National Audit Office

REPORT

Update on the New Hospital Programme

Department for Health & Social Care

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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

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.

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.

- **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).

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.

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).

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).

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).

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.

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.