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Layla Moran MP
Sent by email to:
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Dear Layla Moran,

It was a pleasure for the team to meet with you during your recent visit to Cornwall and I am pleased that your committee held a significant interest in NHS estates and infrastructure which is a subject matter that rarely manages to gain such interest at parliamentary level despite its importance. We are also grateful for the opportunity to hold a follow up session with your administrative team to provide further technical detail that you found of material interest in attempting to understand some of the particular challenges that we face in the delivery of our NHS estates. To ensure that you are able to capture the information that you found of most interest, I have provided a brief prompt of each area in order to assist you in your parliamentary work accordingly.

NHS and Local Authority Estates Collaboration

The colocation and sharing of estate between NHS and Local Authority typically occurs at surface level where particular types of administrative estate lend itself to hot desking, housing back office functions and non-patient facing services and usually where minimal investment is required for adaptions. These initiatives are also supported well through collaboration with our local One Public Estate function, usually hosted by the main local unitary authority within each system.

This is however where the opportunities are usually limited and the common ambition of joint, NHS or local authority derived capital investment for the delivery of

collocated patient and resident facing services is especially difficult to achieve despite the tremendous aspiration systems have to deliver such facilities.
The barriers to delivery span across multiple governance and regulatory framework areas which makes the NHS an especially difficult partner to work with or invest in, despite how attractive we are as a strong covenant as a tenant in investment class assets. Amongst the various prerequisites is the administrative processes that the NHS has to undertake in order to obtain and spend capital funds, or guarantee revenue payments for rental costs and the particular funding framework that primary care services are subject to which is rather unique from a local authority perspective and especially unattractive from a PWLB funding arrangement. I have not drawn into the detail in this section and some of the following points within my letter help expand in these areas, however it is not uncommon for new NHS community assets to take 5-10 years from planning to practical completion which makes local authority partnerships difficult to establish from either a tenant or investment perspective.

NHS Capital Allocations

Recent changes to the regime have enabled multi-year settlements for NHS capital allocations which is much welcome news as we are now able to plan expenditure for three years in advance rather than on an annual cycle.

There are still however many challenging and administrative aspects to this process which from a local perspective does not feel like true change is occurring. Capital allocations for property are not freely allocated to the local system from a practical perspective and held locally for use flexibly as needed. It is very common for projects to slip in time scales due to reasons relating to delays, statutory planning applications or community interests wanting to escalate changes in service provision to a scrutiny committee for example. Where such common delays occur, it would be a regular occurrence for the allocation to be subject to a significant administrative process to then be moved into another financial year, often placed at risk and competing against other allocations locally or within the region which creates further workloads and anxieties that put the scheme at risk. This is due to how the regional NHS finance teams are required to account for the funds within year, and how slippage and allocations are treated. Equally and conversely in order to avoid this situation form occurring, it is common for a requirement to commit or spend the capital allocation for that financial year in a manor to satisfy an accounting and administrative requirement rather than in a way which is most beneficial for the construction project in order to avoid the red tape. In a local authority setting where there is no borrowing, the funds would typically sit in reserve and be available to draw down when required irrespective of financial year and without such conditions as the authority is directly accountable for their finances.

Capital Departmental Expenditure Limits (CDEL)

This is an especially challenging regulation which was highlighted in the Patricia Hewett Review which hampers NHS organisations in the delivery and operation of estate and equipment. We have unfortunately had multiple projects collapse due to an NHS provider organisation failing to hold enough coverage within either its capital

or lease CDEL thresholds for the project due to competing priorities of other investments required. This is one of the largest disincentives for new community facilities to be developed and owned, or leased by an NHS provider organisation unless coverage can be guaranteed.

Section 106 Funds (Health Infrastructure)

The development of NHS primary care and community infrastructure remains heavily reliant on developer contributions secured through Section 106 agreements. In practice, this system presents a number of persistent structural challenges.
Firstly, there is no consistent or mandated approach across local planning authorities (LPAs) in how NHS infrastructure is prioritised relative to other demands such as education, transport, and affordable housing. While there is sometimes increasing recognition of primary care requirements at a local level, this is not consistently applied and remains highly variable. In contrast, acute infrastructure requirements are frequently challenged or refused altogether within planning negotiations, despite clear system-wide capacity pressures. This inconsistency further reinforces the need for a clear national approach that reflects the full spectrum of NHS infrastructure requirements, covering both primary and acute provision.

Secondly, the NHS is required to evidence need and scheme viability at a level of detail that is often disproportionate to the early stage of planning applications when S106 contributions are negotiated. Unlike education, which benefits from clearer national methodologies and assumed pupil yields, there is no universally applied planning model for healthcare capacity. This results in protracted negotiation, delays, and in some cases missed opportunities where agreements are concluded before healthcare requirements are fully recognised.

Thirdly, timescales and alignment present a significant barrier. S106 funds are typically tied to specific developments and trigger points, which do not always align with NHS capital planning cycles, estate strategies, or provider readiness. This can lead to fragmentation, multiple small contributions that are difficult to aggregate into deliverable schemes or funds being at risk of return if not utilised within defined periods.

We have also seen instances where securing appropriate contributions has required escalation or legal challenge, reflecting the lack of a clear statutory footing for NHS infrastructure within the planning system compared to other sectors.

Potential system improvements / policy asks
To address these challenges and support the Government's Neighbourhood Health Centre ambition, the following changes would have material benefit:

- **Nationally standardised methodology** for calculating healthcare infrastructure requirements linked to housing growth (covering both primary care and acute services), analogous to education yield models.
- **Clearer statutory recognition of NHS infrastructure** across primary, community and acute care as essential community infrastructure within the planning framework.

- **Greater consistency in LPA decision-making**, reducing local variation in how healthcare contributions are prioritised and secured.
- **Greater flexibility in the use of developer contributions**, including the ability to pool funds across developments and extend spend timeframes to align with NHS delivery programmes.
- **Earlier and more formalised engagement requirements** between LPAs and NHS systems (e.g. ICSs) to ensure healthcare needs are embedded upstream rather than negotiated late.
- **Consideration of alternative or complementary mechanisms**, such as the Infrastructure Levy, to provide more predictable and scalable funding flows.

Overall, while S106 remains a critical funding mechanism, as acknowledged in the NHS Capital Guidance, its current operation introduces uncertainty, delay, and inequity for NHS estate development. A more standardised, nationally supported approach covering both primary and acute infrastructure would significantly improve our ability to plan and deliver neighbourhood-based care in line with population growth.

Finally I would like to add that we spend £160,000 per annum on staffing overheads for Devon and CIoS, dedicated to undertaking the application and business case work for applying to local authorities for Section 106 funds.

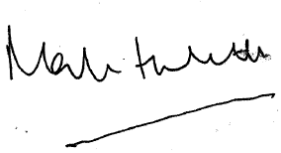
Primary Care Estate Payment Mechanisms

The funding mechanism for primary care estate is especially unique and creates challenges on all fronts with investment funds, tenancy requirements, the sharing of facilities and administrative burdens. Under the legislation that governs this area a specific mechanism designed to protect public funds for rental reimbursement levels also causes significant challenge where the commissioner should only fund a rental reimbursement for primary care services at the specified level via assessment with a District Valuer's report. Since 2020 and in combination with higher interest rates, construction inflation has been significant and developers in many of our schemes are unable to achieve the project delivery at a cost which would result in the rental yield being in line with the District Valuers assessment and therefore a project is unable to materialise under the regulation unless the commissioner finds a way to make an exception under special provisions to fund a rental reimbursement outside of the standard process. This is an especially complicated area but there is a clear trend within our system and a view commonly shared by my counterparts in other systems which makes primary care anchored projects especially difficult to commission.

Given new PPP is being proposed as a key mechanism for the delivery of the Neighbourhood Health Centre programme and with schemes namely anchored by primary care, I would highly recommend a review of this mechanism which would still afford the protection to public funds being paid to a private GP contractor, but would equally provide the flexibility commissioners required to ensure the successful delivery of construction projects.

I hope this letter can assist you further with your parliamentary work, please do not hesitate to contact me should you require further support in any area relating to estates, facilities and infrastructure.

Yours sincerely,



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