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National Audit Office

REPORT

Update on the New Hospital Programme

Department for Health & Social Care

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National Audit Office

Update on the New Hospital Programme

Department for Health & Social Care

Report by the Comptroller and Auditor General

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

Gareth Davies
Comptroller and Auditor General
National Audit Office

7 January 2026

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Contents

Key facts 4

Summary 5

Part One
The reset of the New Hospital Programme 14

Part Two
The revised plan and progress towards building new hospitals 23

Part Three
Managing risks to delivery 36

Appendix One
Our audit approach 51

Appendix Two
New Hospital Programme schemes 53

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Key facts

46

total number of New Hospital Programme (NHP) schemes. The government committed funding to 41 schemes in January 2025, in addition to five that were already complete

£7.5bn

the Department of Health & Social Care's (DHSC's) upper estimate (net present value) of the additional savings and benefits of a centralised programme rather than multiple separate hospital building projects led by individual NHS trusts

£60bn

estimated total cost of the NHP from 2021-22 (adjusted for inflation in future years)

£9.6 billion	confirmed NHP funding for 2025-26 to 2029-30. DHSC expects further funding of around £3 billion a year between 2030-31 and 2045-46
£100 million to £140 million	estimate of the annual total additional cost to NHS trusts to maintain hospital buildings scheduled for replacement under the NHP
39%	vacancy rate within the NHP team as at November 2025
2045-46	estimated year of opening for the final hospitals included in the current NHP, subject to hospital business case approvals
2032-33	year DHSC estimates it will complete the final NHP schemes to replace hospitals built from reinforced autoclaved aerated concrete (RAAC)
6%	DHSC's assumption of the average planned increase in the number of overnight beds across 28 schemes to be built to the new Hospital 2.0 design
92%	bed occupancy rate assumed in the Hospital 2.0 design, in line with NHS England standards. This is less than the assumed rate of 95% when we last reported on the NHP in 2023

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Summary

1 The NHS has around 1,500 hospitals in England, of which around 210 provide emergency care. Where hospitals are older or in deteriorating condition, there may be significant risks to patient and staff safety and high maintenance costs. In 2020, following years of under-investment, the Department of Health & Social Care (DHSC) committed to build 40 new hospitals by 2030 through the New Hospital Programme (NHP). Hospitals in the programme will be built to a standard design with the aims of increasing cost-effectiveness and quality, and utilising the construction industry in a more coordinated way. Hospital construction had previously been funded centrally but designed and delivered locally by NHS trusts. The NHP is a joint endeavour between DHSC and NHS England (NHSE) to coordinate schemes centrally instead. DHSC has overall responsibility for the NHP and NHSE is responsible for its delivery. In this report, we refer to activities undertaken jointly as 'by DHSC' unless otherwise stated.

2 In 2023, we published a report examining whether the NHP was being managed effectively, was making progress on time, cost and quality and whether risks to delivery were being managed effectively.[1] We found that the NHP had so far not delivered value for money, and that the 2030 target of 40 new hospitals was not achievable.

3 Following the July 2024 general election, the new government carried out an internal review of the NHP and announced a new implementation plan in January 2025.[2] The new plan set out a longer delivery timetable and increased funding for the programme.

4 This report provides an update on progress on our 2023 report and whether the programme is now deliverable under the new plan. This report:

- sets out the history of the programme, the new implementation plan announced in January 2025 and what the programme aims to achieve (Part One);
- examines the progress that has been made towards building new hospitals (Part Two); and
- examines how DHSC is managing risks to delivery, including the extent that the new plan addresses issues raised in our 2023 report and by the Public Accounts Committee (Part Three).

5 This report focuses on the management of the programme as a whole. We have not carried out a detailed assessment of progress on individual schemes. We have not examined the wider management of NHS England's hospital estate or its condition. The programme and scheme costs in the report are from the NHP business case and are adjusted for inflation in future years, unless otherwise stated.

1 Comptroller and Auditor General, *Progress with the New Hospital Programme*, Session 2022-23, HC 1662, National Audit Office, July 2023.
2 Department of Health & Social Care, *New Hospital Programme: plan for implementation*, January 2025.

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Key findings

The review of the New Hospital Programme

6 In January 2025, the new government reset the New Hospital Programme, to put it on a more realistic timetable. The government committed to delivering all hospital schemes (including new hospitals, refurbishments or new buildings for existing hospitals) that were already in the programme on a "realistic, deliverable and affordable footing." It did not examine the case for adding or substituting other hospitals on the NHS estate, irrespective of their condition. It considered that this would have led to further disruption and delays. DHSC prioritised the schemes to determine their order of delivery in a revised timetable. It prioritised the seven schemes to replace hospitals built from reinforced autoclaved aerated concrete (RAAC), which needed to proceed at pace due to substantive safety risks. DHSC ranked the remaining schemes based on their deliverability, on existing maintenance and safety risks in the hospitals, and on affordability. Although DHSC carried out analysis to rank the schemes, it ultimately prioritised schemes that were furthest advanced, and any smaller schemes it could afford within its spending review settlement (paragraphs 1.3 to 1.16).

7 Under the revised plan, the government will provide around £3 billion of funding a year to complete 41 hospital schemes over approximately the next twenty years. An additional five schemes were already complete and open when the programme was reset in January 2025 (costing around £700 million), meaning the programme includes 46 schemes in total.[3] The government has allocated the NHP around £9.6 billion from 2025-26 to 2029-30 and plans to provide around £3 billion a year from 2030-31 to complete the programme. As we reported in 2023, not all the schemes are entirely new hospitals. Nineteen are new hospitals, 19 schemes are adding a major new clinical building or new wing to an existing hospital, two are for a major refurbishment of an existing hospital, and one scheme is to be determined. DHSC estimates that total capital funding of £56 billion is required. DHSC plans to deliver the schemes in four waves:

- **wave 0:** Seven schemes under construction (expected cost of around £720 million);[4]
- **wave 1:** Sixteen schemes due to begin construction between 2025-26 and 2028-29 (expected cost £16.6 billion, including £8.1 billion to be allocated from 2030-31) – includes replacement of seven existing hospitals containing RAAC, with construction to begin between 2027-28 and 2028-29;

3 Schemes that were already complete when the programme was reset in 2025: Royal Liverpool University Hospital; Greater Manchester Major Trauma Hospital; Midland Metropolitan University Hospital; Northern Centre for Cancer Care; and Dyson Cancer Centre, Bath.

4 Since the 2025 programme reset, CEDAR programme (wave 0) has opened.

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- **wave 2:** Nine schemes due to begin construction between 2030-31 and 2034-35 (expected cost of £14.5 billion, including £680 million on enabling works before 2030); and
- **wave 3:** Nine schemes are planned to start construction between 2034-35 and 2039-40 (with an estimated cost of £23.5 billion) (paragraphs 1.8 to 1.12 and Figure 3).

8 **DHSC intends to build advanced hospitals, using a standardised design to reduce costs and improve how hospitals operate.** The NHP was set up to identify ways to improve the efficiency and quality of hospital construction, including through standardisation, modern methods of construction and a centralised approach to contracting. The 2025 programme business case asserted that the hospital programme could be delivered at lower cost as a single centralised programme and that, on average, schemes could be delivered two years sooner than through an NHS-trust-led approach. DHSC estimated a total return on investment from a central programme of £3.10 for every £1 spent on the programme, compared to £2.70 under a trust-led approach, providing up to £7.5 billion (net present value) more in quantifiable benefits. Benefits attributed to the centralised approach include improved emergency and ambulance performance, enhanced digital technology from pooling knowledge and reduced risk of hospital-transmitted infection. If all goes to plan, DHSC expects to secure operational benefits from hospitals built to the standardised design (Hospital 2.0) when they open in the 2030s (paragraphs 1.17 to 1.22, Figure 4 and paragraph 3.31).

Progress towards building new hospitals

9 **The delivery timetable is now more realistic than when we reported in 2023, with most hospitals planned to be delivered later.** DHSC expects the seven hospitals in wave 0 (including one hospital scheme which opened in 2025) to open between 2025-26 and 2027-28, of which six will have fewer than 100 beds. For subsequent waves (1 to 3), we report DHSC's current plans for the timing of hospital schemes but these timings depend on the delivery and approval of individual business cases for each scheme. Milton Keynes Hospital, due to open in 2031-32, will be the first hospital built to the Hospital 2.0 design. In total ten out of sixteen hospitals in wave 1 will be built to the new design. These include two hospital schemes (Hillingdon Hospital, north-west London and North Manchester General Hospital) that DHSC is aiming to open in 2032-33, two to three years earlier than when we last reported in 2023. Most other hospital schemes are now planned to be delivered later than when we last reported. Among those most affected are Torbay, Kettering and Musgrove Park hospitals, which we estimate will open nine to ten years later than under the previous plan (paragraphs 2.2 to 2.7 and Figures 5 to 8).

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10 Schemes to replace hospitals built from RAAC are not expected to complete until 2032-33, which has implications for maintenance costs and patient safety. A DHSC-commissioned independent 2022 report recommended that hospitals built from RAAC should be replaced by 2030 at the latest. Despite being prioritised under the revised plan, these hospitals will not be replaced by this date. A further report published in December 2025, concluded that with appropriate mitigation and sustained maintenance, the RAAC hospitals can remain operational beyond 2030, but with significant operational and clinical risk and cost.[5] These seven hospitals have required significant investment – in excess of £500 million by 2025 – to mitigate the most significant risks. Some of the RAAC hospitals (such as West Suffolk Hospital, Bury St Edmunds) already appear to be facing timetable and budgetary pressures against the revised plans (paragraphs 2.8, 2.9, 3.25 and Figure 9).

11 Now that DHSC's timetable is more realistic than when we reported in 2023, estimated costs of the schemes have increased by around 50%. DHSC plans to spread capital spending over a longer period than when we previously reported. DHSC has conducted more analysis and revised its assessment of total costs. As a result of more realistic planning, hospital scheme costs could be around 50% more than when we reported in 2023 (for the total costs of 35 schemes where comparisons are possible). Trusts whose schemes will open later will also face additional costs for maintaining existing hospitals for longer. DHSC estimates that, in total, these are between £100 million and £140 million a year (paragraphs 2.13 and 2.14).

12 Reaching the right design for the new type of hospital is important to achieve savings and fit for purpose facilities, but it is also taking longer than DHSC expected. The New Hospital Programme is aiming to design hospitals that are efficient to operate, are digitally enabled, and provide each patient with their own room. It has constructed a prototype room to help it identify construction and operational cost savings, and to test that staff can administer care effectively. A similar approach is planned for other parts of new hospitals. DHSC originally planned to complete the new hospital design by 2023, but this timetable proved unachievable. The programme currently expects to complete and fully assure the design in April 2026. Thereafter, it plans to update and refine the design on an ongoing basis (paragraphs 2.10 to 2.12).

5 RAAC Strategic Planning, Assessment of the RAAC 7 Hospitals, Mott Macdonald, December 2025.

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Managing risks to delivery and value for money

13 DHSC has established governance arrangements to provide assurance over technical and delivery risks. Following the 2025 programme reset, DHSC reviewed its governance arrangements for monitoring whether the programme is on track to deliver to time and budget and to secure benefits. It has set up a Programme Board to provide challenge and scrutiny, supported by an Executive Committee and sub-committees that monitor programme and scheme-specific performance and risks. The programme has also established governance mechanisms to provide assurance that the Hospital 2.0 design meets requirements and delivers benefits. However, these governance arrangements are relatively untested and will need to operate within a restructured department, given the government's plan to merge NHSE into DHSC by 2027. The programme also depends on other parts of the NHS working differently to reduce the burden on hospitals. Managing the changes across the NHS and understanding the size of hospitals needed will require governance at the most senior levels within DHSC (paragraphs 3.2 to 3.10, and Figures 10 and 11).

14 DHSC has developed a sophisticated model to estimate the capacity needed in new hospitals, but much depends on successfully moving care from hospitals into communities. Modelling of future demand to determine hospital capacity is more rigorous and transparent than when we previously reported. Our previous report identified that plans for new hospitals were based on unrealistic assumptions of future demand, bed capacity and length of stay and could result in hospitals that are too small. For example, the design assumed a bed occupancy of 95%, which could have resulted in hospitals with insufficient capacity to handle shocks. DHSC has now carried out new peer-reviewed and open-source modelling. The new model assumes 92% bed occupancy, in line with NHSE standards, and DHSC's assumption is that it will increase the number of overnight beds by an average of 6% for hospitals built to the new design. DHSC's projection of future demand continues to depend on the wider NHS treating more patients in non-hospital settings. NHS services will need consistent and regular monitoring of demand and patient flow against the model to see whether the shift to treating more patients in the community progresses as expected. DHSC told us that it is already using the model more widely but there is scope to go further (paragraphs 3.11 to 3.16, and Figures 12 and 13).

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15 There are early signs that developing a more standardised hospital design, a more realistic flow of projects and a longer-term funding commitment, are helping the programme to secure more commercial interest than it anticipated. When we reported in 2023, DHSC had identified only four main contractors who would consider building a complex, large new hospital, and faced competition from other large infrastructure projects in the UK. Since the new plan and funding commitments were announced, the programme has had expressions of interest from over 20 potential main contractors, and is taking 16 pre-qualified bidders through 'competitive dialogue' to help them develop solutions and technical specifications prior to submitting final tenders. However, the programme has not yet agreed terms of contract with its main contractors, and risks remain, including delivery of the Hospital 2.0 design on time so that contractors are prepared to commit, and the wider resilience of the UK supply chain. Although DHSC considers that its market capacity risk has reduced, the programme remains exposed to the UK economic climate and global shocks (paragraphs 3.17 to 3.20).

16 Based on current projections, DHSC has sufficient capital funding to cover its plans, but with little contingency in the next few years. DHSC's plans indicate that the total cost of the 46 hospital schemes will be £60 billion (of which £56 billion is capital) to build with a completion date of 2045-46. This represents a £33.8 billion increase on the capital funding proposed in 2023. The total funding includes around £12.4 billion (21%) of provision for unanticipated cost increases, covering risks such as changes in inflation projections, market conditions, engineering and design and environmental risks. DHSC expects this contingency to be needed. Over the next few years, with construction due to begin on all wave 1 schemes by around 2028, there are risks of delivery slipping against a challenging schedule. There is little contingency for cost pressures up until 2029-30, with a risk that cost pressures in the earlier waves could have a knock-on impact, eroding contingency and delaying progress with later waves (paragraphs 3.21 to 3.26 and Figure 14).

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17 **The programme still faces capacity and management challenges.** In 2023, we reported that the programme team had filled 361 posts (including with contractors) but 165 (31%) were vacant. The programme team has continued to have high vacancy rates. As at November 2025, the programme had 138 vacancies out of a full complement of 357, a vacancy rate of 39% for public sector roles. An additional 314 contractors worked on the programme as part of its contract with the Programme Delivery Partner (PDP, appointed in March 2025). Although the appointment of the PDP boosted programme capacity, the plans to dissolve NHSE have resulted in some disruption to the programme. Senior staff within NHSE who understood the programme and had been involved in key decisions resigned, there were delays in approving funding and signing contracts due to changes in responsibilities and a recruitment freeze has led to delays and challenges in recruiting staff needed on the programme. DHSC has rated the risk of vacancies leading to delays as red, and capabilities affected included digital, legal, commercial, project delivery and technical knowledge. These capability gaps could slow delivery, cause over-reliance on the PDP and delay later waves, which include the larger schemes. DHSC recognises that this is a significant risk to the programme, but its ability to mitigate it is limited while future departmental structures are not yet settled (paragraphs 3.27 to 3.30).

18 **Securing the benefits from the new hospital design will require changes to operational practices and buy-in from staff.** The programme is not only developing a new hospital design, it is also planning how hospitals will operate differently to achieve efficiencies and improvements in patient care. For example, hospital staff should have shorter distances to walk, will use paperless patient records, and technology such as infrared sensors will alert them when a patient falls. However, some trusts are concerned that hospitals delivered to the new design may be more expensive to run than existing hospitals. DHSC is testing how the new space will be used and it told us it is learning from practices in the recently constructed Royal Liverpool University Hospital. It also recognises that it will need to deliver training to staff to use new spaces and digital systems in phases. It told us it plans to increase levels of engagement with staff and trusts in each wave as the construction of new hospitals progresses (paragraphs 3.31 to 3.35).

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Conclusion

19 New hospitals are badly needed after many years of under-investment and in the context of a large maintenance backlog. When we reported in 2023, we found that delivering 40 new hospitals by 2030 was not a realistic goal given the level of funding committed, limits on market capacity and progress to date. We also identified substantial risks to value for money, such as building hospitals that were too small.

20 The latest reset of the New Hospital Programme has put DHSC's plan to build new hospitals on a more stable, long-term footing. The plan to standardise the construction of hospitals has the potential to bring benefits in reducing construction costs and delivering economies of scale over time. As well as benefiting the NHS this approach is likely to be more appealing to constructors to enter the market, provided there is a sustainable pipeline of work. There are clear lessons to be learned about the need for well-managed investment in the public estate.

21 The New Hospital Programme is ambitious in that it seeks to transform how hospitals perform. It is important that DHSC takes the time needed to get the design for new hospitals right, plans the programme well and then executes the plan efficiently. In particular, the seven schemes to replace hospitals built with RAAC need to be delivered as a matter of priority once a credible plan is in place. The construction schedule over the next few years is challenging as schemes adapt to the new approach, and there are risks of delivery dates slipping and construction activity being squeezed into later spending review periods. This could lead to budgetary pressure on later waves of the programme. Close monitoring is needed and scheduling of schemes kept under review.

Recommendations

22 DHSC should take forward the following recommendations with support from NHSE.

a DHSC must maintain rigorous oversight of the programme to keep it on track, learn lessons between schemes and waves of construction and respond to evolving developments in healthcare, if it is to deliver hospitals that meet the future needs of clinicians and patients.

b DHSC needs to get the design of Hospital 2.0 right, not just for the construction but also to achieve operational efficiencies in how new hospitals are run. In setting the timetable, DHSC needs to allow sufficient time to test that the design is fit for its stated purpose, with enough input from the staff and leaders of trusts who will work in and run new hospitals.

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c As it finalises its long-term plans, DHSC should improve the cost estimates of its schemes and ensure there is close alignment between the delivery profile and the funding profile. DHSC may need to adjust expectations of the funds required or bring plans for building some new hospitals forward. Any decision to bring plans forward should be weighed against the delivery risk of delivering more schemes in parallel, the wider capacity of the construction industry to support government infrastructure projects, and the risk of driving up prices.

d The programme's future demand model is a good example of a transparent, open-sourced and peer-reviewed model. DHSC should seek to make the outputs of the model widely available within the NHS so that local decision-making is on a consistent basis, and ensure that sufficient feedback is in place to refine and improve the model. DHSC should share and disseminate this good practice more widely across government.

e There is a risk that if the shift of care from hospital to community does not develop as expected, DHSC could build hospitals that are too small. It should monitor this carefully and use the data to a) refine its model of demand and b) identify maximum tolerance levels should levels of demand not reduce as predicted. It should develop contingency arrangements should tolerance levels be exceeded. In developing contingency arrangements, DHSC should ensure it has considered potential investments in other parts of the health system, including primary care, as well as increases in hospital capacity.

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Part One

The reset of the New Hospital Programme

1.1 This part of the report covers the review of the New Hospital Programme (NHP), the new implementation plan announced in January 2025 and what the programme aims to achieve.

1.2 The Department of Health & Social Care (DHSC) has overall responsibility for the NHP. It selects and approves schemes and oversees development of the Hospital 2.0 standard design. NHS England (NHSE) is responsible for delivering the NHP. Its role is to align the programme with wider NHS objectives and provide expertise on technical decisions, such as the assumptions regarding the Hospital 2.0 design. In this report, we refer to activities undertaken jointly as 'by DHSC' unless otherwise stated. The programme and scheme costs in the report are from the NHP business case and are adjusted for inflation in future years, unless otherwise stated.

Government review of the NHP in 2024

1.3 In 2019, DHSC published the Health Infrastructure Plan to create a long-term, rolling five-year programme of capital investment in response to years of under-investment in hospitals (**Figure 1**). Under the 2019 plan, DHSC planned to build six new hospitals by 2025, and 21 NHS trusts received initial funding for plans to redevelop further hospitals as part of the programme between 2025 and 2030.

1.4 In October 2020, following an election manifesto pledge, the government announced an expansion of the scheme and stated that the NHS would build 40 new hospitals by 2030. DHSC set up the NHP in 2020 to deliver this commitment.

1.5 In 2023, we examined whether the NHP was designed and set up effectively, was making progress on time, cost and quality, and whether risks to successful delivery were effectively identified and managed.[6] We concluded that the government had not achieved good value for money so far and would not deliver the planned schemes by 2030. We recommended that future long-term capital project announcements reflect uncertainties in funding and that decisions on where to build hospitals in future should be more transparent.

6 Comptroller and Auditor General, *Progress with the New Hospital Programme*, Session 2022-23, HC 1662, National Audit Office, July 2023.

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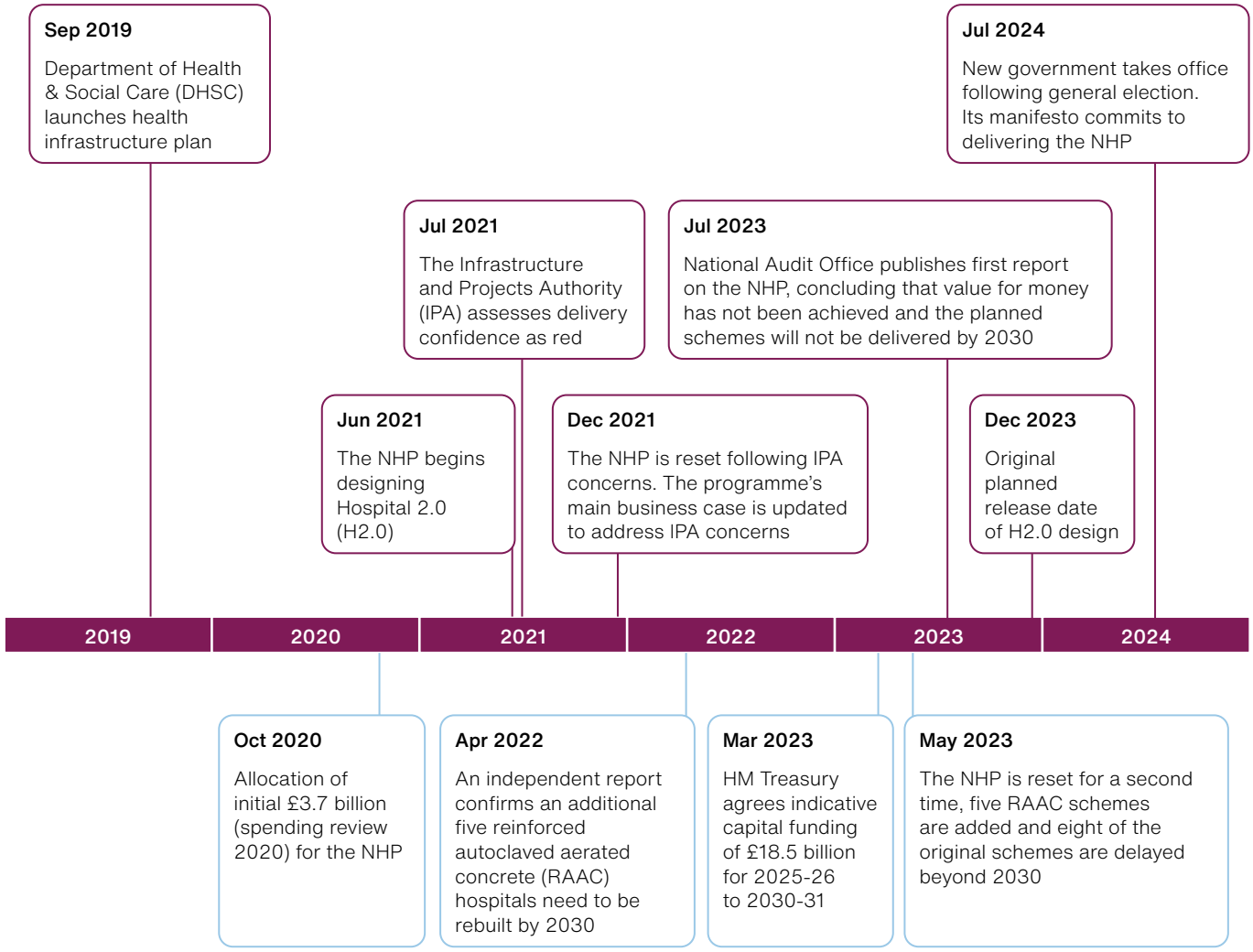
Figure 1

New Hospital Programme (NHP) timeline of key events prior to the new plan for implementation

The NHP has had several changes to scope and timetable in its first five years



Source: National Audit Office analysis of New Hospital Programme documents, provided by the Department of Health & Social Care

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1.6 In 2024, the Darzi review reported a significant shortfall in NHS capital investment developed in the UK in the 2010s compared to similar countries. It estimated a shortfall of £27 billion compared to EU countries, £35 billion compared to Nordic countries, and £46 billion compared to predominantly English-speaking countries.[7]

1.7 Following the 2024 General Election, the government announced a review of the NHP. The review aimed to put the programme on a "realistic, deliverable and affordable footing." This is the third time that the programme has been reset, following resets in 2021 and 2023.

1.8 In January 2025, DHSC announced the outcome of the review in a new implementation plan.[8] Under the revised plan, the government will provide £8.9 billion of capital funding and 0.7 billion of revenue funding between 2025-26 and 2029-30, followed by five-year funding waves averaging around £3 billion a year from 2030. DHSC plans for the total cost of the NHP to be £60 billion, with total revenue costs of around £4 billion and total capital costs of around £56 billion.

1.9 While the NHP will play a role in improving some of the estate, there are other hospitals with problems outside the programme, which DHSC must address through wider spending on repairs and maintenance. DHSC has reported that, overall, the total backlog of work required to improve the NHS estate to an adequate level was £15.9 billion in 2024-25.

The new implementation plan

1.10 DHSC aims to deliver a total of 46 hospital schemes through the NHP. The programme business case estimates that total capital funding of around £56 billion (including contingency funding) is required, comprising:

- **completed schemes:** Five schemes were already open when the programme was reset in January 2025; (around £700 million);[9]
- **wave 0:** Seven schemes under construction, forecast to cost around £720 million up to 2027-28;[10]
- **wave 1:** Sixteen schemes are due to start construction between 2025-26 and 2028-29, forecast to cost £16.6 billion, including £8.1 billion from 2030-31 – this wave includes all seven schemes in wave 1 where existing hospitals contain reinforced autoclaved aerated concrete (RAAC);
- **wave 2:** Nine schemes are due to start construction between 2030-31 and 2034-35, forecast to cost £14.5 billion, including £680 million on enabling works before 2030; and
- **wave 3:** Nine schemes are planned to start construction between 2034-35 and 2039-40, with an estimated cost of £23.5 billion.

7 Independent Investigation of the National Health Service in England 2024, page 101.
8 Department of Health & Social Care, *New Hospital Programme: plan for implementation*, January 2025.
9 Five schemes were already complete when the programme was reset in 2025: Royal Liverpool University Hospital; Greater Manchester Major Trauma Hospital; Midland Metropolitan University Hospital; Northern Centre for Cancer Care; and Dyson Cancer Centre, Bath.
10 Since the 2025 programme reset, CEDAR Programme (wave 0) has opened.

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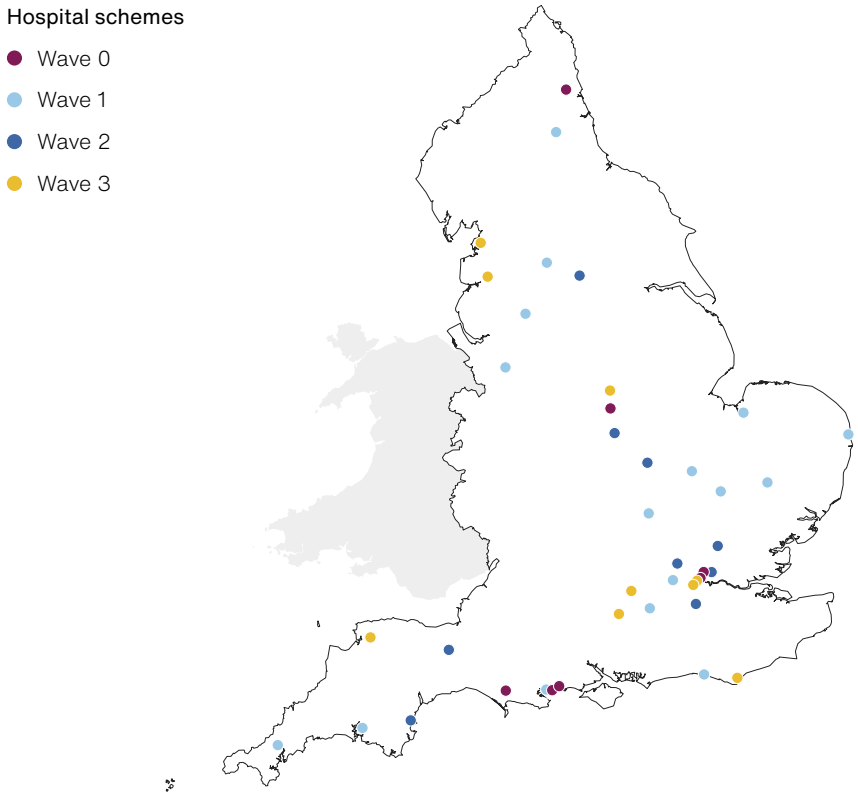
1.11 **Figure 2** shows the location of the hospital schemes across England. A list of the schemes in each wave and their estimated costs, is at Appendix Two (Figure 15).

Figure 2

The location of 41 New Hospital Programme (NHP) schemes that the government committed to building in January 2025

In January 2025, the government committed to building 41 new hospital schemes across England, in addition to five schemes that were already complete



Notes

1 This figure includes 41 schemes that the government committed to delivering when the NHP was reset in January 2025, including CEDAR Programme (which opened since the 2025 reset) and the Brighton 3Ts Hospital redevelopment (for which stage 1 is open with later stages to be completed later as part of wave 1). The figure does not include five schemes that were already open when the programme was reset.

2 Wave 0: Schemes under construction or completed after January 2025. Wave 1: Schemes due to start construction between 2025-26 and 2028-29. Wave 2: Schemes due to start construction between 2030-31 and 2034-35. Wave 3: Schemes planned to start construction between 2034-35 and 2039-40.

Source: National Audit Office analysis of New Hospital Programme documents provided by the Department of Health & Social Care, Office for National Statistics licensed under the Open Government Licence v.3.0. Contains OS data © Crown copyright and database right 2025

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1.12 The government committed to delivering all 41 schemes that were previously in the NHP, in addition to five schemes that were already complete. Nineteen of these schemes are whole new hospitals, 19 schemes are to build additional wings, two schemes are refurbishments, and one is to be determined (**Figure 3**). DHSC limited its review to those schemes and did not examine the case for adding or substituting other hospitals on the NHS estate, irrespective of their condition relative to the existing schemes. DHSC determined that adding new schemes at this stage would have led to further disruption and delays, given that time and resources had been spent on developing plans.

Re-prioritising the schemes

1.13 DHSC carried out analysis to decide how to re-prioritise the schemes in the programme. It used an analytical tool (Multi-Criteria Decision Analytic, MCDA) to prioritise the schemes according to:

- **clinical and operational risk:** To quantify this risk, DHSC drew on estates maintenance data and clinical incidents that had arisen because of infrastructure issues, weighting this measure most heavily (60% weighting);
- **deliverability of the schemes** based on an assessment of the progress in planning and readiness of the schemes (30% weighting); and
- **opportunity for service transformation:** DHSC considered that better-performing NHS trusts and schemes with more beds would be more capable of service transformation (10% weighting).

1.14 DHSC ranked the results of this prioritisation exercise. Fourteen schemes that were already open or in progress and the seven RAAC schemes (which needed to proceed at pace due to substantive safety risks), were excluded from the ranking. Although the MCDA produced an indicative score for the remaining schemes, DHSC told us that the analysis was not the ultimate decision-making mechanism for prioritising them. The prioritisation was also informed by the 'professional expertise and judgement of clinical, programme, construction and finance colleagues' and other factors, such as affordability.

1.15 The outcome of the review meant that some schemes were due to enter construction later than previously anticipated. Teams on most of the later schemes needed to be stood down. DHSC recognised that communicating these changes would require careful handling and developed a plan to engage with key stakeholders (including NHS trusts, stakeholders in the wider NHS and health sector, and suppliers already providing services to the programme or involved in procurement activity). The plan included conversations with trust Chief Executive Officers at the schemes most affected on the day of the review announcement.

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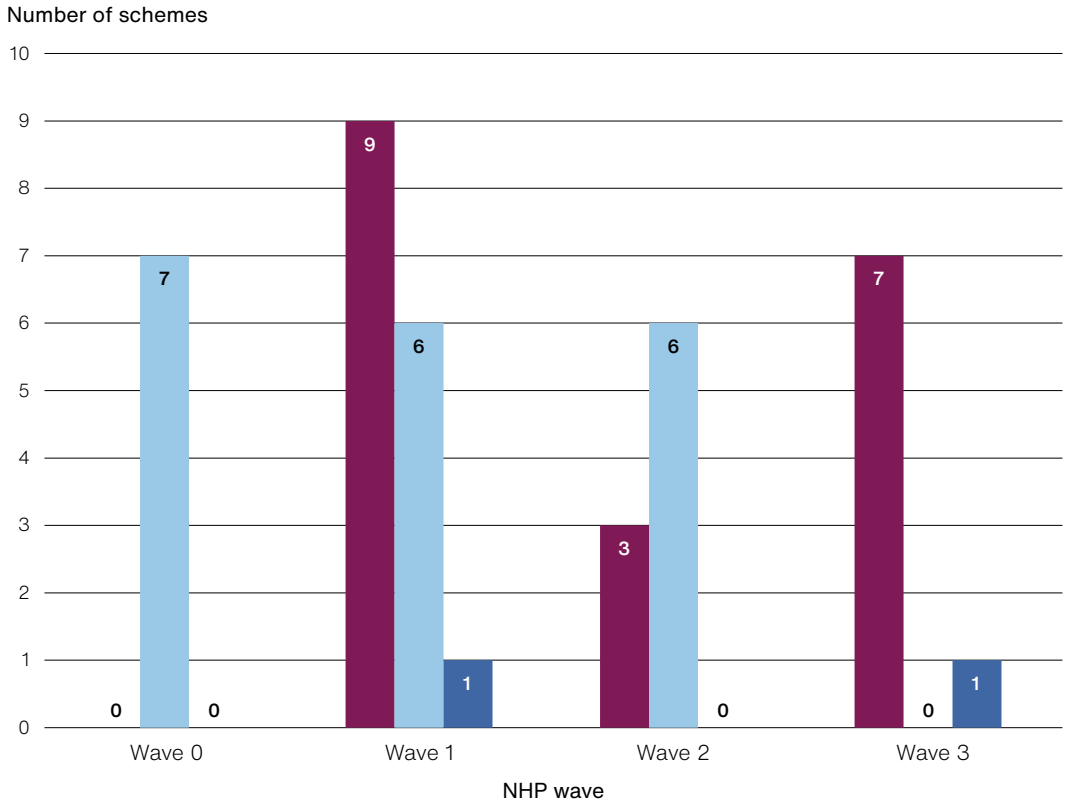
Figure 3

Types of schemes planned under the New Hospital Programme (NHP)

Schemes include refurbishments and new wings as well as whole new hospitals



Notes

1 This figure includes 40 schemes that the government committed to delivering when the NHP was reset in January 2025, including CEDAR Programme (which opened since the 2025 reset) and the Brighton 3Ts Hospital redevelopment (for which stage 1 is open with later stages to be completed later as part of wave 1). The figure omits the Queen's Medical Centre & Nottingham City Hospital (wave 3) because DHSC told us that the scope of this scheme is yet to be decided. The figure does not include five schemes that were already open in January 2025.

2 This figure is on the basis of information provided to us by DHSC. There are no firm commitments for the scope of projects until scheme business cases are approved. Most schemes for waves 1, 2 and 3 had not reached this milestone as at end 2025.

3 While 19 schemes are whole new hospitals, the cost estimates for these schemes range from £500 million or less, to over £2 billion.

4 Ten of the schemes in wave 1 and all schemes in waves 2 and 3 will be built to the new Hospital 2.0 design.

5 Wave 0: Schemes under construction or completed after January 2025. Wave 1: Schemes due to start construction between 2025-26 and 2029-30. Wave 2: Schemes due to start construction between 2030-31 and 2034-35. Wave 3: Schemes planned to start construction between 2034-35 and 2039-40.

Source: National Audit Office analysis of New Hospital Programme documents provided by the Department of Health & Social Care

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1.16 However, some hospital trusts were concerned about their schemes opening later. For example, non-RAAC schemes had not been prioritised but still faced significant safety risks across their estates. Schemes also raised concerns about transparency, and wanted to understand more about why they had been delayed relative to other schemes. DHSC told us that it had decided not to publish or share the output of the MCDA analysis with trusts, because it considered that the short timeframe did not allow for meaningful engagement with all trusts, and it was concerned that sharing scores could lead to unproductive discussions. It did not consider that sharing the scores was needed to inform the trusts' understanding of the prioritisation.

Aims and vision of the programme

March 2025 business case

1.17 DHSC reassessed the programme in a third programme business case in March 2025. The need to rebuild a large number of hospitals is increasingly urgent, due to concerns about safety and the growing cost of operating old and inefficient buildings. Day to day, maintenance issues can mean that parts of hospitals are taken out of use or have their capacity reduced. This is most notably the case where hospitals built from RAAC pose critical infrastructure risks. Given these requirements, the March 2025 business case concluded there was no option for doing nothing (not building new hospitals).

1.18 Through the NHP, DHSC expects to deliver hospitals at lower cost and in less time than under multiple separate projects developed locally. Its aim is to improve the efficiency and quality of hospital construction, including through greater standardisation, modern methods of construction and a centralised approach to contracting. Where hospital construction had previously been funded centrally but delivered locally by NHS trusts, designing new hospitals scheme by scheme, the NHP takes a centralised approach. It aims to realise efficiencies of procurement and scale through producing a standardised design of a hospital ('Hospital 2.0'). The programme also aims to improve the cost-effectiveness and quality of new hospitals by making increased use of modern methods of construction.

1.19 DHSC estimates that the programme can build new hospitals more quickly and more cheaply than through a trust-led approach. NHP's March 2025 programme business case asserted that:

- The NHP can build schemes on average two years faster than through a trust-led approach; and
- the hospital programme could be delivered at lower cost as a single centralised programme. It compared the costs and benefits of delivering the 46 schemes in the New Hospital Programme centrally or as separate trust-led schemes. It assessed that the capital costs of a centralised programme are 90% of a trust-led approach.

We have not validated the underlying analysis in the business case.

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Strategic and operational benefits

1.20 As well as building new hospitals more efficiently, the business case states that the NHP will now support the three transformational healthcare shifts announced in the July 2025 10 Year Health Plan:[11]

- **hospital to community:** supporting clinical strategies to ensure only patients who absolutely need hospital care are treated there;
- **analogue to digital:** deploying new digital technology in modern buildings where it can benefit patients most; and
- **sickness to prevention:** introducing new testing equipment and advanced clinical practices.

1.21 The NHP's expected strategic benefits include improvements and enhancements to patient experience and care, workforce wellbeing and efficiency, digital technologies, productivity, sustainability and local integration. DHSC has set out its vision for how it expects the Hospital 2.0 design will transform patient care and result in resilient hospitals that are adaptable to change and built to last (**Figure 4** overleaf).

1.22 The March 2025 business case quantified the operational benefits that the NHP aims to deliver, and estimated a total return on investment from a central programme of £3.10 for every £1 spent on the programme, compared to £2.70 under a trust-led approach, providing around £6.1 billion to £7.5 billion (net present value) more in quantifiable benefits.[12] The three largest individual estimated benefits are:

- improved emergency department and ambulance performance (£1.1 billion to £1.3 billion, applied only to the centralised programme benefits);
- enhanced digital technology benefits (at the same cost) through pooling knowledge (£1.0 billion to £1.2 billion higher than in a trust-led approach); and
- reduced mortality via national-level standardised designs, maintenance and monitoring of hospital water systems reducing risk of certain infections (£0.6 billion to £0.7 billion, applied only to the centralised programme).

11 Department of Health & Social Care, *Fit for the future: 10 Year Health Plan for England*, July 2025.
12 These costs are taken from the NHP economic business case and exclude inflation and are discounted (as per HM Treasury Green Book guidance). They are not directly comparable with the nominal costs (for example, of total programme cost) elsewhere in the report and are included to show the relative gains that the NHP expects to achieve.

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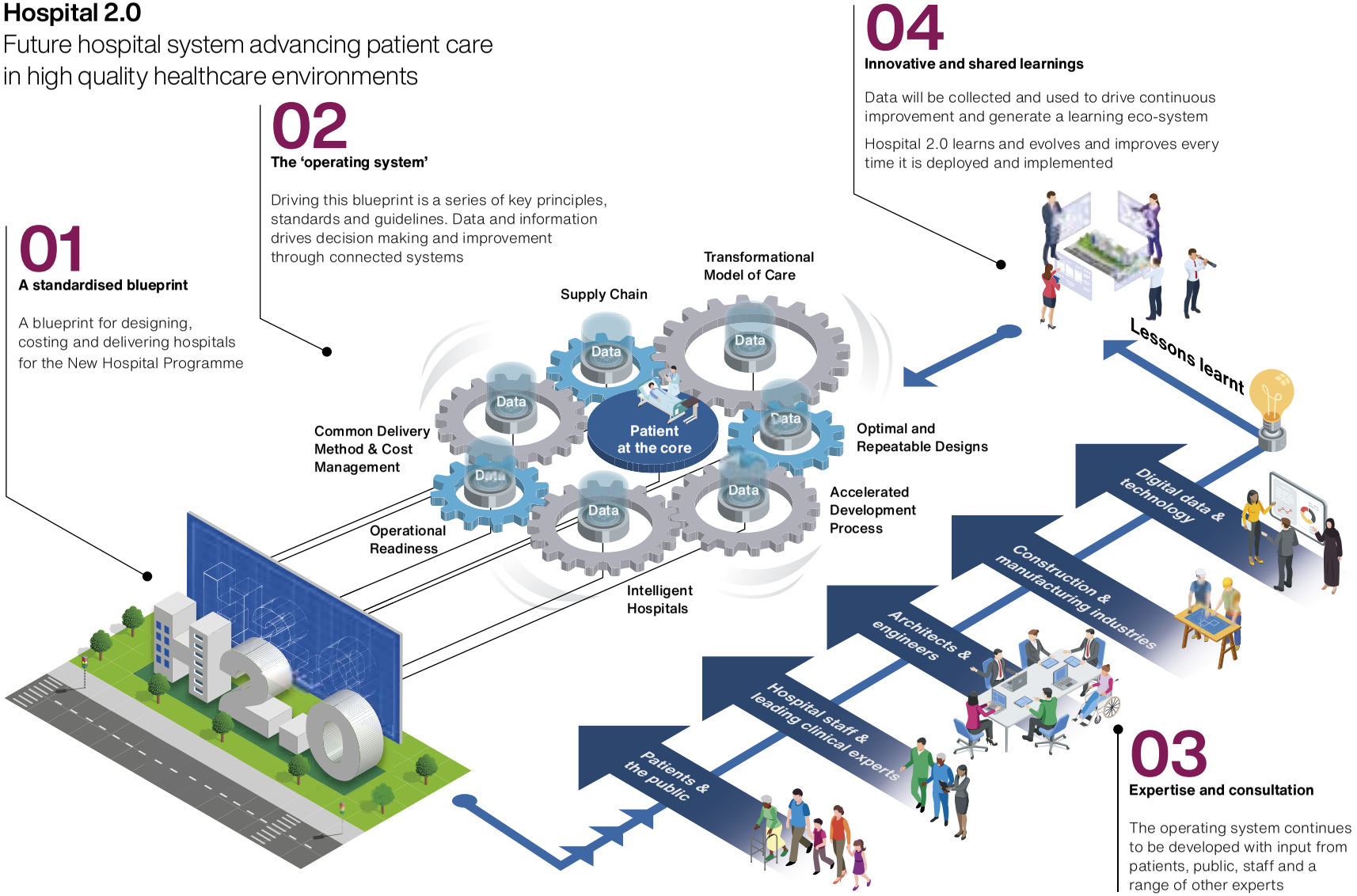
Figure 4

The Department of Health & Social Care (DHSC) vision for the Hospital 2.0 design

Hospital 2.0 is centred around four key principles and aims to overhaul the way NHS hospitals are designed and delivered



Source: Department of Health & Social Care

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Part Two

The revised plan and progress towards building new hospitals

2.1 This part of the report considers the revised plans that the New Hospital Programme (NHP) is now working towards, and early signs of progress. We consider what the revised plans mean for:

- completion dates for hospital schemes;
- dates for replacing reinforced autoclaved aerated concrete (RAAC), hospitals;
- the timetable for the new type of hospitals to be built to the new standardised Hospital 2.0 design; and
- costs.

The revised dates for hospital schemes

2.2 Hospital schemes take years to develop. They must go through planning gateways to provide assurance that they are value for money and to release funds for their construction. Buildings must be designed and constructed in line with planning processes and building regulations. The NHP schemes are expected to take an average of eight years for delivery (ranging from six to ten years, depending on the length of construction), from scoping to the scheme opening. **Figure 5** overleaf sets out the average timeline for delivering hospital schemes.

2.3 The January 2025 Implementation Plan set out a new timetable for delivering 41 hospital schemes in four waves of construction. Five additional schemes were already complete in January 2025. The plan set out two- to four-year periods for starting construction on the schemes. It did not set out how long it expected each scheme to take to plan and construct, nor did it confirm when the hospitals would open to patients and staff.

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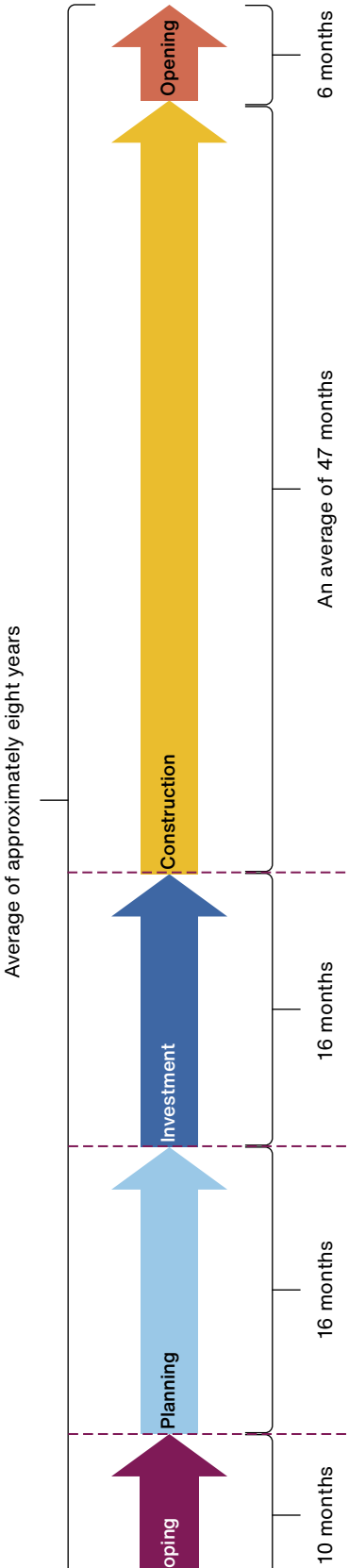
Figure 5
Average planned timeline for delivering a New Hospital Programme (NHP) hospital

NHP schemes are expected to require an average of eight years from scoping to scheme opening



Notes

1 Timeline based on NHP description of timings in the NHP's multi-criteria decision analytic for prioritising schemes in the programme.

2 Arrows are scaled to the length of time in months.

Source: National Audit Office analysis of New Hospital Programme information provided by the Department of Health & Social Care

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2.4 **Figure 6** on pages 26 to 29 shows the earliest hospital opening dates estimated for each hospital scheme. Wave 0 schemes are in progress whereas the timings for schemes in wave 1 to 3 depend on the delivery and approval of final business cases:

- hospital opening dates for wave 0 are based on NHP forecasts;
- hospital opening dates for 13 wave 1 schemes are NHP plans – for the remaining three wave 1 schemes, we estimated the hospital opening dates from NHP data; and
- for waves 2 and 3, we based our estimates of construction start dates on NHP spending profiles, to determine the approximate years that construction of these schemes is planned. To estimate an indicative earliest hospital opening date, we assumed that the scheme would open in the first quarter of the year following the final year of construction.

2.5 **Figure 7** on page 30 shows the delivery profile for the hospital schemes between 2025-26 and 2045-46 (based on the earliest opening dates estimated for each hospital scheme set out in Figure 6).

2.6 Under the new implementation plan, the first seven hospital schemes in the programme are due to open between 2025-26 and 2027-28. These wave 0 schemes are relatively small, with the average cost of schemes in waves 1 to 3 between ten and twenty-five times larger than those in wave 0. Of the sixteen hospitals in wave 1, ten will be built according to the new standardised Hospital 2.0 design. The first of these hospitals, Milton Keynes Hospital, is planned to be the first hospital built to the Hospital 2.0 design, and DHSC expects it to open in 2031-32. All wave 2 and wave 3 schemes will be built to the Hospital 2.0 design. According to our analysis, the earliest opening dates for schemes in waves 2 and 3 are expected to be between 2038-39 and 2045-46.

2.7 Under the new plan, most hospitals are expected to open later than they were when we reported in 2023, reflecting DHSC's aim to put the programme on a more realistic footing (**Figure 8** on pages 31 and 32). Two hospital schemes (North Manchester General Hospital and Hillingdon Hospital, north west London) were ranked highly based on their deliverability, level of risk and transformation opportunity, and are now planned to open in 2032-33, respectively two and three years earlier than planned when we reported in 2023. Some hospitals may open much later. For example, we estimate that Torbay, Kettering and Musgrove Park hospitals will open nine to ten years later than planned when we reported in 2023.

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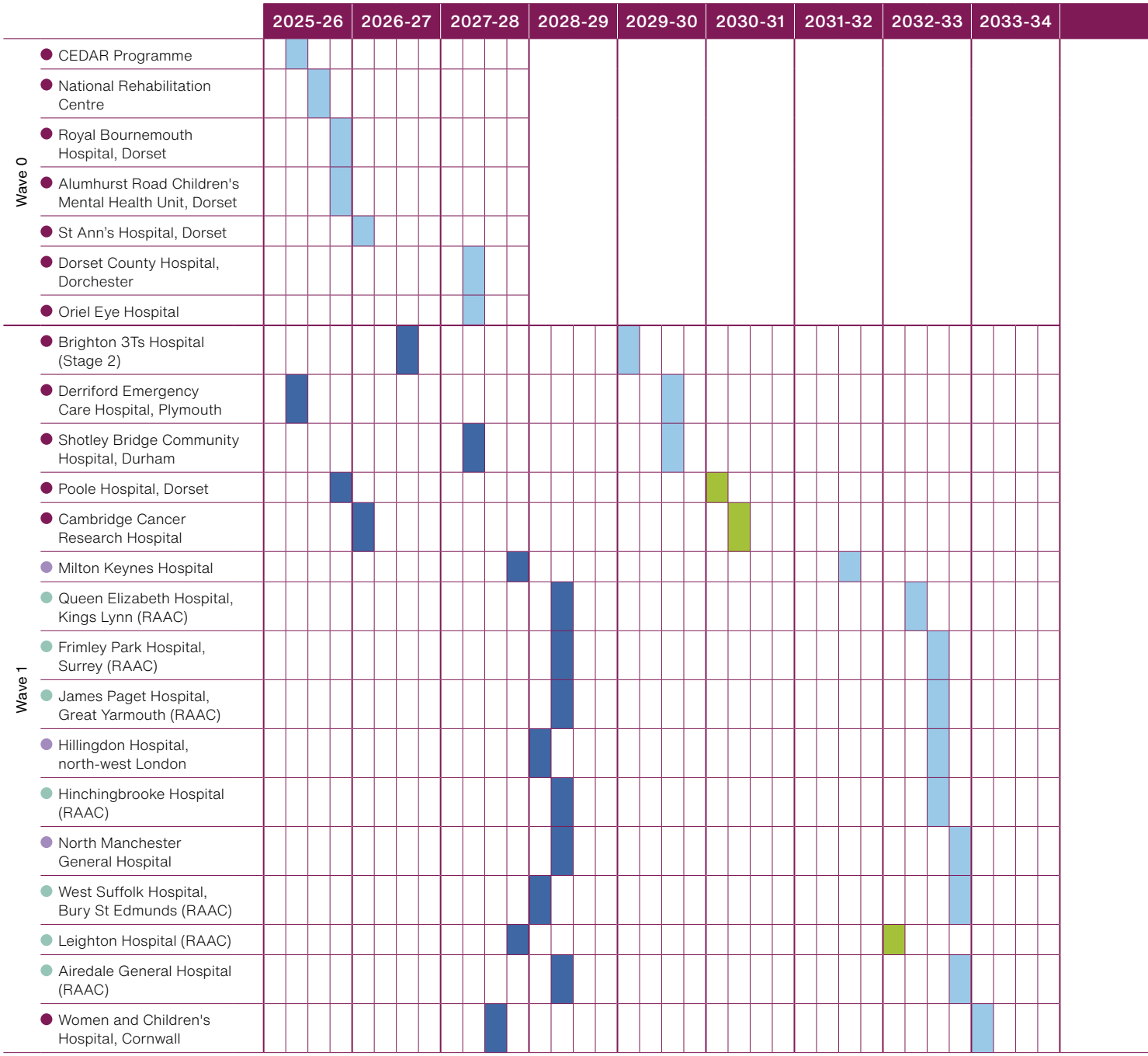
Figure 6

New Hospital Programme (NHP) and National Audit Office estimates of NHP scheme opening dates

The 41 hospital schemes in waves 0-3 of the NHP are estimated to open between 2025-26 and 2045-46



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	2034-35	2035-36	2036-37	2037-38	2038-39	2039-40	2040-41	2041-42	2042-43	2043-44	2044-45	2045-46

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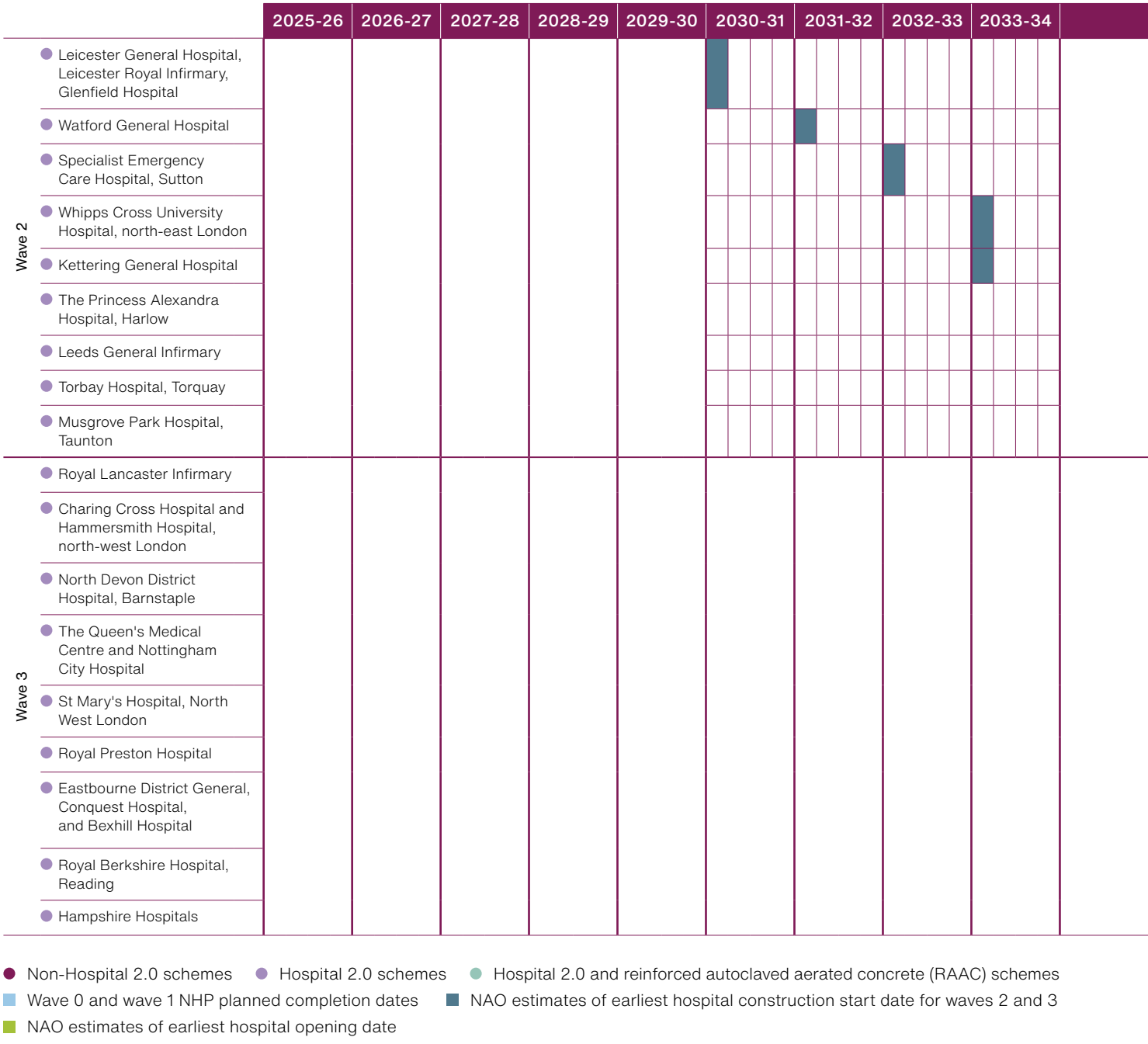
Figure 6 *continued*

New Hospital Programme (NHP) and National Audit Office estimates of NHP scheme opening dates



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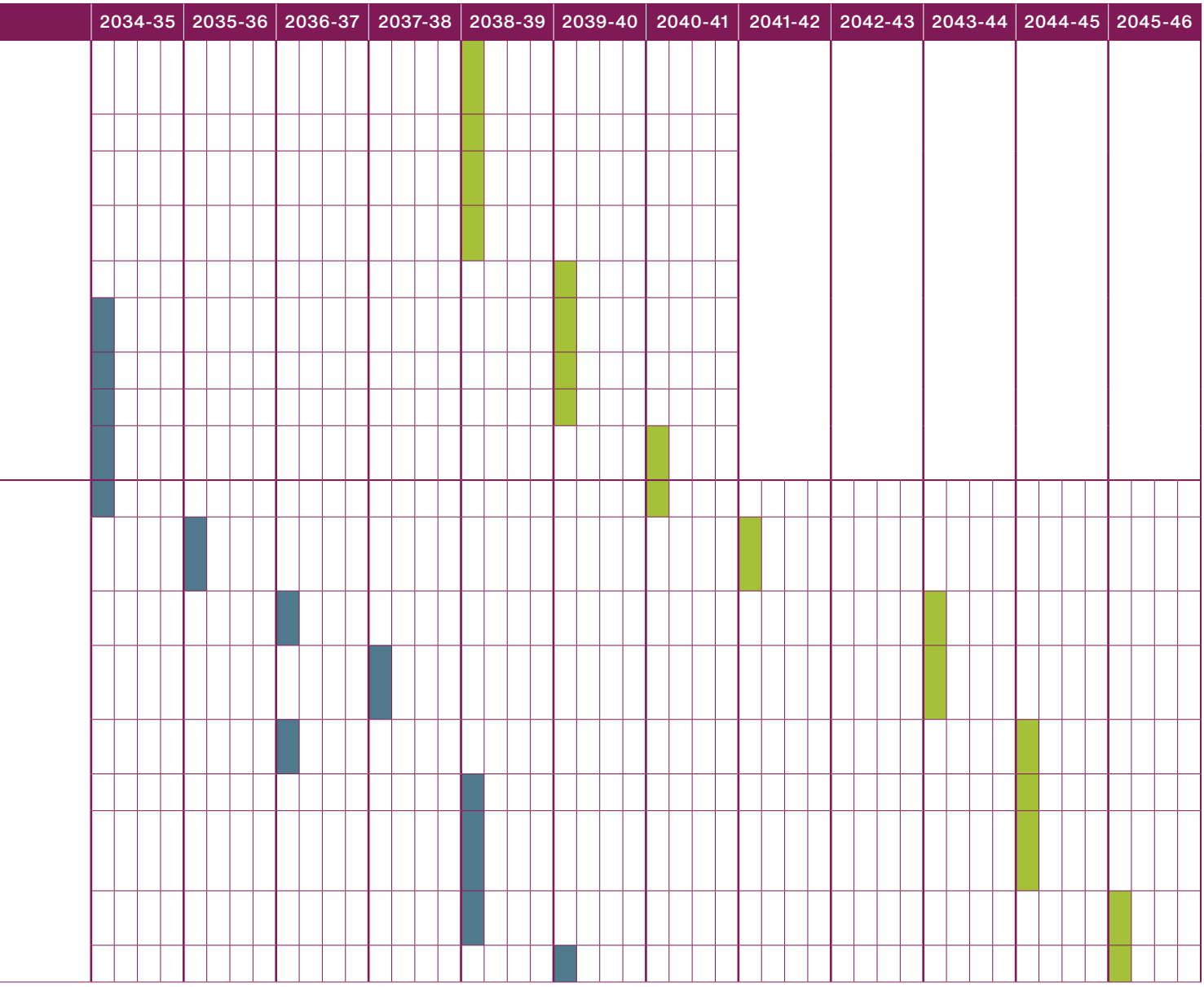

Notes

1 This figure includes 41 schemes that the government committed to delivering when the NHP was reset in January 2025, including CEDAR Programme (which opened since the 2025 reset) and the Brighton 3Ts Hospital redevelopment (for which stage 1 is open with later stages to be completed later as part of wave 1). The figure does not include five schemes that were already open in January 2025.

2 Completion dates for all wave 0 schemes are DHSC forecasts. For 13 wave 1 schemes we are reporting DHSC's current planning, subject to delivery and approval of final business cases. We have estimated the remaining three earliest hospital opening dates for wave 1 schemes using NHP data.

3 Timings for waves 2 and 3 schemes are more uncertain. We used NHP spending profiles to determine the approximate years that construction of these schemes is planned. To estimate an indicative earliest hospital opening date, we assumed that the scheme would open in the first quarter of the year following the final year of construction.

4 The National Rehabilitation Centre was not open by the end of 2025. DHSC told us that it now expects the scheme to complete in Q4 2025-26.

Source: National Audit Office analysis of New Hospital Programme information provided by the Department of Health & Social Care

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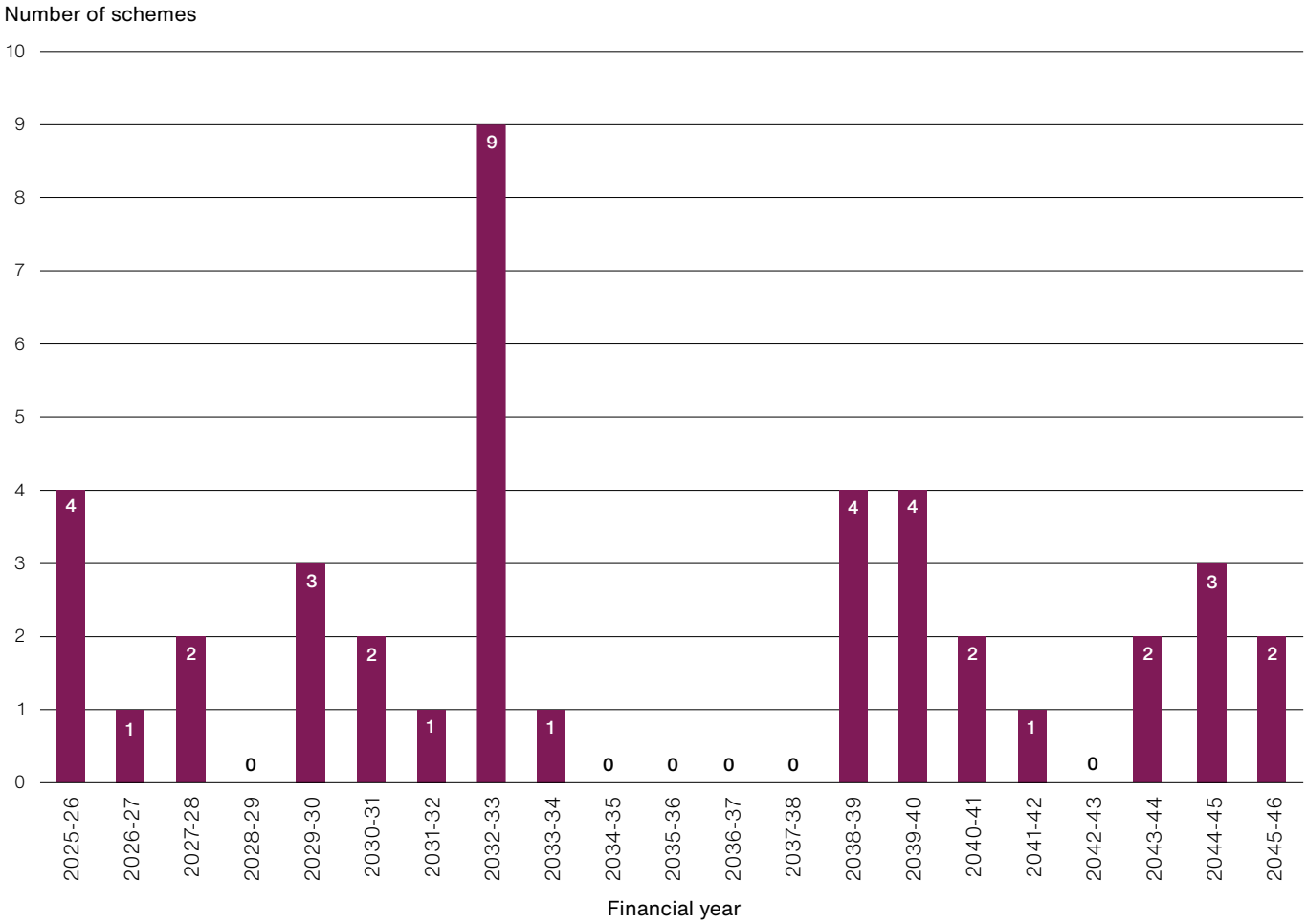
Figure 7

Estimated earliest opening dates for schemes in the New Hospital Programme (NHP)

41 new hospitals are due to open between 2025-26 and 2045-46, based on NHP forecasts, plans and National Audit Office estimates for each scheme



Notes

1 The figure includes all 41 schemes in the NHP, including seven wave 0 schemes that were already under construction when the programme was reset in 2025. It includes CEDAR Programme (which opened since the 2025 reset) and the Brighton 3Ts Hospital redevelopment (for which stage 1 is open with later stages to be completed later as part of wave 1). The figure does not include five schemes that were already open in January 2025.

2 The Department of Health & Social Care (DHSC) aims to deliver the NHP in four waves. Wave 0 and most wave 1 hospital scheme opening dates are based on DHSC forecasts or plans. For later waves, we estimated scheme opening dates based on DHSC's expected construction funding profile. Timings of schemes in wave 1 to 3 depend on the delivery and approval of final business cases.

Source: National Audit Office analysis of Department of Health & Social Care data

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Figure 8

Current planned New Hospital Programme (NHP) hospital opening dates compared to those we reported in 2023 (waves 1 to 3)

Twenty-three NHP hospital schemes in waves 1 to 3 are expected to open later than they were when we reported in 2023

Scheme	Expected year of opening when we reported in 2023	Current planned year of opening	Approximate change in opening date
			(years)
Brighton 3Ts Hospital (Stage 2)	by 2027	2029	2
Derriford Emergency Care, Plymouth	by 2028	2029	1
Shotley Bridge Community Hospital, Durham	by 2028	2029	1
Poole Hospital, Dorset	by 2028	2030	2
Cambridge Cancer Research Hospital	by 2028	2030	2
Women and Children's Hospital, Cornwall	by 2028	2033	5
Milton Keynes Hospital	by 2030	2031	1
Hinchingbrooke Hospital (RAAC)	by 2030	2032	2
James Paget Hospital, Great Yarmouth (RAAC)	by 2030	2032	2
Leighton Hospital (RAAC)	by 2030	2032	2
Queen Elizabeth Hospital, King's Lynn (RAAC)	by 2030	2032	2
Frimley Park Hospital (RAAC)	by 2030	2032	2
Airedale General Hospital (RAAC)	by 2030	2033	3
West Suffolk Hospital, Bury St Edmunds (RAAC)	by 2030	2033	3
Kettering General Hospital	by 2030	2039	9
Torbay Hospital, Torquay	by 2030	2039	9
Musgrove Park Hospital, Taunton	by 2030	2040	10
Hillingdon Hospital, north-west London	by 2035	2032	–3
North Manchester General Hospital	by 2035	2033	–2
Watford General Hospital	by 2035	2038	3
Whipps Cross University Hospital	by 2035	2038	3
Specialist Emergency Care, Sutton	by 2035	2038	3
Leicester Royal Infirmary	by 2035	2038	3
Princess Alexandra Hospital, Harlow	by 2035	2039	4
Leeds General Infirmary	by 2035	2039	4

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Figure 8 *continued*
Current planned New Hospital Programme (NHP) hospital opening dates compared to those we reported in 2023 (waves 1 to 3)

Scheme	Expected year of opening when we reported in 2023	Current planned year of opening	Approximate change in opening date
			(years)
Royal Lancaster Infirmary	after 2030	2040	–
Charing Cross and Hammersmith Hospitals	after 2030	2041	–
North Devon District Hospital, Barnstaple	after 2030	2043	–
Queen's Medical Centre & Nottingham City Hospital	after 2030	2043	–
Royal Preston Hospital	after 2030	2044	–
St Mary's Hospital, north-west London	after 2030	2044	–
Eastbourne District General	after 2030	2044	–
Hampshire Hospitals	after 2030	2045	–
Royal Berkshire Hospital, Reading	after 2030	2045	–

Notes

1 Expected year of opening when we reported in 2023 is taken from Figures 13–18 in our 2023 report *Progress with the New Hospital Programme*. The current earliest expected year of opening is based on either the Department of Health & Social Care's (DHSC's) forecasts, plans (subject to final business case delivery and approval), or our estimate based on DHSC's expected construction funding profile.

2 This figure excludes the seven wave 0 schemes that were already under construction when the programme was reset in 2025. It also excludes five schemes that were already open at that time. Schemes labelled 'RAAC' are to replace hospitals built from reinforced autoclaved aerated concrete.

3 We have not calculated the change in opening date for schemes that were in cohort 4 when we reported in 2023 due to the lack of precision in the delivery date when we reported in 2023 ('after 2030').

Source: National Audit Office analysis of Department of Health & Social Care programme data

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Progress with schemes to replace RAAC hospitals

2.8 Hospitals made from RAAC face significant risks until they are replaced. These seven hospitals have required significant investment, more than £500 million by 2025, to mitigate the most significant risks. An independent April 2022 report for NHS England and DHSC estimated 2030 as the latest possible replacement date of hospitals built from RAAC. A further report published in December 2025 concluded that with appropriate mitigation and sustained maintenance, the RAAC hospitals can remain operational beyond 2030, but with significant operational and clinical risk and cost.[13] RAAC hospitals are prioritised in the new plan but not expected to open until 2032-33, with implications for maintenance costs and risks to patient safety (**Figure 9**).

2.9 Some of the RAAC hospitals appear to be facing timetable pressures against the revised plans. For example, West Suffolk Hospital, Bury St Edmunds told us it has little time left before its planning permission expires.

Figure 9

Progress with schemes to replace hospitals built from reinforced autoclaved aerated concrete (RAAC)

All the hospital schemes to replace RAAC hospitals are expected to open later than 2030, the latest replacement date recommended in a 2022 independent report[2]

RAAC scheme	Estimated opening date	Approximate delay beyond 2030	Red/Amber/Green rating (project delivery element at most risk)
		(years)	
Leighton Hospital	2032	2	Amber – cost
James Paget Hospital, Great Yarmouth	2032	2	Amber – cost
Frimley Park Hospital, Surrey	2032	2	Amber – time
Hinchingbrooke Hospital	2032	2	Amber – cost
Queen Elizabeth Hospital, King's Lynn	2032	2	Amber – time
West Suffolk Hospital, Bury St Edmunds	2033	3	Amber – cost
Airedale General Hospital	2033	3	Amber – cost

Notes

1 Estimated opening dates are based on Department of Health & Social Care (DHSC) plans.

2 Hospitals made from RAAC face significant risks until they are replaced. An independent April 2022 report for NHS England and DHSC estimated 2030 as the latest possible replacement date of hospitals built from RAAC. A further report published in December 2025, concluded that with appropriate mitigation and sustained maintenance, the RAAC hospitals can remain operational beyond 2030, but with significant operational and clinical risk and cost.

Source: National Audit Office analysis of New Hospital Programme data, provided by the Department of Health & Social Care

13 RAAC Strategic Planning, Assessment of the RAAC 7 Hospitals, Mott Macdonald, December 2025.

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Progress with new types of hospital

2.10 As set out in Part One, through the NHP, DHSC aims to design hospitals that are efficient to operate, are digitally enabled and provide each patient with their own room. It assumes this will reduce hospital-based infections, and the average time that patients are in hospital, freeing up beds. Through a standardised construction approach, rooms will be built to a standard design, and DHSC aims to reduce construction costs and achieve economies of scale through this approach.

2.11 DHSC plans to build ten wave 1 hospitals and all wave 2 and 3 hospitals to the new Hospital 2.0 design. When we reported in 2023, DHSC faced challenges and delays in developing the standard hospital design (Hospital 2.0). It has since made progress in key areas. It has:

- constructed a prototype room to identify opportunities to reduce size and cost, and to test the space. DHSC told us that it had identified savings including less space needed to accommodate wiring and plumbing, and cheaper door designs. DHSC plans to route mains plumbing and wiring for wards through corridors so that maintenance and repairs can be carried out without affecting patients' rooms. DHSC told us that it plans to use telemetry to forewarn maintenance teams before repairs are needed;
- tested that staff can administer care effectively in the prototype room (for example, responding to cardiac arrest, and helping patients after a fall); and
- produced 15 'clinical design briefs' in collaboration with clinicians to outline the clinical and functional requirements for specific areas in the hospital, including urgent and emergency care, outpatient services, maternity and paediatrics.

2.12 It is important that DHSC gets the design of new hospitals right if these are to be fit for the future and deliver operational efficiencies. Completing the design for the new type of hospital has taken longer than DHSC expected. DHSC originally planned to complete the Hospital 2.0 design by December 2023, which proved unachievable. This was revised to May 2024 (as reported in our 2023 report) and subsequently again to October 2025. DHSC told us that schemes are now using the Hospital 2.0 design to develop their plans and that it currently expects to have a fully assured design in April 2026 following market testing. A completed Hospital 2.0 design is necessary for making progress with some wave 1 and all later schemes in the programme. The expected start date for construction on the Milton Keynes Hospital and Leighton Hospital schemes is 2027-28, and 2028-29 is the expected start date for multiple schemes to be built to the Hospital 2.0 design and to replace hospitals built from RAAC.

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Cost pressures

2.13 With activity spread over a longer period than when we previously reported, capital spending should be more affordable and an extended timetable may be less likely to drive up market prices in the short term. However, the long-term costs are likely to be higher, as compounding levels of inflation on construction costs are spread over a longer and later period. With more realistic planning, hospital scheme costs could be around 50% more than DHSC estimated when we reported in 2023 (for the total costs of 35 schemes where a comparison is possible). The higher construction costs are driven by:

- increased inflation, DHSC estimates that around half of the cost increase is due to inflation as the hospitals are being built later (under the more realistic plans);
- revised analysis of the current costs of building hospitals including what is needed to meet net zero targets and new safety regulations; and
- revised assumptions on the size of individual schemes.

2.14 Trusts whose schemes will open later must maintain existing hospitals for longer. DHSC estimates that, in total, additional maintenance costs are between £100 million and £140 million a year.

Expenditure to date and what's next

2.15 In total, DHSC spent £2.29 billion on the programme between 2021-22 and 2024-25, out of a budget of £3.7 billion. The programme had spent a further £312 million in 2025-26 by November 2025.

2.16 Seven hospital schemes have opened in total. Five schemes that were originally part of the 2019 Hospital Improvement Programme and formed part of cohort 1 of the NHP prior to the 2025 reset, were already open when the programme was reset: Royal Liverpool University Hospital, Greater Manchester Major Trauma Hospital, Midland Metropolitan University Hospital, Northern Centre for Cancer Care and Dyson Cancer Centre, Bath. Stage one of the Brighton 3Ts Hospital redevelopment is also open, with later stages of this scheme to be completed as part of wave 1. Since the 2025 reset, CEDAR Programme (wave 0) has also opened.

2.17 The programme is approaching important milestones. In particular, it aims to award the Hospital 2.0 alliance contract in early 2026 and complete the Hospital 2.0 design by April 2026. Four wave 0 schemes (National Rehabilitation Centre; Royal Bournemouth Hospital, Dorset; Alumhurst Road Children's Mental Health Unit, Dorset; and St. Ann's Hospital, Dorset) are due to open by the first quarter of 2026-27. Construction on Derriford Emergency Care Hospital, Plymouth has begun, and construction on most of the remaining wave 1 schemes is due to begin by 2028-29.

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Part Three

Managing risks to delivery

3.1 This part of the report examines how the Department of Health & Social Care (DHSC) is managing risks to delivery, including the issues that we and the Public Accounts Committee identified in our previous reports. It examines the governance and assurance arrangements DHSC has established with the aim of keeping the New Hospital Programme (NHP) on track.

Governance and assurance

Government's oversight of the programme

3.2 The NHP is included on the Government Major Project Portfolio (GMPP). Projects on the GMPP are the government's largest and most complex projects and are subject to scrutiny from the National Infrastructure and Service Transformation Authority (NISTA) and HM Treasury (HMT) to ensure their successful delivery. NISTA tracks progress on GMPP projects through an annual report.

3.3 In 2025, NISTA rated NHP 'Amber', an improvement upon the Red rating from a NISTA assurance review in 2024.[14] NISTA stated that the 2025 rating was based on the programme having an agreed, realistic implementation plan, together with agreed changes to funding to the waves approach and the appointment of the Programme Delivery Partner in April 2025.

3.4 Departmental accounting officers must produce timely assessments of all projects on the GMPP, but DHSC has not done so. The assessments should be updated when departments make significant decisions on the scope or cost of programmes, including feasibility and value-for-money assessments. DHSC had assessed the NHP in February 2025, a month after the government announced the new implementation plan, but did not publish the assessment until 17 October 2025, undermining timely and transparent reporting.[15] In November 2025, DHSC provided assurances to the Public Accounts Committee that it would publish Accounting Officer Assessments on a timely basis in future.

14 NISTA's definition of Amber is that: "Successful delivery appears feasible but significant issues already exist, requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun." NISTA's definition of Red is that: "Successful delivery of the project appears to be unachievable. There are major issues with project definition, schedule, budget, quality and/or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project may need re-scoping and/or its overall viability reassessed."

15 New Hospital Programme: accounting officer assessment – GOV.UK.

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3.5 The government recently set criteria for particularly risky, costly and complex projects ('mega projects'), including level of spend, strategic importance and scalability, and made changes to how these projects would be managed, including greater Parliamentary scrutiny, streamlined decision-making, fixed capital funding, flexibility to move funding between years and freedom to determine pay for specialist roles.

Governance arrangements for the programme

3.6 Following the 2025 reset, DHSC has reviewed its governance arrangements for monitoring progress on the programme (**Figure 10** overleaf). The programme board currently reports to the DHSC and NHS England (NHSE) boards. Its primary role is to provide challenge and scrutiny to ensure the NHP delivers within agreed time, cost and benefits realisation parameters. It is supported by an executive committee whose duties include monitoring progress against the programme business case and benefits realisation plan. The executive committee is supported by sub-committees that play a role in ensuring the programme remains on track. These include:

- **programme performance committee** to consider scheme-specific performance against time, cost and quality metrics – it reviews data for each scheme to assess delivery risk;
- **finance sub-committee** to monitor in-year spend, long-term forecasts and the impact of reprofiling and inflation;
- **people committee** to provide oversight on people management and organisational design – it has authority to recruit and create roles within delegation limits; and
- **an independent panel** to provide assurance on the Hospital 2.0 design.

3.7 These arrangements remain relatively untested, as there has not been sufficient time since the reset to assess how effectively they are working. Furthermore, in March 2025, the government announced plans to dissolve NHSE and bring its functions into DHSC within two years. This means that the programme's accountability and governance arrangements (reporting into NHSE and DHSC boards) will need to be revised to align with future departmental structures that are not yet settled. The programme also depends on other parts of the NHS working differently to reduce the burden on hospitals. Managing these risks will require governance at the most senior levels within DHSC.

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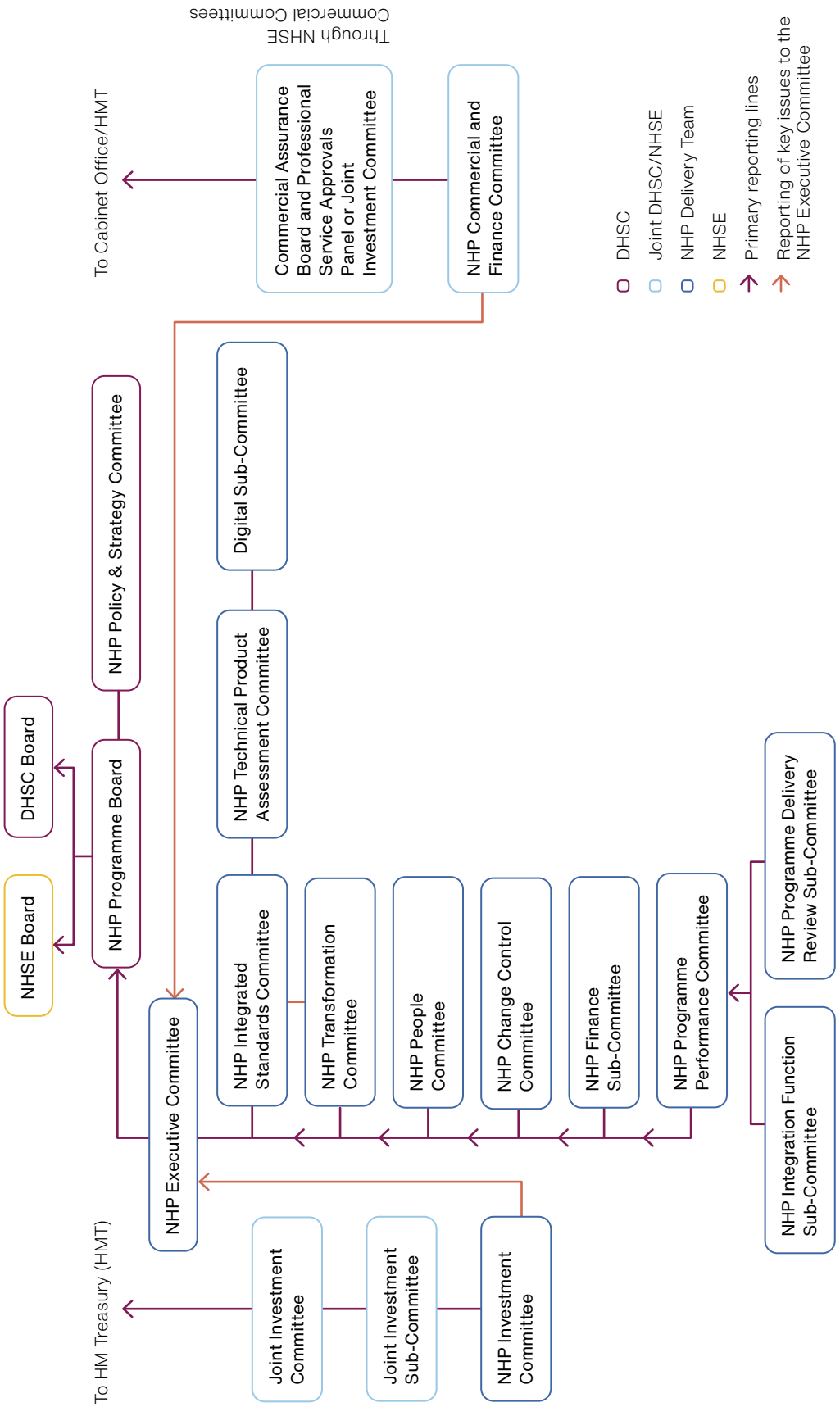
Figure 10
New Hospital Programme (NHP) governance and reporting arrangements

The NHP delivery team reports to both the Department of Health & Social Care (DHSC) and NHS England (NHSE)



Note

1 The NHP Investment Committee and Commercial and Finance Committee primary reporting lines are to committees that form part of the wider control environment. This figure also recognises that key issues may also need to be reported directly to the NHP Executive Committee.

Source: National Audit Office analysis of New Hospital Programme documents, provided by the Department of Health & Social Care

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DHSC's assurance processes

3.8 DHSC has processes in place to mitigate the risks of delivering the programme including the following.

- **Investment wave approach.** DHSC intends the investment wave approach to smooth the programme. It is beginning with smaller, more deliverable schemes. The wave-based approach is similar to the previous plan's cohort-based approach. Delaying the larger schemes may result in programme and industry capacity challenges. DHSC expects transfer of learning between waves to help mitigate these pressures.
- **Affordability and industry capacity.** In reviewing the programme, DHSC assessed delivery options which varied according to the maximum amount of funding available each year and the delivery timetable, with faster spending resulting in hospitals opening sooner. The option selected by HMT and DHSC considered the broader cross-government fiscal position, the wider departmental portfolio, construction industry capacity, and DHSC's wider capital expenditure and capacity to deliver health infrastructure. We have not examined the wider cross-government analysis supporting this decision.
- **Cost forecasting.** The programme business case states that revised costs in the new plan represent better analysis of hospital size and current costs of building hospitals, including what is needed to meet net zero targets and new safety regulations. Nevertheless, DHSC acknowledges that there is limited evidence of an appropriate cost baseline as there are no recent examples of building large hospitals to new standards. Work to develop costing the standard Hospital 2.0 design is ongoing.
- **Assurance at scheme level.** Detailed size, scope, cost and delivery schedules will be agreed and assured through individual scheme business cases.

Managing key risks identified in our previous report

3.9 DHSC has established a risk register for scoring programme risks and setting out the mitigation action it is taking. As at October 2025, 42 risks were live, of which six were rated 'Red'. The risk register is reviewed monthly by the NHP Programme Board.

3.10 Our 2023 report identified various risks to value for money. We examined the risk register to establish the current position on key risks, including the RAG rating and score (**Figure 11** overleaf). The following sections describe the progress made in these areas since we reported in 2023, current issues and mitigating actions.

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Figure 11

Current position on key risks to the New Hospital Programme (NHP) identified in our previous report

The Department of Health & Social Care (DHSC) is monitoring the risks we identified in 2023; staffing the programme team has the highest risk rating

Risk or issue we reported in 2023	How this risk is reflected in current risk register[1]	NHP's current Red/ Amber/Green (RAG) rating (score)[2]
There was a risk that the hospital design would result in hospitals that are **too small** and unable to respond to **growing demand or health crises**	A long-term risk that assumptions of a shift in 'models of care' from hospital settings to out-of-hospital care settings would not be delivered on time was added to the risk register in June 2025. The consequence would be hospitals that are too small, backlogs and poor patient experience and outcomes.	Amber/Green (6)
The programme had not engaged meaningfully with the **construction industry** and there were high demands on their **capacity**	Mechanical, electrical and plumbing market capacity risk was downgraded from Red (20) to Amber/Red (12) in February 2025 reflecting interventions aiming to increase market engagement and reduce delivery and design risk. The impact of UK economic instability on supply chain resilience was rated Amber/ Red (12) as at October 2025.	Amber/Red (12)
Affordability: until 2023, the programme did not know whether sufficient funding was available to build new hospitals	The risk that cost escalation and inflation will consume contingency funds and impact on the level of funding available later in the programme is recorded as Amber/Green (6).	Amber/Green (6)
The programme had difficulty **staffing its team** and depended more than it wanted to on delivery partners to provide **professional and technical skills**	A risk relating to capability, capacity and continuity has been recorded since October 2024. The risk was rated Amber/ Red (12) until June 2025 then merged with a risk reflecting the impact on people of disruption from organisational change. The merged risk was rated Red (20).	Red (20)
The programme had yet to demonstrate that it could achieve **efficiencies and benefits** through an innovative, standardised **hospital design**. Completing the design was taking longer than planned, limiting progress with later schemes	The risk of delay to Hospital 2.0 technical and transformation documents and the impact of this on the overall timetable is rated Amber (9). Delays to NHS professional engagement with the designs caused by pressure on trusts and wider organisational changes in the NHS impacting capacity to engage is rated Amber (9).	Amber (9)
	The risk to timely delivery of remaining schemes with an impact on associated benefits was rated Amber (8) between October 2024 and October 2025.	Amber (8)

Notes

1 We examined NHP risk registers from October 2024 to October 2025.

2 DHSC scores risks based on an assessment of the combined likelihood and impact of the risk.

Source: National Audit Office analysis of New Hospital Programme risk registers

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Hospital capacity – 'right-sizing' hospitals

3.11 Our previous report identified a risk that the Hospital 2.0 design would result in hospitals that are too small. We raised concerns that the assumptions underlying the programme's minimal viable product (MVP) approach could have resulted in hospitals with a lower capacity than required. DHSC had assumed that any increases in the demand for healthcare, including population growth, would be mitigated entirely by shifting care out of hospitals (into adult social care, outpatient services, community and digital healthcare) and reducing the length of time patients stay in hospital.

3.12 The programme is no longer using the MVP design and has updated its assumptions about the hospital capacity needed. The new schemes are planned to provide more capacity than the existing hospitals currently do. Overall, the programme business case assumes that the average increase in overnight beds across all 28 schemes that DHSC plans to build to the Hospital 2.0 design is 6%. DHSC has carried out new, more detailed, modelling to estimate the capacity required for eight wave 1 hospitals (including seven schemes to replace hospitals built from reinforced autoclaved aerated concrete – RAAC), and it intends to model the capacity required for all the schemes that will be built to the Hospital 2.0 design. DHSC told us that, for overnight beds only, the planned increase in the seven RAAC-replacement hospitals was 11%. We found that across all eight schemes where the capacity required has been modelled, the increase in the number of total beds ranges from 1% to 34%, an average increase of 12% (**Figure 12** overleaf).

3.13 Although we have not evaluated the new modelling, we note that it is more transparent than when we previously reported, and features many aspects of good practice, including using an open-source model and peer review. DHSC now has a consistent approach that it can apply across the NHP, working with schemes to assess the likelihood of any changes that could impact on the capacity requirement. **Figure 13** on page 43 sets out how the assumptions in the modelling have changed compared with when we reported in 2023.

3.14 The programme's projection of future demand for hospital capacity is dependent on the wider NHS treating more patients out of hospital and on shorter lengths of stay. The programme's central length of stay assumption is that it will reduce by 0.5% annually, plus an additional one-off reduction of 8 to 10% when the new hospital schemes open. This is ambitious, as research has indicated that the clinical and economic impact of changing to single-room wards is likely to be modest.[16] DHSC recognises that efficiencies in hospital settings may not be delivered on time to meet the programme's needs. Its demand assumptions will need to be carefully monitored and a clear expectation of demand and patient flow across NHS services will be critical.

16 Bertuzzi et al, 2023, Clinical, humanistic and economic outcomes, including experiencing of patient safety events, associated with admitting patients to single rooms compared with shared accommodation for acute hospital admissions: a systematic review and narrative synthesis. *BMJ Open*, 13:e068932.

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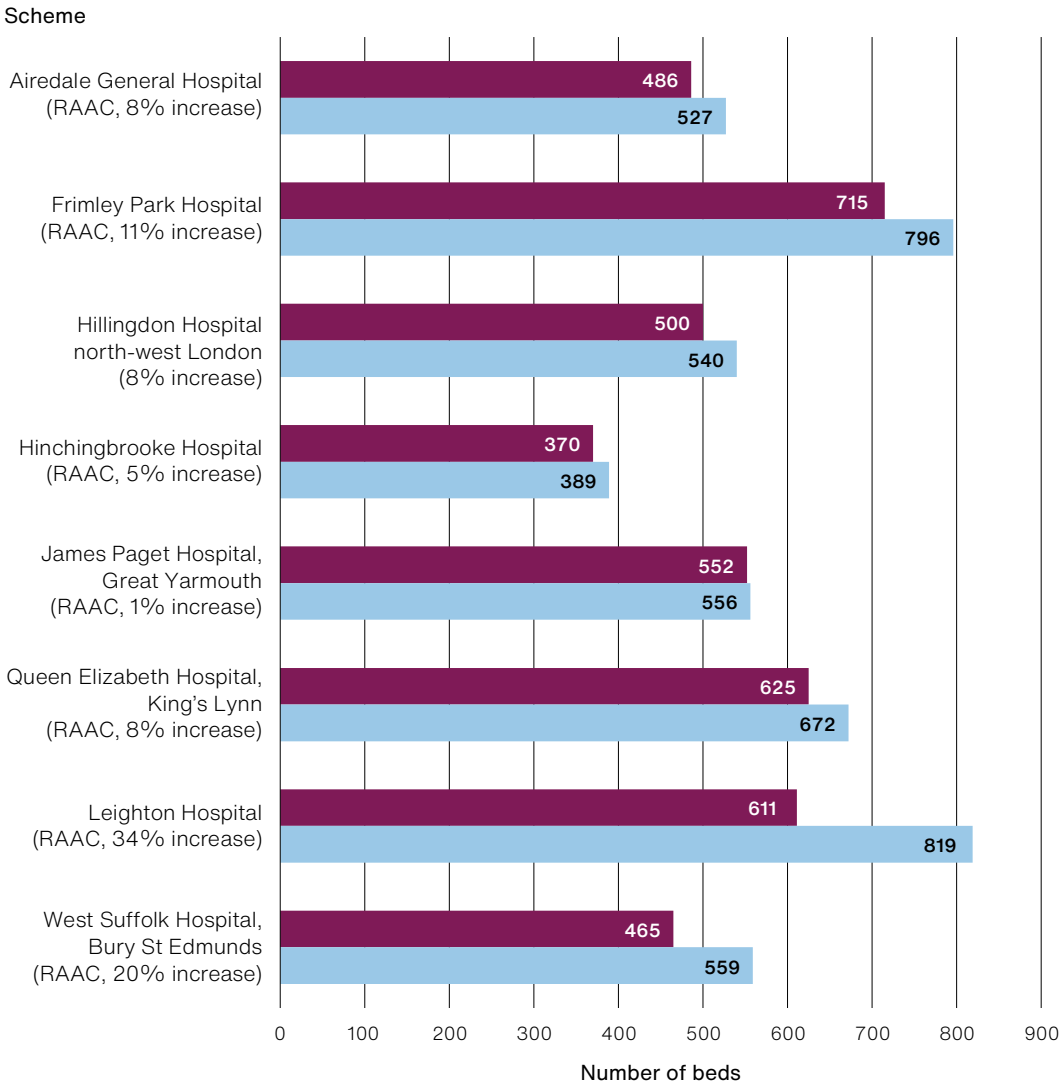
Figure 12

Modelled increase in bed numbers at eight New Hospital Programme (NHP) schemes where the Department of Health & Social Care has projected the capacity required

The increase in bed numbers required is projected to average 12% across the schemes, ranging from 1% (James Paget Hospital, Great Yarmouth) to 34% (Leighton Hospital)



Notes

1 The baseline number of beds is the number used in the NHP modelling at the beginning of the projection period for each scheme. This analysis is based on total beds. It is a different measure of bed capacity to that in Figure 15, which shows overnight beds.

2 The average of the percentage increases across these schemes is 12%.

3 Schemes labelled 'RAAC' are to replace hospitals built from reinforced autoclaved aerated concrete.

Source: National Audit Office analysis of New Hospital Programme information provided by the Department of Health & Social Care

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Figure 13

Projected change in overall hospital capacity at eight New Hospital Programme (NHP) schemes where the Department of Health & Social Care (DHSC) has modelled the capacity required, and underlying assumptions

Bed numbers are projected to increase by an average of 12%

Hospital capacity (compared to existing hospitals)	Planned change in capacity when we previously reported in 2023	Projected change in capacity according to DHSC's current modelling (eight wave 1 schemes)[2]
Change in number of beds	0.4% reduction	An average increase of 12%, ranging from 1% to 34% across the schemes[3]
Underlying assumptions	**DHSC's underlying assumptions when we previously reported in 2023**	**Underlying assumptions underpinning DHSC's current modelling**
Bed occupancy	95%. Running hospitals very full may have affected their ability to cope with variations in demand	92%, in line with NHS England standards
Length of stay	12% reduction	0.2% to 1.2% reduction annually (depending on the scheme), equating to 3% to 17% reduction over 15 years[1]
Reduction in need for hospital capacity as patient care is shifted out of hospitals	1.8% annual reduction	An average annual reduction of 0.4%, ranging from 0.2% to 1.1% across the schemes

Notes

1 One scheme (Leighton Hospital) is forecasting an increase in length of stay of 0.3% due to higher comorbidity in older age groups.

2 Required hospital capacity has been modelled for eight wave 1 schemes including Airedale General Hospital, Frimley Park Hospital, Hillingdon Hospital, Hinchingbrooke Hospital, James Paget Hospital (Great Yarmouth), Queen Elizabeth Hospital (King's Lynn), Leighton Hospital and West Suffolk Hospital.

3 This capacity analysis is based on total beds. It is a different measure of bed capacity to that in Figure 15, which shows overnight beds.

Source: National Audit Office analysis of New Hospital Programme data provided by the Department of Health & Social Care

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3.15 DHSC told us that the demand model is being used more widely across the NHS. For example, it has used the model to estimate that around £3.6 billion of annual activity needs to move from acute care to the community by the end of the 10 Year Plan (2035). To achieve this, DHSC estimates a 50% increase in community health services is required across all age groups, with a 65% increase for older people's services.

3.16 Extending use of the model further can help DHSC and NHS bodies to better monitor whether community-based care is reducing pressure on hospitals. The model can help DHSC estimate how demand for services will change and better inform investment decisions at system, regional and national levels. It has the potential to standardise how hospital demand is forecast and inform plans to shift care to the community.

Industry capacity

3.17 We previously reported that the programme had only identified four main contractors who would consider building a large complex hospital, and faced competition from other large UK infrastructure projects. Other risks included a shortage of factory capacity to manufacture building components. Delays in developing Hospital 2.0 and agreeing programme funding had constrained the programme's ability to engage with industry.

3.18 Since the new plan and funding commitments were announced, the programme has had expressions of interest from over 20 potential main contractors and is taking 16 pre-qualified bidders through competitive dialogue to help them develop solutions and technical specifications prior to submitting final tenders.

3.19 However, as at December 2025, the programme had not agreed terms of contract with its main contractors, high demands on the construction industry continue, and risks remain:

- DHSC does not expect to have a fully-assured Hospital 2.0 design until April 2026 (Part Two);
- backloading – as noted above, the programme involves delivering the larger, more expensive, schemes later in the programme (waves 2 and 3), which could put more pressure on contractors and their supply chains. It also allows time for the industry to develop capacity and capability in building the new hospital design;
- supplier insolvency has increased by 15–20% since 2024, with an average of 300 construction insolvencies in 2025. Suppliers to the NHP may be new or unable to withstand the shocks; and
- competition for similar supply chains from other infrastructure programmes throughout the UK.

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3.20 DHSC's mitigation plan focuses on monitoring the financial health of supply chain partners, monitoring market constraints and ensuring that industry has early visibility of the pipeline of work. DHSC has downgraded the market capacity risk from 'Red' to 'Amber/Red'. However, the programme remains exposed to the UK economic climate and developing geopolitical situations that may cause supply chain shocks.

Funding the programme

3.21 We previously reported that until 2023, the programme did not know how much it could spend on building 40 new hospitals by 2030. In March 2023, the government confirmed that it proposed to provide maximum capital funding for the programme of £22.2 billion. However, the Public Accounts Committee remained concerned about the affordability challenges the programme faced.[17]

3.22 The January 2025 plan to deliver the schemes by 2045-46 appears to be considerably more realistic in terms of the amount of capital funding allocated and the delivery timetable. DHSC proposes to provide a total of £60 billion of funding to build all 46 hospital schemes (of which £56 billion is capital, a £33.8 billion increase on the funding proposed in 2023), with a completion date of 2045-46. Under the revised plan, the government has allocated £8.9 billion of capital funding to the programme between 2025-26 and 2029-30 and plans to provide up to £15 billion of capital funding in each of the new spending review periods in 2030-31, 2035-36 and 2040-41, averaging around £3 billion a year. Most of the capital funding up to 2030 is planned to be spent on the wave 1 schemes (£8.1 billion, approximately 90%) with £450 million (around 5%) planned for wave 2 schemes and £253 million (around 3%) planned for wave 0 schemes.

3.23 The programme funding includes contingency to cover unanticipated cost increases. Total contingency across the £60 billion programme is £12.4 billion (21%). The current spending review settlement of £8.9 billion includes £850 million contingency (10%). In calculating the level of contingency it considers it needs, DHSC told us that it has drawn on historic data on cost overruns, on cost modelling, and on good practice guidance from HM Treasury, the National Audit Office and the Institution of Civil Engineers.[18] Of the total £12.4 billion contingency:

- **£4.1 billion is allocated to the NHS trusts** responsible for individual schemes. Contingency held by the trusts is to cover scheme-specific risks, such as engineering and design risks, site-specific conditions, health & safety and environmental risks, and logistics risks such as the cost of decanting; and
- **£8.3 billion is held centrally.** Contingency held centrally is to cover risks such as changes in inflation projections, market conditions, specification changes, and political risks, such as a change in government.

17 HC Committee of Public Accounts, *The new hospital programme,* First report of Session 2023-2024, HC 77, November 2023.

18 HM Treasury Green book provides optimism bias benchmarks for different project stages. For projects at Outline Business Case stage this is typically 6% to 66%. The Institution of Civil Engineers reports 155% average overrun for major projects.

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3.24 Figure 14 shows the cumulative capital funding for the programme up to 2045-46 (as set out in the March 2025 programme business case) by wave, and the planned profile for the centrally held contingency. Total centrally held contingency (£8.3 billion) is 15% of the total capital funding, although the proportion varies over time, with little headroom in the first five years:

- **2025-26 to 2029-30:** £0.3 billion contingency, 3% of total funding for the period;
- **2030-31 to 2034-35:** £2.3 billion contingency, 18% of total funding;
- **2035-36 to 2039-40:** £2.3 billion contingency, 13% of total funding;
- **2040-41 to 2044-45:** £3.1 billion contingency, 22% of total funding; and
- **2045-46:** £0.252 billion contingency, 100% of total funding.

3.25 DHSC told us that it expects all the contingency to be needed. Up until 2029-30, the centrally available contingency is very low. Although the earlier schemes are less complex and more advanced, some schemes may face cost pressures above the available contingency. For example, one scheme we spoke to, West Suffolk Hospital, Bury St Edmunds (wave 1) is already concerned about increased costs, forecasting a rise from £1.3 billion to £1.5 billion. After 2030, and particularly after 2040, the available contingency provides more headroom. However, there is still considerable uncertainty in the long-term cost projections for building later schemes. There is a risk that cost pressures in the early waves could have a knock-on impact, eroding contingency for later schemes and leading to delays.

3.26 In the short term, with construction due to begin on all wave 1 schemes by around 2028, there are risks of delivery slipping against a challenging schedule. DHSC recognises the risk of delays in the early stages of the schemes. For example, it has recorded the risk of delays in approving scheme business cases leading to underspends against budget as 'Amber/Red'. To avoid bottlenecks, it has established processes for tracking progress in developing business cases, providing training for teams and learning lessons. Delays or changes to the Hospital 2.0 design could also slow progress with individual schemes.

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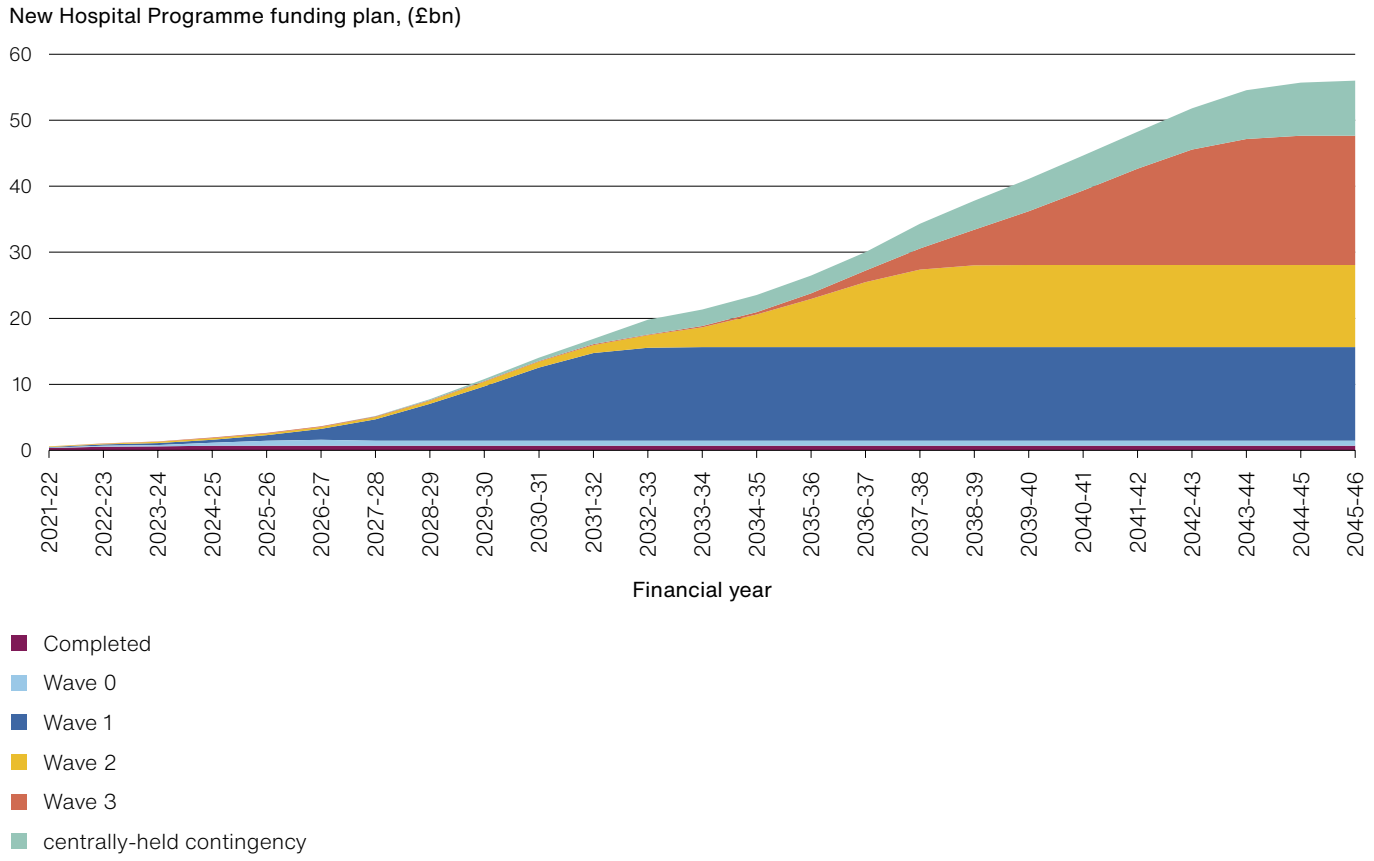
Figure 14

Cumulative capital funding by wave and contingency held centrally for the New Hospital Programme (NHP) (2025-26 to 2045-46)

The March 2025 business case for the NHP estimates the total capital cost of the programme at £56 billion, including £8 billion contingency held centrally by the programme



Notes

1 The planned funding (not including contingency held centrally) is: for completed schemes, around £700 million between 2021-22 and 2026-27; for wave 0 schemes, £720 million between 2021-22 and 2027-28; for wave 1 schemes, £14.2 billion between 2021-22 and 2033-34; for wave 2 schemes, £12.5 billion between 2021-22 and 2039-40; and for wave 3 schemes, £19.6 billion between 2021-22 and 2044-45.

2 Centrally-held contingency of £8.3 billion is planned to be used between 2025-26 and 2045-46.

3 Funding profile is from the NHP business case and is adjusted for inflation in future years.

Source: National Audit Office analysis of New Hospital Programme data provided by the Department of Health & Social Care

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Programme capability and capacity

3.27 In 2023, we reported that DHSC had had difficulty staffing its NHP team and had depended more than it wanted to on consultancy services. By February 2023, the NHP team had filled 361 posts (including contractors) but 165 (31%) were vacant. Progress in 2025 to build capability has included appointment of a Programme Delivery Partner (PDP) for the programme. The PDP will provide expertise in scheme design, programme and project management and will work with NHSE and trusts to standardise design and delivery.

3.28 NHP has continued to face recruitment challenges. As at November 2025, the vacancy rate for public sector roles was 39%, with 138 full-time equivalent (FTE) vacancies on the programme within a full complement of 357 funded posts (public sector FTE). As at November 2025, 314 additional contractors worked in the project team. DHSC told us that these contractors were provided to the programme team as part of its contract with the PDP, and that the number of contractors provided varies over time depending on the service required.

3.29 The risk of the public sector vacancies on deliverability is rated 'Red', and capabilities impacted include digital and IT, legal and commercial, project delivery, technical and industry knowledge, and analysis. These capability gaps could slow delivery, cause over-reliance on the PDP and delay later waves, particularly given that the larger schemes are backloaded into waves 2 and 3 of the programme. Recruitment freezes following the announcement to abolish NHSE have made it difficult for the programme to recruit staff with the skills needed to manage the programme. Uncertainty over available funding to run the programme has also made it difficult to recruit staff. DHSC did not agree the programme's revenue funding for 2025-26 before June 2025, and resource funding to run the programme has not been agreed beyond 2025-26.

3.30 Although the programme team has identified these capacity risks, and taken some steps to mitigate them, it is limited in how much it can do. The programme team is seeking a three-year revenue funding commitment and has secured some exemptions to the recruitment freeze to allow it to fill priority roles. It has also developed clearer contract documentation and more efficient recruitment processes. However, recruitment risks will continue to persist with the programme relying on case-by-case exemption decisions. The risk that the dissolution of NHSE will delay the programme is rated 'Red' in the NHP risk register as at October 2025.

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Hospital design – meeting clinicians' and patients' needs

3.31 Through the NHP, DHSC aims to build hospitals quicker and more cheaply than they would have been under a trust-led scheme, and to deliver hospitals that operate differently, achieve efficiencies and improve patient care (Part One). For example, hospital staff should have shorter distances to walk, paperless patient records, and technology such as infrared sensors to alert them when a patient falls. The schemes that will be built using the new Hospital 2.0 design are in wave 1 onwards, so are due to begin construction from 2027-28, opening in the 2030s. Operational benefits of these schemes will accrue from the date of opening.

3.32 The programme has developed a prototype of a single bed hospital room to test how the room will be built and maintained, and how it will be used by clinicians and patients (paragraph 2.11). DHSC told us that it is also learning from practices in the recently constructed Royal Liverpool University Hospital. We reported on the construction problems at Royal Liverpool University Hospital in our 2020 investigation into the rescue of Carillion's PFI hospital contracts.[19] DHSC has adopted an investment wave approach to maximise the transfer of learnings between schemes. In practice, it is likely that the hospital design will need to keep evolving with each wave, with the potential for greater benefits to accrue to the later waves.

3.33 The future benefits from the Hospital 2.0 design are not guaranteed, and the programme needs to manage risks to ensure they are realised. In particular:

- Hospital 2.0 will only result in future benefits if clinicians are able to work differently in the new hospitals. Securing buy-in from all clinicians may be challenging. As at October 2025, the risk of delays to NHS professional engagement with the designs was rated 'Amber' due to pressure on trusts and wider organisational changes in the NHS affecting their capacity to engage. DHSC recognises that training staff to use new spaces and digital systems will need to be delivered in phases, due to the scale of change. It told us it plans to increase engagement with staff and trusts in each wave as the construction of new hospitals progresses; and
- some trusts are concerned that hospitals delivered to the new design may be more expensive to run than existing hospitals. For example, West Suffolk Hospital, Bury St Edmunds told us that it expected the single-room model to require more staff and that it was concerned that while the innovative technology incorporated in the design would benefit patients, it may not deliver financial benefits for trusts.

19 Comptroller and Auditor General, *Investigation into the rescue of Carillion's PFI hospital contracts*, Session 2019-20, HC 23, National Audit Office, January 2020.

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3.34 DHSC has established governance arrangements to provide assurance that the Hospital 2.0 design meets requirements and delivers benefits. These include:

- **technical products assessment committee** to evaluate all technical products for the Hospital 2.0 design, covering clinical safety, cost effectiveness and alignment with objectives;
- **transformation committee** responsible for approving non-technical products including demand modelling;
- **digital sub-committee** to provide assurance of Hospital 2.0 digital products, including over cost-effectiveness, commercial viability and alignment with programme objectives;
- **change control sub-committee** to provide assurance over exemptions or deviations from the Hospital 2.0 standard design; and
- **independent technical review panel** of independent experts to provide peer review of whether the design meets standards and requirements.

3.35 DHSC recognises that realising clinical and operational benefits from the programme will require ongoing learning of lessons. It has established an evaluation and learning framework to support continuous improvement, which includes stakeholder engagement, joint working and learning activities. Ongoing engagement with trusts and clinicians and a clear benefits realisation plan will be vital to ensuring that the programme's strategic objectives and benefits are achieved.

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Appendix One

Our audit approach

Our scope

1 Our report examines whether the Department of Health & Social Care (DHSC) has a realistic and credible plan that gives the New Hospital Programme (NHP) the greatest chance of success. This report focuses on the management of the programme as a whole. We have not carried out a detailed assessment of progress on individual schemes. We have not examined the wider management of NHS England's hospital estate or its condition. Actions not taken under the new government (such as the initial scheme selection) are not within the scope of our report.

Our evidence base

2 Our independent conclusions on whether DHSC has a realistic and credible plan for building new hospitals were reached following our analysis of evidence collected between July and November 2025.

Interviews

3 Our study team conducted around 15 semi-structured interviews for this study. Main topics covered in interviews included the January 2025 plan for implementation, governance of the programme, funding and expenditure, the Hospital 2.0 design and its design process, scheme reprioritisation and risk management. Interview findings were used to broaden our study team's knowledge of the NHP and develop our recommendations for this report. Most of these interviews were carried out virtually; however, the team also visited the Hospital 2.0 prototype (see below).

- We interviewed DHSC and NHS England (NHSE) officials involved with the NHP. We selected interview topics and DHSC and NHSE selected relevant interviewees for these topics.
- We also interviewed other government bodies, including HM Treasury and the National Infrastructure & Service Transformation Authority.
- To understand trusts' perspectives, we spoke to NHS Providers (the membership organisation for NHS hospital, mental health, community and ambulance services) and directly with two trusts: West Suffolk NHS Foundation Trust and University Hospitals Sussex NHS Foundation Trust.

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Visit to the Hospital 2.0 Prototype

4 We visited the Hospital 2.0 prototype to help us gain greater knowledge surrounding the ward design of Hospital 2.0 and its practical implementation.

Analysis

5 We made 57 requests for data and information, and reviewed the documents provided to us by NHP. These included governance information, scheme business cases, planning documents, programme performance and risk reporting, and modelling outputs.

6 Our study team considered the outputs from two separate data models – the Multi-Criteria Decision Analytic (MCDA) model and the Demand and Capacity model – but did not independently assess these models. The MCDA contained data used to inform the prioritisation of hospital construction. We have applied some assumptions contained within the MCDA to provide approximate estimates of hospital opening dates. The Demand and Capacity model is used by NHP to inform the Hospital 2.0 design. We compared the assumptions and outputs of this model against the assumptions and outputs of modelling from the 2023 NHP. We also assessed scheme costings data from the third NHP business case and used these to estimate the approximate dates of construction for wave 2 and 3 schemes.

7 The programme and scheme costs in the report are from the NHP business case and are adjusted for inflation in future years, unless otherwise stated.

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Appendix Two

New Hospital Programme schemes

Figure 15
New Hospital Programme schemes

The 41 New Hospital Programme (NHP) schemes that the government committed to delivering when the NHP was reset in January 2025, including seven schemes to replace hospitals built from reinforced autoclaved aerated concrete (RAAC)

Scheme[1]	Type of scheme[2]	Total number of overnight beds	Estimated cost[3]
Wave 0			
Alumhurst Road Children's Mental Health Unit	2	8	£500 million or less
Royal Bournemouth Hospital	2	244	£500 million or less
St Ann's Hospital, Dorset	2	54	£500 million or less
Oriel Eye Hospital	2	15	Not provided
Dorset County Hospital, Dorchester	2	24	£500 million or less
National Rehabilitation Centre	2	70	Not provided
CEDAR programme	2	66	Not provided
Wave 1			
Poole Hospital, Dorset	3	617	£500 million or less
Derriford Emergency Care Hospital, Plymouth	2	76	£500 million or less
Cambridge Cancer Research Hospital	2	151	£500 million or less
Shotley Bridge Community Hospital, Durham	1	16	£500 million or less
Milton Keynes Hospital	2	222 (PBC)	£500 million or less
Women and Children's Hospital, Cornwall	2	150	£500 million or less
Hillingdon Hospital, north-west London	1	478 (PBC)	£1 billion to £1.5 billion
North Manchester General Hospital	2	499 (PBC)	£1 billion to £1.5 billion
West Suffolk Hospital, Bury St Edmunds (RAAC)	1	744 (PBC)	£1 billion to £1.5 billion
Hinchingbrooke Hospital (RAAC)	1	372 (PBC)	£501 million to £1 billion
James Paget Hospital, Great Yarmouth (RAAC)	1	470 (PBC)	£1 billion to £1.5 billion
Queen Elizabeth Hospital, King's Lynn (RAAC)	1	656 (PBC)	£1 billion to £1.5 billion
Leighton Hospital (RAAC)	1	630 (PBC)	£1 billion to £1.5 billion
Airedale General Hospital (RAAC)	1	430 (PBC)	£1 billion to £1.5 billion
Frimley Park Hospital, Surrey (RAAC)	1	653 (PBC)	£1.5 billion to £2 billion
Brighton 3Ts Hospital (later stages)	2	36	Not provided

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Figure 15 *continued*
New Hospital Programme schemes

Scheme[1]	Type of scheme[2]	Total number of overnight beds	Estimated cost[3]
Wave 2			
Leeds General Infirmary	2	616 (PBC)	£1.5 billion to £2 billion
Specialist Emergency Care Hospital, Sutton	1	434 (PBC)	£1.5 billion to £2 billion
Whipps Cross University Hospital, north-east London	2	541 (PBC)	£1 billion to £1.5 billion
Princess Alexandra Hospital, Harlow	1	525 (PBC)	£1.5 billion to £2 billion
Watford General Hospital	1	706 (PBC)	£1.5 billion to £2 billion
Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital	2	605 (PBC)	£1 billion to £1.5 billion
Kettering General Hospital	2	423 (PBC)	£1 billion to £1.5 billion
Musgrove Park Hospital, Taunton	2	281 (PBC)	£501 million to £1 billion
Torbay Hospital, Torquay	2	393 (PBC)	£501 million to £1 billion
Wave 3			
Charing Cross Hospital and Hammersmith Hospital, north-west London	3	432 (PBC)	£1.5 billion to £2 billion
North Devon District Hospital, Barnstaple	1	376 (PBC)	£1 billion to £1.5 billion
Royal Lancaster Infirmary	1	394 (PBC)	£1 billion to £1.5 billion
St Mary's Hospital, north-west London	1	583 (PBC)	£2 billion or more
Royal Preston Hospital	1	977 (PBC)	£2 billion or more
Queen's Medical Centre and Nottingham City Hospital	TBC	946 (PBC)	£2 billion or more
Royal Berkshire Hospital, Reading	1	745 (PBC)	£2 billion or more
Hampshire Hospitals	1	897 (PBC)	£2 billion or more
Eastbourne District General, Conquest Hospital and Bexhill Community Hospital	1	428 (PBC)	£1.5 billion to £2 billion

Notes

1 Five schemes previously included in the programme – Royal Liverpool University Hospital, Greater Manchester Major Trauma Hospital, Midland Metropolitan University Hospital, Northern Centre for Cancer Care and Dyson Cancer Centre, Bath – were already open when the programme was reset in 2025, These hospitals formed part of cohort 1 of the programme prior to the 2025 reset.

2 There are three types of schemes in the NHP: 1) A whole new hospital on a new site or current NHS land; 2) A major new clinical building or a new wing, providing a whole clinical service, at an existing hospital; and 3) A major refurbishment and alteration of all but the main structure of an existing hospital. These data are based on information provided to us by the Department of Health and Social Care. There are no firm commitments for the scope of projects until scheme business cases are approved. Most schemes for waves 1, 2 and 3 had not reached this milestone as at December 2025.

3 Scheme cost data from Department of Health & Social Care, New Hospital Programme; plan for implementation, January 2025.

4 Wave 0: Schemes under construction or completed after January 2025; Wave 1: Schemes due to start construction between 2025-26 and 2028-29; Wave 2: Schemes due to start construction between 2030-31 and 2034-35; Wave 3: Schemes planned to start construction between 2034-35 and 2039-40.

5 The NHP Programme Business Case (PBC) sets out scheme level data based on programme assumptions. In this figure, where we have reported bed numbers from the PBC, rather than programme management information, we have annotated the bed numbers as "(PBC)". Final bed numbers will be agreed as part of the business case approvals process. Overnight bed numbers is a different measure of bed capacity to that reported in Figure 12 (total bed numbers).

Source: National Audit Office analysis of New Hospital Programme data provided by the Department of Health & Social Care

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