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Summary

The New Hospital Programme (NHP) was intended to be a landmark programme, addressing the escalating backlog of investment in hospital buildings by delivering 40 new hospitals in England by 2030. The programme has been marked by slower progress and higher costs than promised, a lack of transparency in scheme selection, and until a few months ago uncertainty about overall funding, scope and timetable. It is now clear that NHP will not deliver all 40 new hospitals by 2030 and is highly unlikely even to construct the 32 new hospitals (under its 2020 definition) that it is now aiming to complete.

The Department of Health and Social Care (DHSC) was aware in 2020 that there were seven NHS hospitals built entirely of reinforced autoclaved aerated concrete (RAAC) which had become structurally unsound. Yet only two of these seven were selected for inclusion in the programme at that time. In May 2023, DHSC reset NHP and included the other five RAAC hospitals. In all seven, costly mitigation measures are required to keep services running until new structures can be built. The 2023 programme reset had the effect of delaying eight other hospitals, which DHSC now will not complete until after 2030, a major disappointment for people living in those communities.

An important feature of NHP is DHSC's aspiration to develop new cheaper and faster approaches to hospital construction. This includes a new standardised hospital design called 'Hospital 2.0'. Resourcing and design capacity issues have hampered the progress of Hospital 2.0 and development of the design and process is now running at least five months behind schedule. The delay to Hospital 2.0 has impacted the programme in two key ways. It has reduced the time available to pilot the new design in real-life scenarios, risking baking-in and replicating design and construction problems across England. The delay has also hindered meaningful engagement between NHP and the construction industry on the details of the design and the commercial pipeline of work. There are big questions about the industry's capacity and appetite to build the required number of hospitals in the new way and to a very tight timetable.

Most worryingly of all, the latest version of Hospital 2.0 is based on assumptions that appear very likely to produce hospitals that are too small. The NHP team is assuming future bed occupancy rates of 95% and reductions in length of patient stay that are unsupported by research it commissioned. The assumptions look particularly heroic in the context of the UK's growing and ageing population, while there is as yet no social care plan in place to alleviate the increasing pressure on hospitals.

DHSC and NHS England have generally failed to build capacity within the NHP team. With 62% of NHP posts filled using consultancy services in February 2023, the programme has been over-reliant on consultants, creating risks of lack of continuity and capability at the heart of the programme as well as making it more expensive.

The Government indicated in March 2023 that the maximum capital funding available to deliver 32 new hospitals by 2030–31 as well as completing eight pre-existing schemes would be £22.2 billion (made up of the original funding up to 2024–25 of £3.7 billion plus an additional £18.5 billion from 2025–26 onwards). The Committee sees multiple affordability challenges which DHSC needs to grapple with, including the fact that changes to the assumptions underlying Hospital 2.0 to make the design fit for purpose will likely increase costs.

Introduction

The NHS in England has around 1,500 hospitals, where most emergency and elective care occurs. The NHS estate contains many old buildings, and its condition has been deteriorating, with some 43% built before 1985, and 15% pre-dating the NHS itself. The value of the total maintenance backlog in NHS hospitals (that is, the estimated cost of restoring all its buildings to an appropriate state) had reached £10.2 billion in 2021–22, compared with £4.7 billion in 2013–14. In 2020, the government committed to build 40 new hospitals by 2030, as well as completing eight schemes that were already in construction or pending final approval.

DHSC set up the New Hospital Programme (NHP) to deliver this commitment. Where hospital construction schemes had previously been funded centrally but delivered locally by NHS trusts, NHP would take a new approach, managing projects as a portfolio and standardising processes and designs with the aspiration, once fully implemented, of making significant time and cost savings in the development of new hospitals. HM Treasury initially provided funding of £3.7 billion for the period to 2024–25. In early 2023, it set an indicative maximum for capital funding of £18.5 billion for 2025–26 to 2030–31, taking the total to £22.2 billion (though the amount is subject to future spending reviews).

Following a reset of the programme in May 2023, NHP now includes the replacement of all seven hospitals built entirely of reinforced autoclaved aerated concrete which has become structurally unsound. The scheduled completion date of eight new hospitals promised in the original programme has now been delayed until after 2030, and in total only 32 of the new hospitals are now planned for completion by 2030.

Conclusions and recommendations

1. **We are extremely concerned by the lack of progress the New Hospital Programme has made in the three years since its creation.** In 2020, when government committed to build 40 new hospitals by 2030, DHSC named 32 of the sites and provided details of what patients could expect in each place. From the perspective of patients, however, very little has happened since. By October 2023, no new hospitals had yet opened, and, in May 2023, DHSC abandoned the idea of building all 40 by 2030. Given the prominence and importance of this commitment, progress has been worryingly slow. Furthermore, with a very large number of hospitals planned to be in construction simultaneously in the last years of the decade, we have no confidence that even the reduced target of 32 new hospitals is achievable by 2030.

   Recommendation 1: ***DHSC should urgently examine how the programme can be made to deliver some tangible results for patients. This should include considering:***

   - ***whether the central programme team has the capacity and capability to manage all aspects of the programme as currently configured, including the eight schemes that do not count towards the 40 new hospitals commitment; and***
   - ***whether more new hospitals should commence construction sooner using pre-existing approaches to design and contracting.***

2. **DHSC has failed in one of its most basic duties by keeping no proper record to justify its final selection of schemes for the programme.** DHSC and NHS England officials carried out an assessment exercise which recommended 20 schemes for inclusion in the Health Infrastructure Plan (HIP), a 2019 programme that became the main basis for selecting schemes for NHP. In finalising the schemes for announcement, DHSC removed seven of the 20 schemes from the shortlist for HIP and added another 14 that had not been recommended. DHSC told us it was satisfied that those decisions were made on an appropriate basis, but it admitted that no documentation whatsoever existed to explain the decisions. We are troubled that a gap like this can occur regarding such an important investment, particularly since at least some of the seven excluded schemes are known to have an urgent need for major investment or rebuilding. This Committee has previously expressed concern about a lack of evidence to justify scheme selection, and a lack of transparency in selection processes, for the Towns Fund in 2020 and for levelling-up funding in 2022.

   Recommendation 2: ***For major programmes that involve the selection of schemes from a long list of potential candidates, government should always publish information on selection criteria before decisions are taken and should always be able to provide transparent written evidence to demonstrate why successful schemes were selected.***

3. **Recent events have shown that DHSC will need to go faster with its efforts to deal with reinforced autoclaved aerated concrete (RAAC) in hospitals.** The hospitals named in the government's October 2020 announcement of NHP included only two entirely constructed from RAAC. Five other RAAC hospitals that DHSC knew

about were not included then, only to have to be added later. By early 2023, DHSC had identified a total of 41 NHS buildings with RAAC. Removing or mitigating the risk of RAAC is disruptive, complex and expensive. DHSC has set aside a total of £685 million to fund RAAC works up to 2024–25 and has committed to removing all RAAC from the NHS estate by 2035. After the scale and impact of RAAC problems in schools escalated in August 2023, NHS England contacted trusts to determine whether there was more RAAC than it previously knew about. After our evidence session DHSC reported that, as at 17 October 2023, there were 42 hospital sites (at 39 NHS trusts) where RAAC needs to be removed. Rebuilding the seven RAAC hospitals by 2030 will be extremely challenging, yet there is a serious risk, if these projects are not accelerated and prioritised, that some hospitals may have to close before replacements are ready.

Recommendation 3: ***DHSC should revise its plans for managing the RAAC crisis, including:***

- ***Expediting surveys of the NHS estate and publishing the results in full so the extent and scale of the RAAC problem is known.***
- ***Reviewing whether the commitment to eradicate RAAC from the NHS should be brought forward from 2035, and, in light of NHS estate survey results, reviewing whether the existing £685 million fund up to 2024–25 is sufficient.***
- ***Aiming to start construction before the end of 2025 on replacements for the seven entirely RAAC hospitals.***
- ***Appointing a named senior official to oversee delivery of its RAAC plan and to support NHS trusts to make the right decisions on the safety of RAAC buildings.***
- ***To ensure transparency on this issue, writing to the Committee alongside its Treasury Minute response with its latest assessment of the scale of RAAC in other parts of the health and social care systems, including community settings, GP practices, and the adult social care sector.***

4. **DHSC must quickly complete and test its standardised hospital design to avert further delays to hospital construction, and to reduce the current high risk of cost and quality issues in years to come.** DHSC has taken too long to get its Hospital 2.0 design off the drawing board. It continues to be optimistic that the design and a related new commercial model will reduce future construction costs by 25% and could even reduce the total time taken to develop new hospitals from 11 years to six. Yet, until the design is complete and has been tested, these claims are at risk of being just pipe dreams. Unlike Denmark's programme for building 'super hospitals', DHSC has not allowed time for proper piloting of its new standard hospital. Failure to pilot thoroughly could store up problems for future generations because of defective or poorly thought through standardisation.

Recommendation 4: ***For the twin purposes of piloting and making progress, DHSC should aim to be ready to start construction during 2024 of at least one early scheme that uses its standardised hospital design, with a particular focus on trialling new clinical infrastructure such as standardised operating theatres.***

5. **DHSC is at risk of locking in a standard design that will result in future hospitals being too small, which could lead to significantly greater expenditure and disruption in the long run.** The version of Hospital 2.0 that DHSC used in its business case for NHP, and the basis on which HM Treasury has provided indicative future funding, is founded on unrealistic assumptions. It assumes that increasing demand for hospital care from a growing and ageing population can be mitigated by a very high level of bed occupancy (95%), substantial reductions in patients' average length of stay in hospital, and a significant, recurring 1.8% per annum transfer of patient care out of hospitals into community settings. The NHS already has very high levels of bed occupancy and short average lengths of stay relative to the health services of other advanced nations. It is common knowledge that many parts of the primary and social care sectors are under great strain. Making these assumptions more realistic, at either a programme or scheme level, is likely to increase the cost of new hospitals and make the programme more expensive, meaning this is an issue that needs urgent attention and may well require a further reset of NHP.

Recommendation 5a: ***DHSC should amend its Minimum Viable Product version of Hospital 2.0 so it does not result in future hospitals that are too small, and should set out clearly how these future hospitals fit into its assessment of total required hospital capacity nationally and by region.***

b) ***The Health and Social Care Committee may wish to consider holding an inquiry into DHSC's assumptions about the design of future hospitals.***

6. **There appears to be insufficient funding for DHSC to build all the hospitals it plans, and to an adequate size, by 2030.** HM Treasury initially allocated £3.7 billion to NHP for the period up to the end of 2024–25 with no indication of what further money it would give up to 2030. In early 2023, it finally set an indicative maximum for capital funding of £18.5 billion for the following six years, making a total of £22.2 billion. Funding is needed for the schemes to be completed by 2030, as well as for early works on the eight schemes that will now complete after 2030. Long experience suggests that many schemes in NHP will come in over budget. Schemes in NHP's cohorts 1 and 2 have already seen forecast costs increase by 41%. Getting the standard design of future hospitals right may also have the effect of increasing estimated costs. Other factors such as high inflation, insufficient capacity in the construction industry, and the need for many more factories to manufacture modular units offsite could drive up costs further.

Recommendation 6: ***DHSC should be realistic about the likely cost of schemes and what can be afforded by 2030. As well as addressing the shortcomings in its Minimum Viable Product version of Hospital 2.0, it should engage further with the construction industry to understand and manage likely capacity constraints. It and HM Treasury should agree explicitly and in writing whether the pre-2030 costs of eight delayed cohort 4 schemes are to be met from the current agreed funding envelope.***

7. **The Programme is over-reliant on consultancy services.** NHP has depended heavily on external consultants since its creation, with 62% of posts filled using consultancy services in February 2023. DHSC estimates it will spend a further £842 million on consultancy services between 2023–24 and 203031. Some use of consultancy is to be expected on major construction programmes, but, as well as being expensive, over-reliance risks a lack of continuity and failure to build in-house capability. NHP aspires to be a long-term programme of hospital improvement well beyond 2030, so it is vital that the public sector itself acquires and retains the right skills.

   Recommendation 7: ***DHSC should work with HM Treasury and the Cabinet Office to develop a strategy for attracting into the civil service and retaining there the skills it needs to run a rolling programme of hospital construction; it should write to the Committee by March 2024 setting out what it will do differently in future.***

8. **The raiding of capital budgets in the recent past is an underlying cause of the estates crisis the NHS is now in.** As this Committee has highlighted several times, DHSC has for some years focused on short-term financial viability in ways that failed to consider the long-term consequences for services and patient care. DHSC diverted £4.3 billion of NHS capital funding from planned capital spending to day-to-day spending between 2014–15 and 2018–19; and by 2021–22 there was a record maintenance backlog of £10.2 billion. Under-investment in the estate has resulted in a situation that now requires urgent action. This includes but is not limited to the crisis with RAAC. Working in out-of-date buildings that have not been well maintained also makes it hard for the NHS to modernise and recover its performance to the standards required in the NHS Constitution, and is only likely to exacerbate problems in attracting and retaining staff.

   Recommendation 8: ***DHSC should not reduce planned capital investment to meet day-to-day spending needs in future; if officials were to consider doing this again we would expect the Permanent Secretary to write to Ministers explaining the likely real-life consequences of such a course of action.***

1 Progress in construction and developing new hospital design

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health and Social Care (DHSC) and NHS England about the New Hospital Programme (NHP).[1]

2. The NHS in England has around 1,500 hospitals, where most emergency and elective care is carried out. The NHS estate contains many old buildings, and its condition has been deteriorating with some 43% built before 1985, and 15% predating the NHS itself. The value of total backlog maintenance in the NHS (that is, the estimated cost of restoring all its buildings to an appropriate state) had reached £10.2 billion in 202122, compared with £4.7 billion in 2013–14. In 2020, the government committed to build 40 new hospitals by 2030, as well as completing eight schemes that were already in construction or pending final approval.[2]

3. DHSC set up NHP to deliver this commitment. Where hospital construction schemes had previously been funded centrally but delivered locally by NHS trusts, NHP would take a new approach, managing projects as a portfolio and standardising processes and designs with the aspiration, once fully implemented, of making time and cost savings in the development of new hospitals. HM Treasury initially provided funding of £3.7 billion for the period to 2024–25. In early 2023, it set an indicative maximum capital funding of £18.5 billion for 2025–26 to 2030–31, taking the total to £22.2 billion (though the amount is subject to future spending reviews).[3]

4. Following a reset of the programme in May 2023, NHP now includes the replacement of all seven hospitals built entirely of reinforced autoclaved aerated concrete (RAAC) which has become structurally unsound. The scheduled completion date of eight new hospitals in the original programme has now been delayed until after 2030, and in total only 32 new hospitals are now planned for completion by 2030.[4]

Progress with constructing new hospitals

5. During the period 2015 to 2020, the backlog of maintenance across the NHS estate grew and only six new hospitals were completed.[5] In October 2020, the government announced NHP and committed to build 40 new hospitals by 2030, as well as completing an additional eight (pre-existing) schemes that were in construction or pending final approval. This marked an expansion of the commitments in DHSC's Health Infrastructure Plan, which had been set up in 2019 as a rolling five-year programme to modernise the NHS estate.[6]

1 C&AG's Report, *Progress with the New Hospital Programme*, Session 2022–23, HC 1662, 17 July 2023
2 C&AG's Report, paras 1, 7 and 1.2 and Figure 2
3 C&AG's Report, paras 7, 8, 19 and 1.11
4 C&AG's Report, para 20
5 C&AG's Report, *Progress with the New Hospital Programme*, Session 2022–23, HC 1662, 17 July 2023, Figure 2 and para 1.7
6 C&AG's Reports, paras 7 and 1.8

6. Thirty-two of the 40 new hospitals were identified and detailed in the October 2020 announcement.[7] Of these, none had opened in the first three years after the announcement. When we took evidence, the first new scheme—the Dyson Cancer Centre, in Bath—was due to open by the end of 2023. There has been some progress with the eight schemes that are part of NHP but which already existed before the 2020 announcement. Though these schemes were not part of the government's original definition of 40 new hospitals, the achievements are welcome.[8] Progress with pre-existing schemes includes:

- three that have opened for patients – Northern Centre for Cancer Care in Carlisle, Royal Liverpool University Hospital, and Brighton 3Ts (phase 1 being open, with phases 2 and 3 still to complete);[9]
- two that have entered construction since the programme started – the National Rehabilitation Centre, near Loughborough; and Moorfields Eye Hospital in London; and[10]
- two that are expected to open for patients soon – the Greater Manchester Major Trauma Hospital and the first phase of the CEDAR Programme in Northumberland.[11]

7. Overall, however, progress has been slow even with early schemes that count towards the 40 new hospitals commitment, despite these being selected by NHP as being relatively quick, cheap and straightforward to deliver. For example, by April 2023 none of the ten schemes in cohort 2 had an approved full business case and seven were running late.[12] DHSC told us at the end of September that only one of these schemes was not yet in full business case stage.[13]

8. In May 2023, DHSC changed what it would count as a new hospital for the purposes of its 2030 commitment. At that point DHSC decided it would also count the eight pre-existing schemes which in 2020 were already pending approval or in construction. Based on its original definition, however, it is now aiming to build 32 new hospitals by 2030. DHSC told us that it was developing a full programme business case for the latest list of hospitals announced in May 2023 and that it intended to deliver all of them by 2030.[14]

9. DHSC claims that its plans to standardise approvals processes and that hospital design will reduce the time taken to build a hospital from as much as 11 years to about six. We asked whether there was a case for rebuilding some hospitals using traditional methods so that more work could be done sooner – as discussed later in this report, DHSC is delayed in creating the new standardised process and design. DHSC's view was that reverting to the traditional method would actually take longer.[15] We note though that the Infrastructure and Projects Authority has previously highlighted issues with the

7 HM Government, PM confirms £3.7 billion for 40 hospitals in biggest hospital building programme in a generation, 2 October 2020; accessed at www.gov.uk/government/news/pm-confirms-37-billion-for-40-hospitals-in-biggest-hospital-building-programme-in-a-generation
8 Q 45; C&AG's Report, para 12 and Figure 5
9 C&AG's Report, Figure 8; [DHSC letter 26/9]
10 Qq 42–43
11 Qq 56–57
12 C&AG's Report, Figure 9 and para 2.18
13 Letter from Shona Dunn, DHSC dated 26 September 2023
14 Qq 47, 52; C&AG's Report para 20 and Figure 12
15 Qq 29–31

capability of NHP's leadership. As NHP has structured its programme, its central team will need deep expertise in large-scale programme management as well as design and construction skills.[16]

10. After the evidence session, DHSC provided us with its current detailed schedule showing the approval and construction stages for each scheme to be completed by 2030. DHSC told us that this would be subject to detailed re-planning which is underway and asked us not to publish the information on the grounds of commercial sensitivity, in particular with future competitive tendering processes in mind.[17] However, with 19 new schemes (cohorts 3 and 4 and the additional RAAC hospitals) all to be completed by 2030 but not yet ready to start construction, it is clear that a very large number are currently scheduled to be under construction simultaneously during the last years of this decade. This is in a context in which a total of just four main contactors appear to be willing to consider building a large new hospital.[18]

Developing and testing a new standard hospital design

11. DHSC aims to improve the cost-effectiveness and quality of new hospitals by standardising hospital design, including the business case process, and making increased use of modern methods of construction.[19] Many traditional hospital construction schemes suffered from cost overruns and delays, which the NHP team believes it can reduce through a more centralised, modern approach. But NHP's estimates of the level of savings that can be made are very ambitious. It has previously said that schemes that fully adopt its new approach would cost 25% less and take 20% less time to build than under traditional design and construction approaches. Then, at our evidence session in September, DHSC was more optimistic regarding time savings, telling us the model would reduce the total time taken to develop new hospitals from an average of 11 years to about six. This would amount to a time saving of some 40%, twice as much as was estimated earlier in 2023.[20]

12. In practice, these future time and cost savings also need to be set against the time and cost taken to develop the new approach and additional costs as a result of inflation while schemes wait to proceed. The Infrastructure and Projects Authority recommended that the NHP team should complete its standardised design by the end of 2022, for use in early proof of concept testing. Instead, the NHP team plans to release the template design, known as Hospital 2.0, in stages during 2023, with the final release by December 2023. However, by July 2023 the NHP team was running around five months behind schedule.[21] DHSC told us that some elements of the design had been finished and that the complete package would be ready by May 2024.[22] The C&AG's report of July 2023 highlighted that there were delays in recruiting a temporary design team of up to 300 specialist designers. Remarkably, in September, DHSC told us that it had now recruited the team it needed to complete Hospital 2.0.[23]

16 C&AG's Report, paras 3.24 and 3.25
17 Letter from Shona Dunn, DHSC dated 26 September 2023
18 C&AG's Report, para 17 and Figure 12
19 Q 29; C&AG's Report, para 3.6
20 Q 29; C&AG's Report, para 3.6
21 C&AG's Report, paras 3.8 and 3.9
22 Q 84
23 Q 31; C&AG's Report, para 3.9

13. Among DHSC's other commitments, the need to rebuild the seven RAAC hospitals by 2030 is particularly pressing. RAAC hospitals are costing taxpayers a lot of money as remedial measures are taken to keep them safe and open.[24] In this context, insisting on using Hospital 2.0 designs for all seven schemes seems questionable. The seriousness of the RAAC issue and the need to complete these rebuilds by 2030 creates a strong case for procuring and constructing the seven hospitals under traditional methods, even if that would mean not complying fully with the as yet incomplete Hospital 2.0 design.[25]

14. More generally, we asked DHSC whether it should commit to first building one hospital according to Hospital 2.0 designs in order to discover its viability in practice, the true scope for cost and time savings, and problems and snags that could be removed, before the design is repeated across multiple schemes. DHSC seemed reluctant to accept the desirability of rigorous real-life testing, replying generically that it was always looking for opportunities to accelerate the programme.[26]

15. Before the evidence session, we visited a "super hospital" project in Denmark. The Danes had built a prototype of a new operating theatre on the edge of an existing hospital and each surgical team was given access to it so they could test how it worked in practice. Using the lessons from these clinicians, the new hospital was being built with theatres that were already known to work for all types of surgery. We asked whether the NHP team was planning to use similar live clinical exercises. DHSC told us it was consulting with clinicians but was not currently planning live testing. The NHP team will look at organisations that already have new facilities.[27] However it decides to proceed, NHP needs to get the Hospital 2.0 design and build right, otherwise all new hospitals will have problems in years to come.[28]

Assumptions underlying new standard hospital design

16. With the aim of minimising costs while still meeting its programme objectives, the NHP team has been focusing on a basic version of Hospital 2.0, known as the 'minimum viable product' (MVP). Under MVP, hospitals will have the minimum viable set of services, in the minimum viable building size, built to the minimum viable specification, and at the minimum viable cost and time to build. All hospitals from cohort 3 onwards will have single rooms only, instead of open wards.[29] But some of the assumptions used to determine the size of an MVP hospital are likely to result in hospitals that are too small to meet future needs, which would be a risk to efficiency and effectiveness as well as presenting clinical challenges:[30]

- MVP assumes there will be a 1.8% reduction each year in hospital capacity needed as a result of more people being treated outside hospital, in the community.[31] This may be unrealistic because NHS England does not currently have a funded strategy to deliver such reductions and government has not produced

24 C&AG's Report, para 6
25 Qq 29–31
26 Qq 60, 117
27 Qq 78–79
28 Q 117
29 C&AG's Report, paras 3.9–3.11
30 Q 61; C&AG's Report, para 24
31 C&AG's Report, para 3.14

a long-term plan for social care. Neither does the assumption take account of a number of significant pressures outside hospitals, including in adult social care, community mental health services and GPs.[32]

- MVP also assumes that future patients will stay in hospital for 12% less time on average. This may be unrealistic because England already has one of the shortest lengths of stay per patient of any country in the Organisation for Economic Co-operation and Development (OECD) – 4.5 days on average in England in 2019–20, compared with 8 days in the OECD. NHP even paid for research which did not back up this assumption.[33]
- Finally, MVP assumes that future bed occupancy will run on average at 95%. Once again, this may be unrealistic because England already has a very high rate of bed occupancy relative to other countries – 90% in 2019 compared with an OECD average of 76%. NHS England currently has a priority to keep occupancy below 92%.[34]

17. In written evidence to us, NHS Providers advised that the standardised design had to be sufficiently future-proofed to handle changes in demand, practice and public expectations. It was concerned that future planned bed occupancy levels should be safe, and warned that 95% occupancy "may not be sustainable" and might not be flexible enough to allow hospitals to cope with fluctuations in demand.[35]

18. We challenged DHSC about the realism of the MVP assumptions, particularly in the context of a growing and aging population, and asked if it would review them. DHSC told us that these were baseline assumptions, enabling like-for-like comparisons to be made between schemes, and that it was going through a process to decide what size each new hospital needed to be. It assured us it was going to review the assumptions rigorously.[36] As discussed later in this report, however, any deviations from MVP to make individual hospitals bigger may create an affordability problem for NHP, because the hospitals will cost more.

19. We asked NHS England whether it was concerned about the assumptions and if switching to wards with single rooms only was safe. It told us that it was working with the NHP team and that Hospital 2.0 must be fit for purpose and thoroughly tested. It also wanted services in community, primary care and social care to change in a way that would support the aim of reducing the time patients spend in hospital.[37] Regarding the safety of single rooms, NHS England assured us that new hospitals could safely monitor and oversee single rooms by adapting their clinical models of care. Some other developed countries already have single rooms as standard and in some it is a legal requirement.[38] NHS England acknowledged that there would need to be a change in staff mix, and potentially an increase in staff numbers, to cope with the new single-room layout.[39]

32 Qq 61, 66; C&AG's Report, para 3.14
33 C&AG's Report, para 3.14
34 C&AG's Report, para 3.14
35 NHP0005
36 Qq 61–66
37 Qq 65, 74
38 Q 69
39 Q 70

2 Dealing with reinforced autoclaved aerated concrete (RAAC) and transparency of selection

Dealing with RAAC

20. Reinforced autoclaved aerated concrete (RAAC) is a lightweight building material that was widely used from the 1960s to the 1980s. From the late 1990s, industry bodies warned that it was unlikely to remain structurally sound for more than 30 years after construction. NHS England became aware of its problem with RAAC from around 2019, after a school roof collapse led to a national alert in 2019 about the risk of sudden failure.[40] Mitigating the risk of structural failures from RAAC can be very disruptive to a hospital's operations. We visited two hospitals with RAAC and saw for ourselves the impact on clinical work. This included wards having to close urgently and the managing of patient admissions based on weight because of the risk of a floor collapse. DHSC confirmed that there was an impact on clinical spaces and NHS England told us "the management of RAAC can be really burdensome for local teams" and that mitigations could not completely eliminate risks.[41]

21. When the government announced the first 32 new hospitals in October 2020, it included just two hospitals with RAAC throughout (West Suffolk Hospital and James Paget University Hospital).[42] Five other hospitals with RAAC throughout that DHSC knew about and wanted to replace were not then included in the Programme. These five were added to NHP only when it was reset in May 2023.[43]

22. NHS England told us that it had set up a separate programme in 2019 to deal with RAAC.[44] In 2020, government committed to remove RAAC from the NHS estate by 2035, subsequently allocating £685 million for RAAC management and remediation for the period up to 2024–25.[45] This has been supplemented by £18 million of additional funding from NHS England in 2021–22 and 2022–23 as well as an unspecified amount from trusts' own capital.[46] By December 2022, DHSC had identified 41 NHS buildings with RAAC, spread across 23 trusts. This includes the seven hospitals with RAAC throughout.[47]

23. After the RAAC crisis in schools escalated in August 2023 and the Institution of Structural Engineers' guidance was updated, NHS England asked all NHS trusts to confirm they were confident that all RAAC buildings had been identified. At the time of our evidence session, NHS England thought it likely that some further RAAC buildings would come to light. Although it did not know the precise number, it thought it was likely to be in the tens and not the hundreds.[48] NHS England told us it aimed to have full surveys done of all the known RAAC sites in a matter of weeks, but the timing depended on having

40 Q 1; C&AG's Report, para 6
41 Q 24
42 C&AG's Report, Figure 12
43 C&AG's Report, para 10 and Figure 1
44 Q 1
45 C&AG's Report, para 6 and Figure 3
46 Qq 9–10; Letter from Shona Dunn, DHSC dated 26 September 2023
47 C&AG's Report, Figure 3
48 Qq 1–3

surveyors available. After our evidence session, DHSC published an update of the number of NHS trusts and hospital sites: as at 17 October 2023 there are 42 hospital sites at 39 NHS trusts where RAAC is still to be removed.[49] There are a limited number of specialist engineering firms that can undertake this work, and NHS England acknowledges that it is "fishing in the same pool" with the Department for Education which also needs surveyors for schools.[50] This is vital work but also time-consuming. Visual inspections of ceilings may be insufficient as they cannot substantiate one way or the other whether structures above the ceiling are made of RAAC. Invasive inspections can in themselves be disruptive.[51] In written evidence to us, the Manufacturing Technology Centre advocated a RAAC mitigation strategy to coordinate and resource the response across government.[52]

24. NHS England also provided us with an update on its progress in dealing with known RAAC buildings. At the time we took evidence in September, it told us that there were projects to remove RAAC from the then 24 sites where it had a full understanding of the issues. It was aiming to eradicate RAAC in most places by 2030.[53] We asked whether there would be enough money to continue and complete remediation after 2024–25, when current funding runs out. DHSC told us that it had no reason to think there would not be enough funding but that this would have to be considered as part of the next spending review.[54]

25. We asked whether NHS trusts were getting adequate help from national bodies given the risks they had to manage. NHS England told use that it was helping trusts to source the right technical support, but trusts themselves were responsible for managing their estate and the risks within it.[55] Trusts were already expected to complete a full survey of their estate every five years.[56]

26. The seven RAAC hospitals each has a replacement cost estimated at between £500 million and £1.5 billion.[57] NHP intends to build all seven RAAC replacement hospitals by 2030 using its standard Hospital 2.0 design. DHSC and NHS England are prioritising NHP schemes above other kinds of capital investment and recognise that they must replace the RAAC hospitals as quickly as possible.[58] They told us it would be a challenge to complete them by 2030 because of the size of the schemes and the fact that only some of them have previously developed plans.[59] Hospitals with extensive structural problems due to RAAC, even with mitigations, might be at risk of closure right up until the day they are replaced.[60]

49 DHSC, Transparency data: Hospitals with RAAC in England, 19 October 2023; accessed at www.gov.uk/government/publications/reinforced-autoclaved-aerated-concrete-raac-in-hospitals-management-information
50 Qq 5–6
51 Q 28
52 NHP0007
53 Q 1
54 Q 8
55 Qq 16–20
56 Q 22; Letter from Shona Dunn, DHSC dated 26 September 2023
57 C&AG's Report, Figures 17 and 18
58 Qq 13, 25
59 Qq 1, 14–15, 25
60 Qq 24, 111

Transparency of the scheme selection process

27. DHSC launched a major capital investment programme, the Health Infrastructure Plan (HIP), in 2019. It comprised 27 schemes, all of which joined NHP in 2020. When one of the HIP schemes was split into five separate schemes, the total number grew to 31. An additional scheme (Shotley Bridge Hospital) was then added, making 32 new hospital schemes in the original NHP announcement. A further eight unspecified new hospital schemes were also promised.[61] To bring the total schemes under NHP's management to 48, eight pre-existing schemes were also moved into the programme.[62]

28. Selection of the 27 HIP schemes was carried out by DHSC and NHS England. NHS England produced a long list of 56 possible schemes, and DHSC reduced this to a shortlist of 20 schemes using clear, evidence-based criteria.[63] However, to arrive at that 27 schemes that were announced, DHSC included only 13 of the 20 shortlisted schemes, and removed the other seven. DHSC added another 14 schemes. These had previously been considered but had not scored highly enough in the assessment exercise. Officials told the National Audit Office (NAO) that there was no further documentation available to explain how this final selection was arrived at. This failure of documentation practices meant the NAO had no basis to determine why DHSC selected the 27 HIP schemes and not some of the other shortlisted schemes.[64] NHS Providers noted that all NHS trust leaders would be concerned about this and would expect such decisions to be made transparently, using clear criteria to evaluate all schemes that applied.[65]

29. We asked DHSC how this serious failure could have occurred and what it was doing about it. DHSC's Second Permanent Secretary confirmed that there was no record from that time which was "extremely disappointing" and said she had improved record keeping in DHSC and hoped a similar omission would not occur now. She told us there were a lot of discussions about scheme selection for HIP. Her predecessor told her he was satisfied that the decisions were made on an appropriate basis. We asked whether interventions in respect of ministers' or special advisors' political priorities might have caused the evidence-based shortlist to change in a way that was not appropriate. The Second Permanent could only say that she was "pretty confident" that her predecessor would have been "pretty confident" in calling out such behaviour.[66]

30. We have previously expressed concern about a lack of evidence and transparency to justify scheme selection in other parts of government.[67] In our 2020 report on the Towns Fund, we found that the Ministry of Housing, Communities and Local Government was not open about the process it followed and did not disclose reasons for selecting or excluding particular towns. This lack of transparency fuelled accusations of political bias in the selection process.[68] In our 2022 report on local economic growth, we found that the

61 C&AG's Report, paras 1.8 and 2.7, Figure 5
62 C&AG's Report, para 1.10
63 C&AG's Report para 1.9
64 C&AG's Report, paras 9, 1.8 and 1.9
65 NHP00005
66 Qq 102–107, 115, 116
67 Q 108
68 Committee of Public Accounts, Selecting towns for the Towns Fund, Twenty-Fourth report of Session 2019–21, HC 651, 2 November 2020

Department for Levelling Up, Housing & Communities' principles for awarding grants of levelling-up funding were only finalised by ministers after they knew which bidders would win grants as a result.[69]

31. We asked witnesses about the implications for the seven schemes that had been removed from the shortlist. For example, it was reported that in August 2023 a ceiling at the hospital in Doncaster collapsed and that there was a risk of the facility closing. NHS England told us that the NHS had to manage these and other risks, such as flooding and fire, "day in, day out". This was linked to the big increase in the maintenance backlog and NHS England had other funds available to help with these situations. It would though continue to argue for increased investment.[70]

69 Commons Committee of Public Accounts, Local economic growth, Fifth Report of Session 2022–23, HC 252, 8 June 2020

70 Qq 111–113

3 Future funding, use of consultants and transfers of capital

Future funding

32. The Government's announcement of the New Hospital Programme in October 2020 stated that the 40 listed schemes (cohorts 1 to 4) would be "fully funded". However, in the 2020 Spending Review, HM Treasury only allocated capital funding of £3.7 billion to the NHP for the four years up to 202425; this did not amount to full funding for the 40 new hospitals and the eight pre-existing schemes. There was no indication at that point of what further money it would give up to 2030. In March 2023, HM Treasury finally agreed a funding envelope and scope for NHP up to 2030–31 (subject to future spending reviews). According to this, the maximum NHP could expect to spend on the programme from 2025–26 to 203031 was £18.5 billion.[71]

33. We have previously reported on many of government's major projects and, time and again, we have seen difficulties with keeping to budgeted costs.[72] This might well be repeated with NHP. Forecast costs for the 18 schemes in cohorts 1 and 2 increased by 41% between 2020 and 2023.[73]

34. DHSC faces a number of specific pressures that could make cost overruns more likely. If any of the key assumptions underlying the MVP model of Hospital 2.0 prove overly optimistic or detrimental to future healthcare provision, such as the assumed 95% bed occupancy rate, then NHP may require more funding than has currently been allocated by HM Treasury.[74] DHSC also told us that the current funding does not include hospitals scheduled to commence reconstruction in the 2020s but to complete after 2030.[75] That would mean substantially more funding being required from HM Treasury to build the eight cohort 4 schemes that were recently delayed into the 2030s.[76]

35. The NHP team also has to manage a number of commercial risks to the programme which could impact affordability and deliverability. These include a lack of capacity in the UK construction industry, and the significant investment needed in new factory capacity for modular, offsite construction. High inflation in the construction sector (around 14% a year from May to December 2022) might also result in companies being increasingly unwilling to bear the risk of inflation in contracts.[77]

36. We highlighted to DHSC that there seemed to be a black hole in the funding allocated compared with what would be required to get all the hospitals in the programme built, and asked whether it was discussing the issue with HM Treasury. DHSC told us that it had frequent discussions with HM Treasury and considered the funding was sufficient and

71 C&AG's Report, paras 8 and 19
72 Committee of Public Accounts, Lessons from major projects and programmes, Thirty-Ninth Report of Session 2019–21, HC 694, 29 January 2021
73 C&AG's Report, para 13, Figure 8 and Figure 9
74 Q 73
75 Q 46
76 C&AG's Report, para 4.2; Letter from Shona Dunn, DHSC dated 26 September 2023
77 C&AG's Report, Figure 11

that it had taken account of optimism bias and inflation. It intended to confirm details through the full business case process.[78] It said that if circumstances continued to change then DHSC would have to take account of new pressures as they arose.[79]

Use of consultants

37. NHP is a long-term programme with at least eight of the current schemes now due to complete sometime during the 2030s, as part of what DHSC intends will be a rolling programme.[80] One of NHP's strategic objectives is to build national capability in planning and delivering new hospitals. This is to be achieved through a central team, the NHP team, whose functions include some previously performed in local NHS trusts with assistance from private-sector partners. It is normal for consultants to have a role to play in programmes such as NHP, where specific professional or technical expertise is required for certain activities.[81] Typically a programme would aim to have a strong core team and bring in consultants to fill gaps at the margins or for short-duration tasks.[82]

38. In February 2023, 223 (62%) of the 361 positions in the NHP team were filled by consultants. Consultants outnumbered permanent employees by roughly two to one. Over the period from April 2021 to March 2023, £70 million (79%) of the NHP's total day-to-day expenditure went on consultancy services.[83] DHSC told us that it had to choose between making an extremely slow start to the programme, with just those individuals it could recruit, or to start with a larger amount of external consultancy support. It told us it expected later to make a transition to a new operating model, suggesting it would rely less on external support in future.[84]

39. However, DHSC's actual plans seem to contradict this, indicating an ongoing reliance on external delivery partners to provide professional and technical skills and for specific assignments. It estimates that it will spend £842 million on consultancy services between 2023–24 and 2030–31, which represents 75% of its total day-to-day expenditure for those years.[85] Such a reliance in a long-term programme can be very expensive as well as risking a lack of continuity and loss of knowledge.[86] DHSC said that many of the consultants would always be necessary but, having firmed up the scope of the programme, it was now starting to recruit towards the planned operating model.[87]

Transfers of capital funding

40. This committee has highlighted many times in the years since 2016 that DHSC has focused on short-term survival of NHS services, while neglecting long-term sustainability,

78 Qq 49–51
79 Q 94
80 Q 91; C&AG's Report, para 4.2
81 C&AG's Report, paras 3.17 and 3.19
82 Q 109
83 Q 109; C&AG's Report, para 18
84 Qq 109, 110
85 C&AG's Report, para 18
86 Q 110; C&AG's Report, para 18
87 Q 110

and has criticised DHSC's lack of long-term planning for capital investment.[88] A key aspect of this has been the diversion of the NHS's planned capital funding to meet daytoday funding pressures: DHSC diverted £4.3 billion of capital funding in this way from 2014–15 to 2018–19.[89] Under-investment in the NHS estate partly caused the record maintenance backlog of £10.2 billion in 2021–22, which was twice as high as in 2013–14.[90] In February 2023, we again warned about the increasingly decrepit condition of much of the NHS estate, the escalating maintenance backlog, and how DHSC seemed unable to make timely decisions to address these problems.[91] This Committee has also reported before that Accounting Officers only rarely flag concerns they have about value for money using the formal mechanism of seeking a ministerial direction, which would alert Parliament to high-risk decisions.[92]

41. In written evidence, the NHS Confederation also highlighted to us that the NHS was suffering because of the under-investment in capital. It said this was hampering productivity and efficiency at a time when record numbers of adults were unable to work owing to ill health and progress needed to be made on the long NHS waiting lists.[93] According to the NHS Constitution, NHS providers are required to comply with legal requirements to deliver care in a clean, secure and suitable environment that is properly maintained. Parts of the NHS estate do not meet the demands of a modern health service.[94]

42. We asked DHSC whether NHP would affect the maintenance backlog. DHSC told us that the programme would help to address the backlog because around a third of the reported backlog was at sites that would be redeveloped or replaced by an NHP scheme. NHS England accepted that there would be some interim spending on the maintenance of buildings that would be replaced, but also noted that this might be necessary for patient and safety care.[95]

88 Committee of Public Accounts, Sustainability and financial performance of acute hospital trusts, Thirtieth Report of Session 2015–16, HC 709, 15 March 2016; Committee of Public Accounts, Financial sustainability of the NHS, Forty-third Report of Session 2016–17, HC 887, 27 February 2017; Committee of Public Accounts, Sustainability and transformation in the NHS; Twenty-Ninth Report of Session 2017–19, HC 793, 27 March 2018; Committee of Public Accounts, NHS financial sustainability: progress review, Ninety-First Report of Session 2017–19, HC 1743, 3 April 2019; Committee of Public Accounts, NHS capital expenditure and financial management, Eighth Report of Session 2019–21, HC 344, 8 July 2020.

89 C&AG's Report, para 5

90 C&AG's Report, para 5

91 Committee of Public Accounts, Introducing Integrated Care Systems, Thirty-Fifth Report of Session 2022–23, HC 47, 8 February 2023

92 House of Commons Committee of Public Accounts report, Accountability to Parliament for taxpayers' money, Thirty-Ninth Report of Session 2015–26 [summary], HC 732, 4 May 2016

93 NHP0004

94 C&AG's Report, para 1.2

95 Qq 86, 90

Formal minutes

Thursday 9 November 2023

Members present

Dame Meg Hillier, in the Chair

Sir Geoffrey Clifton-Brown

Mr Jonathan Djanogly

Mrs Flick Drummond

Peter Grant

Ben Lake

Anne Marie Morris

Sarah Olney

Declaration of interests

The following declarations of interest relating to the inquiry were made:

7 September 2023

Sir Geoffrey Clifton-Brown declared the following interest: Fellow of the Royal Institute of Chartered Surveyors.

The New Hospital Programme

Draft Report (*The New Hospital Programme*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 42 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

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

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

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

Adjournment

Adjourned till Monday 13 November at 3.30 p.m.

Witnesses

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

Thursday 7 September 2023

Shona Dunn CB, Permanent Secretary, Department of Health and Social Care; **Natalie Forrest**, Senior Responsible Owner for the New Hospitals Programme, Department of Health and Social Care; **Amanda Pritchard**, Chief Executive, NHS England; **Julian Kelly**, Chief Financial Officer and Deputy CEO, NHS England; **Professor Sir Stephen Powis**, National Medical Director, NHS England Q1–117

Published written evidence

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

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

1 Action4Whipps (NHP0006)

2 British Medical Association (NHP0008)

3 Manufacturing Technology Centre (NHP0007)

4 NHS Confederation (NHP0004)

5 NHS Providers (NHP0005)

6 New Hospital Campaign (NHP0003)

7 Puntis, Dr John (NHP0010)

8 Ruane, Dr Sally (NHP0009)

List of Reports from the Committee during the current Parliament

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

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