

Health and Social Care Committee

Oral evidence: Delivering the Neighbourhood Health Service: Estates, HC 1567

Wednesday 15 April 2026

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton.

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Witnesses

[I](#): Beccy Baird, Senior Fellow, King's Fund; Ruth Rankine, Director, Primary Care Network & Community Network, and SRO for Neighbourhood Health, The NHS Alliance (formerly NHS Confederation and NHS Providers); and Martin Steele, CEO, NHS Property Services.

[II](#): Dr Mark Hellowell, Senior Lecturer and Director, Global Health Policy Unit, University of Edinburgh; Barry White, Co-author, White Fraiser Report; and Lord John Hutton, Chair, Association of Infrastructure Investors in Public Private Partnerships.

Examination of witnesses

Witnesses: Beccy Baird, Ruth Rankine and Martin Steele.

Q1 Chair: Welcome to this Health and Social Care Committee hearing on delivering the neighbourhood health service, with a particular focus on estates. It is the first of these hearings that we have had, and we are very grateful to our panels for joining us today. To start, please tell us who you are and what organisation you are part of.

Martin Steele: My name is Martin Steele and I am the chief executive of NHS Property Services, a strategic NHS estate delivery partner providing property and estate management expertise. We are part of the NHS and owned by the Department of Health, providing services to about 10% of the NHS estate, or 3,000 properties.

Ruth Rankine: Good morning. I am Ruth Rankine, director of primary and community care at the NHS Alliance. I have overall responsibility for neighbourhood health across the alliance. Just for your information, the alliance, previously known as NHS Providers and the NHS Confederation, is a membership body representing NHS providers and commissioners across England, Wales and Northern Ireland.

Beccy Baird: Hello. I am Beccy Baird, a senior fellow in health policy at the King's Fund, an independent health think-tank, and I specialise in primary and neighbourhood healthcare.

Q2 Chair: Lovely. Let us start with the basics. What do you understand the Government to mean when they say they want a "neighbourhood health service"? I ask this question because there is a bit of confusion as to what exactly they are aiming for. Help us understand from your perspective. What do you think they are aiming for, Beccy?

Beccy Baird: That is a really good question. In some ways, it is not clear because neighbourhood health means different things to different people, and people use it to mean different things. We, at the fund, group it into three different areas. There is neighbourhood healthcare, which is about the delivery of health services to people, often about integrating services particularly for frail elderly people, people with long-term conditions or particularly high needs, through integrated delivery and multidisciplinary teams. That is a very narrow focus of neighbourhood health. Certainly, initially, that was where the Government put a lot of their energy: into a neighbourhood health service that would target this very high needs group of people, mostly to keep them out of hospitals. They were really targeting emergency admission rates and discharge rates. That was the focus.

Another view of neighbourhood health is broader than that. It is about integrating all health and care services, including those provided by health organisations, local government, social care and voluntary sector



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organisations. It is a slightly broader view, much more at the place and neighbourhood level, looking at local relationships.

Then there is the view that neighbourhood health is actually about how you bring together communities and community assets to support people to live healthily in their neighbourhood. That is much more of a prevention and population health focus.

We find that that is quite a helpful way to look at the three bits of neighbourhood health. The Government's health guidance says they want to do all of those, but their focus is very much on that top end, the first bit.

Q3 **Chair:** Thank you. Ruth, is that your shared understanding?

Ruth Rankine: Very much so. Certainly from the work that we have been doing with our members, I would say that people are passionate about a system that addresses the wider social determinants of health. They feel that we are continually on a hamster wheel of trying to manage and stem demand. Unless we really get into prevention, focusing on health inequalities and on the things that impact people's health, not just symptoms, we will never get out of this hamster wheel.

Q4 **Chair:** This Committee is very passionate about that, too, but this is about the Government's focus. My question was about what you think the Government are aiming at, their top priority. This is a question for you, Ruth, but perhaps the others could comment on it, too. Do you think ICBs have a clear idea about what they need to be doing to help deliver this?

Ruth Rankine: On the first point, of what I think the Government are trying to do, as Beccy said, I think that the vision is the one described, but we have this very real pressure in the short term, in terms of our waiting lists, A&E waiting times and GP access. Naturally, there is a focus on those in the short term. We would say to the Government in our conversations that you design with the longer term in mind, and that will help you to deliver in the short term.

Q5 **Chair:** Do you think there is a risk that by aiming for one you might miss the longer-term opportunity?

Ruth Rankine: I think if we set out with the sole focus of just thinking about those short-term targets, we may not necessarily end up with the right design for the longer term. Do I think ICBs and local authorities have enough information? I think it comes back to what we think should be defined nationally versus left up to local determination. We welcomed the neighbourhood health framework. It has given us a set of guide rails, and set a clear vision, objectives and goals. It has metrics in there in terms of the measures of success. A lot of our members, particularly ICBs, welcomed that framework, which then gives them the local flexibility.



I think what people would say is that neighbourhood health might be a new definition, but it is not a new way of working. Lots of areas in the country have been working like this for a number of years. What is critical is that whatever guidance comes out does not inhibit what is already working well or fracture those existing relationships. Through this framework, I hope we have the ability to do that and to enable ICBs to work with communities, their providers and the local authority to really design what is needed for their communities, given their particular situation.

Martin Steele: As you rightly point out, Chair, it is still a developing definition. I will talk from an estates perspective. As it is still developing, I think what we have been tasked with providing is flexible, adaptable space that will change over time as the health needs of the local population change. It is important that we bring out some of those standards and they are defined: standardised footprints; the ability to physically flex the space when we need to; bringing in proptech as a standard; and understanding how the buildings are utilised—we have significant utilisation across the NHS estate.

Effectively, it is providing adaptable space that in turn provides multiple services from multiple NHS organisations in a single building. A one-stop shop might need to be tailored for local needs, but you must have that adaptability. Too often, you see properties that are not adaptable without significant investment. Modular builds, modern methods of construction and speed of execution all need to be thought through. Look at the existing estate: a lot of that functionality can be delivered through the existing estate by relatively low levels of capital investment and at pace. That is something we are pushing for pretty strongly.

Q6 **Chair:** We will definitely come back to probe into that a bit more. My last question is: we have the common description of neighbourhood health guidance forthcoming, but what would you like to see in it, Beccy?

Beccy Baird: We have had the framework. From our perspective, and certainly from the work that I have done going around the country, talking to people delivering neighbourhood health, I think that, as Ruth said, they welcome the framework. It allows for flexibility.

There are two points I want to make. First, the disruption in ICBs and in local government at the moment is really disrupting change. Relationships are being fractured. People are leaving. The local government reorganisation is adding to that, and adding to that fracturing of relationships, which makes some of this stuff harder to do. In that situation, there is a danger that people will look up for guidance. The NHS has a terrible tendency to always look up, to want to be told what to do. There is a danger that, as Ruth said, really great work that is happening all over the country—I am sure she can point to many examples, as can we, of amazing neighbourhood work that really builds on communities—will get disrupted by trying to fit into frameworks, tick boxes and meet targets.



It is really important that the ICBs have the capacity to sit and work with communities and the voluntary community sector particularly, which is a great conduit into local communities, to really understand what will work. They need to work with primary care, with GPs, but also with pharmacists, optometrists and all the other elements that need to be pulled together in this. It is a complex piece of work, and there is a huge amount of disruption with that. I welcome having some framework, but we would not want to see something so rigid that a service needs to look the same in Westminster as it does up in Fleetwood.

Q7 Chair: Can I summarise what you just said? It is local flexibility.

Beccy Baird: Absolutely.

Ruth Rankine: Just to add to that, two enablers underpin all of this, of which we have not yet seen the detail. One is the financial payment mechanisms, which do not necessarily currently support left shift or care closer to home. We know that work is under way to look at that, so we look forward to seeing more detail later in the year. Secondly, there are the contracts that will support the commissioning of neighbourhood services at multi-neighbourhood and single neighbourhood level. As Beccy says, people look for guidance. They also look for the sort of hard levers that will enable them to drive forward the change that is needed.

Q8 Chair: Do you have anything to add there, Martin?

Martin Steele: The only thing I would add is that, again from estates, I would like to see some guidance on standardisation, and what footprint and types of occupation would be needed in neighbourhood health centres. We have some experience in that: we have delivered several hundred neighbourhood-type properties in the last several years.

I would also like to see some guidance on streamlined decision making. We can develop and convert existing properties within a six or nine-month timeframe. We can build a new health centre within 13 or 14 months. Sometimes it takes six or seven years to get a spade in the ground. Something around that area needs to be challenged.

Also, as I said before, the integration of technology, real-time utilisation of existing estate, is key to enabling informed decisions. We built that technology. It is owned by the NHS. I would like to see guidance coming out saying that that should be deployed pretty much across the estate.

Q9 Chair: I need to move on to other colleagues in a second, but I was really struck that 13 to 14 months is what you could do, but six years is what often happens. What are the main barriers to delivering that faster timeframe, if you could just list them? I think we will come back to some of these.

Martin Steele: There is a whole series of linear decisions that need to be made. First, of course, you have to develop a clinical strategy, but could that be expedited? There is the procurement process. I can give you a



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live example in Surrey, where a property of ours burned down nearly 10 years ago. We could have re-provided that within 18 months, probably, or two years maximum. That will not be delivered until next year. It has taken that time because of the level of consultation at county council level. I am not saying they were wrong; quite rightly, they were looking at how they developed the entire town centre. But when it becomes scaled up and extended, it becomes unaffordable, and gets passed back to us to deliver what we could have delivered several years ago for, frankly, half the price and a bigger property. There is something about streamlining that whole process. Our view is that, from the point of inception to delivery for those kinds of facilities, it should be a 24 to 36-month timeframe, not a six, seven or eight-year timeframe.

Chair: Thank you. Dr Beccy Cooper, please.

Q10 **Dr Cooper:** Thank you, Chair. I will continue a bit with this line of questioning. The neighbourhood rebuild programme states that we are going to get 250 new centres by 2050. Martin, based on what you just said, do you think we will get 250 new centres by 2050?

Martin Steele: Did you say 2050? I think it is 2035.

Dr Cooper: Is it 2035? I was giving you more time. You have less time, Martin. Sorry about that. We are down to nine years.

Martin Steele: Look, I believe that that is entirely possible if you do two things. First, rework existing estate. That is really fast, expedient and a much lower cost, in our experience. That is why we produced a document just before Christmas, "Making Neighbourhood Health Centres a Reality". It is practical advice on how you can do this. There are two strands. One is to utilise existing stock which is underutilised. You can do that pretty quickly.

Q11 **Dr Cooper:** We have quite a lot of existing, underutilised stock.

Martin Steele: Yes, absolutely.

Q12 **Dr Cooper:** How many of these 250 centres do you think could be provided through existing stock?

Martin Steele: I cannot really comment on the other 85% or 90% of the estate, only the 10% that we own and manage. Across our estate, we identified 160 properties that we believe are in the right location, in the heart of the community, and that with relatively low levels of capital investment could be brought up to the NHC standard. Now we have been commissioned by the Department to roll out 11 of these by next March. We will do that. We could do more, but we will ensure that we execute that first 11 of wave 1.

Q13 **Dr Cooper:** That is interesting, thank you. Thinking about the neighbourhood rebuild programme and reflecting on what you have said already about services that should be included in these health centres, I am interested in the flexibility component and the idea of reducing



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burden on hospital care while at the same time providing proper neighbourhood health. They are two different ideas which do not necessarily make easy bedfellows, but they could potentially end up working together. I do not know if this question is for Martin or Beccy, but how easy is it to design a space that allows hospital preventive services to be there alongside wider, determinant, longer-term neighbourhood health models?

Martin Steele: I think that with the right inputs it is relatively straightforward. We are led by the clinical strategy, and it is up to commissioners to determine that.

Q14 **Dr Cooper:** When you talk about clinical strategy, Martin, I am interested in that as well. If you get 250 different clinical strategies, is that still deliverable?

Martin Steele: That is a good question. I am not entirely sure I can comment. I would be surprised if there were 250 different clinical strategies. Having seen the quite recently published archetypes for neighbourhood health centres, there are three or four different ones. Most of them have a commonality in terms of certain services that will always be there. Then there is the optionality depending on local health needs.

Q15 **Dr Cooper:** Is that deliverable?

Martin Steele: Yes.

Q16 **Dr Cooper:** What you are saying is that you have a core service. You think, okay, the space is going to do this. Then, depending on what the 250 different centres say, you can option out that amount of space.

Martin Steele: Absolutely right. Importantly, the space that is designed needs to be used by different parts of the NHS for different services, so it needs to be flexible enough to do that. We can build that.

Q17 **Dr Cooper:** Amazing. Beccy, do you want to come in?

Beccy Baird: I would add that this is not just about moving NHS services. The neighbourhood health centre is not just about lifting and shifting hospital services to a different location.

Q18 **Dr Cooper:** No, and do you think that is understood, or being planned for?

Beccy Baird: I think it varies. In some places, yes, they do understand. In my experience, and talking to people in the system, one reason we get a lot of underutilisation of existing buildings is because of not just the inflexibility of the space but the rules around finance and accountability.

Chair: We will come to this, yes.

Beccy Baird: That is absolutely key. It is quite difficult to design spaces that will work for lots of different organisations, but not because it is



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technically difficult to design them. That seems to be easier to do. It is very difficult to make the rules work, to use that space in a way that makes sense, so that voluntary sector organisations can afford to use it, GPs get their rent reimbursed, and all those kinds of things.

- Q19 **Dr Cooper:** I absolutely hear you. It is not necessarily a space issue. You can absolutely design it; you sound very good at designing different spaces. Instead, it is a case of what we can allow to go into that space based on who is using it, their terms of reference and various governance issues. That is really clear. As the Chair says, we will come to that.

I want to move on to developing guidance for systems to inform estate planning. The Government are currently developing this guidance on how to integrate national health centres with community diagnostic centres. Do you have thoughts about what this should specifically contain?

Beccy Baird: The only point we would make on the CDC is that an awful lot of that development still seems to be happening on acute hospital sites. It seems to be a lot easier for that to happen. One risk of combining those programmes is making sure that neighbourhood health is not a neighbourhood health centre that still sits on an acute hospital site.

- Q20 **Dr Cooper:** Do you think there is a risk of that?

Beccy Baird: Yes, I do.

- Q21 **Dr Cooper:** Okay. Martin, the sites that you have identified presumably do not sit on hospital sites.

Martin Steele: That is right. The CDCs that we have delivered and continue to deliver are generally not in acute sites. We are involved in primary care. There are several opportunities to do more of those.

- Q22 **Dr Cooper:** Okay. When you say it is easier for CDCs to be delivered on hospital sites, just for the record, why is that? What are the barriers to getting them out into the neighbourhood?

Beccy Baird: Often, a hospital estate is just much more flexible. It is easier for the NHS to develop on those sites because they often own them. I do not know much more about the technicalities of it, but that is how it seems to be. Also, there are the demands and pressures of having extra diagnostics on hospital sites, because their own diagnostics are quite under pressure. There is a real business case for them to want to use that setting, too, and also for staffing purposes.

- Q23 **Dr Cooper:** Can anything be done to incentivise it to come out of hospital sites? Is there anything that is not being done that would make it easier for them to allow CDCs to come out into the neighbourhood?

Beccy Baird: I do not know any detail about it. Ruth may know more.

Ruth Rankine: On what the right services are to move, I think it comes back again to Martin's comment about clinical strategy. I would say,



"What is the plan? What is the future service model for these communities?"

Q24 **Dr Cooper:** Does that feel clear to you, Ruth?

Ruth Rankine: I think it is work in progress. ICBs are working on their neighbourhood health plans at the moment. Those plans have to engage with the local authority. They have to be signed off by health and wellbeing boards. This is not just an NHS problem. It is a cross-government issue.

Q25 **Dr Cooper:** Do you think it will become a cross-government issue? We all know how difficult it is to work across Government. Beccy, as you said, at the moment ICBs are reducing in size. Devolution is happening for many areas. Government reorganisation is happening for many areas. Do you think, cross-government at regional level, it is possible to allow these neighbourhood centres to come together in a holistic way?

Ruth Rankine: I think yes, so long as the framework is there that directs them to work together, which is what we have through the neighbourhood health framework. A lot of it comes back to local relationships and the willingness of people to go outside their boundaries and talk to other people who have a real stake in this.

Q26 **Dr Cooper:** Being slightly cynical about that, it can be problematic, especially in today's world where people's job security feels slightly threatened, or perhaps where things are changing fast. That can make it problematic to get people to be more flexible in terms of their jobs.

Ruth Rankine: This is at the heart of the problem of the neighbourhood health service. To work well, its success relies on people from across different organisational boundaries. When every organisation is being measured on its own performance, that is its focus. Where is the incentive for an acute trust, for example, to really take risks and move services out, when the demand may still end up coming in? Where is the funding to build capacity in primary and community services? It is not there. We are reliant on a shift in resources. There are massive risks around all this. The bit that I do not think we have got right yet is getting people bought into the vision of what we are trying to achieve, and the how. This comes back to financial frameworks, contracts and that joined-up plan around everyone's role.

Specifically around CDCs and neighbourhood health centres, there are two other things to mention. We have a new hospital programme. We have the community diagnostic centres, neighbourhood health centres, and neighbourhood mental health centres. All of these have different streams of funding, different plans and different timetables. But, actually, when you look at all of that, it is all about the same thing.

Q27 **Dr Cooper:** You could not have been clearer. Thank you very much. Sorry, Martin, did you want to add something?



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Martin Steele: Just one thing at a practical level. When we build a new health centre, the different organisations occupying that centre often have specific demised areas. Being practical, we could end up having documentation in place at a lead provider level that allows any organisations to use any part of that space, if it is flexible enough, when it is not being used. What we find in quite new centres is that utilisation levels are low because it is not needed on a particular day by a particular organisation, yet there is no access for another organisation that could utilise it. You have to free that up and break down the silos.

Q28 **Dr Cooper:** That is heartbreaking.

Martin Steele: Absolutely heartbreaking.

Q29 **Dr Cooper:** All my colleagues here will have charities and other organisations wanting to do great things but unable to find space.

Martin Steele: It needs to be opened up and utilised.

Dr Cooper: Absolutely, thank you. I think we all have public buildings in our patches where we cannot understand why they are empty when we have people crying out for space. You have identified why. Thank you so much. Thank you, Chair.

Chair: We move to Jen Craft.

Q30 **Jen Craft:** Thank you, Chair. That leads nicely on to my first question. On the use of space, there is data that around 438,000 square metres of NHS space is not being used effectively. What kind of practical changes could be used to unlock this space? We all recognise that it is a heartbreaking situation, but what could be done?

Martin Steele: One thing is that we could have a different agreement for that particular building so that there is access for all organisations to use it when needed. More importantly, this is about understanding what the levels of utilisation are in real time. We can provide that, having invested in a system that allows that to happen—it is an NHS system. Let us use it more broadly across the estate.

Linked to that is the ability to book that space on a sessional basis. Again, we have the platform to be able to do that right now, called Open Space. For a nominal charge, anyone can use that to utilise that space, and it is pretty effective. We are working with eight ICBs to try to roll out this technology across their footprints. We are rolling it out across all of our estate at the moment. It is about making the space visible, making it bookable at a reasonable cost, and also breaking down some of those silos and red-line barriers that we see from different organisations.

Q31 **Jen Craft:** What are those red-line, siloed barriers?

Martin Steele: It is simple. Someone may have a lease for a particular building and a demised area in that building. Therefore, they may have five consulting rooms and other types of accommodation. That



organisation will use those rooms for their particular service. If they do not need them all week, why not open them up to another part of the NHS system? It is difficult to do that when you work within a lease. We need to break that barrier down.

Q32 Jen Craft: I think I know the answer to this, but is it the case, as you have already reflected, that all organisations basically look at their own interest rather than an overarching understanding of the purpose?

Martin Steele: There is not the incentive for them to take that high-level view, because they are measured on performance around their own delivery. If there was less focus on that, they may be more willing to open up the space for others to use.

Q33 Jen Craft: Are there governance issues with these organisations in allowing their space to be used by other organisations?

Martin Steele: I do not think it is a governance issue, particularly. They just abide by the terms of their occupation and lease. We should be able to find ways to make that more flexible, especially in brand-new builds. We should have a different approach.

Q34 Jen Craft: I was going to ask if it is an NHS Property Services issue. If it is a matter of abiding within the terms of their lease, is that lease from you?

Martin Steele: Partly. Don't forget that we are just 10% of the NHS estate. I am not entirely sure what happens in the other 85% or 90% of the estate, but most will either own their own properties or have leases in place with commercial landlords.

Q35 Jen Craft: Thank you. Beccy, what kind of role do you think non-NHS settings have? Again—you touched on this briefly—there may be issues around contractual liability frameworks. What role could non-NHS settings and services play in delivering a neighbourhood health service? Are there issues around that taking place?

Beccy Baird: There are huge, huge opportunities in using a one public estate approach. We have libraries and leisure centres. I have certainly heard some amazing stories about physiotherapy services being delivered out of local authority leisure centres, which is fantastic. Frankly, it gets more complicated when you need a sink. Infection prevention control rules for clinical space are quite highly specified. Something that has been raised with us occasionally is that the rules around prevention control, which are there for good reason, can make space very inflexible.

I was up in Yorkshire recently visiting a GP practice which had invested in its own new building to reflect a growth in its population. They ended up with an enormous clinical consulting room because of the rules about footprints and floor space that you had to have for a clinical room. That meant a waste of space, given what they wanted to do. That is one thing.



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Price is also a real issue. Some of these buildings are beautiful, high cost and high spec, but then become unaffordable for others to use. Then there are lots of rules. I am sure you have heard from others about the reimbursement rules for GPs.

Chair: I want to come to that specifically later.

Beccy Baird: Great. Yes, there is lots of opportunity to use public sector estate. Also, it is quite difficult to do that. Some of the rules that we have in the NHS for clinical services make some of that more difficult.

Ruth Rankine: Just to add, it is public space, but it is also commercial space. Similarly, we have an example in Yorkshire where the voluntary sector was brought together in collaboration between GP practice, acute trust and social services to rent some space in a shopping centre. The voluntary sector holds the lease, so they get a discount in terms of their business rates. It is really accessible, and has the facilities that people need. There are real examples where, when you get the right partnerships and the right conditions, it makes a huge difference.

Q36 **Jen Craft:** I think the question is: how do you take those examples and roll them out? What are the barriers in other places that stop everyone from being able to do that?

Ruth Rankine: Everywhere is different. I know that one of the topics you want to talk about is rural areas. That will not necessarily work in a rural area. Going back to the neighbourhood health centre guidance, we would like to see archetypes of what these models look like around the country so it gives people ideas about what may work in their area.

Martin Steele: Beccy's example of the consulting room is a good one. By having different but agreed standards in place you can create more space. In Devizes, which is a health hub we developed over the past two or three years, we worked with the ICB to reduce the size of consulting rooms. The standard was 16 square metres. We determined between ourselves that we could run it at 12 square metres. That means we have more consulting rooms in the same footprint. It works pretty well. As for public space, there is a lot out there. We are already using quite a lot of public space either for social prescribing hubs or putting health in the high street using commercial properties. We are doing that as well.

You absolutely need to have expertise on your sites to negotiate with those commercial landlords. I think that is a really important feature and is something we can bring to the table, but we should be using that space more. During the covid pandemic, our organisation provided 25% of the vaccination centres in England and used whatever space we could get our hands on. If we could do it then, we should be looking at the same approach now.

Q37 **Jen Craft:** To come back to the idea of having various organisations potentially just looking after their own interests, is there almost a cultural



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barrier to break down for people to see the overarching aim, which is to serve community health interests better?

Martin Steele: A cultural shift is needed so people can think about it as common shared space. To help them with that, you need to have a different approach to demised areas and how the space is documented through a lease, but the fundamental point is to think of it as one open space that is used by NHS organisations no matter who they are or wherever they sit, to give accessibility to it and visibility as to when it is available.

Q38 Danny Beales: I will ask a few questions about the local planning system and interactions you have with it. What involvement do NHS Property Services and potentially ICBs more generally have with the local plan-making system? Obviously, lots of local plans are being made. They are quite important documents around infrastructure locally. Can you describe your organisation's involvement?

Martin Steele: We have a specific planning team within our organisation which is expert in accessing and understanding how the planning system works and also accessing developer funding as well, whether it is section 106 or community infrastructure levy charge. We provide that service and expertise out into our estate and our ICB and provider organisations.

I will give an example. In Peterborough, an ICB we worked with quite recently were looking for about £1 million-worth of CIL rather than section 106 funding. We got involved. We understood the planning rules and managed to secure about £7.5 million.

Q39 Danny Beales: I will come on to section 106 and CILs shortly, but I wanted to know about the plan-making process itself.

Martin Steele: Town planning?

Danny Beales: In each area the planning authority will write its local plan, which dictates its policies for development, potentially with site allocation documents attached. It is quite an important document in deciding potentially where health sites may go, what sites may come forward to contribute to health provisions, or may need to. I am just trying to get a sense of how NHS Property Services and the NHS more broadly, in articulating their needs, are advocating for them in the local plan-making process, which is a crucial period of policy.

Martin Steele: Our team scans those documents as they are published almost on a daily basis to see where the opportunity is, and then our local team work with customers to see what the opportunity is and develop it. We commissioned a report two or three years ago by AECOM. It recognised that, more broadly across the NHS, frankly, they are not getting their fair share, because they do not have that level of expertise and have not been able to invest in it. So there is a massive opportunity, and we offer out that service.



Q40 **Danny Beales:** I appreciate that. Do you think there should be more formal engagement in the local plan process for health?

Martin Steele: Yes, I think there probably should be.

Q41 **Danny Beales:** Do you think ICBs and NHS Property Services more generally have a clear and articulated outline of their health needs in each local plan area? If I was a planning authority, would there be one document I could go to which would suggest the investment needs for health in that place?

Martin Steele: Every ICB has a clinical strategy and an estate strategy to help deliver that. That should be the source document in terms of what infrastructure is needed. It will help inform the discussion with local planners.

Q42 **Danny Beales:** Does it align with the local plan period?

Martin Steele: I cannot speak for the wider NHS. Certainly, in the engagement we have with ICBs across our own estate, we are absolutely looking to align that with local planning.

Q43 **Danny Beales:** The problem might be that the timescales that the local authority is working towards in planning and decision making, and the NHS and your decisions, are quite unaligned.

Martin Steele: Yes, I would say that there is a bit of a disconnect. Things seem to take a lot longer in both of those streams than we might readily want.

Q44 **Danny Beales:** Do you have any thoughts about how you can better align those processes?

Martin Steele: It is about earlier engagement to share a clinical plan with the town planning document, and bringing in specialist expertise to understand very clearly the processes that need to be adhered to in order to get what you want out of it. I think that, generally, there is not massive capacity—yes, I would say capacity rather than capability—and headroom in the system to be able to make the most of that area. It is what the AECOM report showed.

Q45 **Danny Beales:** Ruth, I think your report highlighted a misalignment in NHS, developer and local authority agreements. I do not know whether you have any comments or thoughts about what might need to change to address that misalignment.

Ruth Rankine: When we talk to our members, particularly ICBs, there is no nationally agreed formula for calculating what the needs are in the health service estate from a planning perspective. A lot of ICBs have developed their own tools, which look at existing space, void space and, therefore, the potential for new space. They also look at it in the context of urban versus rural, but essentially we are replicating that times 20-plus ICBs. We would say that there needs to be a nationally agreed formula.



Q46 **Danny Beales:** Something close to school place planning.

Ruth Rankine: Exactly. We said in our report that, in a similar way to when there are plans for a new housing estate and education needs are taken into account, the same needs to happen for health services.

Q47 **Danny Beales:** One of the challenges from local authorities is that, often in the planning process, they do secure provision and sites, but the NHS is moving at such a different pace and scale that those sites are lost. New health centres and GP centres are secured in developments as section 106 gains, but the NHS is not able to move at pace to take on and sign a section 106 agreement to rent that space or pay a service charge. Even quite nominal fees are sometimes secured.

Ruth Rankine: I think that is fair. Again, it comes back to what we said earlier about the time for the decision-making process. It is not just capital funding; it is revenue funding as well. You can build the building, but if you cannot staff it and fund the staff to be in it—

Q48 **Danny Beales:** Do there need to be more formal arrangements that bring together the planning authority and NHS decision makers in this space?

Ruth Rankine: Absolutely. That should be the role of the ICB, working with the local authority, but then it goes back to Beccy's point. With a 50% cut to ICBs, we are seeing significant loss of ICB capacity and expertise on the estates.

Q49 **Danny Beales:** Turning to section 106 and CIL, Martin, do you have a sense as an organisation of how much CIL and section 106 that can be utilised for healthcare at the moment is unspent?

Martin Steele: I am not sure I know the exact figure. I can tell you that our organisation has a pipeline across our estate of about £60 million that we are tracking to try to secure on behalf of the NHS. It will be much bigger across the rest of the NHS. As I said before, the education sector seems to get access to quite a lot of CIL and section 106, unlike us. It is just more evolved or mature in how it attacks that. I think there is an opportunity there for the NHS to get together more.

Q50 **Danny Beales:** One of the frustrations in my own community is unmet GP need and investment in the primary care estate. I have met pharmacists who want investment in order to have consulting rooms, and hundreds of thousands of pounds of health section 106 is unspent at the civic centre in the same community. It feels like there is a misalignment.

Martin Steele: That is understood, and that is exactly what our team is doing: securing those funds across our own estate.

Q51 **Danny Beales:** Do you think there is enough transparency on section 106 and CIL funding, what is available and the conditions under which it could be allocated?



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Martin Steele: I need to come back on that. I know that our teams have a pretty good view of what the future pipeline looks like in our own areas, although not necessarily across the entire NHS footprint—I cannot answer for the broader NHS.

- Q52 **Danny Beales:** The information we have received suggests that £148 million for health and social care infrastructure in the system is currently unspent. That is not insignificant. You talk about £60 million being accessed, but bearing in mind the level of unmet capital investment need and the ambitions about neighbourhood health, it feels like quite a bizarre situation to be in. There is money in the system that is unspent.

Martin Steele: Agreed.

- Q53 **Danny Beales:** Does anyone else on the panel have any thoughts about how that might be better unlocked?

Beccy Baird: As we have said, in part it is revenue funding. Because funding is agreed annually for the NHS, it is hard to commit, particularly for community services which have their contracts retendered regularly. To commit to a long-term, 20-year lease when you do not know whether you will have revenue funding is quite a risk, so that does have an effect.

The other one is that it is quite hard to access money for revenue funding until the people have moved into the new estate, rather than it being built; we have heard that a lot. Although there is a need and pressure on surrounding GP practices, until there is a critical mass of people, the ICB does not have the money to invest in a new GP practice. There is no upfront pump-priming of that space, so it is hard to build it pre-emptively before people move in. 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. They are independent businesses; their cash flow is incredibly limited, and their ability to pay their own staff and to have cash flow to do development is very tight, so they are incredibly sensitive to any changes like that. That does harm.

I have also heard, although I would need to go back and find more detail, that where section 106 money is tied to very small developments, it is much harder than it is attached to large housing developments.

Ruth Rankine: Beccy's point on sensitivity around small practices is absolutely true, yet at the same time we have seen many GPs take on personal loans to expand their premises because they can see what is happening. They can see a new housing estate being built with no facility for additional medical provision, so they know they will have to expand their premises. Quite often, they do that by taking out personal loans. There is recognition of the need to support small businesses, which can equally be community pharmacies. But I emphasise what Beccy said about long-term contracts: so many of the contracts in the NHS are



annual ones, and nobody is prepared to take that risk in terms of revenue when you do not have the surety of contract.

- Q54 **Danny Beales:** If the system were able to use some of that capital funding to switch to provide security in terms of revenue-based pressures over a set lease term, would that help in the system? At the moment, technically CIL is capital funding, but there are examples of some being used to subsidise revenue pressures in other service areas.

Ruth Rankine: As long as it is not a short-term measure, because you just cannot invest for the future if you are unclear that the funding will continue.

- Q55 **Danny Beales:** Very few contracts or funding pots in any Government areas give funding security for 20 years. Spending review periods are three years. This is not a unique challenge. Why is the health system so hesitant and cautious in this space, where perhaps others in the public sector are not?

Martin Steele: I may be incorrect—I will need to check—but I am pretty sure there are certain Treasury rules about converting capital into revenue spend. That is quite a big barrier for us as an organisation. In the commercial sector you would quite easily convert capital to revenue, or vice versa. That does not happen with us. That could be one of the barriers that needs to be looked at.

Beccy Baird: This is not my area of expertise at all, but I know that CDEL limits also place a real burden—there is real difficulty in investing, because of the national CDELs and the limits on capital spending.

- Q56 **Chair:** I am literally about to come on to all those issues. Picking up the theme of money, I am sure you would all agree—I do not know whether it was Martin or Ruth who referred to this—about shared accountability and the fact that budget flows do not necessarily go to the places they need to as quickly as possible. That is one issue. We identified a number of areas that need reform: under-investment is understood; capital approvals, which we have just mentioned; expenditure limits, which the Darzi review spoke about at some length; capital transfer rules, which you just mentioned; and budget disconnect, such as misaligned incentives and budget flows.

Beccy, coming back to your point about GPs, perhaps I might ask for some advice. In my area, a local GP practice wants to set up on a new site. The local council owns the land and wants to redevelop it at the same time. Everyone is aligned on the obviousness of why this needs to happen. It is an old, crumbling Victorian building, and it is not accessible. We have 5,000 new homes being built around it, so there is some money floating about, but not enough for the multimillion-pound rebuild that will be needed to expand the practice so it can meet the needs of the future population.

We are stuck, in part because of the district valuer calculation of how



much the rent charged to the GP practice should be, which of course the ICB would then go on to reimburse. What the district valuer says that site in north Oxford—not a cheap part of the country—is worth is much less than market value, and that is causing an issue. How do we fix problems like that? Everyone is agreed this is the right thing to do. Everyone can see that in the medium and long term this will save money and improve access to neighbourhood health services, yet we cannot do it because of this rule. It feels as though we cannot overcome it. What do we need to do to fix this, Beccy?

Beccy Baird: There are lots of those kinds of rules floating around, particularly around an estate, which feel intractable. My personal view is that it would be great if Government focused on those rules, as opposed to some of the local detail. I do not know enough detail about district valuation, but I hear it complained about in almost every meeting I ever go to about a neighbourhood estate. There are delays in district valuation, and there are issues with its outcomes. It feels like there is a real issue there that it would be really important to investigate.

There are also rules around rent reimbursement, which is part of the national GP contract. We came across the case of a GP practice which had a branch surgery it did not really need. It wanted to give that branch surgery to district nursing colleagues to have a nursing base and 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. It would lose money by giving that building over to providing other services.

Those rules do not seem to me to be unfixable, yet they get in the way of so much of this work and stop that kind of local development. GPs themselves often take a lot of personal risk to build new practices and take on those mortgages, yet we put in lots of difficulties around how they are then paid for that.

Q57 **Chair:** Ruth, do you have examples of other niggles like that that we need to point the Government to?

Ruth Rankine: Like Beccy, when we talk about estates with our primary care members, GP rent reimbursement is probably No. 1. If you look at Whitstable—I know the Committee heard from John Ribchester—it has at personal expense built a building which to all intents and purposes is a neighbourhood health centre. It has left-shifted services; it delivers day surgery, lots of out-patient clinics and voluntary services, but it is not being reimbursed to the extent that it costs for housing those facilities. As with a lot of things, we have a short-term focus on what things cost now, without really understanding the long-term financial benefit and what we will save in the long term.

Q58 **Chair:** The 10-year health plan talks about five-year capital budgets for ICBs. I imagine you would welcome that move. Is five years enough as a horizon? Will that make a positive difference? If it is going to make a positive difference, what needs to be in place around it to make sure that



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money is spent well?

Martin Steele: It will definitely make a positive difference. We do welcome it. It could be a longer time horizon, and that might be even better, but five years ought to deliver a significant benefit. From our perspective, what needs to be around it is an estate plan that meets the needs of the clinical plan.

Q59 **Chair:** What will it mean in practice to have five years instead of what it was before? What will it actually change?

Martin Steele: You are able to plan for and agree commitments with either practices or commercial landlords further down the track, and therefore you get a better deal and better negotiation. From our perspective, we do not have a massive issue on rent reimbursement of GPs, because they get reimbursed. It may be a policy decision that gets in the way in terms of the district valuation. That is something we cannot change, but it should be reviewed. From our perspective, it is the non-reimbursable costs which give rise to challenges in our practices. The cost of service charges that are not reimbursed comes out of the practice budget, and that is where we find the biggest difficulty.

Q60 **Chair:** Can you give some examples of those charges?

Martin Steele: We provide cleaning or maintenance services to a GP practice. The GP practice has to pay for that; it does not get reimbursed. Why does it not get reimbursed? Those are some of the challenges we have. The rent will always be reimbursed.

Q61 **Chair:** In the financial or capital framework, what else would it be helpful for us to be pushing Government to change? This is your chance. Go on. Rant away.

Ruth Rankine: The main thing we have heard from our members, ICBs and trusts, is that if there is any capital underspent in one year, it cannot be carried forward into the next year; it has to be spent in-year. It is great to have a five-year capital framework. As Martin said, it would be great if it was longer. Again, it comes back to that lack of flexibility in how you use the money. We go back to the timescale for decision making and so on, which impacts on your ability to spend what you need to spend in that year.

Q62 **Andrew George:** We heard about a lot of the impediments and difficulties you have in developing a neighbourhood health estate. Are there any examples of good practice that you know of around the country where communities have navigated their way through the impediments you identified in terms of unused CIL money and delivering precisely what a community needs in a timely fashion that ticks all the boxes? Or does the inertia in the system mean that we are unable to deliver this and that we have to shrug our shoulders and try to carry on?

Martin Steele: I do not think so. We have lots of good evidence of very good practices. A recent example for us is probably Chiswick, and I could



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quote Whitby as well. Chiswick is an example where we took pretty poor healthcare facilities, hived off half of that land and developed with the local authority affordable homes earmarked for NHS workers. There are 55 homes. Half of those are now occupied by NHS colleagues. The other part of the site was redeveloped into a community health centre.

Q63 **Andrew George:** This is your development.

Martin Steele: Yes.

Andrew George: That is your development arm.

Martin Steele: Exactly right. Then we do the construction project management on the back of it, and then we deliver services.

Q64 **Andrew George:** On local authority land.

Martin Steele: Yes. That is a good question. I think it is right. The property is owned by us but is sitting on local authority land. That is how it works. That is one example.

Devizes is another one. Lakenheath, near King's Lynn, is a great example of a modular build delivered at pace. I think it took us just 12 months to deliver a new facility with a prefabricated unit on site. That was done in a very short period of time and at a very good price point because it is using modern methods of construction. There are lots of these all over the country. That is what we are building into our design and delivery programmes.

Q65 **Andrew George:** Are there other communities that do not involve yourselves that you have seen elsewhere? Ruth or Beccy, do you know of others? Martin, you are talking about your own organisation, but you are probably aware of others. Ruth and Beccy may be more aware of where there is good practice.

Ruth Rankine: I have pages of examples in front of me which we can send to you afterwards.

Andrew George: You have, good; okay.

Chair: Send them in.

Andrew George: Please send them in.

Ruth Rankine: In Chesterfield, there is very much a voluntary sector partnership. There is the example I mentioned in Keighley, in Yorkshire, where they brought together different partners and rented the commercial space. It is voluntary sector led. In Herefordshire, the GP federation had bank loans against business reserves and purchased a building. In that building they have consulting rooms, training facilities and social spaces. They are working with the community trust to put in community response teams. They have diabetic services.

Andrew George: There are good examples.



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Ruth Rankine: That is about responding to what that population needs and saying, "How do we provide that in the community?"

Q66 **Andrew George:** In many circumstances there will be an external organisation, say a community organisation or village hall. The Committee will be visiting west Cornwall next week and will see an example where a community CIC has delivered a building it leases to a GP practice: Cober Valley Health. It is a brilliant building. Is there a benchmark for rent levels? Are the benchmark levels generally known? The Chair referred to problems of a district auditor coming up with the wrong figure. Do you notionally have clear ideas as to what the outturn should be in terms of lease rates?

Martin Steele: We are meant to charge market rents driven by the district valuer. The reality of where we find ourselves is that we have not moved those rents forward since 2016-17, so we are probably behind the market on market rents, but it is a policy decision. We follow that valuation process.

Q67 **Andrew George:** A lot of communities are concerned if NHS Prop Co own the building, because they fear that at some stage it might be sold and that money would then go to the centre, whereas if it is locally owned at least they can recirculate the money.

Martin Steele: Exactly.

Q68 **Andrew George:** Has that arisen, or have you been able to reassure a community that the benefit of that asset, particularly where local people may have raised money towards it, should remain in the community?

Martin Steele: It is definitely an issue that has been raised in the past. We do not just sell properties willy-nilly; it is when it is declared surplus, and we have a very clear mandate to get the best value for that back into the system. Historically what used to happen was that that money would come into the centre, as you rightly say, and would be used in another part of the country where it was deemed most needed. Over the past two or three years we have moved to a position where 50% of the disposable receipts go into the local community. When there is a sensible plan that we can stand behind, we will say, "Let's put in 100% of it." We are moving with that policy now. Our recommendation, which I think is in place now, is that 100% will go back into the local community.

There is a challenge in that regard. Properties in central London will have a different value from what they would in the north-west of England. Therefore, how do you get the capital proceeds spread more evenly and fairly across England? There are some challenges with it, but that is definitely the direction of travel. We work with the local teams to say, "Let's reinvest; let's consolidate. Declare it surplus if you can, and we will dispose of it and give you back the proceeds."

Q69 **Andrew George:** Moving slightly away from the estate and buildings themselves, you described earlier, Beccy, what neighbourhood health



might be deemed to be: preventing people, effectively, from going into hospital. So far no one has talked about the role of the private sector; in other words, nursing and residential homes, and private care providers in people's homes. To what extent do they have a role across communities in serving this particular purpose?

Beccy Baird: On neighbourhood health, the best example I have is hospice services, which is less independent sector and more voluntary sector, where they often have really well-located community buildings well loved by the community. We have seen great examples where they are delivering chemotherapy services from hospice sites, which has all kinds of benefits to patients. I have not had as much experience with nursing homes. It has not been a big feature.

Ruth Rankine: There is a contract with primary care networks to respond to the needs of nursing homes, and there can be significant demand from nursing homes into A&E for people who really should not be in A&E. This comes back to the clinical service delivery model around older people or around frailty. When you are thinking about the cohorts who fit under the frailty category, you are also including people in care homes or in nursing homes, and therefore those staff have to be involved in how much they can manage those people in the nursing home without a referral.

One thing I should have said around neighbourhood health and care closer to home is that it starts at home. It is about how we keep people well at home for as long as possible, and that may involve some of the services that you are talking about—voluntary sector or private sector at-home care services. That is absolutely critical in terms of joining things up, irrespective of where patients are, so that their needs are met.

Q70 **Andrew George:** Addressing the issue of delayed discharge from hospital, I am aware that in many parts of the country there is spare capacity within the nursing and residential care home sector, but the commissioners are not keen to discharge there because they deem that the sector is not particularly good at reablement. Therefore, once people go in, they don't come out. Is there anything that can be done to better utilise what appears to be spare capacity as a step on the way to home, as it were, to at least begin the process of discharge?

Ruth Rankine: Absolutely. The discharge process is a whole component around how we reduce waiting lists and waiting times. If patients are ready to leave the hospital but are still in a bed, that impacts further down the system. We have to look at this in the round. We have to look at all the capacity that is available. In some neighbourhood teams, they have step-up and step-down facilities; some of those are run by GPs and some by community services. They are preventive. You might have someone who cannot stay at home but does not need to be in hospital, and who needs a level of care that can be provided by an intermediate care facility. Similarly, if they cannot be discharged home, they need a level of care so that they can step down into intermediate care.



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Q71 **Andrew George:** I understand that, but is anything being done to better utilise the available capacity? That is the question.

Martin Steele: It is part of the clinical social care plan that should be built by the commissioning authorities. I do not think it is anything that I can particularly comment on, but I would expect it to be part of that wider clinical and social care plan.

Q72 **Jen Craft:** I wanted to briefly circle back to non-reimbursable charges. It will probably be no surprise that I have an issue in my constituency with some GP practices. Their issue relates very much to historic service charges to NHS Property Services. You seem to be implying that it is more of a decision, potentially, for the Secretary of State or a Minister as to whether those charges could be written off or changes could happen.

Martin Steele: I did not mean to imply that. If I did, I apologise. In terms of the service charges, we are tasked with operating on a full cost recovery basis. We charge our practices for the services they take. They can provide their own services, and we will help them move to another service provider if they want to. There is no question about that. They are not contracted to us, so we can do that. It is an affordability question, and it goes back quite some way, probably to 2015-16, 2016-17 and the discussion about subsidies that was referenced earlier on. We work with those practices to itemise, in a lot of detail, the service charges we make. Very often the end of the conversation is, "Look, I understand that, NHSPS. I see that perhaps it does represent value for money, because I don't want to go somewhere else, but I'm still not able to pay it because I'm not getting reimbursed for it." That is a challenge.

Q73 **Jen Craft:** Over half a million pounds of historic service charges is not affordable for most GP practices.

Martin Steele: I would not disagree with that, if that is really historic. In the early days of this organisation, it got off to a very difficult start, and our data was not in great shape. You could argue that we should have got better sooner. We are in very good shape now. We understand our estate charges intimately at a property level. If this is historic debt, we aim with our practices to agree a go-forward position based on what it is going to cost going forward. You can take it from us or someone else. Can we then agree a lease with you if there is not a formal lease in place? Then we can do something sensible on historic charges that go back a long way. The challenge we have is in getting that go-forward position. That is one of the hurdles that we have to work hard with.

Q74 **Jen Craft:** It just seems to run counter—I have an historically under-GP'd area—to be faced with losing a GP practice due to levels of historic debt. Do you think writing off that kind of historic debt is feasible or ideal, or something that should not be looked at?

Martin Steele: We have written off historic debt. We write off historic debt and we do a settlement agreement based on having agreed what the go-forward position is. We have a document—a lease—in place and



everyone is happy to pay for value-added services. If we cannot get to that point and it is unaffordable going forward, all you do by writing off the debt is build debt going forward, so we have to have that agreement up front.

Chair: I am afraid we have to move on.

Q75 **Andrew George:** I have a very quick yes/no question. How much of the PFI legacy estate is on your books, or is it all held by ICBs?

Martin Steele: No, we have 26 PFI properties, and I am proud to say that we manage them very effectively. When they come back to us, they are going to be in condition B.

Chair: Thank you so much all three of you for your time. We really appreciate it. We are going to move on to talk about things like PFI in the next panel. Thank you very much.

Examination of witnesses

Witnesses: Dr Hellowell, Barry White and Lord Hutton.

Q76 **Chair:** Welcome to our second panel, where we will move swiftly on to the issue of PPPs, PFI and all the rest of it, and try to get to the bottom of some of this. As with the last panel, could you please introduce yourselves and which organisation you are part of, starting with Lord John Hutton, please?

Lord Hutton: Thank you. I am John Hutton. I chair the Association of Infrastructure Investors in Public Private Partnerships. We represent most of the companies that have significant investments in PFI.

Dr Hellowell: I am Mark Hellowell. I am a researcher at the University of Edinburgh. I have done research over many years on PFI and PPP, both in relation to the UK and internationally.

Barry White: Good morning. I am Barry White. I chair Infrastructure Managers Ltd. I am also a board director of Scottish Water, and I sit as a publicly appointed board director on some PFI/PPP-type concessions, but I am here today in an independent role because I was the co-author of the White Fraiser report. All my views are given in an independent capacity.

Q77 **Chair:** Much appreciated, thank you very much. We will start with a few questions about the evidence for the efficacy of PPP. Perhaps, Mark, I could direct this one at you. There have been meta-analyses done. As we know, the history of PFIs was that the last contract was signed in 2015; in 2018 the then Chancellor, Philip Hammond, said that PFIs would no longer be used; and now they are being introduced perhaps in a slightly different form. We want to understand where the opportunities are but also, going forward, to be clear-eyed about the pitfalls.

Mark, what is your understanding of the evidence base for how well we



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understand PPPs? Linked to that, how well do you think Government understand the evidence base for the pros and cons of PPPs?

Dr Hellowell: Inevitably, it is a very complex question. PFI/PPP is a complex phenomenon. There are all sorts of benefits, costs and risks, and netting all those out is quite a challenging task. Here is how I would think about it.

First, although in many ways the fiscal or budgetary benefit of using private finance rather than public capital is illusory—in the sense that it stems from the accounting regime and the way that you budget public spending and represent borrowing in the national accounts—none the less it has been real. If you are the Secretary of State for Health and Social Care, from your perspective it looks like using private capital gives you a relaxation of your capital budget. Many economists, the IMF and the World Bank would say that, at the international level, that benefit is illusory. From a pragmatic point of view, it is real. The question then is: is that beneficial? What might be some of the costs and risks of that?

On the benefit side, it meant that over a 20-year period the UK was able to deliver a lot of healthcare infrastructure that in other circumstances may have been very difficult to deliver. The Treasury, as we know, is not necessarily minded to provide a capital budget that would allow you to deliver 100 new hospitals, say, which is what we achieved in the UK. Maybe you would say from an economist's perspective that we had suboptimally low levels of capital spending in health, and with PFI/PPP we were able to move closer to where we would like to be. We were able to get around those capital budget constraints and invest in what had previously been a very physically denuded healthcare estate.

On the other hand, from that point of view, we need to bear in mind that, where you have a PFI/PPP monoculture, so that it, is in the old phrase, "the only game in town", you can have a situation where the sorts of projects that go ahead are those that may not be optimal from the health system perspective but that may be the most bankable from the investors' perspective. This is a risk that we have seen in the UK and in many other countries around the world, whereby what makes sense in terms of the model is that large construction, large projects and greenfield construction are the more bankable projects. Other types of projects that may make the most sense for the healthcare system—maybe smaller scale, refurbishment, making use of existing estate—are more difficult to do under these traditional PFI arrangements.

From an economist's perspective, from an allocative efficiency perspective, there are pros and cons. You get more capital. Probably that is good. In the NHS, we spend probably about half as much on capital as other, comparable healthcare systems. At the same time, you do not want this "tail wagging the dog" phenomenon, whereby what we do is what makes sense for the model, not what makes most sense for the UK.



Bringing that home to something like the neighbourhood health centres, the danger is that if you are saying that, essentially, for new builds we do 20% capital, 80% PFI, or something like PFI, does that mean we are slightly distorting the assets—the investment decisions, if you like? We have a financing decision about whether we use private capital or public capital, but, in so far as private capital really is the only game in town for most of these schemes, is that going to exert some kind of influence on what we actually build?

Q78 Chair: The Public Accounts Committee in 2025 found that there is no central record of PFI investment, which means that the Treasury does not have its own sense of value for money because it is not able to compare them all together. As a researcher in this space, what do they have to do to be able to make some of these judgments? Are they just collecting all the different examples and pulling them all together? Do you not think it is a problem that Government do not know and are not able to compare?

Dr Hellowell: One thing that is definitely true from a researcher's perspective—this is also a point that Committees and the National Audit Office have made in the past—is that it is very difficult to do a satisfactory value for money comparison. The only way you could really do that is to have some kind of natural experiment going on whereby you have similar types of projects delivered conventionally versus through PFI/PPP. That tends not to happen in practice, because where you give a Government Department the ability to deliver through private finance, they tend to do that because there is a short-term capital budget constraint relaxation. You rarely have a situation, either in the UK or in an international context, where you have similar types of projects being delivered under different procurement arrangements so that you could do that kind of comparison.

Chair: Not ideal.

Dr Hellowell: Where have we got to? Realistically, we have come to the view that doing that kind of value for money analysis across procurement routes is probably not possible. We know, theoretically and empirically, that private finance is associated with a number of benefits, costs and risks. Netting that out so that you could do that kind of comparison is very difficult. Where I ultimately ended up in my own research was thinking through not so much whether PFI/PPP is better value for money than a public procurement, but whether there are aspects of the model that look like they are bad value for money that we could try to address. From a more constructive point of view, thinking about the neighbourhood health centres, if we are going to use private finance for most of those, there are things that we can learn from the PFI experience. We could say about the PFI experience that there are aspects of bad value for money there.

Chair: I do not want to pre-empt future questions that are likely to come on to this.



Q79 Danny Beales: What is your judgment about the benefits of the lower cost of public borrowing that generally could be secured compared to private resource borrowing, versus other financial considerations such as the speed of delivery and inflationary pressures, particularly in the construction sector? Do you have any sense from the evidence about which of those is outweighed in the system by using PPPs versus public sector schemes only?

Dr Hellowell: This is the nub of the issue. I should be honest: I do not think that, as a research community, we have fully resolved that question. Clearly, from a strictly financial point of view, there is a disadvantage of PFI in the sense that you have equity investment and you have debt investment, and the combination of those two things is definitely more expensive than Government borrowing. The gilt rate might be 4%. The internal rate of return on the combination of equity and debt might be something like 7% to 9%, depending on market conditions. There is an element of additional expense there. The question is: do you offset that from a value for money perspective through some of the disciplines that you bring to bear through PFI or PPP? You have a fixed cost, largely. You have quite powerful incentives to deliver a good building that will last for 30 years or whatever the period of the contract—

Q80 Danny Beales: Is there comparative data on the speed of the delivery of the PPP projects versus the purely public sector projects?

Dr Hellowell: There are two aspects to that. One is: do you actually get projects done? With private finance, the historical experience is fairly clear that you deliver more projects because you are relaxing that capital budget constraint. When we think about the experience of delivering a transformation of the acute care infrastructure in the UK, it is quite difficult to imagine that that would have happened exclusively using public capital. It never happened before.

Q81 Danny Beales: I take that caveat that it did certainly move projects forward that would not have moved forward. Even if you had set the barrier at planning permission—and not conception or design of projects—to finish and completion and handover, is there any data comparing public sector funded projects versus PPP projects on that, to gauge what delivery cost inflation pressures might be in the system?

Dr Hellowell: Yes, there is very good evidence, which is quite well known, that PFI schemes tended to deliver better performance in terms of cost and time overruns than public procurement, although the caveat to that is that, in a sense, it probably depends on where you draw the line. If you draw the line at the point at which contracts are signed, it looks like PFI did very well, and that would be expected because you essentially have a fixed price. If there are cost and time overruns, the risk is with the private sector. It is not so surprising that the private sector tends to deliver on time and to budget more often under PFI arrangements than public procurement. There is a cost to that. These are



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fixed prices, so they are higher prices, because the private sector needs to build in that risk buffer so that if things go wrong, they are not exposed to significant financial losses.

- Q82 Danny Beales:** Does that take into account the time delivery of public sector projects? With the new hospital programme, 40 hospitals pledged by the last Government, I think one was built and maybe a handful of others are slightly in the process of delivery. My own hospital did not even have a business case signed off after 14 years. The project was originally budgeted at my hospital in Hillingdon at £700 million. This Government have now funded it at last for £1.4 billion. That is huge; it is potentially two hospitals-worth of money from 14 years ago. Is that kind of inflationary pressure in the system—the time it takes for a Treasury business case to be signed off and the pressures on the public capital budget, which may lead to slightly slower delivery—and that lost potential assessed in the system?

Dr Hellowell: I think that is unarguable. When Government Departments have been able to make substantial use of private finance, decision makers have had greater certainty, and that has meant that they have been able to move forward with projects more quickly. I do not think we have ever seen historically the level of capital investment that we had between, let's say, 1997 and 2010 in the healthcare estate, and in large part that came through PFI. It would have been very difficult for the Treasury to sign off on investment of that scale. It would not have been impossible, but it is just not the way the Treasury tends to do things.

- Q83 Danny Beales:** Your model comparing borrowing costs looks very much at private sector borrowing based on a repayment model over time. There are obviously other types of public-private finance initiatives or partnerships in the development sector, some of which use asset exchanges. On large hospital sites or large public sector sites, there is often opportunity for housing development, which involves assets that could pay back private sector investment. Have you looked at different sorts of finance models, not just a "build a hospital, build a facility and lease it back" arrangement? There are different financial risks, incentives and costs involved in different sorts of public-private models.

Dr Hellowell: I have not. On the other hand, some of those sorts of transactions were embedded within PFI schemes. In Edinburgh, the sale of the old Royal Infirmary of Edinburgh was part of the big PFI scheme. Those sorts of deals were embedded within the broader transaction, and they were largely designed to try to manage the affordability constraints.

One of the real challenges that we should mention here in relation to the PFI experience is that it created very substantial affordability challenges; those had to be managed, and often they were not managed very well. The long-term revenue cost was higher for hospital providers in PFI buildings relative to the rest of the estate. They had that funding disadvantage, and for many trusts that had significant implications for



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their ability to remain solvent and to maintain the capacity to deliver good services.

That is another thing that we need to think about. If you are going to deliver large amounts of capital investment through PFI/PPP or similar arrangements, you get that relaxation of the capital budget constraint, but there is a long-term cost to that, and that needs to be managed properly. The higher costs to the health authorities, trusts or whoever it is that are part of those deals need to be recognised and subsidised. The failure to do that can create some inequities.

Chair: We are about to expand on this theme with Ben Coleman.

Q84 **Ben Coleman:** To begin, what is the difference between PFI and PPP?

Lord Hutton: PFI is a form of public-private partnership. Public-private partnerships include NHS LIFT schemes, which are constructed in a very different contractual framework, with the NHS having significant equity positions in the investment. PFI was a moment in time in the PPP history and journey in the UK. Following what Mark said, we have learned quite a lot of lessons from that PFI experience.

Q85 **Ben Coleman:** You are saying PFI was one form of PPP. How would you categorise that? How is it different from all the others?

Lord Hutton: How would I characterise PFI?

Q86 **Ben Coleman:** You said it is one form. One form of what? Can you say in one sentence?

Lord Hutton: PFI was a complex contractual framework. If you look at other jurisdictions such as Canada, Australia and across Europe, you see quite different models of PPP. There are different contractual frameworks. PFI was the name given to a particular contractual framework that was a model of PPP.

Q87 **Ben Coleman:** Thank you, that is helpful. Mr White, would you like to comment on that?

Barry White: I broadly agree with what Lord Hutton just said. PPP is a big umbrella term. PFI was one model within that. NHS LIFT was another model within that. That is a joint venture structure.

Chair: We are going to come to specific questions on LIFT in a moment.

Barry White: There is a range of different models. A lot of joint ventures between the public and private sector would fit under that broad public-private partnership. Some of the development partnerships that the previous question touched on fit within that as well, like the hub programme in Scotland. A public-private partnership is a big umbrella term. PFI is one element of that that was a particular structure at a moment in time.



Ben Coleman: You have done a lot of work in this area, obviously. What do you think are the most important lessons from PFI when it comes to designing PPPs to deliver the neighbourhood health scheme infrastructure that we have been talking about?

Paulette Hamilton: You are asking the wrong questions.

Ben Coleman: Am I asking the wrong question?

Paulette Hamilton: You are asking my question. I was going to put it out there.

Ben Coleman: We are just going to confer among ourselves to give you more time to think about the question.

Chair: Carry on.

Q88 **Ben Coleman:** Paulette has the pleasure of rounding off the session. What I really want to talk about are the lessons from PFI and where we go from here. We are talking about delivering neighbourhood infrastructure. What are the specific lessons that we need to learn from PFI?

Barry White: Can I rattle through 10 really quickly?

Ben Coleman: Yes, you can. I have enjoyed reading your report.

Barry White: The first one is trust. I would have a public sector director on the board of one of these new bodies that is delivering these projects and/or an independent chair. That gives a lot more transparency.

The second one is to embed data transparency as part of the original project so that there is a shared set of data between the public and private sector.

The third and fourth ones are both flexibility. What Mark said is quite right: keep the scope very simple. Do not add in things like surplus land; keep it as hard maintenance only. The second bit of flexibility is to make change mechanisms work much better. Really make sure that the work is done with funders up front to keep flexibility, so that variations can go through much more easily. That flexibility of changing buildings is really important.

The next lesson—the fifth one—is a strong operational capability in the public sector, with a central team supporting the procurement and operations.

The sixth one, which overlaps with what Mark said, is an ability to put a programme together so that you have a series of investments that benefit from a pipeline of work where efficiency can be driven through.

Then there are four slightly technical ones. There is the life cycle being kept at a special-purpose company. Rather than being outsourced from



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the special-purpose company that is set up, keep the life-cycle spend, the big maintenance items, as part of that special-purpose vehicle. That means that the ownership of the condition of the asset is the responsibility of the directors of the company, and that changes the dynamic.

The eighth one is to be very clear and hand back what you want to hand back, and any scope for improving that with technological enhancement.

The next two are to be really strong about commissioning an independent certification and about the role of a clerk of works during construction to make sure that there is good oversight.

And, finally, have a better dispute resolution process. One that gives better information to the public sector would make a more balanced dispute resolution process possible.

Q89 Ben Coleman: That is very helpful. I would like to come back on some of those. I just want to get other witnesses' views as well on what the key learnings from PFI are.

Dr Hellowell: I will probably speak at a much higher level here than Barry has just done—less in the weeds, as it were, on a day-to-day level. The key question is: how can we make sure that you make use of private finance in a way that helps us to deliver the kind of infrastructure that we really need, at a reasonable cost and at a high level of quality over a long period of time? If you are talking about traditional PFI schemes, it was often 30 years or more.

There are some difficulties and challenges implicit in doing that. I mentioned the issue of not allowing the financing tail to wag the investment decision dog. This programme that we are thinking about today is an incredibly important one, with a potential to transform service delivery within the NHS, in my view, in a favourable direction. These ideas of getting care out of hospital, having care in the community, supporting digitalisation and so on are definitely positive things, and we want to make sure that the investment decisions we take are those that will drive forward that reform.

Q90 Ben Coleman: I would like to interrupt you. We are discussing the benefits of the neighbourhood approach. What is it that makes you think that there is a danger of the financing tail wagging the public policy dog, to use your analogy? What makes you think there is an actual danger of that?

Dr Hellowell: It is based on empirical experience both here and elsewhere in the world—that what gets done—

Q91 Ben Coleman: What has happened here that makes you think that?

Dr Hellowell: What gets delivered are projects that are bankable, which means that they are acceptable to equity investors and, in particular,



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debt investors. When it comes, for instance, to the acute care infrastructure programme that we delivered over 15 years or so, we might have had a different allocation of capital to acute care relative to other parts of the health service. We might have had a different allocation of capital to greenfield construction projects, new build construction projects, relative to refurbishment or use of the existing estate, had we used a different procurement model.

Q92 **Ben Coleman:** I am going to put words in your mouth, and they may be the wrong ones. We used a procurement model that said we can get money for this, and therefore we should do that, because it is easier to get money for this than to do something else. Is that what we did, or am I misunderstanding what you are saying?

Dr Hellowell: I think we did that. It is quite hard to demonstrate—

Q93 **Ben Coleman:** Why did we do that?

Dr Hellowell: Because it is the only game in town.

Q94 **Ben Coleman:** Are you saying there is no future for PPP that is based on starting with the outcome that you want to achieve? It is always going to have to be adapted, twisted, whatever you want to say, to what the market will actually stump up for.

Dr Hellowell: No, I do not think I am saying that. What I am saying is a bit more constructive, which is that we need to be aware of the risk. The planning process needs to begin with what kinds of services we are trying to deliver and how we are trying to change the delivery model.

Q95 **Ben Coleman:** Did that not happen previously?

Dr Hellowell: I would argue that it did not happen previously.

Q96 **Ben Coleman:** Why do you think that? I am really genuinely interested in this. It is very helpful to have the high-level view, and I am getting a bit granular here, but it is helpful to have the granular. Why did it not happen previously? Maybe Lord Hutton would like to comment on this in a minute after you finish, Dr Hellowell. What was it about the relationship between the public sector and the private sector that meant that that did not happen the way you think it should have?

Dr Hellowell: I come back to this issue of a bankability criterion being different from a health systems case. We have a health systems case. This is the kind of infrastructure that we need because this is the kind of service we need.

Q97 **Ben Coleman:** Did they not set out the health systems case? Fortunately, I think I now understand the broad point. If that was the case, you need to make the health systems case first and then everything flows from that. Did that not happen 15 years ago?

Dr Hellowell: I think not.



Q98 **Ben Coleman:** Lord Hutton, do you want to comment on that?

Lord Hutton: Yes, I would like to comment on that. I agreed with much of what Mark said in his analysis of PFI. I do not agree with his view that there is a material risk of the tail wagging the dog. There is no evidence for that. Remember that all the PFI projects that were completed in the first 10 years of the last Labour Government were NHS planned and delivered. They were conceived within the local NHS. They reflected the NHS's local priorities for refurbishing the capital estate. I was the PFI Minister for much of that time. It is the job of Ministers to ensure that the tail does not wag the dog. The private sector will build the projects that the Government ask it to build. It is not the other way round.

Q99 **Ben Coleman:** Absolutely, and that is what I would have thought would be the case. When, Dr Hellowell, you say that there is evidence that this was not the case, what are you thinking of particularly? Are you thinking of any particular PFI projects?

Dr Hellowell: Yes, I agree with Lord Hutton that it is the job of Government and regional and local health authorities to determine what they want to do, the investment decisions they want to take, and there is a whole business case process that they have to travel through.

Q100 **Ben Coleman:** I understand that. I am going back 15 years where you say there was evidence of the tail wagging the dog. I am asking you to give us some evidence.

Dr Hellowell: I suppose one aspect of the evidence might be that, if you track through a business case cycle from the very early stages of planning through to the final business case and the project that actually gets signed, you will often find that you move from a partly refurbished project through to something that is much more like a greenfield construction new build.

Ben Coleman: If you do not want to go into any more detail, just let me know. You are still talking in generalities, which makes sense as an approach and I appreciate that, but I am asking for evidence. You said there is evidence—Lord Hutton says it is not the case—that the tail was wagging the dog, and I am asking for some evidence.

Q101 **Chair:** Do you have papers or case studies that you could send us afterwards perhaps?

Dr Hellowell: Sure. I do not want to overstate the quality of the evidence base. In some ways, it is quite difficult to know how individual decisions were taken and the rationale for those decisions. My point, I am hoping, is a more constructive one, which is that there is, straightforwardly, a danger that if you have a model—

Q102 **Ben Coleman:** We have got that. That is very helpful, thank you. Lord Hutton, going back to PFI and the problems that there were initially, what do you think we can really learn from your experience? Looking back at



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what you did then, what would you advise people to do differently now?

Lord Hutton: I would advise them all to read Barry's report. That absolutely nails—

Q103 **Ben Coleman:** It is very interesting that you say that. I asked the two previous witnesses we had on that, who were the permanent secretary in the Department of Health and Social Care and the chief executive of NHS England, if they had read your report. They had not. Does that surprise you?

Barry White: I hope that some of their officials did. We certainly spoke to their officials in gathering the evidence, so I am sure their officials would be aware of it.

Q104 **Ben Coleman:** Lord Hutton, back to you.

Lord Hutton: I think it is fundamental. To make the right decisions going forward, we have to learn from the mistakes of the past, and Barry set them all out very clearly. We then get to a point—and this is where I suspect all you guys get involved because there are political choices here—where we can continue with the new hospital programme in the way it has been set out.

The analysis that we have done in the association indicates that, at best, we might get 45 hospitals built over the next 25 years. In the 10 years of PFI, we built 90 hospitals over 10 years. That is twice the output over half the period of time. Yes, I absolutely get that there is a political decision that you guys have to make about whether we deploy private capital, public capital or a mix of both. There is a choice, and this is your choice. If we do not deploy private capital, you will all have to wait probably twice as long for the hospitals that your constituents need.

Q105 **Ben Coleman:** I get the case absolutely that it is quicker to build using PFI. When you build something with PFI, we have the luxury—we do not have it properly with LIFT and other things like that yet, because they are quite new—of being able to look back at all the other extra costs that happened. When you are judging the success of a PFI project, are you just judging how quickly it was built, or are you judging all the things that happened over time—the inflexibilities that added extra costs, or where something was not specified and then the contractor was able to charge 10 times the amount for it? All the challenges that we have talked about need to be taken into account as well, don't they?

Lord Hutton: I would say they do. First and foremost is the patient. This is often a discussion between finance models and what academic studies say. It is the patient that we should be thinking about first and foremost. The patients always gain from having faster access to more modern and better facilities.

Q106 **Ben Coleman:** If you just take as your main criterion that we are going to build quickly and you do not build in a different way, you are not going



to really address the problems of PFI, are you?

Lord Hutton: Building quickly is an important consideration. We should not lose sight of that. Value for money, I absolutely agree, is an important one. The problem—Mark alluded to this very well—is that comparing PFI or PPP-constructed hospitals with hospitals built by using public capital, more traditional routes, is a very complicated process, because we often end up comparing apples with pears. With a PFI or PPP contract, the life-cycle costs are baked into those contracts.

Q107 **Ben Coleman:** Thank you. That is helpful. Barry, taking that point that Lord Hutton made, you have set out a series of improvements that need to be made. There is the high cost of maintaining buildings after the initial expenditure. There is also an issue very strongly put in your report about the ability of the civil service to work appropriately, deal appropriately, negotiate and manage contracts. You say that they mistakenly believed that contracts would monitor themselves; there was insufficient inspection or verification capacity; most authorities lacked adequate contract management resources; there are underskilled public authorities. This goes throughout your report. Is there anything that you see now that reassures you that that very important problem is being addressed?

Barry White: It is a big issue. To respond to Mark's point first, in terms of the points I made on improvement, if you take those points together, I am talking about a big cultural shift. They may appear to some to be in the weeds, but I would argue that actually it is about a cultural shift that those changes would underpin.

The most worrying comment that came to me during the review was something a local authority said: "Barry, it's not as if we choose to under-resource PFI contracts and resource all our other contract management really well. We just under-resource all our contract management." It is not so much about the civil servants; it is much more about people in local authorities or out in local health trusts or in primary care. The issue is about how to get support to those people. NISTA, the National Infrastructure and Service Transformation Authority, has a pool of people it can provide now to support local bodies. You want to try to combine that sense of local ownership, allowing people to own the appropriate project—well thought out, as Mark talked about—but with good central support. That is the right combination to overcome that issue from the past.

Q108 **Ben Coleman:** That sounds sensible. NISTA is there. As somebody who, like a number of my colleagues, has been a local councillor for a long time, I certainly agree with you about the challenge in managing contracts, with housing repairs and all sorts of things. There is a serious capacity issue there. You are providing a solution. How much do you think the NHS gets this?



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Barry White: I think people absolutely get it. Whether they can allocate the resource—

Q109 **Ben Coleman:** How confident are you that sufficient resource is going to be allocated this time round to make the capacity of the public sector to negotiate and manage contracts what it needs to be?

Barry White: That should be embedded in the programme that the Government set up. The Government should make that—

Q110 **Ben Coleman:** I will ask all three of you the same question. From your conversations with the Government or with people close to the Government, how much do they grasp that? Are they sufficiently apprised of the problem that they are going to put the investment into getting the skills in the public sector up to where they need to be? From your conversations, do you think that is likely to happen? How confident are you out of 10?

Barry White: I believe NISTA absolutely believes in that central resourcing and support and getting the right people in. The people who I speak to in the NHS at the centre absolutely understand that. I do not know about the wider landscape. I cannot comment on that.

Lord Hutton: It is well documented that this is a fundamental problem that needs to be addressed. Whether it is then addressed is not clear to me yet. There will have to be specific provision made for that. I would endorse what Barry is saying, Ben, because this really goes to the heart of it. One problem we have experienced in the last 20 years is the absence of a strong counterparty at the centre that can oversee the whole process. These are complicated contracts, by definition.

Q111 **Ben Coleman:** What sort of counterparty do we need, then?

Lord Hutton: We need a strong NISTA at the centre. NISTA has the ability to do that and probably wants to do that.

Q112 **Ben Coleman:** Is it being held back?

Lord Hutton: No, I do not think it is being held back. I do not think Ministers and Government have quite got to the point of decision yet. They have got to be a little bit bolder and braver on that. If we want to really accelerate the new hospital programme, which we should do as a country, it seems to me that we are going to need to go down this path. If we go down that path, let us learn from the mistakes of the past and not repeat them. This is one thing that I would hope that Ministers put front and centre.

Q113 **Ben Coleman:** Looking at the history of PFI, I am struck that there was not one oversight of all the different projects, so we cannot put them against each other and see how they were managed and delivered. Surely, going forward, we need one body that at least can collect all the data, make sufficient comparison and learn from them.



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Lord Hutton: That is a reasonable conclusion.

Q114 **Ben Coleman:** I do not think that has been planned. Okay, that is very helpful.

Last question: Barry, you talk about collaboration between the public and private sector, and the need to have a more collaborative model. Perhaps Dr Hellowell can comment on this as well. Not to be rude about the private sector, but they want to do as little as possible and make as much money as possible. That is perfectly rational. The public sector wants to get as much as possible and pay as little as possible. They are starting from a different place. Can they collaborate effectively? Are you genuinely confident that it is achievable to get this collaborative model that you are calling for?

Barry White: Not only am I genuinely confident that it is possible, but in many places that happens. The important thing to me is that it is productive collaboration. What the report highlights is that in some cases just getting on well together would seem to be collaboration, whereas true collaboration is that when something happens, you solve it by working together.

Q115 **Ben Coleman:** Often, you get the private sector saying, "Oh, we didn't realise you'd want that. We need to charge you this much more for that," and that stops any improvements or things being learned, because there is always this huge cost extra for a badly specified project.

Barry White: Sometimes, it may be the case that something different does cost extra, but that is not always wrong. Good collaboration helps keep that cost down. That is why the transparency that I talked about, where you have a board director who is from the public sector, helps enormously with that, because you have somebody sitting on the board of the special-purpose company. That transparency is a key element to help with busting some of those myths. Sometimes it is a myth and sometimes it is reality. Having that transparency would help enormously.

Q116 **Josh Fenton-Glynn:** Lord Hutton, do you believe that the Local Improvement Finance Trust, or LIFT, schemes address some of the concerns that were raised by previous PPP projects?

Lord Hutton: LIFT schemes, as I recall them, were not designed specifically to address perceived shortcomings with PFI. They were a parallel contractual framework for generally smaller schemes and were designed differently. There is a lot to learn from LIFT for PPPs going forward, but they were not designed as an attempt to address historical deficiencies in PFI.

Q117 **Josh Fenton-Glynn:** One of the issues that evidence to our Committee has shown is that they do not have as much flexibility as you need for providers. Lord Darzi's review said that some LIFT deals have left GPs being "locked into" arrangements where they have limited control over space they occupy. Does this suggest that the model is not really



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delivering?

Lord Hutton: No, I think the model has delivered pretty well over a long period of time. It has not been subject to the same criticisms that PFI has been over that period. If there have been problems like the one that Lord Darzi referred to, I have no doubt at all that they can be managed and addressed within the local LIFT partnerships. LIFT has proven itself to be a valuable extra tool to get new facilities built in the NHS.

Q118 **Josh Fenton-Glynn:** I am going to give you a practical example. In my constituency, Todmorden health centre was built under the Local Improvement Finance Trust scheme by Assura PLC. It was built to accommodate five different health services. It has a large amount of space that is now vacant because the private company that provided the walk-in centre pulled out of the contract after 2011. Lots of efforts to bring it into use have failed because the voiding costs ended up being so great that other people could not take on the project. We have a building, that was built in part with public money, being wasted. To me, it does not feel like we can trust the private finance industry to deliver these buildings.

Lord Hutton: I would just issue one caution. There may have been a problem in this particular scheme, but I do not think we should use that as a general argument that the entire LIFT programme has failed to deliver. I suspect you probably have similar problems in publicly funded local health schemes as well. You could probably find some of those examples around the country if you look for them.

Q119 **Josh Fenton-Glynn:** I did not look for this. It happened in my constituency. The only example I have seen of a LIFT building is one where the GPs are not able to provide the service that people locally need. Now they have moved a lot of the services elsewhere because it is less costly because of the private providers.

Lord Hutton: That sounds unfortunate, but I do not think that is a general criticism of LIFT.

Q120 **Josh Fenton-Glynn:** It is a criticism that comes up in a lot of the evidence that was submitted to our inquiry, and it is a criticism that I have seen at first hand. It seems odd to say that you do not think it is a criticism if that is something that has both come out in the evidence and been shown in my local example.

Lord Hutton: It is clearly a criticism—I am not disputing that—but I do not think it is a generic criticism of the entire LIFT programme.

Q121 **Josh Fenton-Glynn:** Okay. Just moving on with that, how do we learn the lessons for future schemes? Do you think that there is more of a possibility of adapting the current contracts to ensure that we use these buildings properly?

Lord Hutton: Yes, I am quite sure we can do that. Remember, LIFT is a good example of partnership working between the private and the public



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sector. If the public sector partners have a range of issues that they want to discuss with private sector investors who are interested in LIFT schemes, of course they can do that. If there is a way of reaching an agreement about how we go forward, that is absolutely perfect.

Q122 Josh Fenton-Glynn: Do you think that asset owners and investors accept responsibility for ensuring that the health buildings are used for the service that they are meant for, or is that the responsibility of people who draw up the contracts in the first place?

Lord Hutton: It is probably a mix of both. The LIFT programme is designed to deliver certain outputs, and it will be the job of the provider to ensure that is being delivered. Remember that in LIFT schemes the NHS is the joint equity owner of those local trusts. It has a very substantial stake in ensuring exactly what goes on in those contracts.

Q123 Josh Fenton-Glynn: The NHS does, but do you think that the providers have a responsibility to make sure that the buildings they have provided are being used?

Lord Hutton: Of course they do, yes.

Q124 Josh Fenton-Glynn: One big concern is that some trusts pay more than £2 billion a year on old PPP contracts. We have gone back and capped the returns paid for defence contracts, and we have gone back and capped returns in education now. Where would your investors stand if we were to look at capping the returns in healthcare?

Lord Hutton: Any investor in whatever contract they were invested in would want the contract to be observed.

Q125 Josh Fenton-Glynn: Do you think they would resile from looking forward to capping investment and capping that return?

Lord Hutton: Both parties to a contract have obligations to follow and honour the contract that they have signed, and not to unilaterally change it.

Q126 Josh Fenton-Glynn: Moving on, the 10-year health plan has 70 new build health centres and 50 refurbishments by 2030. It might need a new model of private finance. You suggested that that is the most likely way that we get investment into healthcare. What should we learn from previous PPP models for future contracts?

Lord Hutton: As I said, Josh, we should read Barry's report first and centre. That is the first thing we should do.

Chair: Just do that. Easy.

Lord Hutton: It is not beyond the wit of the Government in the UK and their partners in the private sector to devise new models of PPP going forward that do not replicate the failures of the past. That is a perfectly rational thing to think we can manage.



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Q127 **Josh Fenton-Glynn:** What would be the key things that you would suggest that they look to change about our existing models?

Lord Hutton: The 10 things that Barry said that we should look at.

Q128 **Josh Fenton-Glynn:** One issue is that the model that we have at the moment means that we end up doing much larger consultations than they do in most contracts for public-private partnerships, with much larger documentation and clearer outcomes, but healthcare is inherently a system that—whether it is because of demography, pandemics or technology—changes. Do you think that the inflexibility is a problem with contract design, or is it a problem with private finance in itself?

Lord Hutton: It is primarily a problem of contract design. It is not a problem—it is to do with the source of capital in the contract. It is entirely a matter of contract design.

Q129 **Josh Fenton-Glynn:** One of the main recommendations in last year's NAO report, which is almost as good reading as Barry's report, is that forward planning for infrastructure needs to be credible and consistent. Do you feel that the health system's current plans are clearer for investors in the market?

Lord Hutton: There is a clear programme. The NHS has set out the new hospitals that it wants to see across the NHS estate. I do not think that that is the problem. The problem right now is that there is no means to deliver that within a timeframe that is relevant or meaningful to your constituents, and that is the problem that has to be addressed.

Q130 **Josh Fenton-Glynn:** Do you think that the lack of competition in private financing for healthcare infrastructure is an issue?

Lord Hutton: I do not think there is a problem about a lack of competition. Clearly, if you are talking about LIFT, or even if Government were to decide to bring forward a new model for PPP in the acute sector, you would have to talk very closely with investors to make sure that you have designed this process properly and kept costs in the bidding process down to an absolute minimum. You have to structure not just the frameworks for those contracts but the procurement process itself in a way that gives the taxpayer confidence that they are going to get value for money.

Q131 **Josh Fenton-Glynn:** You say that you are not concerned about the lack of competition. Assura PLC, which previously owned Todmorden health centre, was recently taken over by Primary Health Properties. That was waved through by the Competition and Markets Authority. It now has a portfolio of over 1,000 properties. Out of the £12 billion total value of medical centres, it holds £5 billion of that value. It does feel like the market does not have enough competition when I look at those numbers.

Lord Hutton: No, I think that there is plenty of investor appetite in new models of PPP and that there would be healthy competition for new contracts. Remember, at the end of the day, it is up to Ministers to decide



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whether any contract represents value for money. If they do not feel it does represent value for money, they should not let it pass.

- Q132 **Josh Fenton-Glynn:** I appreciate that the easy get-out is that it is up to Ministers to decide, but my issue is whether they are going into a market where there is enough competition. Would you and the organisations that you represent support a move to outcomes-based payments in PPP contracts, in not just the buildings, but the broader health outcomes?

Lord Hutton: They are already outcomes-based contracts. Payments are related to outcomes.

- Q133 **Josh Fenton-Glynn:** Okay. You talked about Ministers. You were a Minister for many years and signed off PFI projects. Do you ever worry that there is a conflict that you are now representing the industry that you signed off contracts into?

Lord Hutton: No.

Josh Fenton-Glynn: Okay.

Barry White: Could I add a couple of comments to the questions that you asked? NHS LIFT was first invented in part to address a big market failure. At that time, there were large parts of the UK where the third-party developers were not developing properties and there was a real shortage, so the intervention was to add competition into that market and bring new ways of delivering where the market was not capable of delivering or not likely to deliver. The view was taken that this was needed to help provide where the market could not otherwise provide. It brought a lot of new players into the market in addition to some of the existing third-party developers.

- Q134 **Josh Fenton-Glynn:** Those seem to have now consolidated a bit.

Barry White: There is still quite a range of people involved who were not involved before LIFT happened. Certainly, I know within the wider investor community that there is the appetite to participate in something like that again. In Scotland, when I was at the Scottish Futures Trust in the public sector, we ran the hub programme. The developers that came into that were from quite a wide range, and not the party that you mentioned earlier. I believe there is a large market of developers and investors out there that will come forward.

- Q135 **Paulette Hamilton:** Good morning, all. Paulette at last. Okay, this is a really quick question, and then I am going to shut up. My question is particularly for Lord Hutton. It regards the Australian precinct model that you recommend, which uses development to subsidise public healthcare buildings. Is that a realistic model for England? What are the legal, financial and planning changes that would be needed for that particular model to be viable? I think it is a good model, and I can see where in the 10-year plan that model would fit well, but there are issues around the legal and financial aspects. What are your views, Lord Hutton?



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Lord Hutton: I agree with you. This could be a really good thing to explore, and it might have the added benefit of bringing the planning process more closely together, to avoid the risk that Mark referred to earlier about the tail wagging the dog. The precinct model involves a high degree of local planning between the acute sector and the non-acute sector, and you end up with a strong set of assets that will meet their local healthcare needs. We should definitely look at that.

Q136 **Paulette Hamilton:** Okay. I am going to go across to you, Dr Hellowell. What are your views? I think it is a good plan. That precinct-type plan is a way forward for the UK, especially if you want to keep people at home for a longer period. How do you think it would fit in with the estate models and PFI?

Dr Hellowell: I am not sure that I am qualified to say, but one issue would be: where does the ownership lie? Is there a clear authority that enters into that transaction and takes accountability for making sure it works for the local area and is affordable and good value for money? That would be my only concern.

Q137 **Paulette Hamilton:** Would you see a problem with the planning aspect of this—getting planning from local authorities?

Dr Hellowell: I am probably not qualified to say.

Q138 **Paulette Hamilton:** Lord Hutton, would you see a problem with the planning aspect of this?

Lord Hutton: No.

Q139 **Paulette Hamilton:** Do you think it would go through quite easily?

Lord Hutton: There would need to be consultation with the planning authority, but there is nothing inherently problematic about combining or integrating acute and non-acute provision in a combined scheme.

Q140 **Paulette Hamilton:** You absolutely see no issues with this particular scheme.

Lord Hutton: I do not see any planning issues, no.

Q141 **Paulette Hamilton:** Any financial issues?

Lord Hutton: No.

Q142 **Paulette Hamilton:** Okay. Barry, you are the last person I will ask. Then I will shut up.

Barry White: I do not know very much or anything about the model that you describe.

Paulette Hamilton: Okay.

Barry White: What I will say, though, is that whenever I have worked on the public sector side, I have always believed you should have an



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ecumenical approach to this and be willing to embrace the options that are out there if they work and are appropriate to the circumstances. Looking internationally, it is something that we always did whenever I was working in the Scottish Futures Trust.

Q143 Paulette Hamilton: Just to press you because you are the research man, would you perhaps say a pilot would be a good way to go? So, look at an area where a pilot would be adequate, and then see if there would be some issues around the legal, financial or planning aspect. Sometimes, do you not think we jump into these things too quickly and do not test them first?

Barry White: I am a big believer in pathfinders rather than pilots because pilots suggest too much time for navel gazing afterwards. If you are going to think about doing something, pathfind with a view to following on if it works rather than standing back for too long. I believe an action-based approach to these things is always best.

Paulette Hamilton: Okay. I am going to shut up there because we are over time. Thank you.

Q144 Andrew George: I am very interested in better understanding the profit and risk-sharing elements of the development and construction side of all this work. There are certain projects that I have seen where—how can I put it?—the public sector takes the risks and the private sector takes the profit. When development budgets are being brought together, how much do developers profit? How much contingency is there? Whose Qs are auditing the development costs of the projects so that you are hitting construction benchmarking that is durable for purpose? Presumably, you have looked at this in great detail, Barry.

Barry White: It is a really mixed picture. Unfortunately, on many occasions, or certainly several occasions that I am aware of, the construction element of a PPP-type contract has lost considerable sums of money, and the contract was structured in a way that those losses stayed with the contractor. I say “unfortunately” because nobody wants a partner involved in a project to lose money. In some ways, the risk management by the structures means that the public sector was protected from that. I was reading about the Dublin children’s hospital, where huge, €1 billion- claims are going backwards and forwards at the moment. These projects have a lot of risk attached. The private sector, I believe, is good at managing those risks effectively on behalf of the public sector. In some ways, that is part of what is paid for in these structures.

Q145 Andrew George: Interestingly, there is an example that we will see next week where the construction of a building that achieved EPC A+ in terms of its energy efficiency, and that is satisfactory and built to a very high standard, was built at significantly less than £2,000 per square metre. I know that a lot of the projects that you are talking about are in excess of £3,500. There are significant additional costs if you build it through the systems that you are talking about, when, in fact, a community-based



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CIC can achieve efficiencies and, if you had open-book auditing, far better value for money for these construction costs. That is why I would be interested in the extent to which there is open-book sharing of information regarding developer profit and contingency costs.

Barry White: It depends how you run your procurement, quite simply. You can run the procurement in a way to achieve a large degree of open-book costing, or you can run it in a way in which you receive very little open-book. Things like the hub programme in Scotland and the LIFT programme achieved a lot of open-book costing, where people could see the underlying costs as new projects were developed. For some other PFI projects in the past, people bid a fixed price and stuck by their fixed price. Overall, looking at the margins that construction contractors have made over the years, it is not that people have made huge windfall profits. In terms of the cost per square metre, I do not believe the mechanisms inflated that as such.

Q146 **Andrew George:** Okay. Are you happy with that, John?

Lord Hutton: The only thing I would add, Andrew, is that the NAO, which looked very carefully at all this, found no evidence at all of excessive profits across the PPP portfolio. In fact, HMT reviews have showed returns broadly in line with expectations, given the risks that were involved and the risks that were transferred.

Q147 **Andrew George:** Does the public side have Qs going through independently on an open-book basis?

Lord Hutton: This comes back to Barry's point about a clerk of works, which I think would be a very helpful reform to introduce going forward.

Andrew George: That is useful. Okay.

Q148 **Chair:** We have read your report. It is important that Government have also read it, understood it, and included everything in it. Of course, it is not just central Government that are going to be delivering this; it is also ICBs, which are currently facing big turmoil and 50% cuts. Lord Hutton, do you have a concern that ICBs, in the state they are currently, have the capability to deliver on these projects if they come forward, or will they have to rely heavily on this stuff? What is your view on that?

Lord Hutton: There is no PPP programme for the new hospitals at the moment. Should there be one, the Government will have to ensure that there is, as Barry said, proper contract management capacity and capability at a local level to make sure that this works.

Chair: All right. Thank you very much, all. Thank you for your patience, as we have run over time, but it was important.