Independent Healthcare Providers Network

FUTURE HEALTH

Building Better Health

Enhancing NHS & independent sector partnerships to boost capital investment and deliver the 10 Year Health Plan

November 2025

About this report

This short report from Future Health and the Independent Healthcare Providers Network (IHPN) assesses current challenges with the current NHS capital regime before setting out recommendations to enhance partnership between the independent healthcare sector and the NHS to deliver improved facilities and services for patients.

The Government's health mission includes a milestone to 'meet the NHS standard that 92% of patients should wait no longer than 18 weeks from referral to start consultant-led treatment of non-urgent health conditions.'

The mission is to be supported through three 'shifts' set out in the Government's Ten Year Health Plan for England: moving care from hospital to community, shifting from treatment to prevention and upgrading services from analogue to digital.

The mission notes the importance of capital in driving improvements in performance and the three shifts through investing in surgical hubs, new diagnostics and technologies.

Significant reductions in the waiting list, health service digitisation and greater neighbourhood healthcare will all require the NHS to work with the private sector to unlock capital investment that increases capacity and improves productivity.

This short report from Future Health and the Independent Healthcare Providers Network (IHPN) examines some of the challenges in unlocking this investment and includes a short set of recommendations and opportunities for addressing them.

As part of the research, Future Health conducted a short literature and evidence review and interviewed five members across the IHPN membership with a range of different interests and expertise.

About Future Health

Future Health is a public policy research centre focused on creating healthier, wealthier people, communities and nations. Future Health publishes regular research papers across its three policy research programmes of health prevention, health technology and the links between improvements in health and economic growth. To find out more visit: https://www.futurehealth-research.com/

About IHPN

The IHPN is the representative body for independent sector healthcare providers. Our members deliver a diverse range of services to NHS and private patients including acute care, primary care, community care, clinical home healthcare, and diagnostics. To find out more visit www.ihpn.org.uk

Executive Summary

There is widespread recognition – across Government and the senior NHS leadership – that investment and reform are required to improve physical and digital infrastructure across the NHS. Lord Darzi's independent investigation highlighted a £37 billion shortfall in capital spending in the NHS since 2010, whilst the recently-published Ten Year Health Plan for England calls for a "new approach" to capital, stating that "underinvestment has been compounded by a capital regime which has widely been described as dysfunctional".

With public spending – including on health and care services – likely to be severely restricted in the coming years, public-private partnerships (PPPs) will play an integral role in supporting the modernisation of NHS services. Whilst the Government has sought to provide greater clarity over the role of PPPs through their Ten Year Infrastructure Strategy, and a constructive debate over the future role for private finance continues, this report focuses on how the independent healthcare sector can effectively partner with the NHS to invest in premises and build capacity through the ongoing delivery of services – a subject which has received more limited discussion by policymakers to date.

This report highlights how partnerships can go beyond 'bricks and mortar', demonstrating how independent healthcare providers have partnered with the NHS to provide packages of investment to:

- Unlock additional investment, enabling NHS providers to utilise their capital allocations to undertake a more diverse range of capital projects

- Utilise the expertise and capacity of the independent healthcare sector to develop new facilities and for new clinical services to be managed by them on an ongoing basis, enabling a broader range of services for NHS patients.

If adopted more widely, these partnerships can provide additional capacity, enable service innovation and deliver productivity improvements amid wider financial constraint across the NHS. This report features case studies of effective partnership across primary and community care, diagnostics, elective, and cancer care.

Based on an assessment of the current challenges (and opportunities) associated with the current capital regime, it makes the following recommendations:

1: HM Treasury should update Green Book guidance, to clarify the off–balance sheet capital investment mechanisms available to senior NHS leadership to stimulate public-private partnerships – particularly those which enable the independent sector to provide finance and deliver services on an ongoing basis.

- Updated guidance should refer to schemes, encompassing primary and community as well as secondary care where NHS providers have already entered effective, ongoing partnership with the independent healthcare sector to work within the current accounting rules.

2: To create a forum for leadership and enable ongoing partnership between Government, the NHS and the independent healthcare sector, a National Strategic Council for Healthcare Infrastructure should be established.

- Its membership should include representatives from HM Treasury, DHSC, the NHS and the independent healthcare sector to enhance collaboration on the enablers of PPPs. Its work should align to the Government's stated priorities in the Ten Year Health Plan.

- In conjunction, DHSC should publish a dedicated set of guidelines for how the NHS will use PPPs, with a focus on an expansion of independent sector led services to tackle waiting times for elective care and diagnostics.

3: The Government should collaborate with the independent healthcare sector to develop a dedicated Neighbourhood Health Capital Fund.

- To avoid the usual difficulties in the existing capital system and to move at pace, a separate and dedicated Neighbourhood Health Capital Fund should be established. Such a Fund would allow the Government to set out the strategic objectives, requirements and levels of investment needed from capital investment into neighbourhood health. The primary aim of the Fund would be to raise private capital investment, but it could also be supplemented by central funds to support the overall capital requirements of the neighbourhood health programme.

- The development of the Fund will also create opportunities for independent sector delivery of some clinical services within these new neighbourhood health facilities, which can be delivered within the bounds of the Provider Selection Regime.

- Alongside this, the National Health Service (General Medical Services Premises Costs) Directions 2024 should be amended in tandem, so that they are supportive of private capital investment into the NHS primary care estate and to enable alignment to the Government's vision.

4: Enhancing accountability for delivering on NHS capital priorities

- The Government will need to follow through on its Ten Year Health Plan aims of speeding up capital programme processes. As part of this it should introduce a new indicator in the NHS Oversight Framework that tracks the performance of NHS organisations on their delivery of capital projects. Such transparency can be used to identify organisations that are struggling with capital builds, identify blocks to progress and work on solutions to these challenges.

5: Increasing PPPs to support elective recovery

- NHS England should publish a set of guidelines for how the Government's commitments in the Ten Year Infrastructure Strategy for more PPPs will be translated into building more capacity to deliver elective recovery. Learning should be taken from those NHS and independent sector organisations who have already been able to make such arrangements work within the current accounting rules.

How does the current NHS capital regime work?

The Treasury manages departmental spending by setting departmental expenditure limits (DELs). This is done through the Spending Review process which allocates a spending 'envelope' across a three-year period, splitting this between 'day to day' resource spending (RDEL) and capital spending (CDEL). NHS providers are the main source of capital funding from the Department of Health and Social Care (DHSC).

Whilst the Government's 2025 Spending Review committed to increase revenue spending for the DHSC by 2.8% a year in real terms between 2025/2026 and 2028/2029, capital spending will effectively be held flat at £13.6bn until 2029/2030.

The 2025/2026 NHS capital allocation is split into three categories (see Box 1 below).

Box 1: 2024/2026 capital allocations

A system-level allocation to fund day-to-day operational investments (£4.9bn)
These are traditionally either self-funded by organisations within integrated care systems (ICSs) or supported by the Department of Health and Social Care (DHSC) through normal course of business loans or system capital support via public dividend capital (PDC).

Previously committed funds (£1.1bn)
To support previously committed and announced schemes from the previous Spending Review period, specifically the New Hospital Programme (NHP), Hospital Upgrades and the reinforced autoclaved aerated concrete (RAAC) programme.

Other national capital programme investments (£4.1bn)
These encompass key national priorities, including enhancing performance in elective recovery, diagnostics, urgent and emergency care (UEC), estates safety, advancing technology initiatives, supporting primary care, and driving progress towards net zero commitments.

Challenges with the current NHS capital regime

Lord Darzi's independent investigation into the NHS, published in September 2024, identified a lack of effective capital investment over multiple years as one of four primary drivers of poor NHS performance:

"The NHS has been starved of capital and the capital budget was repeatedly raided to plug holes in day-to-day spending. The result has been crumbling buildings that hit productivity – services were disrupted at 13 hospitals a day in 2022-23. The backlog maintenance bill now stands at more than £11.6 billion and a lack of capital means that there are too many outdated scanners, too little automation, and parts of the NHS are yet to enter the digital era."

This has proven a long-standing issue. The 2022 'stocktake report', authored by Dr Claire Fuller, which examined the role of primary care services in integrated care, identified 2,000 GP practices operating from premises were no longer fit for purpose.

The NHS Confederation has recently described the NHS capital regime as 'broken'. The Healthcare Financial Management Association identifies the following recurring and emergent issues:

- **Lack of transparency** – the process for allocating funds within the NHS to organisations is unclear.
- **Single-year budgets** – this limits investment opportunities and there are examples of the centre holding back investment in case areas overspend. There are also examples of NHS organisations buying equipment at year end to hit financial year timescales - NHS providers spent 42% of their full year capital budget in February and March 2024.
- **Complex accounting rules** – valuing and accounting for healthcare assets is a complex and technical process.
- **Disparate demands** – for example between maintenance investments and transformation investments. Devolving some capital allocations to ICBs, who themselves are now facing structural uncertainty creates more confusion.
- **Inflationary pressures** – In April 2025 the consumer prices index rose to 3.5% from 2.6% putting pressures and a squeeze on costs and investments.
- **Nascent System working** – There is not a strong history of system working on capital across the NHS. Whilst this is a stated ambition it remains early days, and currently system level working on this is unclearly defined.
- **IFRS 16 leases** – Until now, the CDEL coverage for leases has been held separately to the overall CDEL. NHS bodies are not clear whether it is possible to transfer CDEL from one category to the other or whether the allocation can be transferred between organisations. The Health Service Journal has reported on some of the challenges systems are facing as a result of this change.
- **Changes in the provision of digital services** – Digital services are moving towards software as a service model which makes them a revenue spend – however funding for digital transformation is still primarily capital in nature.
- **The end of PFI contracts** – The coming to the end of certain PFI deals leaves questions about NHS bodies who have to buy the asset at the end of the contract and whether CDEL cover will be needed. This could have a major impact on the availability of CDEL for other NHS bodies.

Addressing these challenges has been the focus of several recent reviews. The 2023 Hewitt Review called for longer-term capital plans, faster approvals, greater flexibility to save or invest capital, clarification on the use of private capital in the NHS and incentives for more efficient system wide working.

The Institute for Government has recently argued that Treasury Ministers should take a strategic view on capital investments and that Ministers in relevant departments should consult a wider range of economists on capital bids and priorities. In a joint briefing authored by the Nuffield Trust and Policy Exchange, the authors called for the adoption of a 'whole public estate' approach to capital.

The value and impact of the independent healthcare sector in NHS capital investment

Independent healthcare providers deliver care to millions of NHS and private patients each year across primary, community and hospital services, with services provided by the sector ranging from MRI scans, ADHD and Autism assessments to knee surgeries and cancer care.

The independent healthcare sector invests substantial sums in capital assets (equipment and facilities) that are available to NHS patients, free at the point of use. This includes diagnostics, where independent healthcare providers deliver 1 in 4 NHS scans and operate many NHS Community Diagnostic Centres. In hospital care, around 1 in 5 NHS elective procedures take place in an independent provider hospital. These assets are, at a conservative estimate, equivalent to the activity delivered by at least 17 NHS acute trusts.

With Government and NHS resource severely restricted, the independent healthcare sector can play an integral role in supporting the modernisation and reform of NHS premises and services. With the most recent Spending Review confirming capital budgets will likely be held flat in real terms to 2029/30 , but with an ambitious reform agenda planned through the Ten Year Health Plan for England along with significant maintenance and service backlogs, unlocking increased investment and enabling the ongoing management of services by the independent healthcare sector would represent a key ingredient in delivering upon the Government's healthcare reform objectives. Yet this option has been subject to only limited discussion in the policy debate on NHS reform.

There are many notable examples across England where the independent healthcare sector has partnered with the NHS effectively, using private capital investment to deliver its ambitions for swifter access to high quality care including diagnostic capability, hospital capacity, specialist cancer care and primary care.

In many cases, capital investment forms just one part of a package of investment which also includes the ongoing delivery and management of efficient, high-quality clinical services.

In the next section, six examples act as case studies – and models that could be adopted more widely.

Case study: InHealth and five new Community Diagnostic Centres and mobile diagnostic services in South West England

Case Study 1: Permanent facilities funded by the private sector boosting diagnostic capacity for patients in the South West, a previously underserved region of the country

Historically, the South West Region had a shortage of diagnostic capacity, contributing to long waiting times for tests, exacerbated by the effects of the pandemic. The Region also has challenges due to its rural geography and dispersed population, leading to inequitable access to services. Plans to address these challenges were constrained by the limited capital resource available for investment in new capacity, and a shortage of clinical workforce in parts of the Region.

The NHS England Regional team coordinated a collaborative Region-wide procurement for an Independent Sector partner to provide five additional Community Diagnostic Centres (CDCs) and Region-wide mobile diagnostic services. A range of diagnostic modalities were specified, including MRI, CT, Ultrasound and Cardio-respiratory Physiological Measurement such as Echocardiography, Endoscopy and Phlebotomy. All services were to be digitally integrated with local NHS services. InHealth was selected as the preferred partner and has been contracted to deliver these services, which will treat in excess of 2 million patients over the life of the contract.

InHealth invested £32m of capital in buildings and diagnostic equipment, plus 13 mobile MRI scanners, 7 mobile CT scanners and 5 mobile endoscopy units which provided early mobilisation of the new diagnostic services. Mobile services commenced on 1st April 2023, providing capacity 12 months ahead of the first permanent facilities being completed. The service has been shortlisted for the Best Provider of Diagnostic Services at the HSJ Independent Healthcare Providers Awards.

The project has delivered some notable results:

- **New permanent facilities** – The five new CDC sites were confirmed as Weston-Super-Mare, North Bristol, Torbay, Yeovil and Cambourne/Redruth. The new CDCs in Weston and North Bristol opened on 1st April 2024, with North Bristol being provided via an innovative "mobile village" solution adjacent to the permanent CDC building which became operational in September 2024. The site in Torbay also opened in September 2024 with the CDCs in Yeovil and Cambourne/Redruth currently under construction due to open in 2026.

- **Improved Accessibility** – All five sites have been chosen to provide the best possible access for the local population in the heart of the communities that they serve, with public transport links and parking. The CDCs are open 7 days per week and up to 14 hours per day, offering a wide range of choice to patients for convenient appointment times. All sites cater for patients with additional needs such as reduced mobility, sensory disability and where English is not their first language.

- **Improved Waiting times** – Patients referred to the CDCs for their diagnostic tests are seen within the NHS Constitution standard of 6 weeks, or sooner if they have been referred with a suspected cancer or on a clinically urgent basis.

Case study: Ramsay Health Care UK and Glendon Wood Hospital

Case Study 2: New day case and diagnostic centre providing additional capacity to treat patients as well as supporting the local economy by increasing employment

Ramsay Health Care UK's day case unit and diagnostic centre at Glendon Wood Hospital is a £20 million facility delivering essential care to thousands across Kettering and the wider region. In the two years since opening, the hospital has received over 10,500 NHS e-Referral Service (eRS) referrals, providing fast access to treatment in key specialties ranging from Ophthalmology, Gastroenterology, Orthopaedics and diagnostics.

Designed to increase capacity and reduce waiting times, Glendon Wood features two modern theatres, a dedicated endoscopy suite, outpatient consultation rooms, and a fully equipped radiology department offering digital Mammography, CT, MRI, X-Ray, and Ultrasound.

Acting as an extension of services already offered at Woodland Hospital—just under four miles away— the new hospital has not only enhanced clinical capacity but also bolstered local employment. Over 70 staff members now support the hospital's operations, with ongoing recruitment and training programs in place across nursing, administration, clinical, and support roles.

This is a prime example of how strategic investment can create lasting value for patients, staff, and the wider health system.

Case study: HCA UK and increasing hospital capacity

Case Study 3: Using existing bed capacity in a private hospital to treat NHS patients

University Hospitals Birmingham (UHB) NHS Foundation Trust has been given operational control of 72 of the 122 beds in the Harborne private hospital on its site, which opened in January 2024, in a partnership between it and HCA, which operates a network of private hospitals in the UK.

UHB did not contribute towards the £100m cost of building the hospital, which provides cancer, cardiac and orthopaedic care, but has taken a lease on two of its eight floors to provide additional capacity for NHS patients.

This additional capacity is enabling patients in Birmingham and Solihull to access faster treatment and is supporting the Trust in its efforts to cut waiting lists.

Case study: GenesisCare UK and high-quality cancer care and support

Case Study 4: Private capital investment to develop a new cancer centre and research hub increasing access for NHS patients to cutting edge cancer care treatments.

In 2024, GenesisCare UK opened a state of the art centre in Guildford, Surrey, marking a major step forward in advancing cancer healthcare in the region.

The new £30 million specialist outpatient centre for oncology and radiotherapy is the result of a partnership between GenesisCare UK and the Royal Surrey NHS Foundation Trust and is helping to increase access to the latest innovations in diagnostics and radiotherapy for patients based in Surrey and beyond. The new cancer centre and research hub will support NHS patients in accessing innovative treatments and clinical trials.

Programmes run by the centre enable patients to access specialist services such as exercise medicine, which is proven to improve patient outcomes, as well as a wellbeing programme and therapies including counselling, reflexology and acupuncture, delivered in partnership with the charity Penny Brohn UK.

Case study: Agito Medical and expanding cardiac services on an existing hospital site

Case Study 5: Capital investment and expertise to create relocatable cardiac catheter laboratory services for NHS patients

As part of work to improve the care pathway for cardiac patients, Epsom and St Helier University Hospitals sought to expand existing catheter lab services at Epsom to include interventional and electro-physiological procedures. Agito Medical, which provides MRI, CT and Cath Lab diagnostic services (including one of the largest fleets supporting the NHS), was tasked with installing a relocatable Cath Lab solution.

During the installation programme Agito proposed a design for a link corridor to seamlessly connect the cardiac day ward to the new lab. This solution created a separate pathway for cardiac patients, ensured excellent infection control standards and created storage areas to support the expanded activities. The resulting, fully integrated lab suite serves as a seamless extension to the existing hospital building.

This case study demonstrates the effectiveness of PPPs based on close collaboration and ongoing dialogue between NHS Trust leadership and independent healthcare providers who demonstrate a deep understanding of the requirements of the clinical service, have the knowledge and expertise to take a flexible approach to project delivery and can deliver long-term capacity solutions.

Case study: OneMedicalGroup and delivering a new community health and wellbeing centre

Case Study 6: Redevelopment of the primary and community care estate, to provide integrated services for a local community.

In 2024, OneMedicalGroup finalised the development of the Aspull Health and Wellbeing Centre, a £4.6m scheme to create an integrated, community-focussed health and wellbeing centre, providing a new home for the local GP practice, a pharmacy and community teams from Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.

OneMedicalProperty, part of NHS primary care provider OneMedicalGroup, led the development and construction of the scheme, providing the capital investment. Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust provided land for the development, illustrating how NHS organisations can unlock capital development programmes, even where they do not directly provide investment.

The flow and layout of the building was designed with service users to be welcoming and inclusive. It was also developed on the basis of anticipated future primary care requirements, featuring a number of generic clinical spaces which can be moulded to meet future need.

The scheme successfully involved a range of key stakeholders including leadership at the Aspall Surgery, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust and Wigan Council, in addition to Age UK, disability access groups, Healthwatch and the OneHouse community space. The design even incorporates a community orchard and artwork from local schoolchildren who were actively involved in the project. The Aspull Health and Wellbeing Centre has been shortlisted by the Building Better Healthcare Awards.

What lessons can we learn from these case studies?

1: Alignment of vision and effective, ongoing partnership between NHS providers and independent healthcare providers is key to a successful PPP style programme (alongside working with relevant local authorities and the voluntary sector, where applicable).

2: Effective identification (and leveraging) of what each party can 'bring to the table'. This includes examples where NHS providers lease land for the purposes of redevelopment (where they may be more restricted in their ability to invest), and independent healthcare sector providers invest and manage the estate – as well as introducing sector-leading innovation to be made accessible to NHS and private patients alike.

3: Boosting partnership with the independent sector is an effective means of enabling access to innovative care for NHS patients and can play an important role in unlocking the investment required to improve premises and capacity across the healthcare system.

4: PPP programmes can help tackle short term service pressures, but the best value for the NHS and patients will come from longer term sustainable partnerships aligned to broader policy goals of shifting where care is delivered and improving service access for the public.

Barriers to unlocking private capital investment and further partnership with the independent healthcare sector

When considering the role of PPPs across the NHS more widely, the Chartered Institute of Public Finance and Accountancy (CIPFA) has identified the following challenges:

- Difficulties of building business cases and securing timely project approval.
- A tendency within the NHS to focus on new projects rather than implementing and delivering those already approved.
- Uncertainty over when funding will become available to start joint projects with partners.
- Cultural risk aversion across some NHS organisations.

Within primary care, a report by the British Property Federation (BPF) outlines two main models for private capital investment in primary care:

- Third party developer – where a private developer builds the asset and the NHS, general practice, or other public body take a long-term lease
- Public-private partnerships – which involve a joint venture between the public and private sector to deliver a new estate with private funding and debt

However, the BPF argue that neither is working particularly effectively due to current accountancy rules and issues with rents.

To inform this report, Future Health interviewed five IHPN members to explore the current challenge with unlocking private capital investment into the NHS. The following provides a summary of the main issues raised by members:

1: Slow and cumbersome processes for approval – Several interviewees raised issues about the lack of speed and clarity of process for approving NHS capital projects.

"We need much clearer accountability and processes but also as importantly objectives about what is wanted."

2: Quality of decision making – Interviewees raised concerns about the quality of decision making processes within the NHS and the reliance on external advisers to navigate the complex processes for developing capital proposals.

"Unfortunately many parts of the NHS do not have the experience or the expertise to do things quickly on capital."

"The complexity of processes means there are lots of advisers involved in the process at significant cost."

"It is not only the quality of decision making that is an issue, it is more fundamental and whether there is decision making power and authority within Trusts and ICBs. Sometimes it does not feel that there is."

3: Short termism and financial planning – Interviewees highlighted examples of NHS Trusts approaching them to deliver capital projects very late in the financial year with unrealistic timelines. Another issue highlighted by two interviewees was misaligned expectations from NHS organisations on the level of return on investment independent sector organisations would require from capital projects. An interviewee also noted that high turnover of senior staff within NHS organisations created instability that affected capital programmes.

"One Trust came to us with a need to spend millions just weeks before the end of the financial year and there was no way, us or anyone else could have delivered what they were asking."

4: Recent experience on 'shifting care' – Unfortunately recent efforts at shifting care, through Community Diagnostic Centres (CDCs) have attracted limited upfront private capital investment due to the way the process was structured, with a lack of early engagement with the private sector. Just 7% of these new community hubs are run by the independent sector and analysis by IHPN found that if one third of all current CDCs had been independent sector-led it would have resulted in a reduction in capital spend of approximately £500 million. There was a lack of a clear framing of the strategic requirement for the CDCs which if addressed would have enabled greater creativity in capital asset and solution provision.

The level of resource needed to shift care was also noted as something where there was NHS appetite, but where constraints in the system (particularly on capacity) were challenging to overcome.

"There has been a clear opportunity for private sector investment in CDCs which hasn't been fully realised. Getting diagnostic capacity into the system can really help the Government shift the dial on waiting lists."

"We speak to NHS CEOs who really do want to shift care, but the amount of effort to do it requires a significant upfront investment in both time and resource. If you can get over that 'hump' then there are benefits to be had and those we speak to who have done it feel it was worth it. But it can feel like a mountain to climb."

5: Accounting rules – There were somewhat mixed views from interviewees on the true impact of the CDEL cap and IFRS 16 accountancy rules. Two saw these as real barriers, but one said there were ways to navigate these with the right system leadership.

"The CDEL cap and IFRS 16 are blockers to getting capital projects in the NHS off the ground."

"In our experience, things like IFRS 16 and CDEL can be used as excuses – there are ways round them in how assets are classified. But this requires leadership and expertise to pull off."

6: System expertise and capacity – One interviewee noted that the most distressed health systems often have the greatest need for capital investment but also have the most significant challenges relating to capacity and capability to delivering change.

"We have been looking to build offers in parts of the country with long waiting lists and high areas of deprivation aligned to the Government and NHS objectives for tackling variations in access to care. But organisations in these areas often will themselves be in a degree of financial distress and need support to help turn things around. Fixing these systemic issues requires more joined-up policy thinking."

7: Competition and tendering – Interviewees understood the need for competitive tendering to ensure value for money for the NHS. However, one interviewee queried whether the threshold for tendering was set at the correct level, and whether this led to efforts being focused on bidding for contracts rather than working at building stable, longer-term more strategic NHS-independent sector partnerships.

"Competitive tendering is important as if the NHS can deliver best value then it should get the contract."

"I think there is a question about whether the threshold for tendering is set at the right level, particularly when set against a need to build more strategic, stable long-term partnerships."

8: Primary care – Concerns raised about capital investment in primary care included (a) issues with low rents for primary care premises having to be subsidised by ICBs – the NHS Confederation has noted that 'the system budgets for notional rents are extremely stretched, creating difficulty for commissioners, developers, GPs, and patients nationwide' and (b) restrictive premises directions – inhibiting investment in more innovative estates – for example in supporting more multi-disciplinary and team based working.

"In primary care we have not seen a proper rent rise since the pandemic. ICBs are having to top up rents that have been depressed which is neither sustainable nor desirable."

"The current Premises Cost Directions are too restrictive and are not enabling more innovative estates to be built."

"There is a danger that there is a disconnect in the ambitions for shifting care from hospital to community with the current poor state of the primary care estate."

9: Secondary care – Two interviewees noted that there was a need to think about a successor scheme to the Private Finance Initiative (PFI). PFI was used from the 1990s to enable private funding to finance public capital projects – such as NHS hospitals. High maintenance charges and high-profile examples of schemes collapsing saw new PFI schemes ended in 2018. However others have pointed to the benefits of the scheme in upgrading the NHS estate and supporting the turnaround in performance seen in the 2000s.

"We need to think about a successor to PFI. PFI clearly had problems and is not viable to take forward. But things were built and services did improve."

The Ten Year Health Plan for England and opportunities for reform

Improving the flow of private capital into the NHS to support service transformation, improvements in performance and the health of communities will be critical to delivering on the Government's healthcare ambitions in the Ten Year Health Plan for England.

The Spending Review (SR) saw a commitment to invest more in health technology, but overall, capital budgets will be exceptionally tight over the SR period. There have been growing calls for increased private capital investment into the NHS. NHS England Chief Executive, Sir Jim Mackey, has spoken of his hope that private finance can be used to help rebuild hospitals and that there will be opportunities for private capital investment into community facilities.

The NHS Confederation have similarly argued that the NHS should be able to 'raise private investment to meet the 2 per cent annual productivity challenge set out in NHS England's long-term workforce plan.' NHS Providers have recently called for an expansion in co-investment models (including with local authorities).

Delivering a new approach to capital investment is regarded as one of the identified 'first steps' in the Ten Year Health Plan for England. The Plan commits to:

- Introduce multi-year capital budgets, set on a rolling 5-year basis in line with wider government capital allocations, with budgets set to 2029-2030
- Devolve more control over capital budgets to the front line with fewer restrictions on what providers can spend their capital on and greater flexibility to spend funding between financial years
- Streamline the capital approvals process to foster dynamism and swifter delivery – this includes commitments to have at most 3 approval levels on the very largest nationally significant schemes (one provider level, one regional/national and one cross government) and reduce by at least 2 to 3 months for a typical scheme and 4-5 months for smaller schemes
- Provide greater certainty to the NHS and industry through the 10 Year Infrastructure Strategy on projects and programmes across the country and allow better coordination of industry and supply chains across government

These commitments are highly welcome.

Recommendations

The Government has set ambitious targets for cutting waiting times and improving the nation's health. The independent healthcare sector is demonstrating a willingness and ability to support the Government in delivering these ambitions and there are many examples of effective cooperation already in action, delivering results.

This report has profiled just a handful of these examples. The following section comprises five key proposals for accelerating action and delivering greater scale.

1: Clear, updated guidance from HM Treasury on how PPPs between the NHS and independent healthcare sector can be unlocked

Whilst there are examples of NHS organisations who have been able to proceed with PPPs to enhance premises, HM Treasury should clarify the off–balance sheet capital investment mechanisms which are available to NHS leaders to stimulate PPPs. Updated guidance should draw from those NHS providers who have already been able to make such arrangements work within the current accounting rules. This is a critical step to providing clarity and confidence to the sector.

2: Creating a more strategic, long-term partnership between the Government, NHS and independent healthcare sector through a National Strategic Council for Healthcare Infrastructure

Consistent feedback from those within the independent sector was of a willingness to partner with the NHS on shared objectives in improving patient access to treatment. However, the lack of a strategic partnership was felt to be a barrier to progress.

Other forums exist that bring together the Government, the NHS and the private sector to facilitate such partnerships. One example is the Life Sciences Council for collaborative working and dialogue on life science related objectives including inward investment, speeding up access to clinical trials and access to medicines.

No such forum though exists for the Government, NHS and the independent healthcare sector to discuss and work on capital investment opportunities. As part of the delivery plan for the Ten Year Health Plan, the Government should establish a National Strategic Council for Healthcare Infrastructure. Its membership should include representatives from HM Treasury, DHSC, the NHS and the independent healthcare sector to enhance collaboration on the enablers of PPPs. Its work should align to the Government's stated priorities in the Ten Year Health Plan.

In conjunction, DHSC should publish a dedicated set of guidelines for how the NHS will use PPPs, with a focus on an expansion of independent sector led services to tackle waiting times for elective care and diagnostics.

3: Establish dialogue with the independent healthcare sector to develop a Neighbourhood Health Capital Fund, to enable targeted investment in the primary and community estate and to expand capacity

The Government's plans for Neighbourhood Health Services, delivered through new Neighbourhood Health Centres, creates an opportunity to build a more integrated and diverse primary and community health offer for patients.

However, to succeed, there needs to be a significant investment in the NHS primary and community care estate. Twenty per cent of the primary care estate predates the founding of the health service and is unsuitable for integrated models of care.

In July 2025, the Secretary of State for Health and Social Care stated that the Government's aim was to build: '250 to 300 new neighbourhood health centres…over the course of this Parliament…A combination of new builds and the refurbishment and rejuvenation of under-utilised existing estate, both in the NHS and in the public sector…The cost of each neighbourhood health centre will vary, from the low millions to around £20 million, depending on whether it is an upgrade, a refurb and expansion or a new build.'

The Ten Year Health Plan for England commits the Government to market engagement with the National Infrastructure and Service Transformation Authority (NISTA) to 'drive competition in the market to incentivise others, including third party developers, to improve their offer to deliver better services at lower cost to the taxpayer.'

To move at pace with this process and to avoid the usual difficulties in the existing capital system, a separate and dedicated Neighbourhood Health Capital Fund should be established. The purpose of this Fund would be to allow the Government to set out the strategic objectives, requirements and levels of investment needed from capital investment into neighbourhood health. The primary aim of the Fund would be to raise private capital investment, but it could also be supplemented by central funds to support the overall capital requirements of the neighbourhood health programme.

The development of the Fund will also create opportunities for independent sector delivery of some clinical services within these new facilities, which can be delivered within the bounds of the Provider Selection Regime.

In the first instance, the Government should announce the intention to establish such a scheme and engage with the independent sector in its development. Such an approach will unlock further capital funding, ringfenced for neighbourhood health, with clear processes and timelines in place for delivery.

Alongside this the Government should update the General Medical Services Premises Costs so that they are supporting the development of more innovative primary care estates, particularly with a greater focus on multi-disciplinary and team based working. The Premises Cost Directions (PCDs), last published in 2024, should also be reviewed to gauge its impact on rent rates in primary care – where there is evidence that rents rates have become unsustainable and unattractive since the pandemic – would also help send a positive signal to the investment community.

4: Enhancing accountability for delivering on NHS capital priorities

NHS England has introduced new measures that reward providers and ICBs for improved operational performance with a partial release of revenue surpluses for capital expenditure.

Whilst such incentives are welcome, there remains a lack of accountability for the speed and processes for delivering NHS capital schemes.

The Government is clear that the culture of financial deficits amongst NHS providers must come to an end. As it takes steps to fix the capital regime it should be similarly bold in its intolerance of delays to capital programmes.

This will mean following through on its commitments in the Ten Year Health Plan on speeding up processes. As part of this it should introduce a new indicator in the NHS Oversight Framework that tracks the performance of NHS organisations on their delivery of capital projects. Such transparency can be used to identify organisations that are struggling with capital builds, identify blocks to progress and work on solutions to these challenges.

5: Increasing PPPs to support elective recovery

The Darzi investigation highlighted a £37 billion shortfall in capital spending in the NHS since 2010. Whilst the Government has – to date - ruled out a return of PFI, there is a clear need for new private capital investment to support the elective recovery programme.

The Government's Ten Year Infrastructure Strategy creates opportunities for PPPs and investment, stating that: 'the government will consider the use of PPPs in projects and sectors where there is a revenue stream, appropriate risk-transfer can be achieved, and value for money for taxpayers can be secured.'

To support this intention, NHS England should publish a set of guidelines for how the Government's commitments in the Ten Year Infrastructure Strategy for more PPPs will be translated into building more capacity to deliver elective recovery. Learning should be taken from those NHS and independent sector organisations who have already been able to make such arrangements work within the current accounting rules.

Conclusion

The Government has set ambitious targets for recovering NHS performance. To achieve its aims, and to deliver the wide-ranging reforms set out in the Ten-Year Plan for Health, significant transformation of NHS services will be required.

With tight public finances, PPPs provide an opportunity for the Government and the NHS to work with the independent healthcare sector to increase capital investment. But these partnerships can go beyond 'bricks and mortar' alone, and can also enable effective, ongoing partnership to deliver additional services, boosting NHS capacity and productivity in the process.

This short report has set out examples from within the NHS today that can be learnt and built upon – alongside policy recommendations which if implemented can help support delivery and improve patient access to care.

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