NHS Confederation

Towards a new co-investment model

What is next for NHS public-private partnerships?

September 2025 Jonathan Barron

About us

The NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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Plenary

The report has been developed with input from Plenary based on their experience in international markets.

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About this report

This report has been developed by the NHS Confederation and a small working group, members of which have participated in an individual capacity. This report does not necessarily represent the views of all members of the group, their organisations nor all members of the NHS Confederation more widely. We recognise that suggestions within the report will generate debate within our membership and in government and look forward to continuing the discussion.

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Key points

- The UK has spent decades underinvesting capital in its healthcare system and now suffers the resultant poor productivity and a £14 billion maintenance backlog that hampers patient care.

- The delayed and underfunded New Hospital Programme, with spiralling costs for poor return, demonstrates the limits of the pure public capital approach.

- NHS leaders believe that a new model of private co-investment, which learns the lessons of the past and has the confidence of the public and private sectors, alongside public investment must play a significant complementary role to public finance in fixing the NHS's capital woes alongside further public investment, as is already being -done in Wales and Australia.

- An effective Public Private Partnership (PPP) model that has the support of both the public and private sector will be critical in rebalancing the NHS estate after decades of underinvestment and given the current fiscal rules

- The NHS Confederation has worked closely with NHS leaders, the investment industry and central government to understand what went well and what didn't during the UK government's PPP programme, the Private Finance Initiative (PFI), in the 1990s and 2000s.

- This report contributes to the ongoing discussion by providing lessons we can learn from PFI in the past and learn from international best practice to make recommendations on what future model(s) should look like.

- A more effective PPP model for the healthcare sector would see a public sector seat on the PPP board to enhance oversight, keep facilities management in-house with the public sector and take a new approach to contracts which is focused on outcomes not rigid specifications. It would also be supported and overseen by an expert central team in the Department of Health and Social Care, working in partnership with local trusts and integrated care boards.

- Putting these lessons into action, while also learning from modern best practice from other countries' PPPs, can shape a working model for a new model of PPP for both neighbourhood health centres and acute hospitals England.

- There are a wealth of models available that have been used successfully in both the UK and across the globe. This report sets out a range of these options as a contribution to the ongoing policy discussion.

Lessons and recommendations

Lesson	Recommendation
1. Private co-investment models that address some of the criticisms of PFI/2, including taking an equity stake in a Welsh Mutual Investment Model (MiM) style project, can keep payments off balance sheet if designed well.	1. The government should outline a framework for acceptable co-investment models that sit within the existing rules. The government may also need to consider the resources available for such co-investment and the entity to deploy and manage such investments.
2. There are options for off-balance-sheet PPP projects but the UK Government must provide the support and guidance necessary.	2. Develop the parameters for systems and trusts to develop their own PPPs to best meet their local circumstances.
3. Don't expect every ICB (or trust in the new operating model) to be able to undertake contract management, especially as they downsize.	3. Create a central office at DHSC that drives contract development. But delegate day-to-day operations of these contracts with the relevant trust.
4. We can avoid the contractual mistakes and challenging relationships from the PFI process with more flexibility and discretion in the contracts, for both the client and the PPP special purpose vehicle.	4. To draw on lessons learned from the PFI programme (eg. the numerous projects that have gone well) as well as other PPP programmes internationally that have moved on and addressed the challenges in traditional PPP programmes.
5. Many of the worst contractual disputes stem from poorly defined performance specifications including, in some cases, soft facilities management.	5. Consider removing soft facilities management to increase contract flexibility, as the MiM model has done. Set out a model contract that includes the list of top lessons outlined in table 1 (page 16). Set out a payment mechanism over the course of the contract that focuses on usability and outcomes that the private sector is able to deliver, rather than focusing on changing availability definitions. Consider more flexible contractual models from successful PPPs in other international jurisdictions.

6. Other countries employ models that aren't riven by contract disputes. In addition, LIFTco succeeded in England in building relatively conflict-free PPPs. It often did this by maintaining sufficient flexibility to build different types of commercial projects, making it more cost efficient.	6. Explore using contract models where contract dispute has been minimal. The government should amend the Green Book to better account for the real-world experience of PPP hospitals.
7. Too often the proposed business cases and vision for proposals such as the neighbourhood health centres are not carried through to operation.	7. Neighbourhood health centres should use LIFTco as a basis for developing their model, including having ICSs on the relevant board.

Background

The UK has spent decades underinvesting capital in its healthcare system and now suffers the resultant poor productivity and a massive £14 billion maintenance backlog that hampers patient care. At the same time, changing national demographics and ever-increasing expectations for better care mean the UK increasingly spends more on healthcare as a percentage of GDP.

In 2022, across both public bodies and private companies, France spent 26 per cent of its GDP on physical capital investment; Germany 25 per cent; OECD members 23 per cent on average; and the United Kingdom just 19 per cent. Since the early 1970s, the UK has spent less than half our OECD peers. The closest we came to the OECD average was during the PFI period in the 2000s.

Over the past two years, the NHS Confederation has investigated how much capital the NHS might need to hit national productivity targets,[1] how we might raise this money (including the option of new private investment models),[2] and how the capital funding system can be reformed to be more efficient.[3] We echo many other important stakeholders when we point out that the NHS needs significantly more capital funding.[4]

NHS leaders believe that a new model of private co-investment alongside public investment must play a significant complementary role to public finance in fixing the NHS's capital woes – as other countries are already doing.

The government said in the 10 Year Infrastructure Strategy that it will investigate a new PPP model in certain circumstances, with a focus on community, primary care and decarbonisation. Similarly, the government's 10 Year Health Plan for England committed to develop an off-balance-sheet solution, with more flexibility and delegated capital spending authority for some trusts. An effective PPP model that has the support of both the public and private sector will be critical in rebalancing the NHS estate after decades of underinvestment and given the current fiscal rules.

This report contributes to the ongoing discussion by providing insights and presents recommendations on what future model(s) should look like, including what we can collectively understand and learn from PFI in the past, as well as lessons from other countries' models. These are based on roundtable discussions and interviews with many of those involved in PFI over the decades, including government figures, NHS leaders and private investors.

While we are aware of the history and controversies surrounding PFI, this report focuses on a new, improved model and we intend these lessons to apply to whatever model(s) and for whichever parts of the health system the government decides to use PPPs.

What can we learn from private finance initiatives?

The Private Finance Initiative (PFI) and its successor PF2 were a series of structured PPP projects for the private sector to finance, design, build and maintain public assets, including hospitals.[5] PFIs became one of the more politically contentious British public policies of recent decades.[6] Critics claim these models provide poor value for money when compared with public investment, were inflexible, lacked sufficient input from the public sector and that poor contract management created looming issues for the first group of PFI projects to be 'handed back' to the public sector.[7]

While it is true that there are plenty of lessons to learn, the PPP world has moved on since the last time the UK was involved in such schemes. There has been a lot of innovation and positive case studies that develop the PPP model in other jurisdictions and sectors that address the previous shortcomings but also bring in the best of private sector innovations and cost control as well as public sector service delivery.

All capital projects create long-term costs for the taxpayer – private investment can allow those costs to be better seen and managed over the whole life cycle if managed well. For example, the ongoing maintenance backlog crisis – now bigger than £14 billion – may not have grown to the same extent if private investment was involved. A 2020 National Audit Office survey found that 71 per cent of assets developed under PFIs were anticipated to be handed back at the end of contracts in expected or better quality than required.

Too often the debate about private investment focuses on comparing the costs of a privately financed hospital with a hypothetical public equivalent. However, the far more relevant question was whether a given hospital would be built at all without private investment, particularly given government budgetary constraints. Those who have worked closely on NHS private finance are clear:

it brought investment that otherwise would not have come to the NHS. Many major hospital builds would not exist without private investment, and very few have been built with purely public capital since PFI was wound down.

This reflects a larger British problem with building large projects.[8] The recent New Hospital Programme – delayed and underfunded – demonstrates the limits of the pure public capital approach.[9] In contrast, most PFI/PPP projects were structured as fixed-price, date-certain projects with risk of cost overruns and delays being passed on to the private sector, albeit with a cost for transferring such risks to the private sector. Being honest about these trade-offs is important: private finance brings speed and certainty and new investment at an increased financing cost.

We believe that, on balance, the financial benefits of more timely and better cost-controlled projects using PPPs can outweigh their higher financing costs. Faster decision-making (as decisions are not subject to the usual central bureaucracy) and risk transfer to the private sector can minimise delay and cost overruns, which can be better value for the Treasury. Additionally, in helping to realise capital projects that would not otherwise have happened, private co-investment can help to regenerate local communities and drive economic growth, providing a return on the investment for the Treasury through higher tax receipts. Two decades of private finance offers a raft of lessons as we develop a new model that works for patients, taxpayers and private investors while helping local growth and regeneration.

We believe that there will be many ways to facilitate private development that meet local needs best. It is the one of the best ways to direct investment into an ageing health infrastructure while public investment remains contentious and often poorly implemented.

Each of PFI's main drawbacks can be mitigated by learning from the experience of the PFI in action this century. The NHS Confederation has worked closely with NHS PFI professionals, the investment industry and central government to understand what went well and what didn't during PFI in the 1990s and 2000s. We ask: how can a new public private partnership model deliver robust capital investment, learning from what's gone before?

Putting these lessons into action, while also learning from modern best practice from other countries' PPPs, can shape a working model for a new model of public-private partnership for the NHS in England. We follow by a range of different recommendations from successful UK and international models that we think help fulfil these goals – helping England avoid the 'gold-plating', the overspecification and the inflexibility that so often affect large infrastructure public projects, by drawing on what already works.[10]

To keep on or off the government's balance sheet?

Off-balance-sheet models mean the debt for a project sits off the government's books – a necessity in the current fiscal climate. As the UK's debt-to-GDP ratio approaches 100 per cent, the need to find models that avoid growing this further is even more important for the current government than it was in the 2000s when PFI was first introduced.[11]

One big reason PFI and PF2 (PFI/2) were abolished in 2018 was because the government – following advice from the Office for National Statistics – decided that they were no longer compliant with the international accounting standard IRFS16 and its European relation, and provided poor value for money. This halted almost all private NHS capital investment.

The Velindre Cancer Centre Mutual Investment Model (MiM) in Wales which is a refinement of the traditional PPP model, demonstrates how a project can be off balance sheet while also addressing some of the perceived challenges of PFIs. The Welsh Government's MiM is off balance sheet, having worked hard to ensure that the complex contractual model they agreed with private industry worked for HM Treasury.

To try to address some of the criticisms with the PFI/2 models, around lack of governance rights for the public sector and the lack of upside sharing opportunity, the Welsh Government took a 15 per cent equity stake via the Welsh Development Bank. The exact equity stake will differ for each project, but finding a 'Goldilocks' amount brings the best of several worlds: an off-balance-sheet investment that addresses some of the criticisms with the PFI/2 model and still retains the private sector confidence to fill the remaining investment share. This builds on a tried and tested approach, without the need

for a complex new set of rules or potentially risky innovative models. Allowing this in England requires a support from HM Treasury and a clear statement of support from the UK Government, like the Welsh Government has done. The risk transfer to the private sector, drawing on historical PFI, helps to ensure MIM is classed as off balance sheet.

However, MIM cannot happen in England without the UK Government deciding to take an equity stake. This limits the English applicability without a strong commitment from the UK Government as trusts or systems cannot create their own MIM equivalents without central government equity. There are, however, existing government or quasi-government entities such as the National Wealth Fund or NISTA that have the expertise to structure, and potentially the capital for, such investments.

There are further benefits to the UK Government too. In being part of the special purpose vehicle set up to run each MiM project, the Welsh Government has a seat at the board, meaning more public sector visibility to reduce risks and a stake in the potential upside.

A MIM model is not the only way that new models can risk share with the private sector. An innovative approach using third party ownership, currently proposed by Guy's and St Thomas's (GSTT) for their new Evelina Children's Centre, will involve selling a long-term lease to the site of an old building. The commercial operator will then build and own a 12-storey building on the site, with the Evelina leasing back six floors over the course of 15 years. The 15-year lease allows GSTT to spread the capital costs over a long timeframe and, importantly, means that the balance sheet risk will be shared between the building developer and GSTT, who will cover the cost of the fit out for their six floors. While not completely off balance sheet, the Evelina example shows that innovative solutions exist for long-term financing that keep at least some of the balance sheet risk away from the government.

A good model for allowing this innovation to spread is where the central team – likely at the DHSC – sets the parameters and best practices, houses some relevant expertise, and makes itself available to support the local teams who are given a large degree of operational autonomy.

Lessons and recommendations

Lesson: Private-public co-investment models that address some of the criticisms of PFI/2, including taking an equity stake in a Welsh Mutual Investment Model (MiM) style project, can still keep payments off balance sheet if designed well.

Recommendation: The government should outline a framework for acceptable co-investment models that sit within the existing rules. The government may also need to consider the resources available for such co-investment and the entity to deploy and manage such investments.

Lesson: There are options for off-balance-sheet PPP projects but the UK Government must provide the support and guidance necessary.

Recommendation: Develop the parameters for systems and trusts to develop their own PPPs to best meet their local circumstances.

Building better contractual relationships

Contractual disputes surrounding the nature, performance and handover of hospitals are one of the biggest problems with existing PFI projects. Multiple reports have criticised the nature of the contracts agreed leading to contracts with issues that either should have been foreseen or that provided perceived lack of value for taxpayers.

From the private sector side, many believe they have been overly 'penalised' compared with non-PFI contracts, often because the local trust uses PFI contracts as a cost control mechanism, with little regard for the potential impact this has on the wider health system's ability to entice providers.[12] Some have described how PFI contracts are often the first cost-saving measure for a trust, with disputes arising to save money with debates about technical performance even if the overall hospital works well.

Compounding things, systems are currently not funded for any capital or investment into PFIs, and they are currently penalised for the sq. m of PFI they have, which is deducted from their allocation. This needs to be rectified before any new PPP can occur otherwise systems won't want to sign up to new contracts.

PFI and PF2 contracts were often overly prescriptive, creating the possibility for disagreements about structure and performance of the hospital that was never foreseeable at the beginning. This idea that 'too much was bundled' into PFI contracts, has been a recurring theme in our conversations with senior leaders.[i]

Changing models of care will further complicate this picture. As we move towards the government's stated – if difficult – aim of moving care into the community, the need to develop more flexible estates and contracts will only increase. Thankfully, there were several rounds of contracts throughout PFI, and then in subsequent models such as MIM.

As it stands, re-using the approach for PFI contracts will not work.

Firstly, there needs to be a better understanding and agreement on what is covered and what happens if hospital specifications change throughout the contract. One of the key benefits of PPPs is the expectation of good maintenance management from the private provider. It is unreasonable to think that this level of expertise will sit at every system or provider. Introducing more flexibility and discretion into future PPP contracts, as other jurisdictions have done, will help to minimise disruption to hospital performance and enhance the ability of trusts to negotiate changes to their buildings.

The Velindre MIM has developed a 'lessons learned' table that offers a template, built on two decades of lessons from English PFIs, which sets out the 19 top areas and technical disagreements that have caused legal disagreements, set out here in table 1 (page 16).

The issue of contract management remains one of the most contentious aspects of PFI. The full detail covered by the White Frasier Report: www.gov.uk/government/publications/white-fraiser-report-private-finance-initiative-sector/white-fraiser-report

Table 1: Contract lessons from PFI schemes

	Contract lessons from two decades of English PFI schemes
1	Drainage systems with limited tolerances/snags/incorrect falls leading to blocks.
2	Drainage systems with too many internal/inaccessible elements.
3	Tight/poorly planned ceiling voids that make maintenance/lifecycle difficult without disruption.
4	Locations of AHU/engineering equipment [DN: clarify] over patient areas hampering maintenance.
5	Elevated water temperatures from too many low-use end points/dead ends.
6	Elevated water temperatures fur to cramped pipework risers/heat transfer.
7	Thin wall low carbon steel pipework – not resilient enough to avoid degradation during commissioning/installation.
8	Commissioning short cuts leading to energy over-use.
9	Insufficient thermal metering leading to uncertainty over energy use and limited opportunity to improve performance.
10	Poorly maintained and inaccurate records.
11	Gaps in finishing work/inadequate fire stopping.
12	Inaccurate concrete pour creating coordination issues.
13	Unreliable low budget lifts.
14	Over-complex door configuration for security and fire issues.
15	Poor mobile phone coverage in building.
16	Difficult routing for equipment replacement.
17	Poor/low spec wi-fi coverage.
18	Limited BMS without access to other client systems limiting SMART capability.
19	Poor detailing on facades leading to drip staining.

Courtesy of Velindre, reproduced with permission.

It is precisely this experience that means the NHS has a readymade head start on what works and what doesn't, allowing years of experience to develop contracts and financial structures that avoid the previous construction and maintenance pitfalls.

In addition, the MIM removes the soft facilities management from the developer's contract as one way of addressing the inflexibility seen in the worst PFI cases. This is one, but far from the only, option. Large projects like this can also be used to inject social and community impact within their facilities management contracts. Examples include building in local apprenticeships to upskill young people or working with local contractors to ensure community use of joint facilities.

Secondly, develop a payment mechanism where the NHS pays only when the overall functionality, as well as agreed outcomes and key performance indicators (KPIs), of the hospital remains high. While this will require significant thought and a collaborative approach between private industry and government, striking this balance will mean clear up-front agreement between the long-term standards the NHS understandably desires, and outcomes that the private sector is able to manage and deliver.

The Victorian Comprehensive Cancer Centre (VCCC), an AUD$1billion, 130,000 sqm development, offers a clear example of how to address contractual issues that plagued PFI and ensuring appropriate risk management, while also embedding community impact as a key part of the project.

The VCCC is home to world-leading cancer research, clinical services and education facilities for the building partners Peter MacCallum Cancer Centre, Melbourne Health, and the University of Melbourne. The facility is a publicly owned and publicly operated PPP with the state entering a 25-year concession with Plenary Health to ensure the facility is available to the public sector provider of clinical and research services, Peter McCallum Hospital and the wider VCCC.

The Victorian Government chose a PPP model primarily because it was the only delivery method that transferred maintenance, site, asset capability and interface risks to the private sector, while also providing optimal whole-of-life costs for long-term maintenance.

Competitive tendering and design meant that Plenary Health future-proofed the facility by funding two levels of expansion space, patient apartments and mixed retail space. An open design competition also delivered an architectural award-winning facility. The original PPP financing was particularly innovative as it was the first Victorian PPP since the financial crisis to include medium-term debt (ten years).

The VCCC has been contractually dispute-free since 2016 with the private sector responsible for a flexible building management regime (reactive/planned as well as lifecycle replacement); help desk; utilities management; cleaning (non-clinical cleaning); security; linen collection; waste management and disposal; grounds maintenance; pest control and small works.

Lessons and recommendations

Lesson: Don't expect every ICB (or trust in the new operating model) to be able to undertake contract management, especially as they downsize.

Recommendation: Create a central office at DHSC that drives contract development. But delegate day-to-day operations of these contracts with the relevant trust.

Lesson: We can avoid the contractual mistakes and challenging relationships from the PFI process with more flexibility and discretion in the contracts, for both the client and the PPP special purpose vehicle.

Recommendation: To draw on lessons learned from the PFI programme (eg. the numerous projects that have gone well) as well as other PPP programmes internationally that have moved on and addressed the challenges in traditional PPP programmes.

Lesson: We can avoid the contractual mistakes and bad relationships from the PFI process with more flexibility and discretion in the contracts, for both the client and the PPP special purpose vehicle.

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Lesson: Many of the worst contractual disputes stem from poorly defined performance specifications including, in some cases, soft facilities management.

Recommendation: Consider removing soft facilities management to increase contract flexibility, as the MiM model has done.

Recommendation: Set out a model contract that includes the list of top lessons outlined in table 1 (page 16).

Recommendation: Set out a payment mechanism over the course of the contract that focuses on usability and outcomes that the private sector is able to deliver, rather than focusing on changing availability definitions.

Recommendation: Consider more flexible contractual models from successful PPPs in other international jurisdictions.

Lesson: Other countries employ models that are not riven by contract disputes.

Recommendation: Explore using contract models where contract dispute has been minimal.

Sharing risk – a delicate balancing act

A further benefit of PPPs lies in their ability to shift risk outside the public sector – and therefore liberating some decision-making from long central processes – to avoid long delays and cost overruns like we have seen with the New Hospital Programme and, in the worst case, HS2. Less well known than the long-term costs to the public sector is the significant risk taken on by the private investor.

PFI was led, and managed to get things done quicker, with a small central team which focused on standardising documents and improving them as each new wave of projects was approved. Trusts were largely allowed to get on with negotiation and starting the projects.

Creating this balance won't be possible without strong, centrally led guidance and contract management with a single public sector point of contact and strategic negotiation and administration. This should allow better standardisation – important if the government is to undertake a large programme of shifting care into the community with new PPP settings – with a reasonable expectation of flexibility to local community and market needs. At the same time, it means there is a single government body responsible for the affordability of all PPPs, rather than relying on local contract management as a way of managing local financial constraints.

One aspect of risk sharing that is not considered often enough is the UK's difficult recent history with public procurement. The New Hospital Programme demonstrates the limits of an approach when all the risk sits with the public sector. More than 140 hospitals around the country applied for the recent round of funding, with only eight making the cut. That is a huge amount of unmet need as well as time wasted preparing unsuccessful bids. There is little way to describe this other than a failure of value for money, scope and approach to building a long-term market.

One big problem with the New Hospital Programme is that – apart from far too little money to meet the project's ambition – too much emphasis has been placed on a central team trying to find the perfect model that works for every project across the country.

The HM Treasury Green Book sets the criteria for how public sector organisations should assess PPP projects.[13] While the book itself presents a mostly nuanced set of criteria to consider PPP value for money, it is too focused on projected differences in costs between PPPs and a model 'control' public sector option without considering the previous experience of real-world PPPs and public equivalents. PFI demonstrates that, if you get the risk sharing correct, then fewer hospitals will be delivered late and over budget. Or at least if they are, the risk for this will not sit with the taxpayer.

Recommendation

Recommendation: The government should amend the Green Book to better account for the real-world experience of PPP hospitals.

Neighbourhood health centres

The experience of LIFTco provides further lessons considering the government's moves to develop neighbourhood health centres.[14] Generally well received, and providing a lower cost basis than traditional NHS estate, LIFTco was a private finance model used to develop community health centres in the same period PFI was used for acute hospitals.[15]

A long procurement framework, spread over the long-term development of the whole initiative, kept private investors on board, as did the fact that the buildings were often mixed-use commercial developments. More than £2.5 billion was invested overall.

Moreover, many of the issues that affected some PFIs including in building quality, have not been replicated in LIFTco in the same way. Pinpointing exactly why this is the case is difficult given there are so many inputs, but stakeholders tell us that these have likely been most successful when there is strong public sector presence on the board – much like the MIM in Wales – as well as owing to a strong replicable contract model.

However, there is often a potential that the LIFTco sites haven't lived up to the productivity and clinical potential. Too often there was a difference between the policy vision and how the premises ended up working in practice. People just kept working as they had before, and too many of the assumptions that went into the business cases and vision for how premises would work never came to pass, such as having a commissioning manager onsite.

Lessons and recommendations

Lesson: LIFTco succeeded in building relatively conflict-free PPPs in England. It often did this by maintaining sufficient flexibility to build different types of commercial projects, making it more cost efficient.

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Lesson: Too often the proposed business cases and vision for proposals such as the neighbourhood health centres are not carried through to operation.

Recommendation: Neighbourhood health centres should use LIFTco as a basis for developing their model, including having ICSs on the relevant board.

Conclusion

The ambitious goals of the 10 Year Health Plan require much more capital investment than the UK has managed over the past decades, perhaps in its history. Yet the options for meeting this challenge remain limited while the government opposes a wider range of PPP options. The recent uplift in public capital spending is welcome, but a true transformative approach – in line with the goals of the 10 Year Health Plan – requires further private investment.

Part of this challenge remains political: taking on board the legitimate criticisms of the PFI regime while also better understanding and advertising its benefits. NHS leaders are committed to support the government with this part of the task and are open to finding new and innovative ways to fund public-private partnerships. This report is one contribution to that ongoing effort, and the NHS Confederation will continue to work with the government and civil service to find solutions that work.

The second half of the challenge is enticing private investment. It's no surprise that there remains interest in investing in the UK. Bringing this investment in requires creating a pipeline of work, one that learns from the difficulties and stop/start nature of PFI.

Thankfully, there are a wealth of options available that have been used successfully in both the UK and across the globe. Each comes with its own pros and cons, and this report doesn't seek to adjudicate on which would work best for the NHS, as we believe there will be a range of options that work well in each situation. This report concludes by setting out a range of options as contribution to the ongoing policy discussion.

Appendix: **Procurement method comparison summary – private capital for public infrastructure**

Model	Scope and payment	Key sectors	Whole of life	Cost certainty	Risk transfer	Programme certainty	Outcome and delivery certainty	Design / innovation	Co-design and transparency	Capture project value through commercial developments	Competition and market
PPP/P3 (Australia/Canada/ UAE/Saudi Arabia/USA/Ireland)	DBFM/DBFOM Core services operations generally retained by the government. Maintenance and lifecycle services provided by proponent. Service payments budgeted and disbursed by the government or government authority.	Broad (transport, civil, social, economic).	Yes. Includes handback condition obligations.	High, fixed payment over life of concession.	High – subject to certain exclusions, private sector bears exposure to delivery, and operating risk over the concession term.	High – private sector capital bears cost exposure to programme delay.	High, with mature and flexible mechanisms to ensure sustainable, evolving and enduring value for money outcomes.	High, given strong market and value for money approach to evaluation (with high degree of process interactivity), and equity risk / reward.	Moderate to high, given established interactive tender process, user groups and design stages (through delivery).	Yes, adjoining commercial developments possible.	Competitive tender process with a mature market of investors, contractors and service providers. In most jurisdictions a stipend is paid.
Mutual Investment Model (Wales)	DBFM Core services operations (e.g. soft FM) publicly delivered and retained by the government. Lifecycle maintenance provided by proponent. Service payments budgeted and disbursed by authority. Government takes an equity stake of up to 20% to participate in upside and governance/project company board.	Social infra/civil, transport (applied to schools, hospitals, roads to date).	Yes. Includes handback condition obligations.	High - consistent with PPPs.	High - consistent with PPPs.	High – consistent with PPPs.	High - consistent with PFI and not as flexible as international PPP/P3.	High to moderate (late-stage procurement with planning in place by authority but has been applied to slightly earlier stage partnership model in schools sector).	Moderate co-design and transparency (authority typically taking limited to no risk on design development), consistent with PPPs depending on the nature of the process/project.	None proposed (all on site commercial operations are by authority).	Competitive tender process, with committed funding, including consideration of social and community benefits with a mature market in line with PPP participant market.
Precinct development (Australia/North America)	DBFM/DBFOM Augmenting the development of infrastructure (often through a PPP or similar model) with additional commercial development incorporated into a broader project to achieve enhanced social and economic outcomes. Value capture, through land payments, offsets or subsidy from the commercial developments may contribute to the financial and social outcomes.	Mixed use, anchored with public infrastructure.	Yes. Includes handback condition obligations.	High, fixed payment over life of concession for core public infrastructure combined with private sector risk on integration of urban renewal/precinct commercial developments.	High, depending on government objectives and land tenure arrangements.	High but with precinct activation warranting a ramp up in commercial activity to achieve sustainable social, economic and urban renewal outcomes.	High –generally consistent with PPPs, subject to precinct activation ramp up timing.	High innovation consistent with PPP models.	High to moderate co-design and transparency, consistent with PPPs depending on the nature of the process/project.	Yes, with key feature of the model providing commercial development that complements core publicly operated infrastructure. Result can be urban renewal and public activation within a single project framework.	Competitive tender processes for the development and underlying infrastructure, including a competitive process for development scope or land payment to government. A stipend is provided for the core public infrastructure bid.
Private Finance Initiative (PFI) / SoPC4 (England and Wales)	DBFM/DBFOM Service payments budgeted and disbursed by the local government or departmental agency.	Broad (social infra, economic, transport, civils, defence, utilities and waste).	Yes. Includes handback condition obligations.	High – consistent with PPPs.	High – consistent with PPPs.	High – consistent with PPPs.	High - delivery and performance standards are defined for the duration of the concession term. Not as flexible as international PPP/P3.	Moderate, as typically late-stage procurement and evaluation methodology for design requirements may be more formulaic or rely on template designs.	Moderate co-design and transparency (authority typically taking limited to no risk on design development), consistent with PPPs depending on the nature of the process/ project.	Typically none.	Competitive tender process with a mature market established through many decades of PFIs in the UK.
Concession (worldwide)	DBFOM Concession is either purchased by the private sector or licenced for a period of time with an upfront payment or royalty payable to the government.	Broad (social infra, economic, transport, civil, government services, utilities, operations).	Yes.	Governments receive a contracted sale price or licence payment. Full revenue and cost risk borne by private sector.	High - private sector bears exposure to delivery (if applicable), revenue, cost and operating risk over the concession term.	Variable, depending upon the nature and requirements of the concession.	Generally high, but sensitive to implications of private sector service delivery.	Depends upon type of asset, but typically conducive to innovation and service reform by private sector owners to achieve targeted returns.	Subject to the nature of the concession agreement.	Yes.	Competitive tender process with a mature market of investors and contractor participants.
Progressive P3 (Canada)	DBFM used for projects of over CAD $100 million or high risk, with appointment of a delivery partner (usually a D&C contractor) to progressively develop the design and delivery solution, the services and the associated costs, financing, and, contractual structure. Core services operations generally retained by the government.	Social Infra. Starting to be applied to civil and economic infrastructure.	Yes, but less integrated than some other forms of PPP.	Moderate. Progressive PPPs build up design and cost with regard to risk allocation. Some risk of cost creep as project elements are progressively built. Ultimately, cost certainty locked in at financial close.	Progressive build up the delivery and services solution in partnership with the government. A higher level of design and joint approach to risk provides a higher level of cost, programme and risk resolution at financial close.	Progressive development of programme in partnership with the government. Fixed programme from financial close.	High, due to the level of joint development undertaken prior to financial close. Subcontracting of key packages can be undertaken progressively providing additional certainty.	Limited given single contractor selected early and then other elements price focused.	High – consistent with PPPs/P3s.	Yes.	Competitive tender process for development partner but as various prices build for each element there may be fewer incentives to achieve whole of life value-for-money and or innovative solutions to ameliorate project costs.
Wide equity (Canada and Australia)	DBM. Core services operations generally retained by the government. Private sector financing of equity only, with the remainder provided by the government. Service payment provides equity return and services payment of O&M).	Social Infra and social infra augmentations.	Yes. Includes handback condition obligations.	High – consistent with PPPs.	High – consistent with PPPs.	High – consistent with PPPs.	High – consistent with PPPs.	High – consistent with PPPs.	High, given closer collaboration with procuring authority through design process.	Yes - can be consistent with precinct development projects depending on the nature of the process / project.	Competitive tender process or bilateral negotiation process for D&C and Services, depending on the nature of the project. Conflicts can emerge if the D&C contractor equity is present, as opposed to an active independent equity model.

Note: Balance sheet treatment for government subject to jurisdiction, government policy and accounting standards

Definitions

DBM – Design, Build, Maintain

DBFM – Design, Build, Finance, Maintain

DBFM – Design, Build, Finance, Maintain

DBFOM – Design, Build, Finance, Operate, Maintain

D&C – Design and construction

O&M – Operations and maintenance

SPV – Special Purpose Vehicle, project company set up to raise financing, manage and operate the PPP/PFI project

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18 Smith Square
Westminster
London SW1P 3HZ

020 7799 6666
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