "relatively small investments still require regional and national approval", creating a "very elongated […] process".[92]

88 The 'Prudential Framework' refers to the Prudential Code and the Treasury Management Code, introduced by the 2003 Local Government Act and 2003 Capital Finance Regulations. It allows local authorities greater freedom to borrow and invest without seeking central Government approval for individual projects, provided that borrowing is affordable, prudent and sustainable and can be met from their resources and revenue budgets.; Local Government Association, The Prudential Code for Capital Finance in Local Authorities and Treasury Management in the Public Services: Code of Practice and Cross-Sectoral Guidance Notes. Consultation., 8 October 2025

89 210

90 Coventry and Warwickshire Integrated Care System Primary Care Team (DNE0024)

91 HM Treasury, Guide to developing the project business case, 2018

92 The NHS Confederation and NHS Providers (DNE0030); Q211

- Fragmented decision making across multiple partners, with the NHS Alliance stating that too many overlapping actors could lead to lengthy decision-making processes which could threaten the viability of projects.[93]

- Complexity and bureaucracy, with the 2024 Darzi Review stating the process was "so byzantine" that it was hard to find an NHS senior manager who understood it. Evidence raised disproportionate levels of bureaucracy as a key blocker of estate development.[94]

45. In many cases we were told the approval process could be longer than the building process itself. Martin Steele, CEO of NHS Property Services (NHSPS), explained that NHSPS could build a new health centre within 13 to 14 months, but that "sometimes it takes six or seven years to get a spade in the ground".[95] This lengthy and complex process can impact relations with other partners. Joe Garrod, Director of Place at Waltham Forest Council, told us that the NHS was "probably the most challenging partner to work with", in part due to the capital approvals process.[96]

46. As well as delaying provision of new services, the lengthy approval process and delays can lead to higher project costs. NHSPS told us that due to slow decision making, Weybridge Community Hospital was taking over ten years to complete, with construction costs rising from c.£13m to c.£21m due to inflation.[97]

47. NHS England said that it recognised "the perception that capital schemes can take too long" due to "unnecessary processes". It listed different delays that could arise from "several linked issues": an immature model of care, uncertain capital or recurrent affordability, site and title issues, planning permission, procurement, valuation, lease negotiation, legal documentation, and the need for approvals from more than one public body. However, it stated that "well-formed cases move through the approvals in a timely manner".[98]

48. NHSE argued that the first wave of Neighbourhood Health Centre investments was illustrative of a streamlined approach and based on proportionate risk-based assurance rather than removing controls. It stated that further practical measures to facilitate approvals included:

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93 The NHS Confederation and NHS Providers (DNE0030); This fragmented joint working is discussed further below, Funding, planning and governance fragmentation

94 Darzi Review; Royal College of General Practitioners (DNE0010); OneMedical Property (DNE0025)

95 Q8

96 Q202

97 NHS Property Services Ltd (DNE0040)

98 NHS England (DNE0068)

> […] standard business-case templates, standardised designs and room types, early legal and valuation input, agreed timetables, a single coordinated request for information, stage-gated decisions, and earlier identification of schemes that are not affordable or deliverable.[99]

49. The 10 Year Health Plan committed to simplifying capital approvals and expanding freedoms for high-performing providers.[100] NHS capital guidance 2026/27 to 2029/30 and the 10 Year Capital Plan for Health and Social Care introduced several significant changes, including higher delegated limits, with HM Treasury approval required only for schemes above £300 million, no further approval required at Full Business Case stage unless total costs exceed £1 billion or scope changes materially, and self-financed delegated limits for NHS trusts and foundation trusts.[101] NHSE told us that those reforms provided "greater certainty" and that the current governance, capital and approvals arrangements provided "a strong foundation" for delivering neighbourhood health ambitions.[102]

50. **CONCLUSION**

Even when systems have the funding to enact transformation, rigid centrally imposed capital controls and excessively long approvals processes are significant barriers to estate development. This results in an unacceptable disparity between the time required to approve a project and the time required to deliver it. We welcome the government's commitment to streamline approvals and increase delegated responsibility.

51. **RECOMMENDATION**

In response to this report, the government should provide further detail on how the new, "streamlined" approvals regime will work in practice to unlock estate transformation for neighbourhood health. Additionally, it should establish clear national targets for capital approval times, publish performance data, and report annually on whether these reforms have accelerated estate investment and delivery.

99 NHS England (DNE0068)
100 Department of Health and Social Care 10 Year Health Plan
101 NHS England, Capital guidance 2026/27 to 2029/30, 11 February 2026; Department of Health and Social Care, 10 Year Capital Plan
102 NHS England (DNE0068)

Accounting standards

52. We were also told that the IFRS 16 international accounting standard might constrain neighbourhood health estate development. Adopted in the public sector from 2022, it requires organisations to 'capitalise lease costs'. This means that lease costs, traditionally treated as revenue expenditure, can count against CDEL, reducing the amount of capital that bodies have available to invest in their estate.[103] We heard this occurred even when Trusts or ICBs felt they could cover the value of the lease, such as through revenue funding or third-party financing, or if no upfront capital was required.[104]

53. Evidence suggested that this 'capitalisation of lease costs' could pose particular challenges for neighbourhood health estate development, as NHSE proposed leasing buildings as an "effective delivery route" without having to construct new buildings. NHSE noted that while the accounting treatment did not make a "sound lease intrinsically poor value", it could constrain otherwise affordable schemes, particularly when faced with critical infrastructure risk priorities.[105]

54. The developer Primary Health Properties PLC stated it would be helpful if there was a way to distinguish between 'actual' capital spending where the money had been invested in the estate or new estate equipment, and 'capitalised' spending (such as lease-based arrangements), which were funded through revenue funding but treated as capital for accounting purposes.[106]

55. 2026 Treasury guidance noted that while IFRS 16 brought leases onto the balance sheet and affected total control, it did not substantially change underlying spending.[107] We asked HMT if it had assessed the effect of IFRS 16 on NHS estate development and its interaction with CDEL.[108] Its response stated that:

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103 The objective of IFRS 16 is to report information that faithfully represents lease transactions, providing a basis for users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases; HM Treasury, IFRS 16 Leases Application Guide, January 2023

104 Primary Health Properties PLC (DNE0034); British Property Federation (DNE0038); York and Scarborough Teaching Hospitals NHS Foundation Trust (DNE0056); Cornwall Visit Note

105 NHS England (DNE0068)

106 Primary Health Properties PLC (DNE0034)

107 HM Treasury, IFRS 16 Leases, Supplementary budgeting guidance, March 2026, p 2, para 3

108 Correspondence to HMT – District Valuer and IFRS 16, 8 September 2026

- It had engaged with DHSC and NHSE during implementation of IFRS 16, through a working group and consultation. It did not, however, identify any specific assessment of the effect of IFRS 16 on NHS estate development.
- Departments are "expected to bid for programmes on the basis of IFRS 16 guidance", meaning they should "bid for the requisite CDEL" to cover lease arrangements.
- IFRS 16 improves transparency and accountability for long-term liabilities.[109]

56. The latter point was reflected by our evidence, which understood the rationale for IFRS 16, but questioned unintended consequences.[110] Bill Shields, for example, told us that from an accounting perspective, IFRS 16 was "absolutely fantastic and really transparent", but questioned the impact the treatment of leases scoring against CDEL might be having on systems seeking to develop neighbourhood health infrastructure.[111]

57. **RECOMMENDATION**
We recommend that HM Treasury undertakes a specific review of the impact of IFRS 16 on NHS estate investment, including its effect on the capital available to NHS organisations and the delivery of neighbourhood health infrastructure. If the review identifies barriers to estate development, government should bring forward proposals to mitigate these impacts on investment in healthcare infrastructure, while maintaining appropriate fiscal transparency and accountability.

Funding, planning and governance fragmentation

58. The final barrier to spending existing money that we encountered was poor alignment and ineffective joint working between the NHS and other partners, particularly local authorities. The Neighbourhood Health Framework (NHF) stated that the Neighbourhood Health Service would "only work as a joint endeavour between the NHS and local authorities, alongside wider partners".[112] We heard that the delivery of neighbourhood estate projects could be delayed or prevented by the different funding systems, accountability arrangements, capital regimes, and timescales

109 Correspondence from HM Treasury – regarding the role of the 'District Valuer' and IFRS 16 in the NHS estate and neighbourhood health ambitions, 23 October 2026
110 Q219 [Bill Shields]
111 Correspondence from HM Treasury – regarding the role of the DV and IFRS 16
112 Neighbourhood Health Framework; NHS England (DNE0068)

of the different partners. We have already discussed many of the reasons for misalignment, including lengthy NHS approval processes[113] and poor engagement between local authorities and the NHS in the planning system.[114] However, another issue we were told about was no single organisation being responsible for overall project delivery. We were told that at a neighbourhood level, there was often a "lack of clarity around who has decision-making over [the] local estate".[115]

59. NHS England 'Neighbourhood health centre guidance' for regions and ICBs states that "NHCs should be […] connected to wider networks of support, health promotion and community activity", and will thus involve NHS bodies, local authorities, landlords, developers and voluntary organisations, all of which operate under different governance and accountability arrangements.[116] Submitters to our inquiry told us that, as a result, it could be seen that no single actor had the authority, financial flexibility and risk appetite to bring forward neighbourhood estate development.[117] NHSE acknowledged the importance of clear governance and aligned funding decisions, but did not set out what steps it was taking to ensure that such arrangements are in place.[118]

60. The NHS Alliance argued that clearer system-level leadership was needed, which could see ICBs convene partners, define roles and establish streamlined approval pathways.[119] The charity Mental Health Matters called for greater collaboration or delegation to local government partners in certain matters of estate development, as it stated there were "expertise gaps" within the NHS in leading capital projects, with local authorities and combined authorities often having stronger experience regarding large-scale capital development.[120]

61. A recent relevant policy announcement is the role of 'Health and Wellbeing Boards' (HWBs) in neighbourhood health arrangements. HWBs were introduced in 2013 and are responsible for producing Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing

113 See earlier in this chapter, Capital approvals process
114 See Chapter 1, Developer contributions
115 South Warwickshire University NHS Foundation Trust, Stratford District Council, Warwickshire District Council, Rugby Primary Care Network, and Warwickshire & Solihull Community and Voluntary Action (CAVA) (DNE0057)
116 NHS England, Neighbourhood health centre guidance for regions and integrated care boards, 16 April 2026
117 Coventry and Warwickshire Integrated Care System Primary Care Team (DNE0024)
118 NHS England (DN0068)
119 The NHS Confederation and NHS Providers (DNE0030)
120 Mental Health Matters (DNE0032)

Strategies (JHWSs), as well as expected to be a core driver for joint working across health and care organisations.[121] Under the Neighbourhood Health Framework (NHF), HWBs will:

- play a leadership role in developing 'neighbourhood health plans', coordinating planning across sectors;
- agree local neighbourhood priorities, ensuring that neighbourhood health reflects local population needs;
- work with communities and local partners to establish local outcome measures; and
- help align neighbourhood health with wider local plans and regeneration agendas.[122]

62. We asked witnesses whether HWBs, given this role in neighbourhood health planning and issues with project responsibility, should be given budget responsibility to effect estate development for neighbourhood health. Joe Garrod raised concerns that HWBs, as partnership organisations, might not be able to take on roles requiring them to be accountable for spending, as the necessary accountability would be diffused over a range of partners. Bill Shields stated that "in principle" HWBs having budget oversight made sense, but that the 'devil was in the detail' of the governance arrangements. He asked:

> […] how you would delegate a budget to a non-statutory body, what would happen in the event that there is overspend and who is responsible for that. A regulatory framework needs to be understood and worked out if that is to be successfully done.[123]

We saw that this role could also be taken by an acute trust where existing relationships with community services are well established, as we saw on our visit to West Cornwall Hospital.[124]

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121 Core membership of HWBs comprises at least one elected member of the local authority; the Directors of Adult Social Services, Children's Services and Public Health; a representative of the local Healthwatch organisation; and a representative of the relevant Integrated Care Board (ICB), though HWBs can invite other organisations, such as VCSE or business sectors, to join. JSNAs are assessments of the current and future health and social care needs of a local community. JHWSs are strategies for meeting the needs identified in JSNAs; Department of Health and Social Care, Health and wellbeing boards – guidance, 22 November 2022; JSNA and JHWS statutory guidance, 24 August 2022, pp 6-8; Health and Social Care Act 2012; Health and Care Act 2022

122 Department of Health and Social Care Neighbourhood Health Framework

123 Qq213-214 [Bill Shields, Joe Garrod]

124 Cornwall visit note

63. We wrote to DHSC asking for further information on the governance, accountability, and financial responsibility measures that HWBs would have, alongside further clarification on outcomes and performance measures, national geography boundary settings, and "local infrastructure committees", but did not receive a response ahead of agreeing our report.[125]

64. **CONCLUSION**
We are concerned that neighbourhood health ambitions risk being undermined by the fragmented funding, planning and governance mechanisms across the NHS, local authorities and wider system partners. Without greater clarity over leadership, accountability and decision-making responsibilities for neighbourhood estate projects, there is a risk that opportunities for estate transformation will be delayed or missed.

65. **RECOMMENDATION**
The government should require each major neighbourhood health estate proposal to identify a lead organisation or body responsible and accountable for coordinating partners and overseeing delivery. As part of each estate approval process, proposals should set out the designated lead organisation and the rationale for selection, determined according to the nature of the project and local circumstances. The lead organisation should act as the primary point of contact across local authorities, providers and community partners.

66. **RECOMMENDATION**
In addition, we ask that the government publish a detailed roadmap setting out its timeframes for the delivery of the Neighbourhood Health Centres it has committed to establishing to date, including the national and local delivery responsibilities, and the options available to adapt the model to meet local needs.

125 In its written evidence, DHSC stated that HWBs should consider how to make the most of local development and regeneration opportunities such as Section 106 monies "through local infrastructure committees", though did not detail what constituted "local infrastructure committees". Section 106 monies are discussed further in Chapter 1, Developer contributions; Department of Health and Social Care (DNE0066)

3 The GP estate

67. The government has described general practice (GP) as the "bedrock" of neighbourhood health. The Neighbourhood Health Framework (NHF) stated that neighbourhood health would strengthen primary care, and that Neighbourhood Health Centres (NHCs) would bring "together GP services with a mix of community, local authority and civil society sector services".[126] As the first wave of NHCs is focused on repurposing and upgrading existing buildings, many existing GP premises and primary care facilities will become, or form part of, NHCs.[127] However, evidence to our inquiry raised serious concerns about the existing GP estate, including its condition, capital and revenue investment issues, ownership arrangements, and premises cost reimbursement processes.[128]

68. We were told that the outdated and aged nature of the GP estate prevented it from effectively delivering its current model of care and would prohibit it from leading future models of care, such as the integrated, multidisciplinary teams that the Neighbourhood Health Service envisions. NHS England data showed that around 60% of the primary care estate is more than 31 years old, with only 4% dating from 2015 onwards. A "material proportion" of the primary care estate is in condition C or worse,[129] with a primary care maintenance backlog of about £224 million.[130] This outdated estate can lead to unsuitable infection control and prevention standards. For example, we heard of anecdotal reports of more than 30 staff sharing a single toilet.[131] Dr Jamie Hynes, Royal College of GPs (RCGP), told us that GP premises "were built for the purpose at the time they were built".[132]

69. Alongside condition issues, evidence raised how a lack of physical space could negatively affect workforce ambitions:

- RCGP reported that 74% of its managers found that a lack of space prevented their practices from recruiting more GPs.[133]

126 Department of Health and Social Care Neighbourhood Health Framework
127 Department of Health and Social Care and NHS England, Communities to benefit from health centres on their doorstep, 26 March 2026
128 Chapter 4 will discuss utilisation and data of GP premises, as well as co-location of services within GP premises
129 Condition A being 'best in class'; NHS England (DNE0068)
130 NHS England (DNE0068)
131 British Medical Association, GP Premises Survey Results 2025, September 2025
132 Q150
133 Royal College of General Practitioners (DNE0010)

- The BMA stated that many premises lacked the space needed for undergraduate/preregistration education, postgraduate training and continuing professional development.[134]
- Evidence noted that there was a lack of space to accommodate other teams and facilitate the multidisciplinary working that was central to neighbourhood health plans.[135]

GP estate investment

70. We also heard that the complexity of the GP funding landscape presented a challenge to expanding and modernising the GP estate to deliver neighbourhood health. Capital funding for GP premises comes through multiple funding routes, often combined within a single project. This includes NHS capital grants, national capital programmes (such as the Primary Care Utilisation and Modernisation Fund 2025/26 (UMF)), NHS capital allocations, private or third-party investment, GP personal investment and other local sources such as developer contributions.[136] 84% of estates leaders surveyed by NHS Property Services (NHSPS) in 2024 found a lack of understanding of the options, and/or challenges in the application process, to be barriers to GP funding, with 54% lacking confidence in combining multiple sources of capital.[137] The BMA's 2025 GP Premises Survey revealed that 42% of GP practices were rejected when applying to improve their premises, despite 88% of those grant applications being for under £150,000.[138] An ICB cluster stated that accessing the UMF required what felt like a "disproportionate volume of paperwork and layers of approval".[139]

71. Particular concerns were raised about the reliance on personal investment, a consequence of the current GP ownership model that sees almost half of GP practices being self-owned.[140] During our visit to Cornwall, we visited a practice that had combined three GP surgeries alongside other services, raising £6 million through personal loans.[141] The RCGP stated that this

134 British Medical Association (BMA) (DNE0053)
135 Anonymous (DNE0006); Mereside Medical (DNE0044); British Medical Association (BMA) (DNE0053)
136 NHS England, Primary care capital grants policy, 25 October 2025; Department of Health and Social Care, Primary Care Utilisation and Modernisation Fund 2025 to 2026, 6 May 2025; NHS England, Capital guidance 2025/26, 30 January 2025; Healthy Urban Development Unit, S106 Planning Contributions for Health (accessed November 2026)
137 NHS Property Services, NHS Estate Funding Survey Report, 2024, p 4
138 BMA, GP premises survey results 2025, 23 September 2025, p 4
139 NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Derby and Derbyshire Integrated Care Board, and NHS Lincolnshire Integrated Care Board (DNE0042)
140 NHS England (DNE0068)
141 Cornwall visit note

model of personal investment was a "considerable financial burden", especially prohibitive for early career GPs.[142] Dr Wood of Mereside Medical spoke of the difficulties GP practices faced in securing loans, as they did not have access to government-backed borrowing, meaning repayment costs would be higher and personal loans had too high interest rates, meaning the practice she represented opted for a third-party developer.[143]

72. There are models for GPs securing loans. In 2018 the Scottish Government introduced the 'GP sustainability loan scheme', providing interest-free loans from Health Boards of up to 20% of the premises value, with repayment over a long period and under specific circumstances.[144] 2023 commentary from legal advisors to Scottish GPs stated this scheme had "not progressed as smoothly as had been hoped", and the scheme was paused in March 2024 due to "a greater than anticipated number of loans".[145] There is no equivalent scheme in England, though GPs operating as independent businesses may have access to general lending schemes such as the Growth Guarantee Scheme, pending eligibility criteria.[146]

73. In addition to personal investment insecurity, uncertainty over future revenue funding can disincentivise GPs from investing in their buildings. GP revenue funding primarily comes through a capitation-based system, practices receiving funding based on the number and characteristics of registered patients.[147] Beccy Baird, Senior Fellow at the King's Fund, told us that as revenue funding is therefore tied to existing activity, resources were only released once services were fully operational. She called for "pump-priming" to build spaces before people moved in. She also spoke of the effect that population moves could have on GP revenue and investment arrangements when considering investment risk:

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142 Royal College of General Practitioners (DNE0010)

143 Q183

144 Specific circumstances include change in ownership or use of the premises, such as no longer being used for medical services; British Medical Association Scotland, GP sustainability loans Frequently Asked Questions, January 2020, p 4

145 David Chalmers Stewart, Update on the GP Sustainability Loan Scheme for Owned GP Premises, 11 July 2023; Scottish Parliament, written question S6W-28082, 14 June 2024

146 British Business Bank, Growth Guarantee Scheme (accessed November 2026)

147 Under the General Medical Services (GMS) contract, the national standard that covers 70% of GP practices, most GP income comes through a global sum payment allocating funding per patient. This allows providers flexibility in how they spend money, though does not account for changes in levels of demand; NHS England, GP Contract (accessed November 2026); British Medical Association, Models for paying providers of NHS services, 28 June 2024; King's Fund, GP funding and contracts explained, 7 April 2025;
GPs also receive premises revenue funding through reimbursement.
This is discussed in more detail below, Chapter 4: Making better use of the estate, Co-location in GP premises

GPs in that area do not want to invest in their own building to accommodate this new influx of people, because they know those people will eventually go to another GP practice and they will lose the income. GP practices, particularly, are incredibly sensitive to small changes.[148]

74. **CONCLUSION**
GPs, and their premises, are likely to be the cornerstone of neighbourhood health estates. Yet, we have found that capital investment mechanisms and revenue funding arrangements actively disincentivise GP estate development and expansion.

75. **RECOMMENDATION**
The government should develop a long-term GP capital and revenue investment strategy that aligns with neighbourhood health objectives. The strategy should:

- improve support for GP practices when navigating the numerous and fragmented estate funding streams, including offering guidance and best practice on how to identify and combine funding sources;
- review ways to reduce the reliance on personal financial risk and private borrowing when investing in GP estates, especially for early career GPs. This could include exploration of a dedicated GP loan scheme that could provide access to government-backed borrowing. Any model should draw on lessons from other schemes such as the Scottish GP sustainability loan scheme; and,
- review whether current funding arrangements create financial barriers to GP premises investment and service expansion, by placing too much upfront financial risk on GP partners before patient activity has generated sufficient sustainable income.

The District Valuer

76. As well as the above financial barriers to GP estate expansion, the role of the 'District Valuer' (DV) in assessing premises valuation was repeatedly raised as a specific issue for GP estate development. The DV has two roles that are relevant to this inquiry. Firstly, it assesses whether a proposed development or expansion represents value-for-money (VFM), which will inform whether NHS England or ICBs approve the proposal. Secondly, it assesses the current market rent (CMR) for the premises, which influences

148 Q53

the level of rent reimbursement available to practices.[149] We heard that these assessments did not always reflect the actual costs of development or occupation. As a result, proposed developments may not receive approval, or practices may be unwilling to invest in new premises where they feel that rental costs will not be adequately reimbursed.[150] Witnesses argued that this could delay or prevent the development and expansion of GP facilities for neighbourhood health purposes. Beccy Baird of the King's Fund told us there were complaints about the DV in "almost every meeting" she attended related to neighbourhood estates.[151]

77. We heard about four main issues with the DV process:

i. **Discrepancy with real-world costs**: Changes in the cost of construction, interest rates, and fluctuations in property values are reportedly not accurately reflected in DV assessments of CMR or VFM.[152] Dr Wood of Mereside Medical told us about a VFM valuation revisited after five years, when the DV proposed only a 4.5% increase despite construction costs having risen by 40% to 50%.[153] The British Property Federation further argued that discrepancy in CMR valuation could lead to projects being put on hold before a viable rent could be agreed.[154] We heard about one practice, Summertown Health Centre, which failed to progress with a development as the DV valued the potential new build's rent lower than the builder estimated the market price of the rent.[155] When we asked HMT about this matter, it emphasised that CMR by definition was "based on market evidence, rather than an appraisal of development costs", and noted that PCDs allowed NHSE to apply "an appropriate settlement" where the CMR assessment alone would not support a development.[156]

149 The District Valuer has more roles than this, that are not discussed in this Report, and can be found in the Premises Costs Directions; The National Health Service (General Medical Services) Premises Costs Directions 2024; HM Revenue and Customs, District Valuer Services (DVS) (accessed November 2026)

150 Anonymous (DNE0006); British Property Federation (DNE0038); NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Derby and Derbyshire Integrated Care Board, and NHS Lincolnshire Integrated Care Board (DNE0042)

151 Q56

152 Anonymous (DNE0006); British Property Federation (DNE0038)

153 Q183

154 British Property Federation (DNE0038)

155 GP Online, Neighbourhoods could fail without GP premises upgrades, warns senior MP, 30 June 2026

156 Letter from HM Treasury - regarding the role of the 'District Valuer' and IFRS 16 in the NHS estate and neighbourhood health ambitions, 23 October 2026

ii. **Opaque methodology**: Dr Wood of Mereside Medical raised that a lack of transparency in DV's valuations prevented them from being challenged and scrutinised. She called for the DV to publish its methodology and appraisals, and for a dispute resolution mechanism with a conversation between the ICB, the DV, the practice, and the developer or the stakeholders involved.[157] HMT disputed suggestions of opacity, stating that District Valuer Service offered "a transparent and consistent valuation process", providing valuation advice and supporting evidence to the commissioning NHS body, and "where appropriate" to GP representatives and developers.[158]

iii. **Delays**: Multiple witnesses spoke about how delays in receiving DV input could suspend the progress of projects, which might have meant funding sources became unavailable.[159] HMT acknowledged the importance of "timely valuation advice", but stated that government did not have a mechanism to identify costs or delays attributable to the VFM assessment. No evaluation had therefore been made of their effect on NHS estate delivery.[160]

iv. **Overreliance on DV assessments:** Witnesses also expressed concerns that the DV was acting as the "single source of truth", and that ICBs use its assessments as a "directive" or "definitive", rather than as an advisory[161] figure.[162] HMT was clear in its response that the DV did "not decide whether a primary care scheme should proceed" and that decisions instead rested with the relevant NHS body, taking account of DV advice alongside "affordability, strategic priorities, funding and other relevant considerations".[163]

78. NHS England told us that there could be multiple reasons for the gap between a developer's required rent and CMR assessment. While it recognised concerns about timelines, consistency and transparency, it argued that "raising reimbursable rent without addressing recurrent

157 Q186
158 Letter from HM Treasury - regarding the role of the DV and IFRS 16
159 NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Derby and Derbyshire Integrated Care Board, and NHS Lincolnshire Integrated Care Board (DNE0042); Qq183, 198 [Dr Wood, Joe Garrod]
160 Letter from HM Treasury – regarding the role of the DV and IFRS 16
161 The Premises Costs Directions require NHS England or ICBs to have regard to District Valuer assessments when determining reimbursement and premises matters, but the Directions do not require those assessments to be followed in every circumstance.; The National Health Service (General Medical Services) Premises Costs Directions 2024
162 Qq183, 186, 210 [Dr Wood, Joe Garrod]
163 Correspondence from HM Treasury – regarding the role of the DV and IFRS 16

affordability would transfer cost to integrated care boards and [would not] necessarily represent best value for money". It listed 'practical responses' to the issues raised: earlier engagement, clear escalation routes, transparent explanation of assumptions, and having a clear route to review when new evidence became available.[164]

79. **CONCLUSION**
The District Valuer process is acting as a barrier to the delivery of primary care infrastructure, slowing or outright preventing delivery of neighbourhood health estates, with disputed valuations leading to projects being delayed or cancelled. Given how regularly issues with the District Valuer were raised during the inquiry we are not convinced that NHSE or the government is taking the issue sufficiently seriously or is actively looking for a solution.

80. **RECOMMENDATION**
The government should review the District Valuer process to ensure it supports, rather than inhibits, delivery of GP and neighbourhood health infrastructure. Methodology used to determine Current Market Rent should be published, regularly reviewed, and a transparent and independent system for escalation and dispute resolution should be created.

NHS Property Service's GP estate

81. NHS Property Services (NHSPS) is a DHSC-owned company that owns and charges rent/facilities management fees on 19% of the GP estate and 10% of the overall NHS estate, giving it a significant role in the delivery of neighbourhood health.[165] 11 of the first 27 Neighbourhood Health Centres are to be made by upgrading existing primary care and GP facilities within the NHSPS estate.[166] However, evidence to our inquiry has consistently raised issues with how NHSPS operates its GP estate, with the British Medical Association (BMA) concluding in evidence that NHSPS was "actively inhibiting the shift to neighbourhood-level care", and that NHSPS had not worked for the practices or the patients.[167]

82. Witnesses raised several concerns with NHSPS ownership of GP premises which they felt inhibit the neighbourhood vision:

164 NHS England (DNE0068)
165 Independent Healthcare Providers Network (DNE0049); NHS England (DNE0068)
166 NHS Property Services, NHS Property Services to help deliver £50m health estates transformation programme improving patient access and care, 26 March 2026
167 British Medical Association (BMA) (DNE0053)

- **Unsustainable charges**: BMA and RCGP told us that NHSPS as a landlord could implement unsustainable or unpredictable rent increases, service charges and repair or maintenance fees.[168]
- **Inaccurate charging**: Alongside increases in charges, BMA's evidence stated that over 65% of NHSPS tenants reported inaccurate charging, with over 50% stating those disputes directly affected the sustainability of their practice.[169] We heard this could lead to practices reducing capacity or scaling back services, and in some cases disputes between practices and NHSPS, with Dr Gilmartin of Fareham Centre Practice arguing this could delay estate decisions.[170]
- **Charging of vacant or underused premises**: The NHS Alliance has reported that NHSPS charges ICBs for unused estate to "disincentivise wasted estate", which has led to recovery of "significant sums" from ICBs and Trusts for empty space in leased buildings.[171] In Cornwall, we were told that NHSPS was charging one practice for a "structurally unsafe, unusable" ward.[172]

83. NHSPS responded to many of these criticisms, stating that concerns over costs in NHSPS-owned buildings were primarily related to non-reimbursable costs, such as facilities management, cleaning and maintenance charges. In comparison, it stated that rents were generally reimbursable under NHS funding arrangements, and that charges were calculated on a transparent and full cost recovery basis.[173] Martin Steele, CEO of NHSPS, told us that in some cases, concerns about affordability were caused by the fact the GP could be reimbursed by NHS for some of the building costs (such as rent) and not others (such as cleaning and maintenance services cost). He questioned the logic behind this arrangement.[174]

84. NHS England told us that it recognised "the concerns raised by some occupiers about the affordability and predictability of rent, service charges and other occupancy costs in [NHSPS] premises", and acknowledged that this could undermine trust, make local budgeting difficult and discourage fuller use of otherwise suitable estate. However, it said that NHSPS had spent "significant" time in recent years improving those "historic issues through improved communications and charging information".[175]

168 Royal College of General Practitioners (DNE0010); British Medical Association (BMA) (DNE0053)
169 British Medical Association (BMA) (DNE0053)
170 Royal College of General Practitioners (DNE0010); Dr Kieran P Gilmartin (DNE0069)
171 The NHS Alliance, Capital efficiency: how to reform healthcare capital spending, 11 February 2025, p 29; The NHS Confederation and NHS Providers (DNE0030)
172 Cornwall Visit Note
173 NHS Property Services (DNE0067)
174 Qq59-60
175 NHS England (DNE0068)

85. The NHS Alliance recommended that where NHSPS was charging ICBs and Trusts for empty space in their buildings, ownership of these assets should be moved to local systems, so they could "optimise use of estate", and said it supported January 2026 DHSC guidance on 'Requesting transfers of NHS property'.[176] That guidance stated that "properties should be placed with the owner who has the best incentive to use them most effectively", detailing how DHSC could approve requests from trusts to transfer NHSPS-owned property to the organisations delivering the care and investing in their development.[177]

86. **RECOMMENDATION**

We heard consistent concerns regarding NHS Property Services ownership of GP estates, including its charging arrangements, management practices and support for long-term estate development. Given the significant role that NHS Property Services is playing in delivery of neighbourhood health infrastructure, the government should commission an independent review of its performance and operating model and set clear targets to drive improvement.

176 The NHS Confederation and NHS Providers (DNE0030)

177 Department of Health and Social Care, Requesting transfers of NHS property, 29 January 2026

4 Making better use of the existing estate

87. Alongside generating new capital investment, the Government's 10 Year Health Plan for England commits to "making better use of the estate", including through repurposing and refurbishing existing premises to deliver Neighbourhood Health Centres.[178] Neighbourhood Health Centre guidance for regions and integrated care boards was published in April 2026, and stated that "across the NHS, local government, wider public sector and civil society, there is already substantial estate that can support the development of NHCs".[179]

88. Stakeholders broadly agreed with the principle of making better use of the existing estate.[180] However, we heard concerns that ineffective utilisation, poor quality of data, issues with reimbursing GPs for hosting other services, and challenges with delivering health services in non-clinical settings could undermine the government's ambition to make better use of existing spaces to deliver healthcare closer to home.

Utilisation and data

89. We were consistently told that more capacity was needed to deliver neighbourhood health, with services struggling to operate under current spatial arrangements, with the overcrowding of existing buildings being a recurring theme. During this inquiry we repeatedly heard of GP and community staff having to hold meetings in cars due to a lack of available meeting rooms.[181] A community hub we visited in Cornwall told us that while workforce capacity and service demand was strong, the lack of physical estate space was the main factor limiting expansion.[182]

178 Department of Health and Social Care 10 Year Health Plan

179 NHS England, Neighbourhood health centre guidance for regions and integrated care boards, 16 April 2026

180 NHS Property Services Ltd (DNE0040); NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Derby and Derbyshire Integrated Care Board, and NHS Lincolnshire Integrated Care Board (DNE0042); Q12 [Martin Steele]

181 Cornwall visit note; Q171 [Dr Wood]

182 Cornwall visit note

90. Nonetheless, we saw data that also showed there may be scope to make better use of existing spatial arrangements. 2024/25 Estates Return Information Collection (ERIC) data returned 230,398 m² of empty floor space and 301,550 m² of underused floor space, equivalent to around 532,000 m² in total (approximately 1.9% of NHS floor area), though it stated these figures were "experimental" and of "low reliability".[183] We heard this data might be an underestimate, with research from NHS Property Services stating that many NHS spaces were actually only 40% utilised.[184]

91. We heard several reasons why NHS estate utilisation data might not be reliable for effectively planning neighbourhood health estate needs. This included:

- A fragmented landscape across multiple datasets.[185] Notably ERIC, the main data source, does not contain information on NHS Property Services (10% of the estate) or GP practices (6,143 across England).[186]
- Poorly defined and inconsistently measured room utilisation. For example, the LIFT Council stated that some utilisation was measured by whether a space was leased or booked, rather than whether it was actually used.[187]

183 2025/26 ERIC data was released on 15 October 2025, though did not include National Level Data, therefore the same figures could not be found as in 2024/25; NHS England, Estates Returns Information Collection, Summary page and dataset for ERIC 2024/25, 16 October 2025

184 NHS Property Services, NHS Estate Optimisation Guide, pp 3, 6

185 The core NHS dataset is the Estates Return Information Collection (ERIC), annually returned by all NHS trusts and covering estate size, utilisation, backlog maintenance, condition, capital assets and more. Patient-Led Assessments of the Care Environment (PLACE) offers annual assessment of the non-clinical healthcare environment which can include building condition, appearance, and accessibility. NHS England Estates and Facilities Data Hub is the umbrella publication area that brings together many NHS datasets. NHS Property Services, which manages roughly 3,000 buildings, also maintains operational data on utilisation, occupancy and available space, including through NHS Open Space and related estate-planning tools. Data on the primary care estate, as it operates under different ownership models, is held by DHSC's Strategic Health Asset Planning and Evaluation (SHAPE) application.; NHS Open Space (accessed November 2026); Department of Health and Social Care (DNE0066)

186 NHS Property Services Ltd (DNE0040); NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Derby and Derbyshire Integrated Care Board, and NHS Lincolnshire Integrated Care Board (DNE0042); NHS England (DNE0068); BMA, Pressures in general practice, 25 September 2026

187 Association for Respiratory Technology and Physiology (ARTP) (DNE0008); The LIFT Council, and Fulcrum Infrastructure Group (DNE0019)

- A lack of room level precision, with datasets like ERIC providing high-level site data but not tracking department-level or clinical room-level utilisation.[188]

92. The poor quality of existing data was cited as one reason why the existing estate was used so ineffectively. A June 2025 NHSPS survey of 21 NHS estate leaders found that 85% had low-to-medium awareness of estate utilisation, with 55% citing incomplete data as the main barrier to optimising space.[189] Witnesses called for a more "granular" view of clinical space utilisation to be developed, including where spaces could support integrated working.[190]

Primary care estate utilisation and data

93. We heard there were specific issues with the primary care estate utilisation dataset–Strategic Health Asset Planning and Evaluation (SHAPE). Primary Health Properties PLC stated that the fragmented ownership model of GP premises led to a lack of ongoing data collection, and that SHAPE data was not widely published or reported on.[191]

94. This situation may be behind the conflicting answers we received on the level of primary care and GP estate utilisation. In 2025 Chair of NHS England Dr Penny Dash stated that the NHS might have "twice as much" floor space for GP practices and associated services as it actually needed, though she noted this was a "finger in the air estimate".[192] In contrast, Dr Wood of Mereside Medical said she had to "laugh at" this estimate, with Dr Hynes of the RCGP stating that 74% of general practice managers could not recruit because they did not have physical space. Dr Wood detailed the issues with how utilisation was measured:

> […] there is a difference between necessary slack in a building to accommodate for on-the-day fluctuations in patient demand, and temporal underutilisation, which is a consequence of having to have

188 Hleb Buziuk (Independent public policy and governance researcher at FairGo CIC) (DNE0002)

189 Association for Respiratory Technology and Physiology (ARTP) (DNE0008); NHS Property Services, NHS Estate Optimisation Guide, June 2025, p 7

190 Anonymised (DNE0006); Association for Respiratory Technology and Physiology (ARTP) (DNE0008)

191 The primary care estate is owned by a variety of organisations of different sizes and scales. Around half of GP practice buildings are owned by GP partners, Others are leased from private organisations and others are owned by the Government through NHS Property Services and Community Health Partnerships.; Primary Health Properties PLC (DNE0034)

192 Health Service Journal, Dash: Primary care has twice the space it needs, 1 July 2026

enough space to accommodate your most busy days, as well as other spaces that you require, such as a hot room for somebody who might be infectious.[193]

95. We wrote to Dr Penny Dash to clarify her remarks.[194] She stated it was based on publicly available data on face-to-face appointments, with NHS England estimating that approximately 20,000 consultation rooms would be required to deliver current levels of activity, compared with around 41,000 consultation rooms recorded across the primary care estate. She argued it was a "high-level illustration", with the calculation intended to demonstrate the potential "to better use high quality estate more effectively", rather than providing a definitive assessment.[195]

96. Dr Dash also told us that the NHS is currently reviewing future estate requirements across primary care, community services and the wider NHS estate with the specific aim of supporting the shift towards neighbourhood health services. She stated the review will examine how existing estate is currently used, where capacity exists, and whether buildings are configured appropriately to support future models of care.[196]

97. **CONCLUSION**
The NHS's fragmented data landscape presents a serious barrier to effective planning and utilisation of estate needs for neighbourhood health. The primary care estate, with its different forms of ownership, presents a particular challenge considering the importance of GPs to delivering neighbourhood health care. To effectively plan for the estate requirements of the Neighbourhood Health Service, the NHS data landscape is due a reform, and we welcome that NHS England is currently undertaking a review.

98. **RECOMMENDATION**
Following the NHS review, the government must establish a single, standardised national estate dataset covering all NHS-owned, leased and operated facilities. This must include a consistent methodology for measuring estate utilisation that provides NHS managers with meaningful data to improve estate utilisation. This should include room-level information to support estate planning, service integration and, where necessary, business cases for additional investment.

193 Q171 [Dr Wood, Dr Hynes]
194 Correspondence to NHSE – primary care estate, 7 September 2026
195 NHS England (DNE0070)
196 NHS England (DNE0070)

Co-location in GP premises

99. One way the Neighbourhood Health Service envisages improving care is to co-locate more services in the same buildings.[197] However, we received evidence that certain rules were preventing effective colocation. Under the Premises Costs Directions (PCDs), last updated in 2024, GP providers are reimbursed for premises costs associated with delivering General Medical Services (GMS), but not for premises costs which are associated with non-GMS services.[198] Witnesses argued that these rules were incompatible with the government's ambition for greater multidisciplinary integration and co-location, as practices were financially penalised for making space available to community, neighbourhood or other multidisciplinary teams.[199]

100. Beccy Baird, Senior Fellow at King's Fund, gave the following example:

> We came across the case of a GP practice which […] wanted to give [a] branch surgery to district nursing colleagues to […] do community services. It could not do that, because it would not get its rent reimbursed since those are not core general medical services.[200]

Similarly, Ruth Rankine of the NHS Alliance stated that a GP practice in Whitstable was operating "to all intents and purposes [as] a neighbourhood health centre" but was not being reimbursed in line with the full costs associated with providing neighbourhood-level services. She stated this was due to current reimbursement arrangements focusing on core GMS activity as opposed to wider neighbourhood working.[201]

197 Department of Health and Social Care 10 Year Health Plan; Neighbourhood Health Framework; NHS England, Neighbourhood Health Centres (accessed November 2026)

198 The Premises Costs Directions (PCDs) aspect of the General Medical Services (GMS) contract, initially issued under the NHS Act 2006 and updated in 2024, sees ICBs (via NHSE) reimburse GP partnerships for their premises-related expenses such as rent, leaseholds and capital development; National Health Service Act 2006; NHS England, Guide to the changes to primary care premises policy, 11 November 2024; National Health Service England, The National Health Service (General Medical Services Premises Costs) Directions 2024

199 Primary Health Properties PLC (DNE0034); Independent Healthcare Providers Network (DNE0049)

200 Q56

201 Q57

101. **CONCLUSION**
We are concerned that the Premises Costs Directions aspect of the General Medical Services contract creates an inherent friction at the heart of the neighbourhood health model. By only reimbursing centres for spaces related to 'general medical services', services are being actively disincentivised from sharing space with wider community partners. This is counterintuitive considering the aim of the Neighbourhood Health Service—to engender co-located multidisciplinary teams at the hearts of communities—and undermines efforts to make best use of the existing NHS estate.

102. **RECOMMENDATION**
To avoid practices being financially penalised for integrating and co-locating services in line with its neighbourhood vision, the government should urgently review the Premises Costs Directions. It should consider how reimbursement rules can better support co-location, multidisciplinary working and the integration of health, social care and voluntary sector services within primary care and GP settings.

Delivering healthcare in non-NHS settings

103. The Neighbourhood Health Framework (NHF) states that it expects neighbourhood health to be a "truly collaborative effort between all partners". NHSE's 'Neighbourhood health guidelines' state that all parts of the health and care system will need to work closely together, building on existing collaboration with the Voluntary, Community, and Social Enterprise (VCSE) sector.[202] The government told us that where appropriate, consideration should be given to delivering care outside of traditional NHS buildings, stating that this could "act as a catalyst for renewal, by fostering innovation and collaboration, increasing footfall and broadening the usage of available facilities".[203] The evidence we received showed there was a large appetite from non-NHS and community spaces to be involved in neighbourhood health.[204] Many submissions argued that effective use

202 Department of Health and Social Care Neighbourhood Health Framework; NHS England, Neighbourhood health guidelines 2025/26, 29 January 2025
203 Department of Health and Social Care (DNE0066)
204 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); Dr Heidi Saxby at The Open University (DNE0014); Royal College of Paramedics (DNE0016); ChurchWorks (Good Faith Partnership) (DNE0031); Hospice UK (DNE0037); Swim England (DNE0050); FuneralExperts (DNE0063)

of the estate should encompass a wider range of assets, including those owned by local authorities and VCSE organisations involved in delivering neighbourhood services.[205]

104. While non-NHS settings are already widely used for services such as social prescribing, outreach, and wellbeing programmes, e.g. 'befriending', we explored whether they could also support the delivery of NHS clinical services.[206] We heard how delivering healthcare in non-NHS settings could have potential benefits:

- Sam Pluckrose-Oliver, Public Affairs Manager at the community organisation membership network Locality told us the community sector was "more strategically important and impactful" due to the "trust, relationship and connections" it often had in communities.[207] York and Scarborough Teaching Hospitals highlighted the Community Stadium in York, home of the local football and rugby teams and with good transport links and parking, offering blood-taking services, rheumatology and ophthalmology outpatient facilities, as an example of services working effectively alongside each other in a non-NHS setting.[208]

- It can enable services to be more conveniently located, reducing travel time and costs, particularly in rural, coastal or poorly connected areas.[209] For example, the Chemo Closer to Home programme, delivered by a Hospice in Oldham, which offers certain chemotherapy treatments to patients without them having to travel across Manchester.[210]

- Trust, comfort, and community engagement can be improved by delivering services in a more welcoming and less intimidating environment.[211] It has been reported that, especially since the COVID-19 pandemic, patients are more comfortable receiving healthcare in non-traditional settings, and that community settings are particularly effective where language, culture, stigma or previous negative

205 Local Trust, and Locality (DNE0015); The NHS Confederation and NHS Providers (DNE0030); NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Derby and Derbyshire Integrated Care Board, and NHS Lincolnshire Integrated Care Board (DNE0042)
206 RABI – the Farmers Charity (DNE0027); ChurchWorks (Good Faith Partnership) (DNE0031); People's Health Trust (DNE0041)
207 Q200
208 York and Scarborough Teaching Hospitals NHS Foundation Trust (DNE0056)
209 RABI – the Farmers Charity (DNE0027); People's Health Trust (DNE0041)
210 Hospice UK (DNE0037)
211 Department of Health and Social Care (DNE0066)

experiences with services have limited engagement.[212] A 2024 poll by UKActive found that 61% of people would prefer to receive treatment or support for a health condition in a gym, leisure centre or pool over a hospital.[213]

105. We heard that there might be a significant amount of underused space across the community and wider non-NHS estate that could support neighbourhood health. This includes more than 9,000 community assets nominated as 'Assets of Community Value',[214] an education estate of over 22,000 schools and colleges, and substantial vacant space in town and city centres, with 14-19% of dwellings standing empty.[215] Community assets such as schools, libraries, churches, leisure centres, gyms, and other buildings were identified as potential locations for neighbourhood health services, often at the heart of communities with easy access and operated by trusted figures.[216] We heard many of these settings could be used strategically during times of lower footfall or activity to support or provide healthcare services.[217]

106. We heard that the positioning of the VCSE sector as a stronger partner in the procurement process may generate better estates value-for-money in the long term. During our visit to Cornwall we heard from representatives of a community health and GP hub, who argued that the use of a Community Interest Company (CIC) model, and a more flexible approach to procurement, rather than traditional NHS routes, allowed them to deliver their project at a much-reduced cost.[218]

107. However, despite Government and NHS England positioning the VCSE sector as a key partner in neighbourhood health, and the evident ambition from many of these settings to be involved, we heard that community organisations were not consistently treated as equal partners in

212 Pinsent Masons, UK 'should take Middle East lead' in move towards alternative locations for healthcare, 23 January 2025; Local Trust, and Locality (DNE0015); Fedcap (DNE0018); National LGBT Partnership (DNE0026); ChurchWorks (Good Faith Partnership) (DNE0031); People's Health Trust (DNE0041)

213 UKactive (DNE0036)

214 Assets of Community Value are buildings or land listed by local authorities under the Localism Act 2011 because their use furthers the social wellbeing or social interests of the local community; Localism Act 2011

215 Q200 [Sam Pluckrose Oliver]; Royal College of Paramedics (DNE0016); ChurchWorks (Good Faith Partnership) (DNE0031); LocatED Property Ltd (DNE0046)

216 The Association of Infrastructure Investors in Public Private Partnerships (AIIP) (DNE0004); ChurchWorks (Good Faith Partnership) (DNE0031); UKactive (DNE0036); LocatED Property Ltd (DNE0046)

217 Royal College of Paramedics (DNE0016); UKactive (DNE0036); Archus (DNE0060)

218 Royal College of Paramedics (DNE0016)

estate delivery.[219] We heard that VCSE organisations were often expected to support delivery while having limited influence over strategic decision-making and estate planning, too often viewed as an "add on" after decisions are made.[220] Survey evidence from the charity People's Health Trust Limited detailed that 39% of community organisations reported no engagement in decisions about health buildings or estate changes, 22% stating they did not know how decisions about health services locally were made.[221] Evidence therefore called for a culture change and for the VCSE sector to be seen as an equal partner in neighbourhood health estate arrangements, including in co-location and co-design.[222]

108. Nonetheless, while many patients support the idea of care out of community settings in principle, several concerns were raised that would need to be addressed:

- **Privacy**: Polling by Healthwatch Leeds showed that the same confidentiality and discretion would be needed in non-NHS settings, especially for matters such as mental health appointments. One respondent to the Healthwatch Leeds survey expressed concern over digital privacy, as use of receptions in non-NHS settings might not have the same protocols for ensuring confidentiality as in health premises.[223]

- **Funding arrangements**: As has been highlighted in our previous reports, we heard that while voluntary and community organisations are expected to play a larger role in neighbourhood health, many continue to operate on short-term funding arrangements that limit long-term planning, shared investment and workforce stability.[224] Evidence warned that reliance on an underfunded voluntary sector risked undermining the sustainability of the neighbourhood health model. We saw this when we visited Cornwall, as one community

219 Q200 [Sam Pluckrose-Oliver]; South Warwickshire University NHS Foundation Trust, Stratford District Council, Warwickshire District Council, Rugby Primary Care Network, and Warwickshire & Solihull Community and Voluntary Action (CAVA) (DNE0057)

220 People's Health Trust Limited (DNE0041)

221 People's Health Trust Limited (DNE0041)

222 Q200 [Sam Pluckrose-Oliver]; South Warwickshire University NHS Foundation Trust, Stratford District Council, Warwickshire District Council, Rugby Primary Care Network, and Warwickshire & Solihull Community and Voluntary Action (CAVA) (DNE0057); Royal College of Obstetricians and Gynaecologists (DNE0061); Cornwall visit note

223 Healthwatch Leeds (DNE0005)

224 Health and Social Care Committee, Fourth Report of Session 2024–26, Community Mental Health Services, HC 566; Eighth Report of Session 2024–26, Healthy Ageing: physical activity in an ageing society, HC 1180; Primary Health Properties PLC (DNE0034); People's Health Trust (DNE0041)

centre described itself as "fighting for [its] life" due to short-term funding agreements, with another hub operating across a fragmented "jigsaw" of 43 different funding streams.[225]

- **Building design and cost**: Non-NHS settings are not designed for clinical use, so it is unlikely they would comply with strict NHS regulations that relate to matters such as wheelchair use, ventilation and infection prevention and control.[226] Evidence argued that retrofitting these spaces to meet clinical requirements would involve much of the expense that a new build would require, thus would be counterintuitive to the goals of utilising the existing estate better.[227] DHSC evidence detailed this barrier and stated that the scope of what could "safely and compliantly be delivered" was "usually limited to primary care, community services and some lower acuity outpatient activity", with Dr Wood of Mereside Medical arguing the potential was "really narrow".[228] Warwickshire & Solihull Community and Voluntary Action called for "investment in the sustainability, safety and accessibility of VCFSE-managed buildings".[229]

109. We heard that "stringent" rules and governance could "severely limit" what premises could be used to support care.[230] While evidence understood the need for those safety requirements, we also heard that rules around prevention control could "make space very inflexible".[231] Beccy Baird of the King's Fund told us that a GP practice that had invested in its own new building could only use it as a consulting room due to "rules about footprints and floor space" for a clinical room.[232] In Cornwall, we visited Cober Valley Health, a derelict supermarket-turned-modern GP practice and communal centre which has been described as a "Neighbourhood health centre".[233]

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225 Cornwall visit note

226 This refers to CQC regulations, Health Building Notes (HBNs), and Health Technical Memoranda (HTMs); Hleb Buziuk (Independent public policy and governance researcher at FairGo CIC) (DNE0002)

227 British Medical Association (BMA) (DNE0053)

228 Department of Health and Social Care (DNE0066); Q162

229 South Warwickshire University NHS Foundation Trust, Stratford District Council, Warwickshire District Council, Rugby Primary Care Network, and Warwickshire & Solihull Community and Voluntary Action (CAVA) (DNE0057)

230 NHS Property Services Ltd (DNE0040); South Warwickshire University NHS Foundation Trust, Stratford District Council, Warwickshire District Council, Rugby Primary Care Network, and Warwickshire & Solihull Community and Voluntary Action (CAVA) (DNE0057)

231 Q35 [Beccy Baird]

232 Q35

233 Cober Valley Health has been described as a 'Neighbourhood health centre' by the healthcare facilities planning organisation MJ Medical, though was not included in the Government's list of first 27 neighbourhood health centres; MJ Medical, Neighbourhood health centre wins European Healthcare Design Award (accessed November 2026); Department of Health and Social Care and NHS England, Communities to benefit from health centres on their doorstep, 26 March 2026

Feedback from leaders was that strict rules governing how premises could be used and regulatory requirements made it "difficult to replicate or adapt such approaches elsewhere", and that a more coordinated approach to public estate management could enable more flexible use of space.[234] NHS Property Services called for shared spaces that might not adhere to strict health regulations to be used for non-clinical services, such as counselling or group work, allowing them to still be co-located in a setting with other, clinical care neighbourhood services.[235]

110. Despite this we did hear multiple examples of settings being used to deliver clinical care successfully. Halton Health Hub utilised an empty unit in a shopping centre to offer core services, blood tests, diabetes checks, nutrition, musculoskeletal and radiology services as well as some "pop-ups" such as GP respiratory clinic and flu jabs.[236] Additionally, The Kendal Leisure Centre housed its local NHS Trust's musculoskeletal (MSK) department, sitting across both primary and secondary healthcare, with the purpose to see patients who were traditionally seen by orthopaedic surgeons to reduce or delay the need for surgery.[237]

111. The Neighbourhood Health Framework set out an ambition for greater integrated working saying that neighbourhood health reinforced "a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception" and that it would require all parts of the system "to work closely together to support people's needs more systematically". However, it did not contain specific guidance on how greater use could be made of VCSE assets as a vehicle for delivering neighbourhood healthcare services.[238]

112. **CONCLUSION**

We agree with the important role that the government has given the voluntary sector in the Neighbourhood Health Service. Its assets, community reach, and existing trusted relationships mean this role can and should be leveraged for neighbourhood health estate delivery. However, we do not believe that the NHS is making the most of these opportunities, with community organisations currently being expected to support delivery without being involved in strategic decision-making. This means that opportunities to make the best use of community assets are likely being missed.

234 Cornwall visit note
235 NHS Property Services Ltd (DNE0040)
236 Local Government Association (DNE0062)
237 UKactive (DNE0036)
238 Neighbourhood Department of Health and Social Care Health Framework

113. **RECOMMENDATION**

The government and NHS England should ensure that in neighbourhood health arrangements, the voluntary, community and social enterprise sector are involved in estate planning and service design, rather than solely in delivery. The government should set out how these organisations will be represented in neighbourhood-level decision-making at a local level and provide detailed guidance on how the NHS can work with voluntary, community and social enterprise organisations to provide healthcare in a more accessible way, using community assets to deliver services nearer to where people live and work. Government should also detail how community services will be involved in the procurement processes of neighbourhood health estate development, to ensure that community benefit is maximised and value-for-money is delivered.

114. **CONCLUSION**

We recognise the tension between ensuring high standards and enabling rapid neighbourhood healthcare expansion. It is essential that service delivery in community spaces is safe and meets clinical standards. We heard both excellent examples of best practice and concerns that current requirements designed for traditional NHS settings could disproportionately restrict delivery of neighbourhood health in community settings.

115. **RECOMMENDATION**

We recommend that the NHS review the Health Building Notes (HBNs), and Health Technical Memoranda to identify whether any changes or allowances could be made to facilitate greater delivery of healthcare services outside the traditional estate.

Conclusions and recommendations

Capital investment in the NHS Estate

1. The NHS has long suffered from capital underinvestment. This has led to an unsustainable maintenance backlog that is constraining the delivery of care. While we welcome the ambitions set out in the 10 Year Capital Plan, we remain sceptical that levels of investment are sufficient given that the current capital budget does not cover the existing repair bill. If the government and NHS are to find the funding necessary to invest in the future of the NHS estate and support its vision for a neighbourhood health service, it will need to think creatively and consider alternative sources of funding. (Conclusion, Paragraph 12)

2. The Committee is concerned by recent announcements that the health and social care capital budget will be reduced by £1 billion over the next four years. In the past, the raiding of NHS capital budgets directly contributed to many of the estates issues we are seeing today. In its response the government should set out the implications of this reduction on neighbourhood health estate development and the efforts to address the existing maintenance backlog. (Recommendation, Paragraph 13)

3. Given that it is likely that external funding will be necessary to meet the government's vision to deliver Neighbourhood Health Centres, and that Public-Private Partnerships will form part of this plan, it is important that the new approach addresses the shortcomings of previous models. These include poor value-for-money, inflexible contractual arrangements, inappropriate risk allocation, weak contract management, and difficulties adapting buildings to changing service needs. While the government has stated that its new neighbourhood health Public-Private Partnership model will learn from these lessons, it has not yet demonstrated how it will address each of these issues in practice. (Conclusion, Paragraph 25)

4. In response to this report, the government should publish a detailed statement setting out how the design of its neighbourhood health Public-Private Partnership (PPP) model reflects lessons learned from previous schemes, including the Private Finance Initiative and the Local Improvement Finance Trust. This should explain:

- how value for money will be secured, particularly for smaller neighbourhood health projects and refurbishments, including if projects will be bundled or aggregated where appropriate;
- how risks will be allocated between public and private partners;
- how contracts and assets will be designed to provide sufficient flexibility to respond to changing clinical and community needs;
- what arrangements will be in place for contract management, performance monitoring and transparency, including how the government will ensure the public sector has the commercial capability, staffing and resources necessary to manage long-term PPP contracts effectively;
- how disputes between public and private partners will be resolved;
- whether a body such as the National Infrastructure and Service Transformation Authority will have a role in providing oversight, expertise or assurance. If not, it should explain why it has not assigned responsibility to a role with a central oversight function, and set out how it will ensure sufficient scrutiny, consistency and assurance of the PPP model across the country;
- what steps the government will take to avoid the maintenance backlogs experienced in much of the non-PPP NHS estate, including whether it will use measures such as ringfenced lifecycle funding to ensure asset maintenance; and
- what measures will be taken to give the Department enough Capital Departmental Expenditure Limit headroom to accommodate Public-Private Partnerships, given that they will be budgeted 'on balance sheet'.

The government should also set out how it will monitor and address performance issues with the existing LIFT estate delivering NHCs. Government should also state whether its PPP arrangement will be mandated for all Neighbourhood Health Centre new builds, or whether local systems will have the opportunity to explore alternative delivery models. (Recommendation, Paragraph 26)

5. Developer contributions could provide an important source of funding for healthcare infrastructure. However, we heard that the health sector is often less effective than other sectors, such as education, at securing and using these contributions. A lack of data, fragmented planning arrangements, limited expertise, and the absence of comprehensive national guidance mean that opportunities for developer contributions are frequently missed. (Conclusion, Paragraph 33)

6. Government and the NHS should reform the way the health sector secures and uses developer contributions. This should include:

   - publishing comprehensive national guidance on identifying, securing, managing and spending Section 106 and Community Infrastructure Levy funding for healthcare infrastructure. This could be based on the guidance currently available for the education sector, and should be available publicly to all NHS organisations, reviewed regularly and updated when necessary;
   - supporting all NHS organisations to develop the expertise and capacity needed to engage effectively with the planning system and maximise opportunities for healthcare investment;
   - improving the collection and publication of data on healthcare-related developer contributions, including funding requested, secured, held and spent;
   - establishing a national performance framework for developer contributions related to the health sector, including reporting on the value of contributions requested, secured, received and used, setting clear expectations for improvement over time. (Recommendation, Paragraph 34)

7. The government's announcements for capital investment in neighbourhood health estates are welcome. However, this capital investment must be matched, where necessary, by sustainable, long-term revenue funding to meet the ongoing costs of operating, staffing and maintaining these facilities. This is particularly important where developments create additional capacity or services, rather than replacing existing premises. Without sufficient revenue support, the full benefits of neighbourhood estate investment may not be realised. (Conclusion, Paragraph 38)

8. In response to this report, we ask the government to set out how it is ensuring that sustainable financial arrangements are in place to cover the ongoing costs of running the new neighbourhood health premises it is planning to create, including the new Neighbourhood Health Centres. (Recommendation, Paragraph 39)

Barriers to investment

9. Even when systems have the funding to enact transformation, rigid centrally imposed capital controls and excessively long approvals processes are significant barriers to estate development. This results in an unacceptable disparity between the time required to approve a

project and the time required to deliver it. We welcome the government's commitment to streamline approvals and increase delegated responsibility. (Conclusion, Paragraph 50)

10. In response to this report, the government should provide further detail on how the new, "streamlined" approvals regime will work in practice to unlock estate transformation for neighbourhood health. Additionally, it should establish clear national targets for capital approval times, publish performance data, and report annually on whether these reforms have accelerated estate investment and delivery. (Recommendation, Paragraph 51)

11. We recommend that HM Treasury undertakes a specific review of the impact of IFRS 16 on NHS estate investment, including its effect on the capital available to NHS organisations and the delivery of neighbourhood health infrastructure. If the review identifies barriers to estate development, government should bring forward proposals to mitigate these impacts on investment in healthcare infrastructure, while maintaining appropriate fiscal transparency and accountability. (Recommendation, Paragraph 57)

12. We are concerned that neighbourhood health ambitions risk being undermined by the fragmented funding, planning and governance mechanisms across the NHS, local authorities and wider system partners. Without greater clarity over leadership, accountability and decision-making responsibilities for neighbourhood estate projects, there is a risk that opportunities for estate transformation will be delayed or missed. (Conclusion, Paragraph 64)

13. The government should require each major neighbourhood health estate proposal to identify a lead organisation or body responsible and accountable for coordinating partners and overseeing delivery. As part of each estate approval process, proposals should set out the designated lead organisation and the rationale for selection, determined according to the nature of the project and local circumstances. The lead organisation should act as the primary point of contact across local authorities, providers and community partners. (Recommendation, Paragraph 65)

14. In addition, we ask that the government publish a detailed roadmap setting out its timeframes for the delivery of the Neighbourhood Health Centres it has committed to establishing to date, including the national and local delivery responsibilities, and the options available to adapt the model to meet local needs. (Recommendation, Paragraph 66)

The GP estate

15. GPs, and their premises, are likely to be the cornerstone of neighbourhood health estates. Yet, we have found that capital investment mechanisms and revenue funding arrangements actively disincentivise GP estate development and expansion. (Conclusion, Paragraph 74)

16. The government should develop a long-term GP capital and revenue investment strategy that aligns with neighbourhood health objectives. The strategy should:

- improve support for GP practices when navigating the numerous and fragmented estate funding streams, including offering guidance and best practice on how to identify and combine funding sources;
- review ways to reduce the reliance on personal financial risk and private borrowing when investing in GP estates, especially for early career GPs. This could include exploration of a dedicated GP loan scheme that could provide access to government-backed borrowing. Any model should draw on lessons from other schemes such as the Scottish GP sustainability loan scheme; and,
- review whether current funding arrangements create financial barriers to GP premises investment and service expansion, by placing too much upfront financial risk on GP partners before patient activity has generated sufficient sustainable income. (Recommendation, Paragraph 75)

17. The District Valuer process is acting as a barrier to the delivery of primary care infrastructure, slowing or outright preventing delivery of neighbourhood health estates, with disputed valuations leading to projects being delayed or cancelled. Given how regularly issues with the District Valuer were raised during the inquiry we are not convinced that NHSE or the government is taking the issue sufficiently seriously or is actively looking for a solution. (Conclusion, Paragraph 79)

18. The government should review the District Valuer process to ensure it supports, rather than inhibits, delivery of GP and neighbourhood health infrastructure. Methodology used to determine Current Market Rent should be published, regularly reviewed, and a transparent and independent system for escalation and dispute resolution should be created. (Recommendation, Paragraph 80)

19. We heard consistent concerns regarding NHS Property Services ownership of GP estates, including its charging arrangements, management practices and support for long-term estate development. Given the significant role that NHS Property Services is playing in delivery of neighbourhood health

infrastructure, the government should commission an independent review of its performance and operating model and set clear targets to drive improvement. (Recommendation, Paragraph 86)

Making better use of the existing estate

20. The NHS's fragmented data landscape presents a serious barrier to effective planning and utilisation of estate needs for neighbourhood health. The primary care estate, with its different forms of ownership, presents a particular challenge considering the importance of GPs to delivering neighbourhood health care. To effectively plan for the estate requirements of the Neighbourhood Health Service, the NHS data landscape is due a reform, and we welcome that NHS England is currently undertaking a review. (Conclusion, Paragraph 97)

21. Following the NHS review, the government must establish a single, standardised national estate dataset covering all NHS-owned, leased and operated facilities. This must include a consistent methodology for measuring estate utilisation that provides NHS managers with meaningful data to improve estate utilisation. This should include room-level information to support estate planning, service integration and, where necessary, business cases for additional investment. (Recommendation, Paragraph 98)

22. We are concerned that the Premises Costs Directions aspect of the General Medical Services contract creates an inherent friction at the heart of the neighbourhood health model. By only reimbursing centres for spaces related to 'general medical services', services are being actively disincentivised from sharing space with wider community partners. This is counterintuitive considering the aim of the Neighbourhood Health Service—to engender co-located multidisciplinary teams at the hearts of communities—and undermines efforts to make best use of the existing NHS estate. (Conclusion, Paragraph 101)

23. To avoid practices being financially penalised for integrating and co-locating services in line with its neighbourhood vision, the government should urgently review the Premises Costs Directions. It should consider how reimbursement rules can better support co-location, multidisciplinary working and the integration of health, social care and voluntary sector services within primary care and GP settings. (Recommendation, Paragraph 102)

24. We agree with the important role that the government has given the voluntary sector in the Neighbourhood Health Service. Its assets, community reach, and existing trusted relationships mean this role can and should be leveraged for neighbourhood health estate delivery.

However, we do not believe that the NHS is making the most of these opportunities, with community organisations currently being expected to support delivery without being involved in strategic decision-making. This means that opportunities to make the best use of community assets are likely being missed. (Conclusion, Paragraph 112)

25. The government and NHS England should ensure that in neighbourhood health arrangements, the voluntary, community and social enterprise sector are involved in estate planning and service design, rather than solely in delivery. The government should set out how these organisations will be represented in neighbourhood-level decision-making at a local level and provide detailed guidance on how the NHS can work with voluntary, community and social enterprise organisations to provide healthcare in a more accessible way, using community assets to deliver services nearer to where people live and work. Government should also detail how community services will be involved in the procurement processes of neighbourhood health estate development, to ensure that community benefit is maximised and value-for-money is delivered. (Recommendation, Paragraph 113)

26. We recognise the tension between ensuring high standards and enabling rapid neighbourhood healthcare expansion. It is essential that service delivery in community spaces is safe and meets clinical standards. We heard both excellent examples of best practice and concerns that current requirements designed for traditional NHS settings could disproportionately restrict delivery of neighbourhood health in community settings. (Conclusion, Paragraph 114)

27. We recommend that the NHS review the Health Building Notes (HBNs), and Health Technical Memoranda to identify whether any changes or allowances could be made to facilitate greater delivery of healthcare services outside the traditional estate. (Recommendation, Paragraph 115)

Annex: Visit note: Cornwall, 21-22 April

Background

Delivering the Neighbourhood Health Service: Estates inquiry

The Committee is holding an inquiry into what is needed from the NHS estate to deliver the Government's vision of a 'Neighbourhood Health Service' – shifting care from hospitals to local communities.

Currently, 11% of the NHS estate is older than the NHS itself and many providers report that ageing premises are unsuitable to deliver community health services.

The Committee's inquiry is examining the physical infrastructure requirements to realise this shift. It is exploring whether current estate plans, funding and leasing systems, and delivery models are suitable, as well as the risks and opportunities of Public-Private Partnerships.

The inquiry is assessing how existing NHS buildings can be repurposed, the role of new builds, and the use of non-NHS spaces to deliver community-based care. It is considering the needs of all communities, including those in rural or underserved areas.

Inquiry terms of reference

1. What is needed from the NHS estate to allow it to deliver the Neighbourhood Health Service?
    - **a.** How does this compare to the current NHS estate?
    - **b.** Do DHSC and the NHS hold sufficient data on the condition and utilisation of NHS estate?
    - **c.** Are there opportunities to better utilise the current NHS estate to support delivery of the Neighbourhood Health Service?

2. What criteria should be used to prioritise the investment in the estate to enable it to deliver the Neighbourhood Health Service?

    a. What lessons should Government take from previous private investment models when using Public-Private Partnerships?

    b. What are the non-financial barriers to more effective estate development and utilisation and how can they be addressed?

3. What lessons can be taken from pilots of Neighbourhood Health Centres for the development of an NHS estate that supports the delivery of the Neighbourhood Health Service?

4. How could non-NHS settings or infrastructure be used to support the delivery of care in neighbourhood settings, and what arrangements would be needed to facilitate it?

    a. What are the challenges of delivering care services in these settings and how would they be addressed?

5. How can local communities and the workforce best be involved in the planning and design of estate transformation for the Neighbourhood Health Service?

    a. How should the estate be designed to meet the needs of different communities, including those based in rural or coastal settings?

Purpose of visit

The visit aimed to build a holistic picture of the difficulties that areas of Cornwall face, what is being done to meet the difficulties already, how the Government's vision may or may not be aiding this, and what more is needed to deliver the Neighbourhood Health Service and improve health outcomes.

The Committee would like to extend its greatest appreciation to all the organisations and individuals that it met with during the visit.

Cornwall: Policy and political context

Cornwall and the Isles of Scilly (CIoS) was selected as one of the 43 Neighbourhood Health Service pilot sites in September 2025, as an area facing potential health difficulties but already showing initiative in providing community-based health through a variety of services and interventions.

Cornwall is a predominantly rural and coastal county with marked health inequalities, an ageing population, and longstanding challenges in access to healthcare, housing and public services.

There are currently 16 Integrated Neighbourhood Teams (INTs) within the CIos Integrated Care System. INTs are groups of health and care professionals who work together to support local communities. INTs use population health data to deliver the priorities for their communities and aim to provide coordinated care that keeps people healthy and reduces the need for hospital visits. Services within these INTs include:

- General practitioners (GPs)
- Community nurses and therapists
- Social workers
- Mental health professionals
- Hospital consultants
- Voluntary and community sector partners

Meetings and activities

Tuesday 21 April (West Cornwall)

1. St Clare Medical Centre (and meeting with Penwith Neighbourhood Teams)

Background:

- St Clare Medical Centre was opened in early 2019 and hosts three GP Practices serving roughly 24,000 patients. It also provides community, education and secondary care and pharmacy services.
- The Penwith Neighbourhood Team launched at the end of 2025. It has engaged with staff as part of the development of long-term improvements alongside projects aimed at delivering rapid improvements. We were informed that over the next ten years, Penwith is expected to see the most significant increase in residents aged 75 and over in Cornwall and the Isles of Scilly.

Summary:

- St Clare Medical Centre is a purpose-built primary care hub developed independently by three GP practices. Following “25–30 years” of unsuccessful attempts to secure public investment, the

partners collectively raised £6 million through personal loans. This "massive financial risk" meant that trust and effective partnership was crucial to opening St Clare.

- St Clare provides a modern, multi-purpose facility with 31 consulting rooms, operating theatres, and rental space for third parties, demonstrating how primary care estates can operate as anchors for neighbourhood health.
- Digital infrastructure was raised as an advantage, with the same IT director working across multiple Cornwall Trust and ICB premises allowing for consistent WiFi connectivity for NHS employees.
- However, digital infrastructure cannot be relied on as a default for all patients, as some lack digital capacity or capability.
- There was strong support for the neighbourhood health model, particularly the principle of delivering care closer to home. Participants emphasised that bringing practitioners together locally can reduce unnecessary hospital visits:
    - "Why does everyone have to go to hospital for something that isn't a blue light?"
- The integration of services, however, remains incomplete. Despite intentions to co-locate community nursing and other services, this was not achieved due to differing rules, timelines, and system requirements.
- Workforce experience highlighted how estate limitations directly affect productivity and care delivery. One social prescriber described working across multiple sites or from their car due to a lack of private space and reliable connectivity.
- Funding arrangements were consistently identified as a major constraint. While the policy direction supports long-term transformation, delivery is hindered by short-term financial cycles. This affects the individuals in charge:
    - "10-year plan, but 12-month funding – these are real humans."
- Participants also highlighted structural imbalances in investment, with funding continuing to favour acute care over community-based services. Population growth was not seen to be matched by increases in primary care capacity.

- Despite these barriers, there was strong evidence of impact from community-based approaches. Investment in community hubs across Cornwall was estimated to have generated significant savings: £11 million for £750,000 spent across 55 hubs. Participants felt that VCSE must be seen as an equal partner in neighbourhood health.
- Cornwall was described as ahead of the Neighbourhood Health framework, pre-empting national guidelines with its historic neighbourhood healthcare models. The attitude described was "we will do it, and show it can work".
- Questions were raised over how to "bottle" and replicate this mindset, which includes permission to try things and go wrong and to learn from mistakes.
- Discussions noted that delivering the neighbourhood shift at scale will require overcoming practical and cultural barriers. These include limitations in public transport in rural areas, a lack of confidence among the public that community services can replace hospital care, and difficulties in accessing planning obligations.
- Estates were described as a "huge issue to get around", with many barriers being "human-made", such as red tape complexity prohibiting GPs from expanding their services.
- It was felt that this specific project could not be replicated, due to changes to funding e.g. the notional rent funding by the NHS that is not at the same level anymore.

2. West Cornwall Hospital

Background:

- West Cornwall Hospital is a key asset in the delivery of local neighbourhood health and care and a project workstream within the Penwith neighbourhood plans, aiming to improve local access to services and experience of care.
- The Committee toured the new outpatients' areas, the Urgent Treatment Centre and the step-up and step-down facilities, which aim to enable people to receive care closer to home.

Summary:

- West Cornwall Hospital plays an important role in delivering care closer to home, with recent investment including £9 million being spent on a state-of-the-art new outpatients' area.
    - However, the old outpatients' area sits vacant and unused.

- Participants emphasised the need for stronger integration between NHS organisations, local authorities, and the voluntary sector. In particular, there were calls for VCSE partners to be embedded as equal partners in system governance, rather than involved at a later stage.

3. Trelya Community Hub

Background:

- Trelya is one of 55 community hubs Cornwall, forming a part of the neighbourhood and wellbeing model. It provides locally trusted access to NHS health and community wellbeing, including food, movement, music, craft-based activities, community nursery, legal-aid services, and mental health support services.
- Trelya is open 50 weeks a year and over 4000 individuals access it. Trelya means “change” in Cornish.

Summary:

- The Committee met and spoke to those running community activities, social prescribers, community health and wellbeing workers and residents supported by the community service. It saw first-hand the range of health and wellbeing services that Trelya provides, including adult mental health hubs, a nursery, refugee and adult education, back to employment and men’s health, and its café.
- Trelya is deeply embedded in its local community, described as “like a family”. It was said that Trelya’s approach is to find out what people need in Penwith and provide those services.
- However, its sustainability is undermined by fragmented funding arrangements. The organisation currently operates across 43 different funding streams, described as “an absolute jigsaw” to manage.
- Estates were identified as the main constraint on growth. While workforce capacity and demand for services are strong, the lack of physical space limits the ability to expand.

4. John Daniel Centre

Background:

- A non-clinical community space in the heart of the Penzance community run by Cornwall Council, bringing together health, care, council and voluntary sector services under one roof in West Cornwall.

- Encourages people to seek help early, be signposted quickly and receive joined-up support for multiple needs.

Summary:

- The John Daniel Centre provides early preventative support and helps individuals access services before issues escalate.
- One resident described how the John Daniel Centre has helped them, describing the "fantastic social worker", free toiletries, and support they had received from the Centre. They said this has allowed them to be clean from drugs for the first time in 16 years, and they now help at the centre themselves.
- Whilst the John Daniel Centre recently secured a lease for six years, they described themselves as "fighting for [their] lives". The condition of the building itself, such as its roof and energy sources, needs attention.
- Access to services is also constrained by eligibility criteria tied to geographic boundaries. Staff reported this can prevent individuals from accessing support even when it is available locally, in some cases "keeping people on the street."

5. Cober Valley Health

Background:

- Originally a derelict supermarket that was transformed into a modern GP practice and communal centre, with a café, community youth dance spaces, and a climbing area.
- It is located in Helston, Cornwall and was opened in November 2025.

5a. Cober Valley Health estates discussion

Background:

- Chance to meet with the team behind the venue and discuss opportunities to replicate this model.
- Cober Valley Health is a community-led health hub developed from a former supermarket site. Designed in partnership with local residents, it integrates clinical services with wider wellbeing facilities, including social and recreational spaces.

Summary:

- Cober Valley was described as an example of integrated community and health with a strong Community Interest Company (CIC) partnership model, operating as a neighbourhood health centre "long before" the Government's 'neighbourhood health' concept.
- It was said that delivery through a CIC model allows the building to operate for community benefit while maintaining financial sustainability. Rental income from clinical spaces supports wider preventative services.
- It engaged the community and young people in the design, and according to one participant delivered a high-quality build "ethically, sustainably and at a lower cost than comparators." Although initially costed at £6 million through conventional routes, it was ultimately delivered for £3 million through a locally led approach.
- Participants attributed its success to flexibility, local knowledge, and a willingness to take calculated risks:
    - "Give a target to people who want to deliver, and they will."
- However, strict rules governing how premises can be used, alongside regulatory requirements and funding constraints, make it difficult to replicate or adapt such approaches elsewhere.
- There were calls for a more coordinated approach to public estate management, reducing fragmentation and enabling more flexible use of space.

5b. Cober Valley Health Workforce Roundtable

Background:

- Introduction and roundtable discussion with neighbourhood partners within the South Kerrier integrated neighbourhood team, including pharmacy, community nursing, local authority and voluntary, community and social enterprise colleagues.
- The South Kerrier Neighbourhood Team launched at the end of 2025 and has been building on relationships and engaging in the development of neighbourhood plans.

Summary:

- Co-location was widely seen as a key enabler of integration, improving communication and enabling more joined-up care. Informal interactions such as shared workspaces were highlighted as particularly important.
- Staff emphasised that workforce challenges closely tie to estate limitations and fragmented systems. Demand pressures are significant, with around 200 new adult social care referrals per week causing difficulties for coordination.
- It was stated that "the barrier between health and social care remains". This includes space issues, rent issues, IT connectivity, and private rooms. For example, social care staff reported difficulties joining NHS systems or NHS-led virtual meetings.
- Participants felt that shared information and interoperability would ease pressures, for example through a 'Single Patient Record'.
- Continuity of care was labelled as key to the provision of patient-centred care. There were calls for integrated neighbourhood teams to be upskilled for continuous care, to keep care closer to home.

5c. Cober Valley Health Strategic Systems Partners Roundtable

Background:

- Discussion with strategic system partner CEOs or representatives, across NHS, ICB, third sector and local authority.

Summary:

- System leaders expressed alignment with the neighbourhood health vision, describing it as a "fundamental shift that allows everybody to be more curious".
- However, they identified structural barriers to implementation: rigid accounting rules, particularly IFRS16 and capital spending limits (CDEL); and bureaucracy and regulatory requirements, particularly around leases, procurement, and estate use.
- It was expressed that opportunities for neighbourhood health need to be strategic and long term – ICBs have been 'input' based organisations, but need to be measuring outputs and commissioning the right services. There were doubts over whether any ICB has the competency to perform the strategic commissioning expected from the 10-Year Health Plan.

- Participants emphasised the need for greater flexibility in estate use; longer-term funding certainty; and stronger integration between health, social care and the voluntary sector.
- The importance of informal spaces and relationships in enabling collaboration, often overlooked in estate planning, was emphasised.
- There was a view that the current system places disproportionate risk on local organisations, "asking people who have the most to lose, to invest the most".
- In primary care, participants expressed that some partners are making a profit whilst others are losing money – finding a solution that fits everyone will be difficult.
- There was a desire for one line of credit, be it a Public-Private Partnership or the Treasury. It was reported there are genuine people at a local level with passion and desire, but unless there is the money to help them, they must "luckily" find the money.
- Shifting to community means shifting resources, not just money. This will have workforce modelling implications, including on scale and where they will be physically based.
    - "We need to be getting services to where people are, and that means a much more innovative and broader approach to estates".

Wednesday 22 April (West and Central Cornwall)

1. Smile Mobile Dental Van

Background:

- This mobile dental van went live in July 2025, working with fishing community, veterans, children and people needing urgent dental care.
- Patients are seen from the NHS waiting list and from higher deprivation areas, and urgent care appointments are scheduled via the call centre.
- Chance to see innovative examples of how to deliver neighbourhood healthcare services to rural or underserved populations

Summary:

- Members were given a tour of the facility.
- Smile was also opened by a CIC and is commissioned by the ICB.
- It works with Fishermen's Mission and the Veteran's Society to provide pre-booked appointments to underserved communities.

2. Camborne / Redruth Hospital

Background:

- Tour and visit of Cornwall Foundation Partnership Trust community hospital site, including its Community Diagnostic Centre (CDC), the Rosedean Stroke Unit, and care closer to home models.

Summary:

- The site represents recent investment in community-based facilities provided by an independent sector partner InHealth, including diagnostic services and improved clinical environments.
- A patient described the centre as "much better" than mobile health units, and appreciating it being closer to home, more comfortable and the ability to book online and by phone.
- Staff report increased morale and pride in working in modern facilities and in addition to training UK workforce through apprentice and graduate programmes, InHealth also have successful partnerships with universities in the Philippines.
- Since opening in December 2025, there has been a steady increase in activity through the site, but it has not seen the impact on waiting lists that has been expected due to various challenges in redesigning patient pathways.

3. Roundtable discussion at Sustenation

Background

- Introduction to North Kerrier Neighbourhood Team
- North Kerrier has rapid demographic growth, deepening inequalities, an increasing long-term condition burden and pressures across health, care and the voluntary sector.

- North Kerrier Neighbourhood Team was initially launched in April 2025. It has added complexity in primary care due to representation of two PCNs and an orphan practice.

Summary

- The roundtable provided a system-wide perspective on estate challenges.
- Participants emphasised that estate quality remains a fundamental barrier to delivering neighbourhood health. Ownership in the healthcare system can be a huge barrier for estates, alongside barriers of bureaucracy:
    - "Private sector commercialism combined with public sector bureaucracy [is the] worst combination"
- Three-year funding cycles were described as a good start, but five would be better.
- NHS Property Services (NHSPS) was widely identified as a major constraint, one participant stating that whilst it is good at maintaining value for money, it thinks in a "London-centric way". A participant stated that delivering neighbourhood health within its framework is "impossible". Issues included:
    - Still paying rent for a structurally unsafe, unusable top floor ward;
    - Investment only coming after critical failure such as the collapse of a ceiling and exposure of rotting timber;
    - "No ability" or desire for long-term investment and planning in the estate.
- In rural areas such as Cornwall, estate planning must reflect local geography. Large, centralised facilities were not seen as effective:
    - "Building a big shiny new centre doesn't really work for our communities."
- There was instead support for flexible, multi-purpose buildings that can be adapted to changing needs over time.
    - "The best thing for neighbourhoods is to make [healthcare] utilitarian"
    - However, it was stated that utilitarianism does not mean specialism should be lost.

- Participants also highlighted the misalignment between responsibility and control. Local teams are required to manage risks associated with estate condition, but lack the authority or funding to address them. Participants called for local teams to be trusted to place money in the right places and take risks.
- The "Cornwall approach" was discussed, with Cornwall being seen as far ahead of other places in terms of neighbourhood health estate transformation, as it takes matters in its own hands through innovative methods.
- One individual spoke to how Cornwall Partnership Foundation Trust's unique ownership arrangements, with most of the estate owned by NHS Property Services and property landlords, leads the Trust to actively look for additional funding, some of which is awarded by NHS England or DHSC. Combining multiple funding streams allows the Trust to achieve an average yearly estate spend of £25 million. This is despite the Trust's Capital Delegated Expenditure Limit (CDEL), which dictates the amount of money it receives to maintain and manage its existing estates, sitting at £2 million.
- However, a cultural shift needs to happen to change how parts of the system work together. Processes are currently not set up to allow people to work together easily.
- Whilst Truro Health Park (below) was described as "exactly what a Neighbourhood Health Centre should look like", attendees felt that due to the PFI model, two Health Parks could have been built for the money spent. Government's reintroduction of Public-Private Partnerships was discussed:
    - "At least give someone the choice whether to use PFI or alternative sources of funding, rather than prescribe it onto them."

4. Truro Health Park

Background

- Truro Health Park offers two GP practices, mental health, podiatry, midwifery, dental and more, delivering an estimated 150,000 additional appointments per year.
- It was selected by Government as a 'Neighbourhood Health Centre' (NHC) scheme, chosen as one of the first NHCs to be opened by 2027.

Summary

- Truro Health Park uses a "campus" model as a way to "create health" rather than simply treat illnesses. This includes reactive, proactive and preventative workstreams alongside sharing of space and information. There were calls for a "hospital passport" to better track patient records.
    - "Patients shouldn't spend a week in hospital because staff don't talk to each other."
- Convincing people of the longer-term health mission was described as difficult. Additional challenges include low space utilisation—with around 30% of clinical capacity being unused—described as "disgraceful".
- Additionally, whilst sharing a space was seen as a massive enabler to shifting the identity and culture around healthcare, integration issues remain. Social prescribers cannot work in clinical settings, social workers are not embedded in the same way, and the mental health team only has one room.
- Difficulties also exist around commissioning and funding flows.
- Truro Health Park was built using the Local Improvement Finance Trust model (LIFT), a form of Public-Private Partnership investment. This was associated with unreasonable costs, described as a barrier: for example, £100,000 to reconfigure a room, £300 to change a toilet roll holder.
- It was also stated that whilst the Truro model works in its current location, co-location in bigger patches of Cornwall would be more difficult.
- We were told that Truro did not nominate themselves as an NHC, rather were chosen as one.

5. Lanivet Community Hub and discussion with Cornwall Health and Wellbeing Workers

Background

- Lanivet Community Hub is one of 55 Community Hubs
- The Cornwall Community Health and Wellbeing Workers (chewies) are a specific team within Volunteer Cornwall. It was inspired by and based on the Brazilian Family Health Strategy, and was cited in the 10 Year Health Plan as a case study for existing effective neighbourhood working.
- Chewies take a hyperlocal focus, with each worker responsible for a number of streets, with areas of need identified through analysis of deprivation data. Chewies are hired through existing VCSE sector organisations, with funding and governance managed by Primary Care Networks and Integrated Care Boards.

Summary

- Lanivet Community Hub and the Community Health and Wellbeing Workers ("Chewies") programme demonstrate a highly localised, relationship-based approach to care.
- Community Hubs in areas of high deprivation have Chewie teams whereas other areas do not – they are "co-concurrent but not co-dependent".
- Chewies are funded by the NHS/local ICB, working with the NHS but not for them. The model usually sees 100-120 properties per Chewie.
- They provide holistic help, often engaging with residents over two core issues they need assistance with. Workers engage with residents through door-to-door outreach, greeting residents, asking if they need help with anything, and building trust over a beverage.
- It was stated that Chewies are very clear about what the service offers and what they do not, meaning that communities and service users do not "overstep" their boundaries.
- It was stated that use of Chewies correlated with a decrease in rates of accessing acute care and an increase in accessing planned care. The impact on individuals was described as substantial:
    - One service user was on the council house list for 17 years, after three weeks of seeing Chewies was moved in.

    - One individual with unmet welfare needs saw an £800 increase in monthly income, meaning they can now afford to heat their residence and eat at the same time.
    - The service was described as “absolutely amazing” and “beautiful”, with one user saying they would not be where they are now without the help of their Chewie.
- The workers raised the point that not every service user wants someone to be in their house, highlighting the importance of third spaces. However, access to these spaces can be limited, for example a dispute with the local council over use of a community centre.
- Transport is a key element for accessing services in rural areas. Additionally, geographical boundaries mean that if a resident moves outside of the catchment that is covered by their Chewie, they lose access to the service.

Formal minutes

Tuesday 10 November 2026

Members present:

Layla Moran, in the Chair

Sadik Al-Hassan

Ben Coleman

Josh Fenton-Glynn

Dr Allison Gardner

Andrew George

Delivering the Neighbourhood Health Service: Estates

Draft Report (*Independent Commission on Adult Social Care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 115 agreed to.

Summary agreed to.

Annex agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Wednesday 11 November at 9.15 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 15 April 2026

Beccy Baird, Senior Fellow, King's Fund; **Ruth Rankine**, Director, Primary Care Network Director and Community Network and SRO for Neighbourhood Health, The NHS Alliance; **Martin Steele**, CEO, NHS Property Services Q1-75

Dr Mark Hellowell, Senior Lecturer and Director of the Global Health Unit, University of Edinburgh; **Lord John Hutton**, Chair, The Association of Infrastructure Investors in Public Private Partnerships (AIIP); **Barry White**, Chair, Infrastructure Managers Limited Q76-148

Wednesday 1 July 2026

Dr Jamie Hynes, Vice President, Member Standards, Royal College of General Practitioners; **Rob James**, Group Development Director, Primary Health Properties PLC; **Dr Louisa Wood**, Chief Operating Officer, Mereside Medical Q149-196

Sam Pluckrose-Oliver, Policy and Public Affairs Manager, Locality; **Joe Garrod**, Strategic Director of Place, London Borough of Waltham Forest; **Bill Shields**, Executive Director of Finance, 'DLN' ICB Cluster Q197-229

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

DNE numbers are generated by the evidence processing system and so may not be complete.

1	Ade, Specialist-Medical	DNE0001
2	Alliance Manchester Business School, University of Manchester	DNE0065
3	Anonymised	DNE0006
4	Archus	DNE0060
5	Association for Respiratory Technology and Physiology (ARTP)	DNE0008
6	Birmingham Community Healthcare NHS Foundation Trust; and University of Nottingham	DNE0054
7	British Medical Association (BMA)	DNE0053
8	British Property Federation	DNE0038
9	Buziuk, Hleb	DNE0002
10	ChurchWorks (Good Faith Partnership)	DNE0031
11	Coventry and Warwickshire Integrated Care System Primary Care Team	DNE0024
12	Department of Health and Social Care	DNE0066
13	Dorset Healthcare University NHS Foundation Trust	DNE0052
14	Equitix Limited	DNE0033
15	Evondos Group	DNE0064
16	Fedcap	DNE0018
17	Feedback Medical	DNE0013
18	Filleul, Mr Keith (Campaign Champion, My L); and Wiltshire, Ms Dawn (Campaign Champion, My Life My)	DNE0009
19	FuneralExperts	DNE0063
20	Galliford Try Construction	DNE0047

21	Gilmartin, Dr Kieran P (GP Partner and GP Trainer, Centre Practice Fareham)	DNE0069
22	Healthwatch England	DNE0017
23	Healthwatch Leeds	DNE0005
24	Hospice UK	DNE0037
25	Independent Healthcare Providers Network	DNE0049
26	Jones, Mr Clive (Member of Parliament for Wokingham, House of Commons)	DNE0045
27	Lisa King	DNE0043
28	Local Government Association	DNE0062
29	Local Trust; and Locality	DNE0015
30	LocatED Property Ltd	DNE0046
31	Mencap (Royal Mencap Society)	DNE0055
32	Mental Health Matters	DNE0032
33	Mereside Medical	DNE0044
34	NHS Dorset ICB	DNE0039
35	NHS England	DNE0070
36	NHS England	DNE0068
37	NHS Nottingham and Nottinghamshire Integrated Care Board; NHS Derby and Derbyshire Integrated Care Board; and NHS Lincolnshire Integrated Care Board	DNE0042
38	NHS Property Services	DNE0067
39	NHS Property Services	DNE0040
40	National LGBT Partnership	DNE0026
41	One Gloucestershire Integrated Care System	DNE0048
42	OneMedical Property	DNE0025
43	People's Health Trust	DNE0041
44	Primary Health Properties PLC	DNE0034
45	Priory	DNE0051
46	RABI - the Farmers Charity	DNE0027
47	Royal College of General Practitioners	DNE0010
48	Royal College of Nursing	DNE0007
49	Royal College of Obstetricians and Gynaecologists	DNE0061
50	Royal College of Paramedics	DNE0016

51	Royal Society for Public Health	DNE0011
52	Saxby, Dr Heidi (Academic, The Open University)	DNE0014
53	Seaton Hospital Steering Committee	DNE0003
54	South Warwickshire University NHS Foundation Trust; Stratford District Council; Warwickshire District Council; Rugby Primary Care Network; and Warwickshire & Solihull Community and Voluntary Action (CAVA)	DNE0057
55	Suicide Prevention Consortium	DNE0012
56	Swim England	DNE0050
57	The Association of Infrastructure Investors in Public Private Partnerships (AIIP)	DNE0004
58	The Chartered Society of Physiotherapy	DNE0059
59	The LIFT Council; and Fulcrum Infrastructure Group	DNE0019
60	The NHS Confederation and NHS Providers	DNE0030
61	The Pharmacists' Defence Association	DNE0029
62	UKactive	DNE0036
63	UNISON	DNE0020
64	University of the West of England	DNE0023
65	York and Scarborough Teaching Hospitals NHS Foundation Trust	DNE0056
66	Yorkshire Cancer Research	DNE0022

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2026–27

Number	Title	Reference
6th	The obesity moonshot: making obesity a political priority	HC 676
5th	Food and Weight Management: Modernising obesity treatment	HC 518
4th	Appointment of the Chair of the Care Quality Commission	HC 633
3rd	Food and Weight Management: Fixing the food environment	HC 223
2nd	Independent Commission on Adult Social Care	HC 420
1st	Health Bill 2026–27	HC 219
3rd Special	Health Bill 2026–27: Government Response	HC 766
2nd Special	Expert Panel: Evaluation of the transition from child to adult health and social care services	HC 238
1st Special	Palliative Care: Government Response	HC 357

Session 2024–26

Number	Title	Reference
8th	Healthy Ageing: physical activity in an ageing society	HC 1180

Number	Title	Reference
7th	Community Mental Health Services: Commentary on the Government Response to the Committee's Fourth Report of the Session 2024–26	HC 1769
6th	Palliative Care	HC 1763
5th	First 1000 days: a renewed focus	HC 802
4th	Community Mental Health Services	HC 566
3rd	Black Maternal Health	HC 895
2nd	Adult Social Care Reform: the cost of inaction	HC 368
1st	Appointment of the Chair of NHS England	HC 743
4th Special	Evaluation of Palliative care in England: Government Response	HC 1722
3rd Special	Expert Panel: Evaluation of Palliative care in England	HC 632
2nd Special	Expert Panel: Evaluation on meeting patient safety recommendations: Government Response	HC 617
1st Special	Pharmacy: Government Response	HC 602