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The Future of Capital Funding and Neighbourhood Health Estates

CHAired BY OZAN GOCEROGLU



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Key Information

ABOUT PPP

Public Policy Projects (PPP) is an independent organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery.

ABOUT PPP'S NEIGHBOURHOOD PROGRAMME

The government has vowed to create a neighbourhood health service. PPP is supporting this objective through an independent policy and engagement series.

This series aims to add value to the national and local debate on neighbourhood health by exploring issues that are not sufficiently addressed in existing forums. The series will focus on the practicalities of delivery, providing real-world route maps, case studies, and step-by-step examples of how local systems can move from strategy to implementation.

ABOUT THIS REPORT

This report summarises the insights from a roundtable held on 26th February 2026, supplemented with supporting and contextual evidence. The roundtable was chaired by Ozan Goceroglu, Relationship Specialist at NHS Property Services Ltd, bringing a strong relationship management perspective across NHS stakeholders, complemented by experience in healthcare investment strategy. A full list of roundtable attendees is included at the end of this report.

Hawley Building Services has provided sponsorship for this roundtable and report. PPP has retained full editorial control over the roundtable agenda and report content.

Foreword



OZAN GOCEROGLU

Relationship Specialist, NHS Property Services Ltd

The NHS estate is about far more than buildings. It plays a fundamental role in shaping how care is delivered, how staff work, and how communities experience health services. As the NHS continues to move towards more neighbourhood-based models of care, it's becoming increasingly important that our infrastructure evolves alongside that ambition.

It was a pleasure to chair this roundtable and bring together colleagues from across the public and private sectors to discuss some of the opportunities and challenges ahead. What stood out throughout the discussion was the shared recognition that delivering neighbourhood health successfully will depend not just on policy ambition, but on practical collaboration, long-term thinking and making better use of the assets and partnerships already available to us.

A consistent theme throughout the conversation was the need to take a more place-based and joined up approach. Delivering care closer to home is not simply relocating services, it requires a clearer understanding of local population health needs, alongside a more deliberate approach to how estate is planned, used and integrated within wider community settings. This includes making better use of existing assets, working more collaboratively with partners and considering how infrastructure can support both clinical outcomes.

The discussion also highlighted the importance of learning from previous capital funding models. As the NHS moves beyond legacy

approaches such as PFI, there is an opportunity to develop more balanced and transparent private capital funding models that better align risk, value, and long-term outcomes. At the same time, ongoing financial constraints mean that organisations must continue to take a pragmatic and commercially informed approach to estate investment decisions.

From my perspective, one of the most important aspects of delivering this successfully is collaboration. None of these challenges sit with one organisation alone, and meaningful progress will rely on partners across the public and private sectors working openly together, aligning priorities and maintaining a shared focus on improving health outcomes for the communities we serve. We must ensure the estate which is developed meets clinical and population health outcomes alongside a funding model which provides value-for-money.

This report captures the key insights from the discussion and contributes to the broader conversation around neighbourhood health and the capital funding element. I would like to thank all participants for their openness, engagement and contribution throughout.

While there is no single solution to the challenges outlined, there is a clear opportunity. By taking a more coordinated, practical, and forward-looking approach, the NHS can shape an estate that support a clinical model which meets the needs of the communities it serves.

Key Insights

1. Evolving from PFI to future partnership models

- **Legacy PFI pitfalls:** PFI structures often lost their initial long-term vision, resulting in overly complex, multi-layered concessions that failed to properly account for ongoing maintenance requirements.
- **Mutual Investment Model (MIM):** MIMs (a form of PPP) could offer a better framework by sharing risk between partners, promoting transparency, and sharing local benefits.
- **Shared accountability:** To avoid inflating project costs, risk cannot solely rest on the private sector; early supply chain engagement and shared accountability are essential for affordable commercial arrangements.

2. Managing financial and legal risks

- **PFI expiry:** With 650 PFI contracts expiring within the next five years, the NHS requires dedicated leadership and resources to manage dispute resolutions and avoid severe financial exposure.
- **Private capital costs:** While private capital enables development, it introduces significant long-term costs, such as high

service charges and strict lease accounting rules that heavily impact NHS balance sheets.

- **Alternative funding:** Trusts are mitigating financial constraints by leveraging Section 2 agreements with local authorities and utilising charitable or developer capital to fund essential infrastructure projects.

3. Value-based priorities for neighbourhood health

- **Place-based planning:** Neighbourhood health requires localised, place-based planning rather than a one-size-fits-all approach. The aim should be integrating services within a community's existing ecosystem and adapting to demographic needs.
- **Rethinking ROI:** Shifting care from expensive acute hospitals into community settings could generate significant savings.
- **Creative asset use:** Delivering the "left shift" requires repurposing existing commercial and green spaces, such as placing diagnostic centres in retail or office outlets or using NHS green areas for social prescribing.
- **Embedded sustainability:** Net-zero targets must be integrated directly into initial partnership models and design requirements.

Roundtable findings

INTRODUCTION

In last year's autumn budget, the UK Government revealed plans for 250 neighbourhood health centres and a £300 million tech boost.¹ This initiative will be delivered through the NHS Neighbourhood Rebuild Programme, which will leverage a combination of public investments and Public-Private Partnerships (PPPs) to repurpose underused buildings and create new facilities.

For decades, capital shortfall within the NHS contributed to worsening productivity, dilapidated buildings, and a nearly £16 billion maintenance backlog crisis.² Establishing modern, efficient, and sustainable built infrastructure will be critical for the long-term financial stability of NHS organisations across the country. Building upon provisions within the 10-Year Health Plan for England (10-Year Plan), there is an opportunity to re-examine how industry service providers can work with NHS leaders to rescue the national healthcare estate and deliver better value for money, especially at a neighbourhood level.

Under the 10-Year Plan, individual trusts will be afforded greater autonomy over their expenditures alongside a renewed push to incentivise third party investment. With ageing buildings, rising backlog maintenance costs, growing patient demand, and evolving sustainability requirements, now is a critical time to consider whether public capital can be protected, directed, and co-invested to create a resilient NHS. For this reason, PPP convened NHS leaders, policy makers, industry experts, and other stakeholders for a timely roundtable discussion around investment strategies and collaborative best practices with the potential to modernise critical NHS assets while preserving service continuity.

Chaired by Ozan Goceroglu, Relationship Specialist at NHS Property Services Ltd, the conversation sought to cover several key issues:

- **Evolving PFI:** Evaluating the lessons learned from the initial PFIs schemes and exploring new ways for the public and private sectors to collaborate, ensuring transparent partnerships and shared accountability.
- **Managing financial and legal risks:** Navigating the expiry of hundreds of PFI contracts and the long-term costs of utilising private commercial/institutional capital.
- **Value-based priorities for neighbourhood health:** Examining flexible, place-based investments necessary to deliver the 'left shift', which involves moving care closer to patients' homes, creatively repurposing existing spaces, and building future-fit assets with embedded sustainability and resilience targets.

This report captures the insights shared during the roundtable, highlighting lessons learned from previous partnerships, creative approaches to capital funding, and significance of a flexible, place-based approach to address pressing local health infrastructure challenges.

INSIGHTS

#1 Evolving from PFI to future partnership models

The UK government plans to build 250 neighbourhood health centres by 2030 and leverage new funding to tackle the nearly £16 billion NHS maintenance backlog. To achieve this goal, investments within urgent repairs and maintenance must accompany new long-term approaches to the management of public health infrastructure. In the context of new neighbourhood health asset developments, the role of private capital ought to carefully avoid structural flaws that defined past funding agreements.

Legacy PFI pitfalls: Introduced in the early 1990s, Private Finance Initiatives (PFI) became a major route for funding NHS buildings through long-term contracts covering construction, operation and maintenance. While many schemes were delivered within agreed timescales and budgets, PFIs have been widely criticised for creating long-term cost pressures, and questioned over whether they provided value for money.³

Factors like high private sector borrowing costs and ballooning projected costs during bidding processes resulted in expensive PFI arrangements. 2019 research by the IPPR found that by 2029, the NHS will have paid more than £80 billion for assets worth only £13 billion, highlighting a significant value-for-money deficit.⁴ Analysis from 2022 also found that 101 NHS trusts still owe just under £50 billion in future unitary payments, and that for four of these trusts, more than half of their total PFI unitary payment goes to interest to private companies. For example, about 58.3 per cent of all the money that Mersey Care spent on PFI was interest in 2020-21.⁵

Even when constructions were completed on time and within budget, PFI contracts locked public sector organisations into complex 25-30-year contracts, which often included rigid operational and maintenance terms. As a result, many agreements failed to adapt to changing clinical and maintenance needs (e.g. expanding hospital wards), leaving trusts with a number of inflexible and costly financial burdens that failed to achieve their evolving clinical objectives.

The long-term vision... is often lost through a multi-layered sort of concession structure where the end result isn't actually what you intended to do in the first place.

Moving forward, healthcare providers ought to avoid asymmetric provisions that characterised the previous generation of PFI contracts. These

severe and long-term financial burdens were so discredited that the Conservative government banned the use of new PFI contracts in 2018.⁶ Instead, healthcare organisations may favour collaborative models that fairly distribute profits and risk, maximise transparency, and mandate greater decision-making power with public partners.

Mutual Investment Model: To avoid past mistakes, newer partnership frameworks like the Welsh Mutual Investment Model (MIM) include various provisions to mandate a greater level of transparency. Under this model, the government co-invests in development projects as a minority equity stakeholder, enabling public sector representation in accountability and decision-making processes while ensuring that some of the project's associated profits are returned to the public purse. Other key characteristics of MIM include the exclusion of soft facilities management (FM) services, the exclusion of financing for capital equipment, and strict obligations on private partners to deliver local benefits.

So far, MIM has been responsible for £1.14 billion worth of investment in Wales.⁷ Used to fund Cardiff's Velindre Cancer Centre, this model aims to balance risk more equitably between public and private investors. Although ensuring effective coordination between partners can pose its own logistical challenges, MIM is generally recognised as providing a more transparent mechanism for securing capital than PFI.

These MIM models are the future; we can't magic money from anywhere. However, our experience with them is one with a lot of lessons learned.

Stakeholders currently using the MIM model expressed that the process of setting up internal teams to monitor the contract and track compliance marks a significant departure from PFI arrangements. Rather than receiving assurance and compliance reports alone, public

partners under MIM have a greater level of involvement and sustained communication throughout the lifecycle of their projects.

Importantly, within the current UK fiscal environment, MIM can enable certain capital investments to be structured in a way that sits outside traditional public balance sheet constraints, thereby limiting the impact on headline public borrowing metrics. In a context of constrained public capital, access to private investment through such models may provide a pragmatic route to progressing schemes that might otherwise be delayed or deprioritised due to wider funding pressures.

However, while MIM represents a positive evolution from PFI, its scalability will depend on system capability to act as an informed stakeholder, particularly in areas such as commercial negotiation, risk pricing and lifecycle asset management.

Shared accountability: Partnership models with greater public investment and sustained involvement could support more affordable commercial contracts, as they'd better share the financial and operational risks.

While previous PFI schemes nominally claimed to transfer risk to the private sector, this assertion is highly contentious in practice. Although private developers took on construction and performance risks, these were typically so heavily overpriced that the true burden arguably remained with the public sector. However, delegates also recognised that health service cannot attempt to pass all liabilities to private developers without artificially inflating total project costs.

We cannot pass all the risks to the private sector... as the NHS, we need to be able to work through how we manage risks ourselves, especially if we are going to have schemes that remain affordable.

Maintaining affordability requires early supply chain engagement to align both parties on the long-term vision, which includes making sure the public sector shoulders a sufficient burden of risk. From a commercial standpoint, true risk transfer must be evidenced rather than assumed. Where risk is inefficiently priced, the public sector tends to ultimately absorb the cost either directly through payments, or indirectly through constrained future investment capacity.

#2 Managing financial and legal risks

As the health sector scales its community-based infrastructure, it faces strict capital spending limits and an impending wave of expiring contracts.⁸ Securing necessary investments requires navigating rigid accounting rules and carefully structuring public-private commercial agreements.

PFI expiry wave: Over the next five years, more than 650 public sector PFI contracts will expire, representing a total capital value exceeding £50 billion.⁹ Managing this transition will require considerable attention and resources. In fact, to avoid costly operational disruptions, the Infrastructure and Projects Authority (IPA) and the National Audit Office (NAO) has warned that public authorities should begin preparing for contract expiry at least seven years in advance.¹⁰

There are 650 PFIs that are coming through for expiry over the next five years... we need to use the dispute resolutions as effectively as possible.

It's essential that NHS organisations understand key provisions for the expiry of their PFI contracts such as their agreed handover processes, asset conditions to satisfy compliance standards, and any continuing obligations that may bind parties after contract completion. This preparation could help trusts navigate legal disputes regarding asset conditions and reinstatement clauses.

Because many legacy PFI contracts feature vague handover criteria, trusts are vulnerable to inheriting degraded facilities that require immediate, unfunded remediation. An NAO survey of expiring contracts revealed that 86 per cent of expected end-of-term disputes relate directly to the quantity and cost of rectification works.¹¹

Without focused leadership, early preparation, and a clear understanding of contract expiry provisions, trusts risk financial exposure and the threat of inheriting infrastructure that fails to meet modern clinical standards. In turn, financial obligations could persist after contract expiration and impact the available capital for future developments.

Private capital costs: While private funding enables immediate infrastructure development, it introduces significant long-term financial burdens. Research by the NAO found that PFI and PF2 (the successor model to PFI contracts, used between 2012-2018) project costs are around 40 per cent higher than projects funded by government borrowing.¹² These prices can be driven by factors like higher borrowing rates for private organisations, substantial risk premiums, and transaction fees for complex agreements.

Organisations must evaluate whether they can sustain associated expenses over the lifespan of a facility. As of July 2025, public bodies are still due to pay £136 billion in unitary charges up until 2052-3 for all 665 ongoing PFI contracts, half of which are set to expire within the next decade.¹³

Private sector money comes at a cost, and we have to be really clear whether we can afford it... you very quickly hit some constraints and that needs to be managed.

Aside from borrowing costs, high service charges and strict lease accounting rules, specifically IFRS 16, place heavy constraints

on organisational balance sheets, effectively restricting financial agility.¹⁴ IFRS 16 requires all operating leases be recorded directly on the balance sheet, so trusts can no longer use leasing as an “off-balance-sheet” workaround. Integrated care systems (ICSs) operate under a strict limit on how much capital (debt/investment) they are allowed to take on, known as the single consolidated capital departmental expenditure limit (CDEL).

This means every private lease agreement directly eats into the same restricted regional budget allocated for capital expenditure spending (physical assets). As a result, some trusts are being forced into less ideal, shorter-term lease agreements to minimise the impact on their CDEL.

Alternative funding: To bypass rigid government capital limits and the high costs of private leases, trusts are increasingly being forced to think creatively, using alternative funding mechanisms that sit outside traditional central expenditure profiles. One growing strategy involves leveraging trust charities. NHS charities currently hold over £3 billion in collective assets.¹⁵ Trusts are partnering with these entities to utilise charitable debt to fund projects like key worker housing.

We are doing a homes for NHS [workers programme] ... using surplus chunks of land, which we're doing with one of the trust charities. So, they are actually going to put some of their own capital in and then raise debt through that model, which enables us to deliver a home for NHS staff at an affordable rent.

ICSs are also establishing agreements with local authorities to transfer public capital flexibly across the health and social care divide. Using Section 256 and Section 75 of the NHS Act 2006, councils and the NHS can legally pool their resources, allowing planners to bypass

traditional, siloed expenditure profiles and share the financial risk of new neighbourhood estates.¹⁶

We are taking leases from our councils; we're using Section 2 agreements in order to transfer money. We are creating affordable models with a more balanced risk-reward relationship.

Beyond financial relief, collaborative funding models further support value-based neighbourhood health. This shift is explicitly mandated by the newly published Better Care Fund policy framework for 2026 to 2027, which positions pooled funding as the primary lever to move care out of acute hospitals and into the community.¹⁷ By pooling resources with local partners, trusts can ensure that new investments are aligned with care outcomes, which in turn are aligned with community interests.

#3: Value-based priorities for neighbourhood health

Moving patient care away from acute hospitals and into local communities requires facilities designed around specific population demographic needs rather than a uniform national standard. Delivering this shift effectively relies on accurately measuring the impact of new community health models and maximising the utility of existing public assets.

Data from the UK Government's State of the Estate report (2022-23) highlights the financial significance of this approach, showing that NHS trusts delivered more than £363 million in estates-related efficiency savings between 2022 and 2024 through measures like strategic co-location and estate optimisation.¹⁸

Place-based planning: Neighbourhood health centres must integrate health services directly into existing community infrastructure. Planners must evaluate local populations to determine

the correct facility locations and healthcare service offerings, factoring in elements like housing, transport, and employment. Recent capital funding initiatives reflect this priority. The current £200 million rollout of the first 27 neighbourhood health centres explicitly focuses on adapting and repurposing existing buildings to maximise value from community-based assets and bring care closer to home.¹⁹

We need to take a population public health approach and enable those health estates to be planned within the wider ecosystem of local services.

Stakeholders argued against isolated clinical buildings and instead supported embedding health services within local spaces that already deliver community services. By physically co-locating diagnostics and medical treatment services with housing, debt, and employment support, capital funding can be used to create convenient and accessible healthcare that treats the root causes of health inequalities. Integrated estates bridge clinical intervention with social support, reducing the long-term strain on acute hospital admissions.

To justify these tailored local investments, financial models must evolve to capture the true economic impact of preventative care.

Rethinking ROI: Standard accounting balance sheets consistently fail to capture the financial value of preventative, community-based care. However, the operational value became clear as stakeholders discussed physical capacity.

The most expensive place you've got to treat anyone is an acute site. You maintain it 24 hours a day and the standards are extremely high... if you stepped back and said we can take X number of patients into a community setting, why wouldn't you?

Under broad economic modelling, the value of community-based healthcare services is consistent with stakeholder perspectives. Research from the NHS Confederation found that that every £1 invested into the NHS yields roughly £4 back to the economy, but this figure jumps to £14 per pound spent in the context of primary and community care, where spending falls short of relative needs.²⁰ This yield is largely attributed to prevention, as effective community services can manage chronic illnesses locally, reduce costly hospital admissions, and improve patient discharge and flow.

Financial returns aside, stakeholders argued that the value of neighbourhood health facilities requires a broader metric that factors in clinical outputs and community well-being.

Value isn't just what appears on a spreadsheet. We should also be measuring output performance, comfortability, how buildings are used, and the happiness of people who are using them day-to-day.

Failure to deliver and maintain health infrastructure can cause output to plummet; in 2024, the NHS lost more than 600 days of clinical time to failures on its estate.²¹ By prioritising user experience and clinical efficiency for local spaces that are less costly to operate, staff, and maintain than hospitals, healthcare providers may be able to better serve local needs.

Creative asset use: Delegates agreed that the health system must repurpose commercial and green spaces to reach patients more efficiently. Nationally, the push to integrate healthcare into commercial settings has supported the deployment of community diagnostic centres (CDCs).

Currently, 170 CDCs are in operation across England, and the UK Government has recently announced £237 million in funding to support their development.²² Many of these are located in shopping centres and retail parks, and have already delivered more than nine million tests and scans away from traditional hospital sites.²³ Placing neighbourhood health infrastructure like CDCs in high footfall areas such as shopping centres, can rapidly increase access to diagnostics, while boosting the local high street economy. Delegates argued that leveraging the NHS covenant more proactively when engaging with commercial partners would help support more favourable terms and strengthen the NHS' position within these settings.

How do we move that capacity and really embed it in our neighbourhoods in a way that actually builds on both patient visits and activity? [Woodgreen CDC] had a positive impact on footfall; the landlord is therefore pleased, and so are we.

Aside from facilities themselves, delegates noted that another high-value use of the NHS estate is to leverage underused land for accessible green spaces. In Britain, one third of people cannot access quality natural spaces within 15 minutes of home. Research shows that community-led green infrastructure delivers significant health benefits, as regular access to green space has been shown to reduce GP visits by as much as 28 per cent and could save the NHS £2.1 billion annually.²⁴

One delegate raised the NHS Greenspace Demonstration Project as an example to underscore how improved greenspace provisions in NHS can support public health. This project, held in partnership between NatureScot, Scottish Forestry, NHS National Services Scotland and Public Health Scotland, to improve the quality, accessibility, and public use of greenspace on NHS sites.

They create spaces for people to freely engage with, use as parks, use for social prescribing, and also to benefit hospital staff. It's been really successful.

Delegates agreed that local health infrastructure could make better use of the outdoor NHS estate to engage with local communities, improve health outcomes for those who receive treatment, support the prevention agenda, and contribute to NHS sustainability mandates, including net zero by 2045.

Embedded sustainability: With 6,500 hectares of land across England, the NHS is positioned to utilise its vast open spaces to restore local biodiversity, sequester carbon, and build physical resilience against climate-related externalities, such as urban heat islands and flooding.²⁵ Delegates agreed that sustainability targets must influence project design from the outset, rather than serving as retroactive additions. Treating sustainability as a fundamental requirement from the planning phase ensures that operational systems align with current environmental standards.

These partnership models have to be designed with that in mind, right from the beginning and as part of the entire maintenance cycle.

Embedding these targets into the initial commercial agreements prevents expensive future retrofits. This point is underscored within the NHS Net Zero Buildings Standard,

which mandates the phase out of fossil fuels for heating and water, embodied carbon limits, and strict efficiency metrics.²⁶ The standard notes that it is “significantly more disruptive and expensive” to retrofit technologies, compared to including these at design and construction stage.

Aside from emission reductions, delegates discussed how long-term resilience against compounding environmental risks such as heatwaves and flooding is central to the financial and operational viability of built assets.

It's also the resilience piece that can't be forgotten. From that very beginning stage, you need to consider the risk of flooding, extreme weather, and heat incidences.

Embedded sustainability builds resilience against the climate-related threats that can trigger operational failures and risk public capital investment. Currently, the NHS remains exposed to these extremes, as data from the UK Health Alliance on Climate Change reveals that over 90 per cent of NHS buildings in England are vulnerable to overheating.²⁷

Accounting for environmental risks during the design and planning phase safeguards neighbourhood health infrastructure from predictable environmental damage. As a result, resilient community hubs could provide local populations with a more reliable standard of service and uninterrupted access to care.

Conclusion

As the UK shifts to delivering care closer to home, the rapid and cost-effective development of neighbourhood health infrastructure will be a critical priority. Achieving government targets will require a careful re-evaluation of how public capital is structured, deployed, and protected.

As the NHS transitions away from the inflexible provisions of legacy PFI contracts, future frameworks must prioritise transparent risk-sharing and early supply chain engagement. By establishing shared accountability and providing the public sector with a greater stake in future collaborative projects, delegates agreed that it's possible to secure more affordable commercial agreements without artificially inflating costs.

However, securing third-party investment introduces financial and legal risks. With an impending wave of 650 expiring PFI contracts and strict commercial lease accounting rules, the health sector must actively manage its exposure. Proactive trusts are navigating these constraints by leveraging alternative funding streams and collaborative undertakings with local authorities to build affordable community assets. In doing so, the NHS can align new investments with local health priorities.

These local interests must dictate the physical design of new facilities as the health service

takes the 'left shift', transitioning care into local communities. Neighbourhood health infrastructure requires highly localised, place-based planning that creatively utilises existing commercial and green spaces. To justify these investments, the healthcare system must rethink its definition of value and parameters for an acceptable return on investment.

For delegates, project success cannot be measured on a standard balance sheet alone; stakeholders should account for broader metrics that include operational improvements and patient wellbeing. Delegates found that green space could be better leveraged to these ends.

Green space is also a component of the sustainability profile for health infrastructure projects, which ought to be prioritised within the initial design phase. Low-carbon and climate-resilient designs preparing for severe climate events, planners can ensure new local health infrastructure remains operationally and financially viable.

Ultimately, delivering neighbourhood health at scale will require a step change in how the NHS approaches using private capital, estates initiatives, moving from reactive capital deployment to proactive with commercially informed infrastructure planning.

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