Infrastructure Strategy 2024 – 2034

July 2024

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Foreword

The North East and North Cumbria Integrated Care System is the largest in the country by area and population encompassing 66 Primary Care Networks, 11 NHS Foundation Trusts, 1193 Adult Social Care Settings and 14 Local Authorities.

As a system we face challenges with variation between isolated rural, coastal and urban populations, deprivation, life expectancy, quality of life and health inequalities. We have developed a comprehensive strategy, Better Health and Wellbeing For All, to tackle these challenges grounded in four core goals: Longer and healthier lives; Fairer outcomes, Better health and care services, and Giving our children the best start in life.

Our infrastructure is a critical enabler for the delivery of our strategy and for the improvement we want to achieve. This ten-year Infrastructure Strategy sets out the change required to ensure we have the right buildings, equipment, workforce, digital, data and technology to underpin our ambitions for better health and care.

Across the North East and North Cumbria we have a history of delivery and innovation in service to our population. We have shown that, with the right mindset, tools and opportunities we can achieve improvements for the people and communities we serve. This is not all about having the best buildings, this strategy will enable us to have environments where teamwork can flourish, that promote health and wellbeing and sees the public estate as local assets that can benefit our communities. Having the right infrastructure is also key to being efficient and productive and using the resources we have wisely.

We recognise that today, much of our infrastructure is old, in poor condition, underutilised, costly, and inefficient. There is a clear requirement for investment. Without investment and the ability to innovate, not only will we not be able to realise the goals in our strategy, but we will also risk being unable to deliver safe, reliable services to our communities across the North East and North Cumbria.

Our Infrastructure Strategy sets out how we plan to work better together with an increased focus on collaboration, partnership working, joint decision making and integrated models of service delivery. Its sets out where we see our priorities as a system, to manage the risks that we face today. It describes how we want to work together, how we want to develop our infrastructure and workforce and sets out the resources that we need to address the priorities and ambitions that we have collectively agreed.

We recognise that this has to be a living document, and we will refresh it on an ongoing basis as we develop more understanding of our needs and mature as a system. We know that we need to establish greater understanding about how we can reach net zero, we need further work to shift from hospital to community with a focus on early intervention and prevention. Together, with partners we need to develop greater collaboration to truly develop an approach to one public estate and maximise all investment opportunities in the public sector estate.

We would like to thank all the partners who have worked together to consider local, and system infrastructure needs and draw together this comprehensive strategy, setting the direction and making a clear case for infrastructure investment across the North East and North Cumbria. We look forward to supporting the implementation plans to drive forward the changes we want to see and the ambitions that we want to realise.

Sam Allen, Chief Executive, North East and North Cumbria Integrated Care Board

James Duncan, Chief Executive Cumbria, Northumberland and Tyne & Wear and SRO for Infrastructure

Executive Summary

Our 10-year infrastructure strategy has been developed in collaboration across the ICS and with the support and input from our partner organisations. It sets a framework through which the development of our estate and infrastructure will support the ambitions of the ICS, and builds on from the good work already underway, and makes the case for significant but necessary investment to ensure we have safe, compliant and future proofed infrastructure.

Our vision

Our Infrastructure vision is "to enable the delivery of integrated, safe, sustainable and quality driven healthcare services, maximising the use of our collective resources, estate and data, continually innovating, transforming and supporting the people and population we serve"

Clinical priorities

The detailed clinical strategy was not available at the time of preparing this Infrastructure Strategy, although the strategic direction of travel has informed this work.

The conclusion on future infrastructure requirements have therefore been established based on existing strategies and plans, health population data, housing growth projections and place-based studies and Trust priorities.

In support of this, our Infrastructure Strategy aims to provide a framework and way of working to enable the delivery of care in the right place (home, community or hospital) and from fit for purpose, safe and sustainable accommodation.

Current situation

Health & Wellbeing Inequalities

We have areas of high deprivation across the ICS; 32% of our population live in the 20% most deprived areas in England. Life expectancy at birth for men is at 59.4 years compared to 63.1 for England, and 60.2 years for women compared to 63.5 for England. 28% of children live in low-income families compared to 19% in England. Our infrastructure needs to support and respond to these significant health and wellbeing inequalities.

Current Estate

The North East and North Cumbria estate extends to circa **3,669 sites** with a total gross internal floor area of **2,130m sqm**, and a total estimated running cost of **£300m pa**. This includes **477 primary care** properties, **95 acute** hospital sites including mental health hospital sites and **71** ambulance sites all with significant backlog **valued at £514m**. Our infrastructure strategy needs to enable efficient and effective planning, management and operations of our infrastructure.

Financial & Operating Constraints

We work within significant financial constraints - operating cost, revenue constraints, capital constraints, short-term financial planning cycle, CDEL constraints, **£514m** of outstanding backlog maintenance and a total annual running cost of **£328m pa.** We are further constraints by our workforce; recruitment, reward and retention. **Our infrastructure strategy makes the case for investment in our infrastructure.**

Our plan

Investment Planning

We have developed an informed **10-year** investment plan valued at **£7.4bn** to address our critical infrastructure, backlog and RAAC and to invest in our accommodation to create more capacity where it is needed in support of our health and care needs.

The Investment Plan has been developed and prioritised by our Provider Collaboratives (Secondary, Mental Health, Ambulance Service and Primary) and is based on the current understanding of investment need.

Delivery

An action and delivery plan for the next 6 months has been prepared which includes clear actions and outcomes for the Infrastructure Board and the respective subgroups across the system.

We require a mandate to deliver this strategy; to unlock resources and our commitment to collaboration, partnership working, and innovation in how we plan, deliver, operate and manage health and care infrastructure. Additionally, key performance indicators (KPIs) should be set for the estate, linked to the Infrastructure Strategy that are regularly reported to the ICB Board.

Introduction

We are at a time of challenge for health and care services, and we need to reimagine the way we deliver services across the North East and North Cumbria to achieve our vision of **better health and wellbeing for all.**

Since the creation of the North East and North Cumbria Integrated Care System (ICS) in July 2022, and despite challenging circumstances, we have achieved a strong track record of delivering good quality services, capital projects and implementing innovation. However, our infrastructure is aging, undersized, and requiring significant investment across all areas.

In December 2022, we published our Integrated Care Strategy. The strategy describes our vision for a more prevention oriented, proactive, integrated, holistic and person-centered approach to health and care, whilst responding to the growing and changing needs of our population across the North East and North Cumbria.

We face huge infrastructure challenges that impact upon our ability to respond to our strategy and support these changing needs, and we therefore need an Infrastructure Strategy that is visionary, holistic, robust and most importantly, deliverable.

The challenges we face today and the need to change gives us huge opportunity for innovation, imagination and creativity in how we deliver transformation across our system.

This strategy sets out, at a high-level, where we are now, where we need to be and the enablers we will need to get there.

It is our NHS infrastructure framework for how we re-imagine, transform and transition to 2034.

Reviewing the Strategy

This strategy is intended to be a '**living strategy**'; an ever-evolving framework to guide us to our 2034 vision. It is reflective of our position in 2024 and will be subject to ongoing revisions and updates. We plan to undertake our first review in 6 months, and thereafter on an annual basis.

Data

All data included and/or referenced within this strategy is based on data available at the time of the strategy development in Summer 2024. No detailed validation has been undertaken of any information, but standard and national data sets have been used to ensure as much consistency as possible. Updating and validating data should be done on an ongoing basis, with figures within this report updated to reflect any changes/corrections.

Provider information has been extracted from the information submitted as part of the 2022/23 ERIC return (published in October 2023).

References

This strategy seeks to minimise repetition from other strategy and policy documents, providing context only. This Infrastructure Strategy should therefore be considered alongside several other North East and North Cumbria Integrated Care Board (ICB) strategies and plans including; the Integrated Care Strategy, the Joint Forward Plan and the Digital, Data & Technology Strategy.

General Election

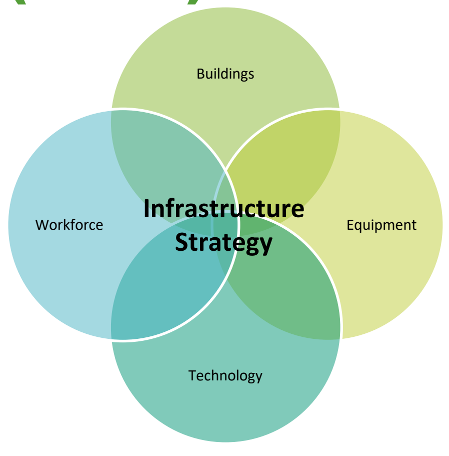
As a result of the recent general election, we appreciate that the new administration may wish to review and refresh current policy and priorities around NHS infrastructure. Therefore, we recognise that this strategy must be adaptable and responsive to any potential changes at a national level.

Infrastructure

In this strategy, the term 'infrastructure' refers to the buildings we use to deliver health and care services, the equipment within our buildings, and the data, digital and technology systems that support the management, operations and planning of our buildings.

Introduction (cont)

For the purposes of this strategy, 'health infrastructure' means the ecosystem of buildings, equipment, technology and our workforce which supports the delivery of health and care services to our population.



Our infrastructure is both an enabler, and a significant overhead.

Poor, inefficient and ineffective infrastructure not only costs the NHS money, but it has a significant contribution towards poor health outcomes. Without high quality environments, supported by the right workforce, excellent digital systems and medical equipment, we struggle to deliver the quality of care we need for our patients and our population. Furthermore, we cannot start to reduce health inequalities locally without the right infrastructure; infrastructure that enables health and care delivery and prevents people needing health services in the first place.

We have some big infrastructure challenges across our ICS that need to be addressed; contextualised by years of under investment, property ownership fragmentation, competitive and often organisationally siloed working.

During the development of this strategy, discussions were centered around system change and ways of working that are required to support system-wide health and care transformation. We also considered the potential for innovation and the collective determination to create the system-wide network of infrastructure that we need across the North East and North Cumbria.

Delivering the right care, in the right place, at the right time is dependent upon safe, compliant and high-quality infrastructure. In developing and delivering this strategy, we must take note on the following 'givens':

1. We must deliver and operate an Estate that is **safe, sustainable and fit for purpose** to meet the changing needs of patients.
2. We must make **best use of what we have** by transforming the way we work and use capacity across our infrastructure and our workforce; taking a 'one-public estate' approach in the way we use space, our skills and our expertise. We need to be imaginative and innovative in our use of existing land and buildings.
3. We need to plan and deliver our infrastructure in **true collaboration** over the next 10 years and beyond.
4. We must continue to build on collaboration; becoming even more mature and strategic in our **system and place level long-term plans**.
5. We **need significant infrastructure investment** across all parts of our system, and we will need a robust investment strategy; one where we are more strategic, targeted and tactical with our requirements for the future.
6. We will need capital and revenue investment to support the development of **new infrastructure, to improve our core and flex buildings** and to fund **the resources that we need to support implementation.**
7. We need to develop **alternative funding approaches** and solutions moving forward as part of a system-wide **commercial strategy** to support our investment needs.
8. **Digital and smart infrastructure** provides us with huge opportunity for transformation, and in-turn the efficient and effective use of our infrastructure that optimises use and drives change.
9. We must consider the **skills we will need across our infrastructure workforce** as we move to an increasingly green, sustainable, data-driven and digital NHS and align this to our workforce strategy.

Our System

The North East and North Cumbria Integrated Care System was established under the Health and Care Act 2022 and consists of:

Integrated Care Board

The Integrated Care Board (ICB) is responsible for planning and commissioning health services across the region for **3.15 million people**, with a budget of around **£6.6bn per annum**. By working with local communities, our partner organisations and our health and care staff, the ICBs ambition is to significantly improve the health and wellbeing of the people who live in our region creating a health care system which is fit for the future.

Our system in 2024 defined its direction of travel, as outlined in our **Joint Forward Plan (1)** where we describe how the NHS will meet the health needs of our population. We will consider our strategic priorities in more detail in Section 3.

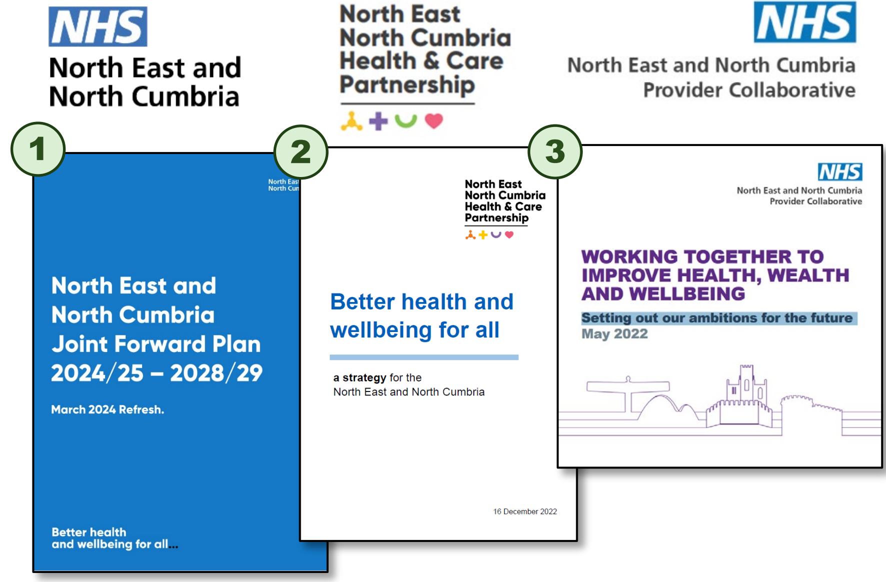
Integrated Care Partnership

The Integrated Care Partnership (ICP) is a committee of the ICB and our fourteen local authorities from across our region.

The ICP has developed an Integrated Care Strategy '**Better health and wellbeing for all**' **(2)** for the region that sets out how we will reduce inequalities, improve experiences of accessing our health and care services and improve the health and wellbeing of people in our region by 2030 and beyond.

North East and North Cumbria Provider Collaborative

The Provider Collaborative is a formal partnership of all **11 NHS Foundation Trusts** in the region (secondary care, mental health and ambulance services). Together they cover the entire geographical footprint of the Integrated Care System and provide the vast majority of all secondary NHS care services. There ambition is set out in the '**Working Together to Improve Health, Wealth and Wellbeing**' **(3)** strategy and they are key to supporting our health and care system more effectively to maximise the use of our collective resources and infrastructure.



Governance

To enable us to hold strategic conversations at the most senior levels across organisations we established a North East and North Cumbria Infrastructure Board in January 2024. We propose enhancements to this Board in Section 4 and 5.

Section 1.

Strategic Context

This section describes the national, regional and local priorities in which this Infrastructure Strategy must reflect and support.

Our Infrastructure

We serve over **3.15 million** people across an area of **13,000sqkm**, supported by a vast healthcare estate with over **3,600** sites of all healthcare types and an estate, facilities and digital workforce of well in excess of **6,000** staff who deliver the full spectrum of estate and facilities management services.

Compounded by the size of our system and the need to provide equitable access to health and care services, we face significant infrastructure challenges; from the quality and suitability of our buildings, to the lack of capital and CDEL restrictions, to the growing value of outstanding backlog maintenance that is required to provide safe and compliant infrastructure.

As presented below, the challenge is substantial, and we need to work better together across the system to build long-term infrastructure resilience in support of our evolving health and care needs.

Key infrastructure facts

3,600+
Properties across the region

2.1M+ sqm
total size of the healthcare estate across the region

20M+ pa
appointments can be delivered

6K+
of estate, facilities and digital workforce

14%
of estate pre-dates the NHS (pre-1948) by GIA

c.30%
of primary care properties owned by NHS & CHP

£514m
Total amount of backlog maintenance (2023)

£328m pa
running costs, including rent, rates, FM and utilities

1.55m tco2e
Total NENC ICS carbon footprint (2021)

2024 infrastructure overview

- We have a vast healthcare estate with more than **3,600** various type properties.
- Our current healthcare infrastructure footprint is over **2 million sqm,** which is equivalent to more than **270 football pitches**.
- Nearly **14%** (or about 300k sqm) of our health buildings pre-date the NHS – 1948 (appendix 1), increasing to 51% of estate in Gateshead.
- Current backlog maintenance across our buildings is over **£514m**, with 42% (or **£223m) of this being significant or high-risk infrastructure backlog** (appendix 2).
- Our estates carbon footprint is **1.55m** tonnes of CO2 emissions (appendix 3).
- We do not yet know the financial investment required to get our infrastructure to net zero or to adapt our buildings in response to climate change to ensure resilience, or how this will be achieved – this is a critical requirement.
- Our current plans include planned expenditure on our infrastructure of circa **£7.4bn over the next ten years**.
- Our approach to funding this strategy is being coordinated through the ICS Infrastructure Board but requires support through national policy and funding.

Infrastructure Risks

Across the ICS we are faced with many significant infrastructure risks that require investment to mitigate the impact on patient safety, quality of care, and operational efficiency. As a system, we are committed to addressing these risks via our objectives, prioritised investment needs and our ways of working. Below we have summarised the many risks that have informed this strategy:

Key System Risks

Primary care space shortfall: Primary care estate is undersized for the volume of clinical activity it is expected to deliver. Many buildings are functionally unsuitable and in poor condition.

Backlog Maintenance: The NHS is currently grappling with substantial backlog maintenance issues, including urgent repairs and replacements. The cost of addressing this backlog across the ICS stands at £514m with issues posing high risks to staff and patients. These high-risk problems require immediate funding to manage the potential infrastructure failure or safety deficiencies.

Underinvestment in Infrastructure: Years of inadequate investment have led to a deterioration in our buildings and facilities; hospitals, community facilities and GP accommodation. This lack of investment hampers efforts to improve health and care productivity, address waiting lists, and maintain patient safety.

Clinical Strategy – The detailed clinical strategy for the ICS was not available at the time of preparing this strategy although the strategic intent of the system has informed this work. Going forward this strategy will be reviewed and updated to reflect approved clinical priorities.

Aging Infrastructure - Our aging infrastructure creates significant maintenance and compliance issues which can in turn create risks to our patients and workforce; across our system nearly 14% of our health buildings pre-date the NHS, increasing to 51% of the Gateshead Health estate.

Capital scarcity: There is not enough capital to meet our needs and ambitions. We need the freedom to be able to innovate and access alternative sources of affordable funding outside the restrictions of CDEL.

Winter pressures: Our Accident and Emergency departments face ever increasing demands leading to overcrowding and long waiting times for patients. We need to do more to improve patient flow through better designed front door assessment and triage; working with primary care to divert patients to more appropriate treatment pathways; working with partners to improve discharge.

PFI and LIFT expiry: Over the next 10 years some of our PFI and LIFT estate will come to the end of their contracts, and we need to plan for the handback process e.g., the condition at handback, scheduling pre handback works and securing capital and revenue allocations post handback, etc.

Net Zero: Responding to our Net Zero challenge and ICB 2030 commitment by improving resourcing, funding and ways of managing our infrastructure.

Maternity services: Gateshead, Newcastle and South Tees all require substantial capital investment to invest in maternity services accommodation to mitigate the risks from aging infrastructure.

Infrastructure Workforce: We have an aging workforce that is further impacted by recruitment and retention challenges.

Underutilisation: There is substantial underutilised primary care estate owned by NHS property companies which represents a significant financial burden to the system. A coordinated approach to primary care estate management will provide an effective solution to resolving this financial pressure.

Strengths to Build On

Across the North East and North Cumbria we have much to be proud of. We have outstanding strengths that provides a credible source of hope and collectively we can make real improvements with confidence and realistic optimism.

We have a strong history of successful investment in capital infrastructure including the imminent completion of three New Hospital Programme schemes (Carlisle Cancer Centre, CEDAR and Shotley Bridge Community Hospital), the delivery of innovative digital programmes including the Great North Care Record, the use of innovative funding models and partnerships with local authority and private sector partners. The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) and Cumbria, Northumberland and Tyne & Wear (CNTW) were the first healthcare organisations in the world to declare a climate emergency back in June 2019, with the ICS declaring a climate emergency in 2022.

Even as a relatively high performing area, the quality of much of our healthcare infrastructure has declined in the past 15 years. Our ability to access alternative forms of finance and to innovate have become much more restricted by CDEL and the introduction of IFRS 16. To stabilise just our acute estate in ‘Business as Usual’ condition is projected to require **£1.5bn** over the next five years.

Our Primary care and Community care estate is aging and significantly undersized. It also requires additional action on backlog maintenance and re-placement of over **£0.5bn**. Investment in training and learning space is also required to support the ambitious workforce recruitment and training plans we require to maintain clinical capacity to serve our patients.

There has been significant improvement in the mental health estate over the last 20 years, however elements of the inpatient estate require urgent investment and the community estate requires significant change in collaboration across ICS partners to meet the aims of our community transformation model.

The prioritised investment set out in this strategy to truly transform our healthcare infrastructure and facilitate our clinical transformation will require an additional circa **£7.4bn** of investment across the 10-year vision encompassed in this document.

Recent successes

Project	Description	Funding
Care Environment Development & Re-Provision (CEDAR) Programme	Three major capital developments across the CNTW estate.	**£72.6m**
Aseptic Medicine Production Facility	New facility for the North East and North Cumbria – at FBC stage	**£29.7m**
Tees Valley Diagnostic Centre	New build for 100,000 diagnostic tests per year serving the Tees Valley.	**£24.2m**
Gateshead & Newcastle Community Diagnostic Centre	New center being built.	**£19.0m**
Digital Diagnostics Programme	Improves technical system interoperability, streamlining referrals and maximising diagnostic capacity.	**£17.9m**
University Hospital of Hartlepool Decarbonisation	Reduces carbon emissions by up to 80%.	**£13.4m**
The Great North Care Record	Integrated care record for 3.2 million people.	**Ongoing development**
Regularisation of GP Occupation	Standardised and capped cost leases for GP providers.	-

National Policy Context

The national NHS policy landscape shapes our approach of delivering exceptional health and care services. Over recent years there have been several national drivers that influence our infrastructure needs:

NHS Long Term Plan (LTP)

LTP aims to improve healthcare for the elderly and those with chronic illnesses. It prioritises **better primary and social care** with earlier interventions, **improved community management**, and **patient monitoring**. To achieve this, the **LTP aligns with an infrastructure strategy** that focuses on building **modern**, **adaptable facilities** and **digital infrastructure**, supporting healthcare providers in delivering new care models, consolidating services for better resource use, and finding cost-saving opportunities.

The Fuller Report

Highlights low patient and staff satisfaction in the NHS. It recommends solutions like **locally tailored care systems**, improved service responsiveness, and continuity of care. The report aims for easier access to local care, **proactive personalised care** by multidisciplinary teams, and a focus on preventative health. These goals will be achieved through neighborhood teams integrating social and secondary care, a **community focus to reach underserved populations**, and **improved access to same-day care** alongside personalised care plans and preventative healthcare initiatives.

Core20PLUS5

To tackle health inequalities in the UK, NHS England's Core20PLUS5 strategy targets the 20% most deprived population (Core20) identified nationally, along with additional local high-need groups (PLUS5). The strategy focuses on improving **five key** healthcare areas: **maternity**, **mental illness**, **respiratory diseases**, **early cancer diagnosis**, and **hypertension**.

Estate

NHS Health Building Notes (HBNs) and Health Technical Memoranda (HTM) provide comprehensive guidance on the planning, design, installation and operating of healthcare buildings and the specialist building and engineering technology – our aging estate and lack of funding struggles to comply.

Workforce

The NHS Long Term Workforce Plan sets a plan to tackle staff shortages by focusing on training more professionals, improving staff retention, and reforming work practices for better efficiency.

Equipment

The NHS Medical Equipment Strategy (2024) sets a plan to have the right medical equipment and technology in the right place, at the right price whilst responding to advancements in health and care delivery.

Digital

The NHS Long Term Plan aims to improve patient care by focusing on preventative care, reducing hospital pressure, and utilising data effectively, with an emphasis on data privacy and ethics.

Useful links

- NHS Long Term Plan (2019)
- The Fuller Stocktake Report
- Core20Plus5
- NHS Five Year Forward View
- NHS Digital Strategy
- UK Medical Technology Strategy

National Policy Context

Core, Flex and Tail

NHS England has established definitions of Core, Flex and Tail premises for local care, set out in the illustration below. The ambition is to move out of tail premises, developing further '**Core**' and '**Flex'** premises.

The focus on Core, Flex and Tail premises aligns with the NHS Green Plan:

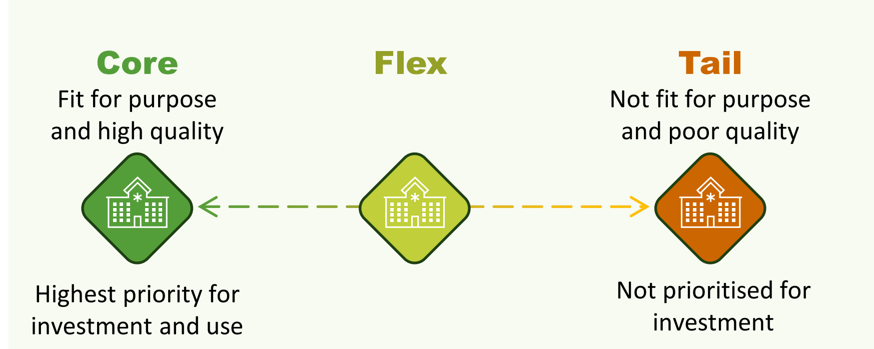
Core – good quality, fit for purpose and future proof estate that aligns with the LTP and ICS clinical strategy.

Flex – estate that is of an acceptable quality, or provides unique access to services, but does not fully enable the ambitions of the LTP.

Tail – Poor quality estate that is not fit for purpose or for patient facing services and should be phased out when alternative estate is available.

Divesting from **'Tail**' estate where alternate estate is available, reduces the overall carbon footprint. Investing sustainably in Flex and Core properties will improve the sustainability of the remaining estate.

We are considering how we adopt and use the '**Core, Flex and Tail'** approach across the full system in support of this strategy. This is reflected in our Next Steps in Section 5.



Delivering a Net Zero NHS

The NHS has set out its environmental and sustainability goal in the 'Delivering a Net Zero National Health Service' (July 2022). The report highlights the intrinsic link between climate and good health and that tackling the causes of climate change will reduce the burden on healthcare.

In support of this, the ICB has set an ambitious target to be **England's greenest region by 2030**. Together the system is committed to developing a consistent approach, with our partners in the public and voluntary sectors, to increased sustainability, reduced consumption and recycling, improved air quality and carbon reduction, as well as increased access to green and blue spaces. Action across the region already includes:

- County Durham & Darlington NHS Foundation Trust's 'Switch it Off' campaign has encouraged a reduction in wasted energy.
- Gateshead Health NHS Foundation Trust has installed solar powered air source heat pumps in seven buildings across its sites – resulting in buildings becoming zero-carbon.
- North Cumbria Integrated Care NHS Foundation Trust are working in partnership with the Cumbria Wildlife Trust to help improve biodiversity at their hospital sites.
- North Tees and Hartlepool NHS Foundation Trust has invested in recycling waste bins, electric car charging points and solar panels.
- South Tyneside and Sunderland NHS Foundation has switched to 100% renewable electricity resulting in an 80% reduction in emissions.
- South Tees Hospitals NHS Foundation Trust has joined the fight to reduce food waste by setting up an eco-shop.

NHS
North East and North Cumbria

Our Strategic Vision

The North East and North Cumbria Integrated Health and Care Partnership published its strategy, **Better Health and Wellbeing for All**, in December 2022.

It is an ambitious, long term, population health focused strategy, which sets out our collective strategic vision. The Better health and care for all strategy is organised around four key goals to deliver '**Better health and wellbeing for all**':

North East North Cumbria Health & Care Partnership

Better health and wellbeing for all

a strategy for the North East and North Cumbria

16 December 2022

Longer & healthier lives

Fairer outcomes for all

Better health & care services

Giving children and young people the best start in life

Healthier & Fairer Lives
- Prevention & Public Health
- Healthcare Inequalities (CORE20+5)
- Social & Economic Disparities

Better Health & Care Services
- Safeguarding
- Carers

Best Start in life
- Maternity & Neonatal
- Child Health & Wellbeing
- SEND

Primary & Community Care
- Pharmacy, Optometry & Dental
- Access to General Practice
- Personalised Care
- Ageing Well
- Continuing Healthcare
- End of Life Care

Urgent & Emergency Care
- Discharge & Transfer of Care
- Ambulance Transformation
- Urgent Primary Care
- Urgent Mental Health
- Urgent Community Response
- Patient Transport

Planned Care
- Elective Recovery
- Cancer
- Waiting Well
- Diagnostics
- Outpatient Transformation
- Long Term Conditions

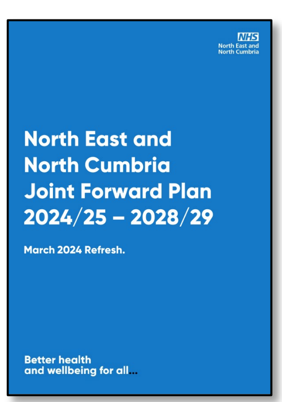
Mental Health, People with Learning Disability & Autistic People
- Suicide Prevention
- Community MH Transformation
- Children & Young People
- Drug & Alcohol Services
- People with SMI
- Homes not Hospitals

FIVE key enablers...
- A skilled, compassionate and sufficient workforce
- Innovating with improved technology, data, equipment and research
- Making the best use of our resources and protecting the environment
- Working together to strengthen our neighbourhoods and places
- Involving people to co-produce the best solutions

Our Joint Forward Plan

Infrastructure is fundamental to the delivery of our Joint Forward Plan; it provides the physical, digital and technological means by which to deliver our vision and address our strategic priorities.

This Infrastructure Strategy is shaped by the plan's vision, strategic priorities and the ways we know we are making a difference. We will explore how our infrastructure needs to respond to each of these priorities in Section 2.



There are key programmes of work that have already started as early foundations of population health improvement, and we have agreed new delivery areas that will have the greatest impact on population health outcomes.

To make progress in our delivery areas, we have identified **five key enablers** for change. These will support new ways of working and represent where the ICS can add value and accelerate equitable outcomes and are all reflective in **how we work better together as a system.**

Our Demographics

NHS North East and North Cumbria is the largest ICS in England by both population and physical geography. We serve over **3.186 million** people across an area of **13,000 square kilometers** (2021 census).

Our population:

Is older

21%

are over 65 years old compared an average of 18.6% in England

Experiences significant socio-economic deprivation

28%

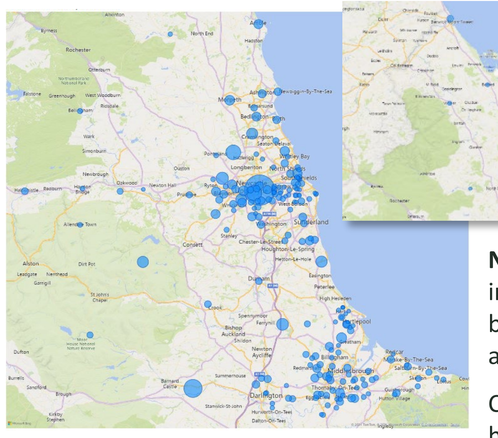
of children live in low-income families – England average 19%

Experiences health inequalities

59.4 years healthy life expectancy at birth for men in the ICS – 63.1 for England

60.2 years healthy life expectancy at birth for women in the ICS – 63.5 for England

Population growth



Source: Local Planning Authorities.

The map shows the predicted housing growth by local authority over the next decade.

Our ICS covers both rural and large urban conurbations, requiring the tailoring of health and wellbeing services to the local area and specific communities to ensure equitable access to services.

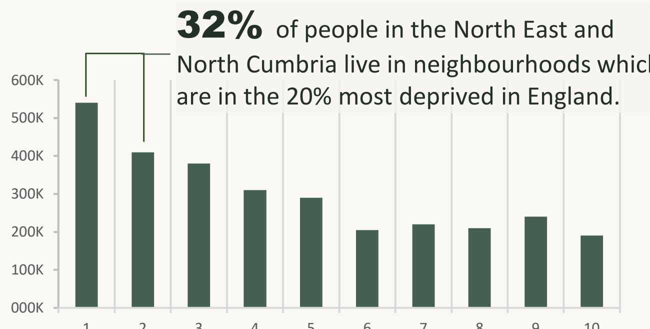
Note: Some housing growth has been amalgamated into ward or area level and therefore the size of bubbles relates to the volume of house building in an area, rather than specific site.

Cumbria is currently undertaking a refresh of its housing growth data. Please refer to appendix 7 for further information.

Deprivation across the ICB

The Index of Multiple Deprivation (IMD) 2019 is a relative measure of deprivation measured across the seven distinct domains. The area level of deprivation is positively correlated with health inequalities, adverse health outcomes and the risk of disease, including the risk of hospitalisation and deaths from Covid 19.

Population by deprivation decile



Source: English Indices of Deprivation, 2019.

One third of people in the North East and North Cumbria live in neighbourhoods which are in the 20% most deprived in England. This is even starker for children and young people, where the figure rises to 40% of infants aged 0 – 4, much higher than the England average of 25%.

This is set to worsen in the context of the current cost of living crisis. Average pay growth is well below the current rate of inflation and in 2022/23 and 2023/24 we are anticipating the largest fall in real incomes since records began. This will have a disproportionate impact on people living in more deprived neighbourhoods.

North East and North Cumbria

Our Service Delivery Approach*

We take a patient-centered approach to health and care planning, bringing together a network of teams across primary care, community support, specialist care, hospitals and our ambulance service to plan for the future.

Local estate strategies align with the national vision...

Several of our ICS partners have developed their own estate strategies. These documents outline each organisation's vision for its estate and facilities and how they align with the broader strategic objectives of both provider and system need. Key points to note:

Primary care

Defines how each PCN will utilise their facilities to deliver care. A broader ICB primary care strategy incorporates key themes from these PCN plans to create a wider vision for primary care delivery.

Community

A community estate strategy by NHS Northumbria Healthcare Foundation Trust is expected in late 2024 and will serve as a blueprint for other community providers.

Provider collaborative

Each Acute, Mental Health and Ambulance Service has its own estate strategy outlining how they will manage and transform their facilities.

System-wide strategy

The ICS plans to develop a comprehensive estate strategy in 2025.

Property type:

Whenever possible, we will deliver care in the community or close to home following a tiered mode of care, with hospitals being used to deliver major trauma, complex, specialist care and mental health. This approach helps to minimises travel and allows people to receive local and familiar support. Complex or highly specialised care will be delivered at our dedicated hospitals. To make this work effectively, we will look to plan our infrastructure to support this way of working, delivering health and care through a tiered approach.

*Please note, at the time of writing a detailed system wide clinical strategy was not available, however the strategic direction of system has informed this work.

Workforce

Ensuring we have the right staff, with the right skills, in the right place is essential to delivering high-quality care and our estate and facilities workforce plays a fundamental role in this. Our estates, facilities and digital workforce is made up of over **6,000** staff who deliver the full spectrum of estate, facilities and digital services.

We face significant workforce challenges across all areas. Since the Covid-19 pandemic, our workforce has been stretched, and in June 2023, the NHS in England was reporting vacancies of more than **112,000.** Across the ICS key points to note regarding our workforce include:

Staff Shortages

There are vacancies in many professions, including nurses, midwives, therapists, doctors, cleaners, estates, and administrative staff.

Recruitment

Filling vacancies is hard due to factors like competition, renumeration, cost of living, and negative media portrayal of NHS work.

Retention

There's a lack of space for workforce training and development, especially in primary care, impacting workforce development efforts.

What we do to mitigate these challenges:

£13.9m

We spent last year (2022/23) in apprenticeship levy.

1,837

Growing the number of apprenticeship in 2022/23 of which **26 are within Estates & Facilities.**

34%

of those starts were degree and level 7, 45% were level 2 and 3

We must note the huge disparity in efforts to address the specific workforce challenges faced by our estates and facilities team and we are now working collaboratively across our Provider Collaborative to plan and address these challenges and we are focusing on:

Apprenticeships

Apprenticeships are key to addressing workforce shortages and create career pathways; we need to encourage growth across Estates & Facilities services.

Existing Staff

Efforts are underway to support existing staff development, including return-to-practice programs and career progression opportunities.

We have set ourselves a target to improve our vacancy fill rate by 50 per cent by 2030, by attracting local people to careers in health and care, and working to retain the people who are already with us.

Our award-winning **Find Your Place** campaign, which promotes the region as a great place to live and work, has already helped increase the number of medical trainees choosing our region.

And an exciting 'mini-scrubs' project led by Northumbria Healthcare has helped primary school children to think about working in health and social care when they are older.

We will continue to be guided by the NHS People Promise, which is_based on staff feedback, setting out aspirations and need as well as sharing good practice and learning right across the health and care system.

Digital, Data and Technology

The North East and North Cumbria Health & Care Partnership has an ambitious digital health strategy that is based around the following themes and actions:

Key themes	Where are we now	What we will do
The essentials Getting the basics right	• Implement regional cyber response • Collaboration among organisations • Secure digital infrastructures.	• Continuously improve cybersecurity • Achieve national standards • Reduce complexity and duplication • Standardise digital systems.
Improving Continuing to advance and innovate	• Launched training programs • Engaged with Primary Care staff.	• Ensure workforce has digital skills • Reduce workforce pressures with new tools • Find new ways to address workforce capacity.
Connecting Linking the region and beyond	• Connected regional systems • Engaged patients with care pathway components • Provided collaboration tools for professionals • Digitised social care records.	• Expand Great North Care Record • Explore secure information sharing beyond region • Deliver digitally enabled diagnostics • Improve maternity care with digital solutions.
Empowering Bringing personalised care closer to home	• Accelerated Digital First Primary Care • Introduced HealthCall programme • Introduced virtual wards.	• Improve digital access to primary care • Develop new digital solutions for managing specific conditions.
Insight Using data in context to deliver action	• Developing Sub National Secure Data Environment • Implemented Population Health Management approach • Data store with some joined-up data.	• Implement Sub National Secure Data Environment • Improve data quality and consistency • Develop predictive analytics capabilities • Build data and analytics capacity.

Future & Innovation

The strategy acknowledges the rapid development of new technologies and plans to explore a toolbox of capabilities including **Artificial Intelligence (AI), Genomics**, **Robotics and Population Health Management**.

We will work together as a system to understand the capabilities of AI, its safe use in healthcare and how it is reflected in our infrastructure going forward.

Key opportunities and benefits to note include:

- **Keeping Well** – To help people stay healthy, by encouraging healthier behaviour.
- **Early Detection** - Already being used to detect diseases more accurately and in their early stages.
- **Diagnosis** - AI can review and store vast medical data.
- **Decision making** - Alignment of health data with appropriate and timely decisions, predictive analytics supporting clinical decisions/actions.
- **Treatment -** Help clinicians with a more comprehensive approach for disease management.
- **End of life (EoL)** – AI can support 'isolation' and help people to remain independent for longer during EoL phase.
- **Research –** Streamline the drug discovery and drug repurposing, potential to cut both the time to market for new drugs and their costs.

Digital, Data and Technology

Across the system we are implementing a digital healthcare strategy to enhance patient care and operational efficiency.

Primary Care

Our focus is on improving access to primary care services. This initiative leverages digital tools to empower patients and streamline service delivery, including:

- **Online consultations**: Patients can virtually consult with clinicians for appropriate health concerns, reducing unnecessary in-person visits.
- **Appointment booking and management**: Patients can conveniently book and manage appointments online, saving time and improving access.

Secondary Care

This initiative tackles the digital maturity of hospitals within the NENC region. It ensures hospitals have robust Electronic Patient Records (EPRs) that meet essential standards.

ICS-wide Initiatives

Several programmes have been undertaken to address broader challenges and opportunities within the healthcare system. These initiatives focus on:

- **Data Sharing**: Securely sharing patient data across healthcare organisations improves care continuity and eliminates redundant tests or procedures.
- **Digital Inclusion**: Ensuring everyone has access to, and can utilize, digital healthcare tools is paramount. This initiative addresses potential disparities in technology access and literacy.
- **Workforce Skills Development**: Equipping the healthcare workforce with the necessary digital skills is crucial for the successful implementation and ongoing use of digital healthcare technologies.

System-wide adoption of these initiatives is core to delivering the infrastructure strategy.

Social Care

Digitising social care records is a crucial step towards enhancing care coordination and streamlining operations for social care providers. This initiative involves transitioning from paper-based records to electronic formats, allowing for efficient data sharing and improved collaboration between healthcare providers and social care services.

Great North Care Record (GNCR)

A significant achievement of the digital healthcare strategy is the GNCR. This shared care record allows healthcare professionals across the region to access a patient's medical information from various health and care settings. This fosters a more holistic view of a patient's health, resulting in improved patient safety, reduced duplication of services, and faster care delivery.

Other initiatives include:

Initiative	Description
Primary care	Improve access to primary care services through digital tools like online consultations and appointment booking.
Secondary care	Improving the digital maturity of hospitals by ensuring they have electronic patient records (EPRs) that meet certain standards.
Social care	Digitising social care records to improve care coordination and efficiency.
ICS-wide initiatives	A number of regional programs to improve data sharing, digital inclusion, and workforce skills.
Great North Care Record (GNCR)	A shared care record that allows healthcare professionals to access patient information from across the region.

Net Zero Carbon

In line with the growing urgency to combat climate change, we are taking a proactive stance towards achieving net zero carbon emissions.

The North East North Cumbria Green Plan was published in July 2022 which set the bold ambition to be England's **Greenest Region by 2030 and** to achieve ***"the maximum health and wellbeing dividend for our population by being sustainable in all aspects of our work".***

Since this commitment was made, sustainability leads from across the Provider Collaborative have continued to meet to progress shared Green Plan initiatives and best practice. Looking to the future the system is developing a proposal to adequately resource net zero delivery at a System and Place level, including an ICB Sustainability Lead.

Our Trust's all have their own Green Plans, and information below provides a snapshot of progress to date:

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (CNTW)

- Aims to achieve net zero carbon emissions by 2040 – in line with the NHS 'Delivering a Net Zero NHS' commitment,.
- Invested in a Sustainability Team with expertise in decarbonisation.
- Established internal governance structure for green initiatives.
- Allocated annual capital funding for sustainability projects.
- Secured funding for various decarbonisation projects but some applications were unsuccessful.
- Collaborates with the ICS on green initiatives.

University Hospital of Hartlepool

- Awarded £13.4 million from PSDS funding for a decarbonisation project.
- Project includes installing 800KW solar panels and ground source heat pumps.
- Expected to reduce carbon emissions by up to 80% upon completion.

South Tees Hospitals

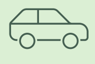
- Secured PSDS funding for both James Cook and Friarage hospital sites.
- Projects include replacing gas boilers with heat pumps, installing solar panels, and upgrading energy-consuming equipment.
- Aims to reduce gas consumption and generate electricity.

Action plan

As part of the proposed Green plan refresh in 2024, we will refresh the ICS Green Plan objectives in line with system organisational refreshes and agree a system action plan focusing on:

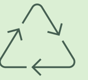
Sustainable healthcare

Travel & transport



Energy

Waste & circular economy



Supply chain & procurement

Greener estates & biodiversity

Adaptions

Clean air

Major Equipment Strategy – Case Study

Northern Cancer Alliance

A key focus for our major equipment strategy is the capital equipment replacement plan for radiotherapy within the Northern Cancer Alliance (NCA).

Radiotherapy is a crucial cancer treatment for nearly half of all diagnosed patients. **Three radiotherapy departments** within the NCA collaboratively deliver this treatment:

1. **The James Cook University Hospital,** Middlesbrough (South Tees)
2. **The Northern Centre for Cancer Care** (NCCC), Newcastle upon Tyne (NUTH)
3. **The Northern Centre for Cancer Care,** North Cumbria (NCCC NC)

These departments collectively treat around 9,000 patients annually and deliver 116,000 sessions per annum. Equipment replacement is limited by the availability of capital, meaning we only replace what we can afford, rather than what is needed. Currently around £9m of equipment investment is currently outstanding at Gateshead Health alone.

Key themes

Equipment Replacement

Radiotherapy equipment linear accelerators require replacement every 10 years due to wear and tear and advancements in technology.

Funding Shift

Previously, trusts managed their own equipment replacement programs. Now, the NCA relies on the ICS for capital funding.

Capital needs

Short-term needs for the next two years are identified as £7.9 million. Predicting long-term needs beyond 2025/26 is difficult due to evolving treatment practices.

Financial Sustainability

A sustainable funding strategy from the ICS is necessary for the NCA to maintain up-to-date equipment and deliver effective cancer treatment.

There is a need for **consistent capital funding from** the ICS to ensure the NCA has up-to-date radiotherapy equipment to deliver effective cancer treatment.

An overview of all radiotherapy equipment across the network is provided, along with an estimated £25 million investment needed for equipment replacement up to 2032/33 (excluding enabling works).

9,000
patients are treated annually across the three radiotherapy departments

116k
treatment sessions delivered by these departments per year

Short-term (up to 2025)
£7.9m*
needed in the short-term to replace major equipment via CDEL funding.

Long-terms (2026-33)
£25m*
needed for equipment replacement (excluding enabling works)

*Please note, the funding request above is a sub-set of the overall system wide equipment request of £799m – please see p62

Major Equipment Strategy – Case Study

Ambulance Service

Electric Vehicle (EV) Fleet North East Ambulance Service (NEAS).

NEAS has a nationally funded programme of fleet replacement up to 2028.

As part of this programme, 600 vehicles will be replaced with EV's with an ongoing 20-year replacement cycle. To support the proposed fleet replacement programme 50KW chargers will be required at strategic locations, including provider Trusts, throughout the ICS geographical area. These chargers would also be utilised by the police who are moving towards an EV fleet.

The investment in the ambulance fleet complements the development of a hub and spoke configuration of ambulance stations.

The Trust currently operates from around 65 'traditional' ambulance stations which it wants to consolidate to fewer hubs (probably North of Tyne, Wearside and Teesside) and spokes (often shared with Fire and Rescue services) to get greater operational efficiency. The current configuration stifles the ability for the Trust to deliver performance improvements.

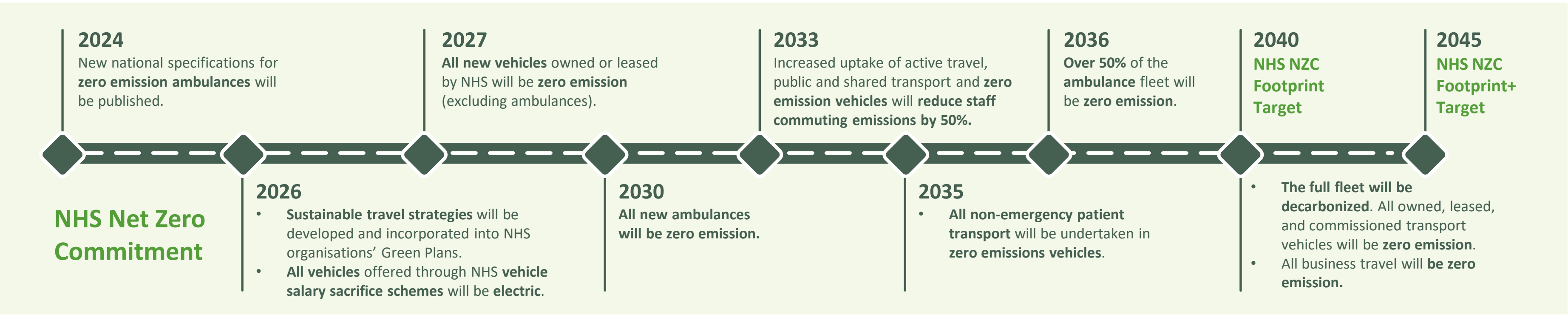
The move to a hub and spoke model will improve response times contributing towards the achievement of the national ambulance response programme (ARP) targets and reducing patient safety risk. Many of the existing garages are old buildings, some of which are not big enough to accommodate larger modern ambulances.

All but two of the ambulance stations (Berwick upon Tweed and Haltwhistle) are at capacity. NHS England and the ICB have allocated additional revenue for extra staff and vehicles, but there is no capital for premises capacity and enhancement. The Trust will be seeking about £20m over 2025 - 2028 for mainly new build facilities to accommodate staff and vehicles. In the intervening period there will be a lead in time in developing proposals and undertaking public consultation.

Please note, North Cumbria is served by the North West Ambulance Service and is subject to other proposals.

Please refer to appendix 18 for further information.

NHS Net Zero Travel & Transport Roadmap



Strategic Drivers

Over recent years there have been several national drivers for the production of infrastructure strategies including the NHS Long Term Plan, Joint Forward Plan, Next NHS Five Year Forward View, the Naylor Report, the Carter Report, the Net Zero Carbon and Sustainability Agenda; and more recently the Fuller Stocktake Report.

This strategy draws reference to the many different national, regional and local and Trust specific policies and strategies (as tabled below) and looking forward this strategy should therefore be considered alongside several other ICB strategies and plans including; the Integrated Care Strategy, the Joint Forward Plan, and the Data, Digital and Technology Strategy to guide future investment priorities.

At the time of writing, the ICB Clinical Strategy is yet to be published, therefore this Strategy is informed by the emerging direction of travel for clinical service transformation and will be continually reviewed and updated to reflect agreed priorities for health and care services at a system and local level.

Below we have listed the key strategies that have informed the development of the Infrastructure Strategy and the key themes that we have carried forward throughout the strategy.

Drivers

Five Year Forward View – Next Steps	Joint Forward Plan	Workforce Strategies
NE NC Better Health For All	Fuller Stocktake Report	NE NC Digital, Data & Technology Strategies
Naylor Report	NHS Long-Term Plan	National Initiatives e.g. CDCs, NHP, etc
Clinical Strategies – Trust	ICS Green Plan / trust Green Plan(s)	Alliance/Neighborhood Priorities

Themes

Collaboration	Integrated Planning	Transformation
Innovation	Efficient	Closer to Home
Greener	Better	Value for Money
Sustainable	Quality	Future Proofed

Section 2.

Where are we now?

This section describes our case for change and why we need to take a long-term view on infrastructure planning

Where Are We Now?

North East and North Cumbria ICS formally came into existence on 1st July 2022 replacing the Clinical Commissioning Groups and the informal North East and North Cumbria Sustainability and Transformation Partnership (STP).

The ICS has made progress in establishing the governance around infrastructure, led by the Executive Chief Digital and Infrastructure Officer. In January 2024 the Infrastructure Board was established supported by various groups that operates across the system including Strategic Estates Groups, Provider Collaborative and One Public Estate.

The Directors of Estates, Finance and Information meet monthly to discuss infrastructure matters, the ICS Infrastructure Board meets quarterly and there is a Primary Care focused Sub Group to the main board that meets monthly - all of which have a focus on system working, collaboration and joined up decision making. It is however, recognised that improvement is needed to support the delivery of this infrastructure strategy.

The ICS and its Trusts have a good track record of capital delivery. Schemes have continued to progress with the West Cumberland Hospital Phase 2 (Upgrades funded) and the CEDAR mental health facilities (New Hospital Programme funded) and both are nearing completion.

South Tyneside and Sunderland Trust are working with Sunderland City Council to deliver a replacement Specialist Eye Infirmary; Gateshead and Newcastle Trusts are working together on a new Community Diagnostic Centre which is being built in the Metro Centre; Northumbria Healthcare is delivering an Aseptic Unit that will serve several trusts in the ICS and are also exploring a new in-house linen and laundry facility.

The ongoing rectification programme underway at Roseberry Park PFI is of particular significance following the Tees Esk and Wear Valley decision to terminate the contract with the PFI provider after serious hospital defects were found.

The ICS and its providers continue to bid for new capital funding and are currently awaiting the outcome of the Accelerated Targeted Investment Fund bids for improving Urgent and Emergency Care performance in 24/25, having successfully delivered a scheme at South Tees from the 23/24 funding.

Estate Overview

The quality and condition of our estate ranges from excellent to poor, with some sites requiring significant investment to meet current health and care standard.

Our system has received investments in some locations, including NHS capital builds, PFIs, LIFT projects, and third-party GP developments. There is, however, an urgent need to address the stark contrast in infrastructure quality across different sites. **This existing disparity highlights the pressing need for enhanced community investment, for hospital replacement (acute and mental health), significant investment across our primary care estate, and investment to manage the backlog and critical infrastructure risks.**

The ownership of our estate is also complex with multiple NHS providers, NHS property companies, GPs, public and private sector landlords. Due to constant evolution in leadership and health and care priorities, estate planning and decision making has often been fragmented, siloed, disconnected and overly commercialised – limiting our ability to be collaborative in our decision making and building use.

Number of Sites*	3,669
477 Primary Care	244 Provide Collaborative

Other sites	
Care Home	*812*
Pharmacy, Optometry, Dentistry (POD)	*1,527*
Other	*609*

*site refers to a location where NHS services are delivered and can include several buildings.

North East & North Cumbria Map

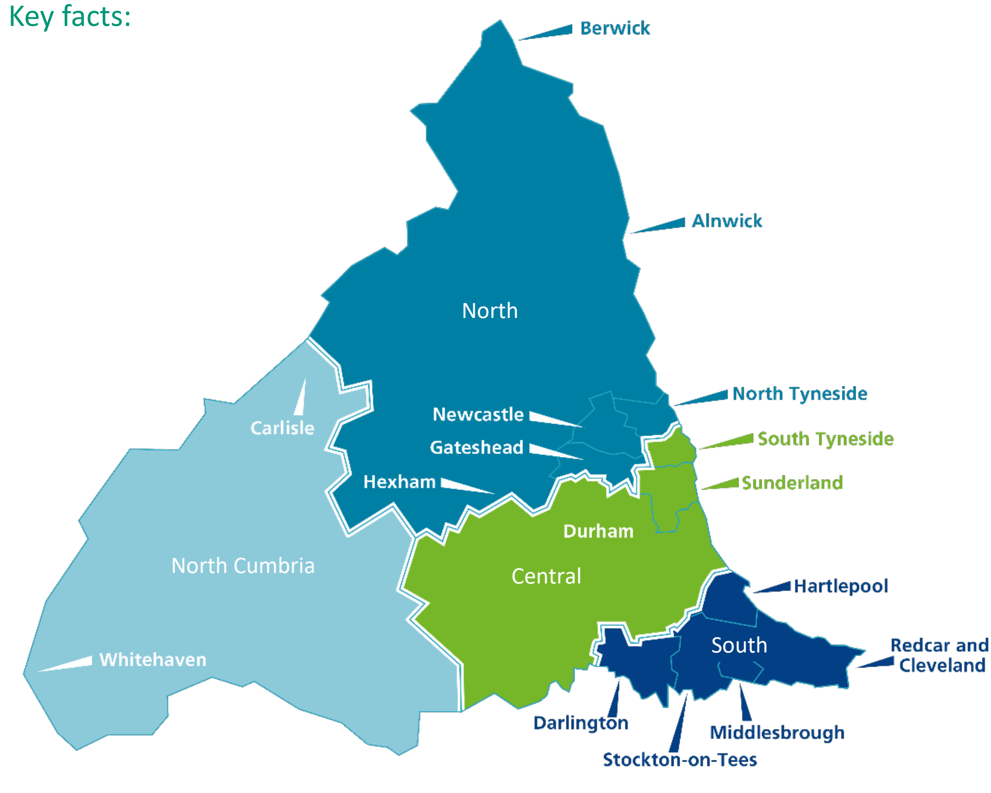
North East & North Cumbria ICB is comprised of **4 'Places'**:

- North Cumbria
- North
- Central
- South.

Please refer to appendix 14 for further information.

Our Infrastructure Landscape

Key facts:



North
Population: 1,079,000
Primary Care Network: 22
GP: 161
3 NHS FT: Northumbria, Newcastle, Gateshead
North East Ambulance Service **Ambulance Stations:** 22

South
Population: 701,000
Primary Care Network: 14
GP: 92
3 NHS FT: County Durham and Darlington, North Tees and Hartlepool, South Tees
North East Ambulance Service **Ambulance Stations:** 16

North Cumbria
Population: 324,000
Primary Care Network: 8
GP: 50
1 NHS FT: North Cumbria Integrated Healthcare
North West Ambulance Service **Ambulance Stations:** 11

Central
Population: 997,000
Primary Care Network: 22
GP: 174
2 NHS FT: South Tyneside and Sunderland, County Durham and Darlington
North East Ambulance Service **Ambulance Stations**: 16

Key healthcare infrastructure facilities:

64 Primary Care Networks	**8** Foundation Trusts	**2** Mental Health Trusts	**2** Ambulance Trusts
477 General Practices	**95** Acute Sector Sites	**78** Mental Health Sites	**71** Ambulance Stations + Support sites

North East and North Cumbria

2 mental health NHS FT:
- Cumbria, Northumberland, Tyne and Wear,
- Tees, Esk and Wear Valleys

Provider Collaborative Estate Overview

Our provider collaborative estate consists of the following site types:

Acute Sector Sites: Hospital and community healthcare facilities that deal with critical illness and injuries. Includes emergency departments, intensive care units, community hospitals, administrative office buildings, etc.

Mental Health Sites: Facilities dedicated to providing mental health, learning disabilities and neuro-rehabilitation services including inpatient hospitals, centres and facilities.

Ambulance Sector Sites: Locations where ambulances are stationed and maintained. Includes traditional ambulance stations, shared facilities with fire brigades and ambulance support facilities.

95 Acute Sector Sites

78 Mental Health Sites

71 Ambulance Sector Sites

Key figures

244 provider collaborative estate sites across the ICB

1.9m sqm total size of the provider collaborative estate

82% of the total provider collaborative estate size are Acute Sector by GIA

c.31% of sites are freehold (41% by GIA)

55% of estate is older than 30 years

c.15% of the provider collaborative estate is PFI by GIA

£506m Total backlog costs (2023)

£83.3M pa Occupational costs, including rates

£245M pa Total costs of utilities and FM costs (2023)

Key Insights

- Provider collaborative estate has a mix of new and old facilities.
- More than half of the existing space for acute sites **(55%) was constructed more than 30 years ago** (appendix 1).
- **More than 8% of the estate predate the NHS**, having been constructed before 1948.
- Significant backlog maintenance exists across the Provider Collaborative estate, with a total reported amount of **£506m.**
- **More than two fifths (44%)** of total provider collaborative backlog maintenance falls under **high and significant risk**, implying critical repairs are required to prevent major disruptions of the healthcare infrastructure (appendix 2).
- Our freehold properties account for 31% of the total provider collaborative estate by site count, while they represent 41% of the total GIA (appendix 13).
- Around 15% of the total GIA of provider collaborative estate is PFI (appendix 11).
- Tenure across the provider collaborative estate is much less varied than primary care estate, with no sites occupied 'at risk' or without formal lease documentation.
- The **annual running costs** for our collaborative estate exceed **£328 million**. This includes **£83.3** million on lease payments, rents, and business rates, along with **£245** million spent on utilities and facilities management.

Primary Care Estate Overview

Our primary care estate, encompassing a network of 477 facilities, plays a critical role in shaping the future of transformed health and social care and includes:

GP Practices: These buildings provide primary care serviced and staffed by a range of primary and community care providers. They are often the first point of contact for patients seeking non-emergency medical care and wellbeing support.

Key figures

477
Distinct GP entities, regardless of location

230k sqm
total size of the primary care estate

4,486
Total number of consultation and examination rooms

c.50%
of sites are freehold (43% by GIA)

23%
of estate is older than 50 years

c.28%
of primary care properties owned by NHS & CHP

£7.6m
Total amount of backlog maintenance (2023)

£46.5m pa
Occupational costs, including rates

52%
of the estate requires upgrade in the next few years

Key Insights

- North East and North Cumbria ICB population creates demand for **21.8m appointments** per year based on national average access rates.
- Our estate **needs an additional 6,800 sqm** of clinical space to align with the England average and 1,000 additional consultation and examination rooms to meet clinical demand.
- **Almost half of the** primary and community **estate was built before 1985** (appendix 1).
- Development of new/replacement primary care buildings is at a 70-year low despite a 25% larger population than in the 1950's.
- Rent (including rates) for primary and community requires **£46.5m per annum**. A **2% rental** rise increases the ICS's rent/rates budget by **£1.2m** (appendix 10).
- Significant backlog of maintenance exists across the primary and community estate, **totaling £7.6m**.

Estate Condition by Tenure:

- **Freehold**: Majority of the NHS owned buildings are in good condition. Almost half of GP owned properties require repair.
- **Leasehold**: Small proportion of NHS estate and Third-Party landlords. Mix of condition ranging from good and needs repair within NHS properties. For third party properties, one half (52%) is good against 48% needing repair.
- **PFI**: Majority in good condition (Condition B), 15% requires upgrade / refurbishment in the next few years.

Please refer to **appendix 12** for further information.

Backlog

The condition of our estate has a marked impact on the quality of care we can provide. The quality of our working environment also has a significant impact on our ability to recruit, retain staff and it limits our ability to transform care.

Shortfalls in capital force us to divert funding to maintain our ageing estate and equipment rather than develop long-term innovative and transformational projects. The realisation of which would reduce our long-term equivalent capital need by enabling us to deliver the right care, in the right place at the right time.

Many of our sites were built many years ago, developed for far fewer patients and to meet historical care standards – and some are now functionally and physically obsolete which in turn creates risks around infection and patient experience.

Site Type	Low	Moderate	Significant	High	Total Backlog
Acute	£121.9m	£154.9m	£131.9m	£73.6m	**£482.3m**
Mental Health	£2.7m	£4m	£16.4m	-	**£23.2m**
Ambulance	£0.5m	£0.01m	£0.4m	-	**£0.9m**
Primary Care	£1.9m	£4.9m	£0.7m	£0.04m	**£7.6m**
Totals	**£127m**	**£164m**	**£149m**	**£74m**	**£514m**

£223M
of which is significant and high-risk backlog (Critical Infrastructure risk)

43%
of total backlog is high and significant risk

NHS North East and North Cumbria

We currently need to invest over

£514m

in our backlog. But the risk is not purely financial – our backlog presents a risk to patient safety, service delivery and care provision.

Please refer to appendix 2 for further information.

The NHS Property Companies

28% of our primary care estate is owned and managed by the two national NHS property companies: **NHS Property Services** and **Community Health Partnerships.**

The Health and Social Care Act 2012 created a fragmented estates landscape, where the local ownership, management and share holding (in the case of LIFT) of community estate moved in most cases from Primary Care Trust's to the two national NHS property companies - **NHS Property Services and Community Health Partnerships.**

Challenges

Across the system there is a perception that both companies have created unnecessary additional layers of management, bureaucracy and cost that can hinder our ability to be transformational and logical in our decision making at a local level. Lease and license occupancy arrangements in some areas do not offer enough flexibility and our ability to integrate services and teams where individual organisations have demised spaces (e.g., their own space) is limited.

These challenges are heightened by the increasing cost of '**void space**' - a system cost, currently valued at **£17.7m per annum**. As part of a national directive, the ICB is required to pay market rent on the void estate, including void space where NHS Property Services hold the freehold ownership. Whilst NHS Property Services do invest in the region, it is substantially less than the rent paid on the void estate. In the last 5 years NHS Property Services has delivered no new health buildings in the region, nor has plans to do so in the future. NHS Property Services has launched a **Vacant Space Handback**, but opportunities to utilise this have been largely exhausted. We need to think innovatively to increase the clinical benefit of funding spent on estate and we are starting look at how agreements can be made easier to enable us to provide care in the community where patients live.

Opportunities through LIFT

As we progress towards LIFT expiry dates, we need to start working on our ICB strategy for the long-term future of the LIFT buildings. We know that our LIFT portfolio is expensive in comparison to benchmarks and is in some cases underutilised and we must address this. Key areas of focus must include **End of Term Planning** e.g., options to bring control back into the local system whilst considering management and financial responsibilities e.g., debt liabilities. This could extend beyond LIFT buildings to include NHS Property Services and Community Health Partnership freehold assets.

Void Estate Costs – NENC

Type	Annual value
Service Charge	£3.7m
FM Charges	£1.7m
Rent (Gross)	£5.9m
Rent (Net)	£5.6m
Rates	£0.8m
Total	**£17.7m**

126
number of NHS Property Services buildings

14
number of Community Health Partnerships (CHP) buildings

6
number of LIFT buildings across North East And North Cumbria

Please refer to appendices 11 and 13 for further information.

Celebrating Success

Three new hospitals, as part of the New Hospital Programme are in the North East and North Cumbria:

Carlisle Cancer Centre

£36m of national capital was originally awarded to North Cumbria Integrated Care (NCIC) for the delivery of the Carlisle Cancer Centre on the Cumberland Infirmary site under wave 1 of the STP Capital upgrades programme. When the New Hospital Programme was announced this was rebadged as one of the 40 and completed under the NHP. The scheme completed in 2021/22 and was the first to do so under the New Hospital Programme.

CEDAR – Mental Health Medium Secure Units

£55m of national capital was awarded to Cumbria Northumberland Tyne and Wear (CNTW) Mental Health Trust to re-provide and expand their Adult Medium secure facilities in a new build at the Northgate site in Morpeth, the Bamburgh Unit in Newcastle and for an extension to the Children's and Young People's medium and low secure, general learning difficulties and PICU facilities at Ferndene in Prudhoe. Construction at Northgate completed in 2023/24. Work is continuing at Ferndene and Bambrough Units.

Shotley Bridge Community Hospital

Currently £55m has been allocated for the replacement of the existing Shotley Bridge hospital with a new community hospital in Consett. The scheme is at OBC stage.

The ICS submitted 6 bids into the 2021 bidding round for the "final 8" additional New Hospitals. None of these were successful.

Please refer to appendix 8 for further information.

Carlisle Cancer Centre

CEDAR – Mental Health Medium Secure Units

Shotley Bridge Community Hospital

Celebrating Success

Community Diagnostic Centres (CDCs)

Working together, the ICB collectively agreed where national funding for three new Community Diagnostic Centres would be best invested in the region. Work is now well underway on all three CDCs with expected go live dates as follows:

- **Castlegate Shopping Centre, Stockton** - opening August 2024
- **Metro Centre, Gatehead -** opening October 2024
- **Workington Town Centre** - opening June 2025.

The rollout of Community Diagnostic Centres across the region will support our collective ambition to reduce waiting times for patients as we manage the overall increase in demand for diagnostic tests and scans. We have seen this increase by a staggering 11% since pre-pandemic levels (2019/20) and the new CDCs will add much needed capacity into the system so that we can see and diagnose more patients.

Aseptic Medicine Production

The Provider Collaborative has led the business case process to secure **£29.7m** for a new aseptic medicine production facility for the region. The funding is from NHS England and is part of a national fund of £75m. The new **'Medicines Manufacturing Centre'** will be based at Seaton Delaval and work as part of a new hub and spoke model with existing aseptic units. It will produce large quantities of ready to administer injectable medicines, including antibiotics, chemotherapy and 'over labelled' medicines. This will also help to free up valuable nursing time on our hospital wards to allow staff to provide other clinical care, rather than having to prepare medicines. The business case is currently at FBC stage and is due to be approved by NHS England at the end of July 2024. The new facility will be constructed across a 12-15 month build period and production is planned to commence from Q1 2026.

Tees Valley Diagnostic Centre (TVDC)

The TVDC forms part of the national plan to develop diagnostic facilities outside of acute settings. **£24.19m** funding was approved for the development of what will be the largest scheme of its type in the North East. It will deliver **100,000 diagnostic** tests per year and serve the whole of the Tees Valley whilst helping to address the significant population health issues in the area.

Tees Valley Diagnostic Centre

Aseptic Medicine Production in Seaton Delaval

Planned Activity

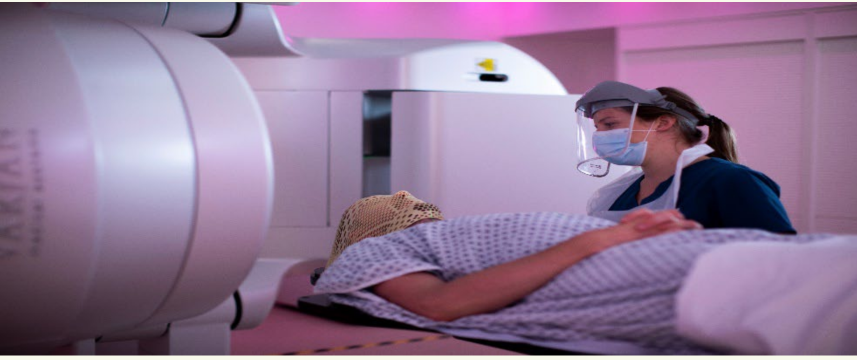
NHS
North East and
North Cumbria

Major equipment investment

Therapeutic Treatment Equipment – Linear Accelerators

The North East and Cumbria ICS operates 16 Linear Accelerators. There are 8 based in Newcastle, 6 in Middlesbrough and 2 in Carlisle.

The machines cost **£2.5m** each plus building enabling works and are required to be replaced every 7 to 8 years. This requires funding of **£5m** per annum to replace ageing equipment and it was previously the case that this was funded nationally. National funding is not currently agreed for replacement machines going forward. At James Cook there are 5 MRI scanners, high value radiology and radiotherapy equipment which require planned replacement over the next 5 years, at a cost of £6m per annum



Diagnostic Equipment – CT, MRI, SPEC CT

ICS partners operate many major pieces of diagnostic kit costing c.**£1.5m** for the kit and associated additional works to support compliance with HTM/HBN. Over half of these have been funded nationally over the last 5 years and all require replacement every 7-10 years. Most Trusts in the ICS will not have access to the level of capital funding required to keep pace with such a replacement programme going forward.

North Cumbria Integrated Care NHS FT (NCIC) was awarded **£33m** to continue with the next phase of Redevelopment at the **West Cumberland Hospital** (WCH). Phase 2 of the new hospital is on track to complete in July 2024 and will replace 89 of the inpatient beds at WCH transforming the facilities for care in Stroke, Community, End of Life, Paediatric and Care of the Elderly services.

West Cumberland Hospital

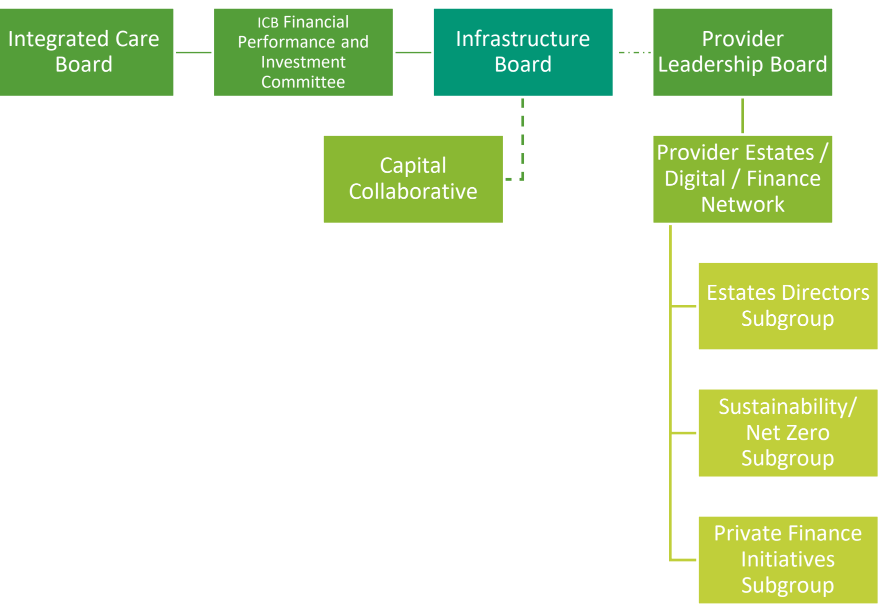
NCIC were also successful in obtaining **£15m** of funding from the National Endoscopy fund to create a new Endoscopy facility at the Cumberland Infirmary in Carlisle. Land has been taken out of the PFI Project Agreement and enabling works are underway on site. Once complete (target date of early 2025) the new Endoscopy facility will provide 4 diagnostics rooms and will be linked to the main hospital. The existing decontamination unit will also be expanded.

NCIC recently acquired the freehold on land adjacent to the West Cumberland hospital which it has been using for temporary car parking throughout the Redevelopment of the hospital site. This newly acquired land provides a strategic solution to staff car parking and potentially unlocks the lower part of the site for further redevelopment and potentially some disposal proceeds.

Governance

Our Infrastructure Board reports to the North East and North Cumbria ICB Finance, Performance and Investment Committee and provides regular updates to the North East and North Cumbria Integrated Care Board and the Provider Collaborative Provider Leadership Board.

The Infrastructure Board, as depicted below brings a range of partners together from across the ICS to provide strategic oversight, planning and direction to support the development, implementation and ongoing review of a fully integrated Infrastructure Strategy (including Estates, Finance and Digital). It reports to the ICB FPIC and provides regular updates to PLB. It meets quarterly.



Infrastructure Board Membership

Position	Organisation
Provider Collaborative SRO for Capital / Estates Chair of NENC Infrastructure Board	CNTW
Chief Digital and Infrastructure Officer / Vice Chair of NENC Infrastructure Board	NENC ICB
Assistant Director of Estates, Facilities and Environment	NEAS
Specialist Advisor, NTW Solutions Ltd	CNTW
Director of Estates	CNTW
Director of Estates, Facilities and Capital Planning	SFTH
Associate Director of Estates and Capital	NT & HFT
Director of Estates, Facilities and Capital	TEWV
Associate Director of Estates and Facilities	NCIC
Estates National Capital Oversight SRO	NHSE
Managing Director	CDDFT
Associate Director of Estates and Facilities	GHFT
Director of Estates	NuTH
Director of Estates and Facilities CHoICE	STSFT
Director of Estates and Facilities	NHCT
Estates National Capital Oversight SRO and Regional Delivery Director (NE & Yorkshire) Partner	NHS E
Director of Finances from across the system	
Executive Chief Digital and Information Officer/SIRO	NENC ICB
Deputy Director of Estates & Premises	NENC ICB
Chief Information Officer (CIO) Network Chair	Provider Collaborative

Infrastructure Workforce

NHS North East and North Cumbria

Our infrastructure workforce is spread across providers and NHS property companies. To deliver this strategy, additional support is required at a system and place level.

Our ICB strategic infrastructure resource is currently very limited, restricting our ability to take forward strategic programmes to support system thinking, communication and ownership. Furthermore, this is combined with limited strategic capacity across our provider organisations, at Trust level.

The growth and evolution of our infrastructure workforce to better support our changing needs is limited by our ability to recruit and retain. There are however many new initiatives in-track to manage these limiting factors including our workforce model, where an increasingly collaborative approach is being taken.

We know that both our strategic and operational workforce will need to transition to support our evolving infrastructure vision and that we need new skills as we move forward, and we need to start to plan this now.

The NHS Estates and Facilities Workforce Action Plan has identified several challenges with the NHS workforce across infrastructure workstreams. It sets out a number of the themes we need to focus on around our national workforce; looking after our people, belonging in the NHS, new ways of working and delivering care, and growing for the future. Further themes are picked up in the NHS Long Term Workforce Plan.

Partnership Working

Partnership working was historically integrated into the working of Primary Care Trusts and Clinical Commissioning Groups. The North East in particular was seen as an exemplar with multiple joint infrastructure schemes delivered under the mantra of '**Thinking together, Building together, Delivering together**' and across the North East and North Cumbria area, internationally recognised 'partnership' schemes have been delivered and new ones are planned:

- **Bunnyhill Customer Service centre and Primary Care centre** – a single facility accommodating a GP practice, walk in centre, diagnostics and outpatients together with a library, café, gym, nursery and pharmacy.
- **Houghton Primary Care centre and Leisure centre** – a single facility accommodating Minor Injuries and x-ray, 24 rehabilitation beds, a range of healthy lifestyle services.
- **Blaydon Primary Care Centre** – incl Minor Injuries and Illness Service, Community Dental service, Community Physiotherapy, Range of community services including podiatry, and sexual health, Primary Care Mental Health, Audiology, X-Ray, Breast screening, a range of healthy lifestyle services. Leisure services include a gym and swimming pool.
- **Construction of a new Community Hospital** at Berwick using off site modular construction with a north east Modular building firm – Merit Construction. (BAU capital – Under construction)
- A new **Specialist Eye Infirmary** at Sunderland (Partnership with Sunderland City Council)
- **Newcastle University** have started a £500 million redevelopment 10-year project on the site of Newcastle's former General Hospital. This will create a **"Health Innovation Neighbourhood"** which will see the old hospital grounds transformed with research labs, NHS and other health-related facilities, and 1,250 new homes - 15% of which will be affordable. (Partnership with University).

Continued partnership working is key to the success of this strategy; **going further, faster.**

SWOT Analysis of the Current State

By understanding our current Strengths, Weaknesses, Opportunities and Threats, we can identify areas for improvement and capitalise on opportunities to build a more resilient and efficient infrastructure base.

Internal

Strengths

- **Collaboration**: Growing collaboration across the system (e.g., CNTW managing PFI works) and a dedicated Infrastructure Board to promote coordinated infrastructure development.
- **Resource Optimisation**: Initiatives like reducing void space and double-counting will result in better utilisation of existing infrastructure.
- **Innovation**: Piloting alternative financing models and expanding successful programs (Northumbria Primary Care model, Elective Hubs, etc) encourage creative solutions.
- **Data-driven Decision Making**: Utilising data to identify needs and opportunities (e.g., theatre capacity in Bishop Auckland) facilitates strategic resource allocation.

Weaknesses

- **Aging Infrastructure**: Outdated facilities, backlog, derogation from HBNs requires significant funding to address including urgent needs in mental health.
- **Workforce Challenges**: An aging workforce, recruitment and retention difficulties across the system threaten service delivery.
- **Fragmented Estate**: The undersized and fragmented estate hinders efficient service provision e.g., some rooms being 40-50% of HBN standard.
- **Funding Constraints**: Limited capital investment, CDEL limitations, tighter financing rules and lengthy business case process and approvals restrict infrastructure development.
- **System Integration**: Inconsistent system working and competition between providers create inefficiencies.

S W O T

External

Opportunities

- **Improved Collaboration:** Strengthening system-wide collaboration (e.g., One Public Estate) can optimise resource use.
- **Digital Transformation:** Expanding digital solutions (e.g., triage, wearables, robotics) can enhance service delivery.
- **Right-sizing Infrastructure:** Matching facilities to clinical need can improve efficiency (right building, right location). Collaborating with ICS partners can support the expansion of the community mental health estate.
- **Centralisation:** Centralising specific services (e.g., Seaton Deleval) can streamline operations, and provide better value for money.
- **Right sizing to support service change –** for example, mental health services historical reliance on inpatient beds, and ambition for transformed community-based services.

Threats

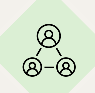
- **Health Inequalities**: Addressing disparities in health outcomes across rural, remote, and socioeconomically deprived areas requires specific strategies.
- **Digital Divide**: Unequal access to digital technologies can hinder service delivery in some areas.
- **Net Zero Target**: Achieving status as '**England's greenest region by 2030'** necessitates significant investment in sustainable infrastructure and creates additional challenges for infrastructure development.
- **Building Condition**: Significant outstanding backlog and critical infrastructure risks, including RAAC at the University Hospital of North Tees (Residency blocks) and at the James Cook University Hospital (Maternity Department).
- **Decant Space** – no available decant space to progress works to eradicate backlog.
- **Workforce** - with a national shortage in skilled estate labour, more attractive private sector salaries we will continue to struggle to retain an in-house workforce.

Summary

Our infrastructure challenge is significant, but we have the evidence to understand what our priorities are, and how we need to work differently to make better use of the infrastructure we have and to target investment where it is most needed.

Funding

- Scarce NHS capital, significant controls on progressing schemes via non-NHS capital (finance leases, PFI, 3PD, LIFT) and CDEL controls have limited progress in delivering new infrastructure.
- We still invest in new builds and refurbishments without a longer-term, clinically driven investment, or funding strategy to align projects against.
- We need longer term, place-based capital investment plans that support the direction of travel to deliver care locally, close to home with complex or highly specialised care delivered from our hospitals.

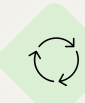


Governance

- To deliver our infrastructure commitments our governance, ownership, communication and integration structures need to be strengthened, and we anticipate that different sub and working groups will need to be formed such as 'Place Infrastructure Forums'.

Net Zero

- Despite making a system-wide commitment to be **England's Greenest Region by 2030** and delivering many successful Trust level projects, we recognise that greater system level support is needed to realise our ambition including significant investment.



Utilisation

- Despite the growing pressure for space, we do not always use the space we have effectively. We know that we have theatres, equipment and clinical spaces across our system that are not used effectively when we have significant capacity pressures in other parts in particular the space required to train doctors, clinicians and other health and care workers.
- Underutilised space is both a financial pressure (financial impact of void space) and it is a missed opportunity to optimise and transform our ability to deliver health and care outcomes.
- First and foremost, we need to better use what we have before we invest in more, and when we do invest, we should never replace like for like and always look to future proof and support the transformation health and care services.

Data and Information

- We have no live central dataset for system wide infrastructure which limits our ability to effectively analyse data, impacting on our ability to be clear with our prioritisation requirements. Furthermore, we know that data, transparency and analysis is a key enabler to our future infrastructure planning.
- We will look at this in Section3, but we need to start embracing digital systems, connectivity and better analysis of our information to start to support a better use of our resource; from investment to using the space we have better.

Section 3.

Where do we want to be?

Our roadmap to 2034 and our key areas of focus

Our Vision

Our infrastructure vision is "**to enable the delivery of integrated, safe, sustainable and quality driven healthcare services, maximising the use of our collective resources, estate and data, continually innovating, transforming and supporting the people and population we serve"** and we will achieve this by "**thinking** together, **working** together, **delivering** together and **transforming** together for the benefit of our **citizens and our environment**. The diagram below illustrates how our Commitments, Principles and Objectives will work together to deliver our vision.

Commitments

1. Improve the quality of our primary care and hospital infrastructure (e.g., backlog & critical infrastructure risks)
2. Invest in primary and community facilities (e.g., Heath Innovation Hub, Blyth Care Hub, CDCs & Hubs)
3. Future proof and update our facilities to meet the evolving health and care needs of the system (e.g., prioritising backlog investment.)
4. Make our infrastructure net zero by 2030
5. Improve efficiency across all healthcare facilities
6. Develop workforce and digital systems for infrastructure management
7. Collaboratively plan our medical equipment needs across the system.

Principles

Collaborate
working together and sharing good practice to optimise infrastructure utilisation

Delivering quality
optimising management and maintenance to make the best use of our infrastructure

Integrate
infrastructure responding and supporting our evolving health and care pathways

Innovate
maximising the use of digital and technology across infrastructure and in service delivery

Future proofed
making informed, evidence-based infrastructure decisions

Maximising funding opportunities
proactively make the case for infrastructure investment, including alternative sources of funding

Sustainable
implementing our vision to be the greenest ICS

Attract and retain our workforce
attract, retain and grow an inspired and flexible workforce

Objectives

1. **Quality**
Our infrastructure is safe and of good quality, is of the right size and in the right location, and is flexible, adaptable and responsive.
2. **Transform**
Infrastructure is an enabler to system wide health and care transformation
3. **Affordable**
Our future infrastructure is affordable, financially sustainable and future proofed.
4. **Digital**
Using Digital, Data and Technology to enable our Workforce to make the best use of our Infrastructure
5. **Place making**
Our infrastructure shapes healthier places, is inclusive and active in reducing health inequalities.
6. **Net Zero**
Implementing our ambition to become **England's greenest region** and integrate this ambition into decision making

Our vision

Objective 1 – Quality

Our infrastructure is safe, secure and of the right quality. It is the right size, in the right location, flexible, adaptable and responsive to our evolving health and care needs.

Where do we want to be?

We need the ability to flex and adapt our spaces as health and care needs change and therefore our infrastructure should be adaptable, responsive and resilient to transformation. We also need to be assured of the compliance of our infrastructure, as per specific HTMs and HBNs.

To do this we need to:

1. Reduce our backlog, improve condition and compliance and we need to progress towards infrastructure decarbonisation.
2. Identify the future quantum and location of infrastructure for our health and care system; across our system, at place, and within Primary Care Networks.
3. Take a one-public-estate approach to all our infrastructure decision making and continue to develop new and different models to use spaces to deliver care e.g., from the high street, to supermarket car parks, to home.
4. Standardise our accommodation offer (e.g., accommodation typologies) to align with our health and care delivery models, providing consistency across the system.
5. Build flexibility into our infrastructure; from adaptable physical spaces, agile occupancy and flexible use enabled through digital systems (e.g., space booking).
6. Consider infrastructure within our health and care strategies, policies and decision making.

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North East and North Cumbria

Objective 2 – Transform

Infrastructure is an enabler to system wide health and care transformation

Where do we want to be?

We will use our infrastructure as a tool for improving prevention, targeting health inequalities and delivering accessible services and it must support and enable the systems ambition to move care closer to home.

To do this we need to:

1. Optimise and modernise the way we manage our infrastructure and the way we work together across the system that supports health and care delivery.
2. Transform the quality and sustainability of our system's infrastructure across all our pathways and by optimising the efficiency of our infrastructure delivery.
3. Work alongside our health and care practitioners to proactively support the evolving health and care priorities with, where appropriate, infrastructure change and investment.
4. Improve the quality of our hospital, community and primary care infrastructure through improvements to existing spaces, as well as new buildings and different types of infrastructure.
5. Enable a standardised model of infrastructure across our system that supports the delivery of transformed health and care.
6. Work beyond boundaries; with other ICBs and other partners to transform how health and care services are delivered.
7. Develop alternative funding approaches and solutions moving forward as part of a system-wide commercial strategy to support our infrastructure needs that are not funded via National Programmes or CDEL.

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North East and North Cumbria

Objective 3 – Affordable

Our future infrastructure is affordable, financially sustainable and future proofed.

Where do we want to be?

As our financial challenges persist, we will continue to do more with less. From an infrastructure perspective, we need greater control of where our money is spent, and we need a longer-term view on our infrastructure needs.

We need consistent, system wide approaches to managing space demand and capacity in support of the Carter Metrics, utilising technology to be as efficient and effective as possible, maximising the funding available, and we need to take a '**whole life'** view on capital and revenue affordability. To do this, we must:

- Look to optimise the size of our footprint (where possible) in line with appropriate HTM and HBN standards, and build (when required) to meet changing and increasing service demands.
- Take a standardised, system approach to infrastructure to streamline the way we work to achieve greater economies of scale and reduce costs.
- Have energy efficient buildings and infrastructure.
- Benchmark all capital and revenue costs, manage contracts effectively and test the market to prove value for money across all infrastructure.
- Take a whole life approach to all infrastructure investment decisions.
- Continue to explore and realise efficiencies in relation to energy, materials and design across our infrastructure.
- Be commercial and maximise opportunities to generate income e.g., renting space on a commercial basis, energy generation and selling land / buildings when surplus to system requirement.
- Develop plans for how we work together to share resource, capacity and expertise; re-shaping of our workforce to ensure we are maximising value of our skills and expertise across the system.
- Encourage the consolidation and centralisation of back office and supporting function across the system and the supporting accommodation e.g., Aseptic Unit at Seaton Deleval, and other functions.

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North East and North Cumbria

Objective 4 – Digital

Using Digital, Data and Technology to enable our Workforce to make the best use of our Infrastructure

Where do we want to be?

Our digital and physical infrastructure can no longer be discussed, planned or managed in isolation of one another, and most importantly, smart and intelligent infrastructure will be a fundamental part of realising our system wide ambition.

Since the pandemic, the use of technology in our everyday lives and within health and care continues to advance at pace, and by 2034 we will be a digitally mature system that supports the expectations of our workforce and citizens; with smart and intelligent buildings where built and digital infrastructure seamlessly operate together to support the delivery of **better care for all.**

To do this we need:

1. A better understanding of digital technologies and what a digital health and care service means for the future of our NHS built infrastructure.
2. Interoperable systems and open digital architecture to enable the standardised collection and use of our data across the system.
3. An increasingly digital health and care service offering, where the digital space will be as important for future health and care delivery as physical spaces.
4. To enable our citizens to make the best use of our digital systems
5. A digitally astute and competent workforce
6. To target and optimise investment in our digital infrastructure
7. To work closely across digital infrastructure workstreams to better explore all partnership working and collaboration opportunities.
8. Proactively use digital to influence the design of our buildings; digital by design.

Objective 5 – Place Making

Our infrastructure shapes healthier places, is inclusive and active in reducing health inequalities.

Where do we want to be?

We want to proactively consider how we use our infrastructure to generate social value and help shape healthier places. We need an ever-greater focus on influencing, partnering and collaborating to use our infrastructure to reduce health inequalities.

Where we are making significant and at scale changes to infrastructure, moving service delivery, or shifting to a different model of patient care, we must be holistic in our infrastructure planning; proactively engaging with local planning departments, focusing on broader considerations from public transport, to road access, to digital connectivity, and utilising our 'One Public Estate' partnerships.

To do this, we must:

1. Be part of local place-led strategies (e.g., regeneration) to embed prevention and reduce health inequalities.
2. Be part of system wide, placed based conversations around infrastructure so we can influence partner plans.
3. Utilise strong place-based networks, public and private, to realise opportunities to influence investment and regeneration decisions so that health needs are incorporated e.g. One Public Estate Partnerships.
4. Work more closely with Local Authorities on our health infrastructure requirements; joint planning, policy frameworks, local plans, to influencing development decisions.
5. Find the most appropriate place to deliver services e.g., leisure centres, to youth centres, to extra care facilities, etc.

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Objective 6 – Net Zero

Implementing our ambition to become England's greenest region and integrate this ambition into decision making

Where do we want to be?

By 2030, we will be England's Greenest region.

Net Zero will be a golden thread in all decision making for our infrastructure, our transport, our supply chain and our workforce. We will use data and intelligence to target investment and improve performance to reduce our impact on the environment.

To do this we need to:

1. Align all infrastructure decisions with the ambition to be England's greenest region by 2030.
2. Embed net zero as a core value of our infrastructure workforce.
3. Reduce our infrastructure carbon footprint and utilise space more efficiently within the region
4. Collaboratively invest in options to procure and generate low / no carbon energy.
5. Deliver against our digital priorities to enable carbon reduction
6. Invest in our buildings to ensure energy optimisation and reduced consumption
7. Adopt the principles of the Net Zero Building standard'
8. Work collaboratively to adapt our infrastructure to the impacts of climate change.
9. Work towards a fully electric ambulance fleet with supporting EV charging infrastructure.

Section 4.
How do we get there?

Our approach, buildings and enablers

NHS North East and North Cumbria

Delivery

To deliver this strategy we need to be strategic and decisive in our planning and decision making; this can only be achieved together, working as a system.

We identified the following tools to support delivery:

Collaborate
Work collaboratively across the system with all stakeholders to optimise infrastructure utilisation.

Partnerships
Growing and expanding our partnerships to enable us to maximise transformation across our infrastructure.

Innovate
Take advantage of digital technology and new ways of delivering care.

Standardisation
Taking a one system approach across all infrastructure management, decision making and investment.

Workforce
Use our infrastructure to attract and retain a motivated and flexible workforce.

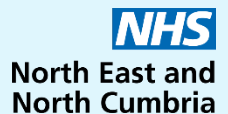
Core, Flex & Tail
Categorising our assets & buildings based on health and care needs, asset performance and ability to achieve net zero.

Investment
Using data and evidence to make the case for investment and maximise funding through system working.

Places
Creating the right network of local infrastructure to support our system.

Leadership & Governance
Right resources, roles and structures to lead delivery, make informed decisions and act as the custodian of the strategy.

Data & Intelligence
Using data and intelligence to drive action and enable innovation.



Delivery Tools

Collaboration

To deliver this strategy and fulfil our infrastructure vision, we must work as a system to forge stronger, and sustainable collaborations; across providers, NHS companies, our local and combined authorities, industry and others.

We should collaborate at every step of the infrastructure lifecycle:

- **Planning:** Investment based on objective need including patient engagement.
- **Procurement:** Purchasing the infrastructure asset.
- **Deployment**: Putting the infrastructure asset to use.
- **Utilisation**: Using the infrastructure asset effectively.
- **Maintenance:** Regular upkeep and repair of infrastructure.
- **Disposal:** Properly disposing of the infrastructure asset when it is no longer needed.

Sharing good practice and lessons learned will be key to how and why we collaborate. We will use learnings from recent and innovative developments to help grow and upskill our workforce and create 'big system' discussions around infrastructure, building for the future or virtual delivery.

Healthcare professionals are integral to our collaboration, and the conversation must be two-way. Clinical delivery and infrastructure opportunities and limitations must shape thinking and decision making and overtime the collaboration will be embedded in how we work. Furthermore, this approach, where appropriate, should also include wider public sector representation from local authorities and the voluntary and community sector.

Leadership and governance

We need to make best use of our Infrastructure Board to progress the development and delivery of this strategy at a senior level across the full system and make system wide investment decisions in support of this strategy – see Appendix 16

We need to identify an appropriate structure to facilitate 'Place Based Infrastructure' discussions, such as a Place Infrastructure Forum or an existing One Public Estate forum. The purpose is to undertake strategic, place-based infrastructure planning and decision making that is based on local intelligence and need. Membership and Terms of Reference for these forums will be carefully considered; with likely representation from NHS place leads, local authority, third sector, NHS property companies and the ICS infrastructure teams.

As we develop the Place Based Infrastructure Forums, we will need to form clarity on where responsibility will sit for the planning of local place-based infrastructure and therefore what the group will be responsible for – this will be an immediate action.

We also plan to establish an Infrastructure Programme Management Office (PMO) to act as the nerve centre for delivery. The PMO will support the Infrastructure Board and will embody the strategy's principles for collaboration, partnership working, using data and intelligence. The PMO will coordinate all delivery activities working with partners from across the system including members of the Infrastructure Board. This proposal will be worked up in detail post approval.

Delivery Tools

Investment

We need significant investment in our infrastructure to support the evolving health and care needs of our system and to manage the risk of infrastructure failure. Going forward we need a consistent, system wide approach to planning and prioritising our future infrastructure investment requirements.

We need an agreed approach to strategic and transformational investment decision making that is transparent, based on need (clinical and infrastructure), is commercial and drives value, and should cover everything from primary care investment, to prioritising backlog and critical infrastructure work, to innovative infrastructure ownership solutions (e.g., 'PFI mark II') and how we leverage resource and funding from local partners.

We will explore public-private partnerships and strengthen our relationship with local industry and the commercial sector to allow us to tap into local or regional non-NHS funding opportunities. We will also consider options and delivery models such as finance leases that enable the NHS to obtain long term ownership of strategic assets, following the initial lease period.

We will continue to work with local authorities to plan and respond to housing growth and demand, looking at everything from joint planning, to policy frameworks to influencing development decisions. We need to be better at consistently accessing Section 106 and Community Infrastructure Levy monies to support healthcare accommodation investment. This will require collaboration between the ICB and Local Planning Authorities and an understanding of how population growth increases clinical demand. A recent success story is the Wallsend Health Centre where S106 funding was accessed in 2023 to create 3 new clinical rooms and a further 2 rooms for counselling services. This investment has enabled the practice to deliver an additional 28,000 appointments per year – an approach being taken across the system.

Partnerships

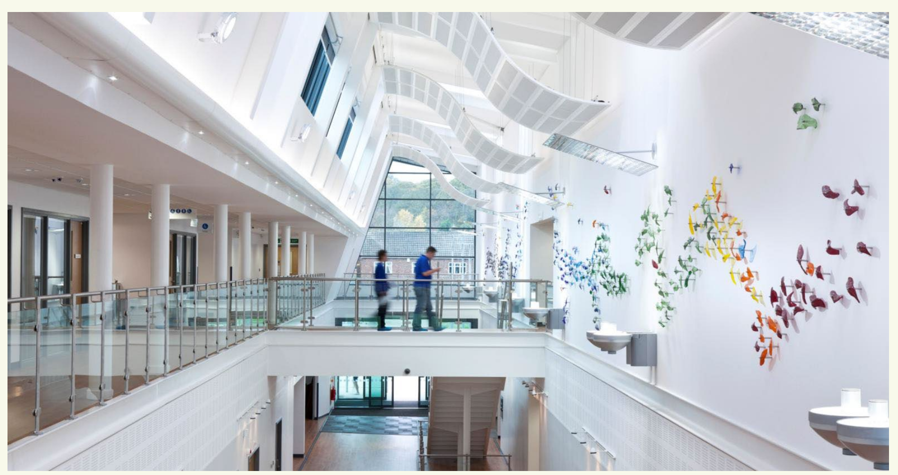
We will use our governance arrangements, and communication channels to strengthen and grow our partnerships to garner wider support from across our system.

Our partners must include; local government, higher and further education, registered providers (housing), the third and voluntary sector, SMEs, local anchor businesses, commercial partners, industry, pension funds and other funders.

We will work with higher and further education partners across various learning networks to explore opportunities to support research and be more innovative in healthcare delivery.

We must also continue to develop our relationships across the provider collaborative infrastructure teams and with the NHS property companies.

We must work openly and transparently across our infrastructure partners to provide each other with clarity on both system and place need, risks and opportunity and work in partnership to find deliverable solutions.



Delivery Tools

Data and intelligence

Data is fundamental to our future infrastructure; from strategic planning, to investment prioritisation to our ongoing operational management, data is the common thread that ties each step together.

Looking forward, we need to proactively use data to optimise and align our infrastructure to health and care delivery – the opportunity is vast.

Our buildings need to be digitally enabled and intelligent. Operational and management decision making should be augmented with automated insights, and we should use population health data to drive innovation in how care is delivered and accessed.

Key opportunities to be explored include:

- Clinical and Infrastructure data driving infrastructure operational and investment requirements across the short, medium and long-term.
- Data guiding the strategic categorisation of our buildings into core, flex and tail.
- Data optimising the utilisation and occupancy of our built infrastructure
- Real time data analysis to enable proactive decision making – e.g., anticipating problems before they happen.
- Tracking our carbon footprint across the region.
- Analysing Infrastructure data to identify potential cost-reduction initiatives e.g., maintenance call outs.

Workforce

Our workforce is adapting and must continue to do so as we respond to our future infrastructure needs whilst maintaining the right skills, values and commitment.

Looking forward, this infrastructure strategy presents an opportunity to grow, adapt and strengthen our workforce in a consistent, one-system standard. To do this, we need to better understand the opportunity of a system-wide approach to estates and facilities e.g., taking a ‘single workforce’ view, benefitting from economies of scale and a more streamlined service delivery model across our provider landscape, building on from the work already being done in this space.

To do this, we will need additional resource to develop our strategic thinking; we will need to map where there are skills across the system to support us to improve, evolve and transform our infrastructure. We also need to identify any skill gaps.

When we bring in specialist skills from other partners or the private sector, we will maximise the learning and skill-sharing amongst our own NHS staff, to add value and improve our understanding in specialist areas.

Within this we also need to explore opportunities for system-based standards in working practices and in return, the benefit will be greater staff retention, quicker recruitment, the potential to share skills and expertise across the system, plugging skills gaps, targeted learning and development and we need to work toward this as a system.

Overall, it is however recognised that a system-level response to our workforce should be researched, tested and challenged before any commitments are made.

Delivery Tools

Places

To support and enable health and care transformation, and the push to deliver care closer to home, we need to create the right network of local infrastructure to support our system; from digital systems, to equipment, to the buildings and spaces we use.

Our ways of working mean that we do not need to own the buildings we use to deliver health and care services, when we do own a building, we manage it as a system resource, and we always allow our partners to use it in support of health and care outcomes.

Having this consistent, one-system approach will enable us to better use the spaces that we have, better understand what is needed for the future and most importantly, provide greater flexibility that will be further enabled through better digital connectivity and adoption of smart systems and technologies e.g., room bookings, building access and staff portability.

Furthermore, we must ensure that buildings are fit for purpose, safe, compliant and effective and we should develop a set of common standards that support our NHS standards (e.g., statutory compliance regulations and HTM / HBN standards) and the core principles of this strategy, supported by local control, oversight and management.

We will continue to participate and support our local One Public Estate partnerships and look for opportunities to broaden this to include infrastructure – 'One Digital Estate' - where we look at digital and other infrastructure along side buildings.

We must get a better, full system view on utilisation to provide the data to enable us to manage demand and capacity across the system more effectively; ranging from unknown theatre capacity, to huge areas of void space in primary care, to unfulfilled demand for training accommodation (there is an opportunity to use void space for GP training).

Finally, we need to be more creative in the use of space within community settings to improve space utilisation, enabling more service to be delivered from a community setting.

Innovation

We cannot simply default to doing the things the way we have done in the past. Where appropriate we need to challenge the norm using appropriate, safe and sustainable solutions; driven by increased creativity and greater innovation. We need to apply this way of working to improving the things we already do, to developing new infrastructure and more broadly, to shaping our future infrastructure requirements.

We need to be more innovative with the way we approach our infrastructure challenges, harnessing the ability to think more freely and challenge the norms.

We need to tap into wider sources of intelligence such as our partners in Health Innovation North East and North Cumbria, Higher and Further Education establishments and in Research and Development to broaden the reach of problem solving to deliver more and have greater benefit.

Furthermore, we will also consider how we develop and embed the right culture of innovation across our staff, our partners and the public we serve – where we encourage and promote more innovative thinking across our whole workforce; welcoming ideas from everyone and educating everyone so that we all understand and accept the reasons behind change and embrace it.

How Do We Get There

Acute Hospital and Ambulance Services

- We need investment across our network to reduce our backlog and support service transformation. This includes replacement hospitals in Alnwick, Blyth and North Tees as well as upgrades, refurbishments and new developments across existing sites, in our equipment and digital infrastructure, and investment in ambulance stations in support of the Hub and Spoke model.
- The development of 'Hubs' like the Day Treatment Centre at the Freeman Hospital in Newcastle and the Community Diagnostic Centre at the Metro Centre. These facilities have the potential to reduce hospital admissions, especially for people with complex needs and/ or frailty; where people can go to be monitored, assessed and receive short-term care. The need to explore the development of additional 'hubs' has been identified across the system.
- We need to undertake a detailed mapping of our system (health and care) infrastructure requirements against current estate supply to allow us to plan for long term investment, allowing us to take a system approach moving forward.

Primary Care

- Our local ambitions for integrating primary care respond to the Fuller report; streamlining access to care and advice when people need it; providing more proactive, personalised care with support from a multidisciplinary team of professionals, helping people to stay well for longer, and overall, locally driven primary care integration.
- We will invest in locally driven solutions alongside the right governance and communication channels to enable strategic infrastructure development at a place level - allowing teams to work together, to best serve their local communities.
- We need to continue to identify sites to deliver out-of-hospital/non-acute infrastructure to bring more healthcare to local communities.
- We will continue to expand models to support people to manage conditions at home to improve health, reduce admissions and to take more control of their own care.

Mental Health

- We will continue to transform community services working in partnership at Place, exploring opportunities for co-location with partners and utilising community assets / hubs.
- We will reduce reliance on beds whilst ensuring a safe, resilient inpatient estate, providing appropriate facilities for de-escalation and maximising the benefits of assistive technology to enhance patient safety. We will progress essential safety works at Roseberry Park Hospital and implement the secure services bed configuration in line with NENC PC Clinical Services Review.
- We will Build the Right Support for people with learning disability and people with autism with more intensive community support.
- Our buildings will be therapeutic, promote recovery and reflect neuro-diverse needs.

Community Care

- To support the push to move care closer to home by delivering more in the community we will continue to consider, where appropriate, ways to support this model.
- We will continue to develop hubs where community and primary care services will come together along side other health provision.
- We will continue to use our community diagnostic centres to provide more diagnostic capacity in the community, building on our existing CDCs in Tees Valley and at the Metro Centre.
- We need to map our needs for different rehab models locally that enable people to be discharged from hospital for intensive recovery and rehabilitation.

How Do We Get There

Housing

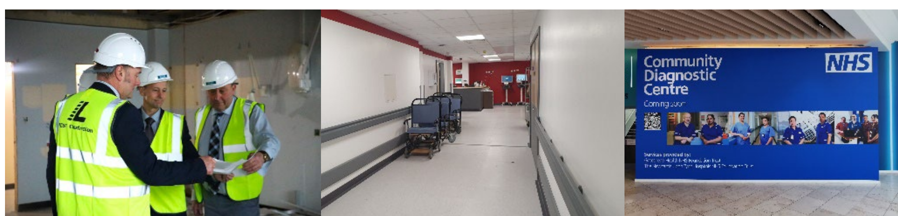
- Working with our local authority partners, we will support the creation of more specialist housing for people who have different needs including cognitive impairment, neurodegeneration and learning disabilities.
- We need to promote the health benefits of good housing to improve the quantum and quality of housing stock at place level.

NHS key worker housing

- Building on from the recent White Paper Delivering NHS Homes we should consider key worker accommodation for our NHS staff in line with local workforce strategy, local supply and wider system need to form a system wide delivery plan.

Voluntary, community, faith and social enterprise (VCFSE)

- We need to integrate with the VCFSE sector to develop a better understanding and to create opportunities for sharing space and supporting service delivery.



Digital, Data & Technology

- As well as investments into our buildings, we will develop options for how we use digital infrastructure and technology to support service delivery and operational buildings management; we will plan for the opportunities and challenges of a digitally mature hospital system and how this may impact our buildings in the future.
- We need to understand how increased virtual delivery impacts on our infrastructure and the potential to shrink or adapt out buildings.
- Digital equipment, technology, wearable and other connected devices will be fundamental to support the delivery of effective place-based models of care–improving choice – we need a system level response to how we manage it.
- We need to ensure we are embedding digital connectivity at the heart of our plans for staff, patients and citizens given the need to expand the type and quantum of care and work settings across our system; at home, in the community, in a ‘hub’ or in a hospital.

Occupancy Agreements

- We need occupancy agreements that are reflective of our current and future ways of working – greater flexibility, value for money, and no hidden management fees.

Financial Environment*

NHS capital spending is a critical for healthcare, and yet the NHS is widely agreed to have seen underinvestment in capital for many years including the recent restraints of Capital Departmental Expenditure Limits (CDEL). A review of the financial challenge facing the North East and North Cumbria has previously been undertaken, assessing our financial risk based on a do-nothing assumption. Alongside this work an assessment of our combined approaches to manage this challenge was undertaken and work continues to progress on developing this. This is in the context of a strong track record of collective delivery.

The approach is reflected in and supported by this strategy, in terms of looking to maximise the efficiency of the estate, rationalise and consolidate services where appropriate to maximise clinical effectiveness and ensure that the estate remains fit for purpose. This work is being refreshed and updated as part of our approach to developing our ICS Long Term Plan.

While organisations collectively are committed to delivery, the transformation of infrastructure will require a combination of flexibility to use available cash resources across the ICS footprint, access to sources of borrowing and innovative finance, and availability of national PDC Funding.

Our current planned expenditure on our estate is **£7.4bn** over the next ten years, of which the ask for further new national capital is **£3.8bn**. The **£7.4bn** represents the current identified funding need and does not include a fully costed solution to net zero, take into consideration future depreciation in terms of funding not being made available to deliver our strategy, and the re-direction of clinical services not currently in the plan.

Our approach to funding this strategy is being coordinated through the ICS Infrastructure Board but requires support through national policy, and new funding programmes and initiatives.

National Funding Requirements

Moving forward, a decision is needed to determine whether the whole of the current CDEL allocation is required for 'business as usual' or whether any should be top sliced and allocated to any identified/agreed 'regional' priority schemes.

If it is ultimately determined that the priority is to allocate all the current CDEL allocation to Trusts for BAU purposes, then discussions will need to take place in terms of alternative funding sources but also how to highlight unmet capital needs identified in the framework.

£7.4bn
total value of capital expenditure required over the next 10 years

52%
capital required is to be sourced through new national schemes or alternative sources of funding

£3.8bn
total value of **new** investment required

£514m
value of **existing** schemes funded via National Programme such as NHP

*The financial information provided within this Strategy is based upon our current ambition and is not constrained by our current financial limits.

Investment Principles

To support capital planning, all Trusts identified their urgent priorities for development in the current year. The process by which schemes are prioritised was therefore considered to provide a better sense of relative priority between schemes.

The methodology considers both the issues below based upon scoring against the weighted criteria in the table opposite:

1. the current service configuration, and
2. the position after the proposed capital investment to get a sense of its 'value added'.

Finally, the scheme's 'value added' score is then adjusted for:

1. the size of population that would benefit from the capital investment, and
2. the degree of betterment achieved by the capital investment to give greater weight to 'transformational' schemes.

The Scoring Criteria was approved by the Provider Leadership Board on the 2nd June 2023. Going forward, as we obtain greater clarity on future funding, it will be used to prioritise funding requests.

Scoring Criteria

Criteria	Description	Weight
Clinical Quality	Patient safety: avoidance of risk to patients. Removing hazardous functional relationships and adjacencies or infrastructure problems. Fostering the further development of standards of excellence in clinical outcomes	20%
Resilience	The extent to which schemes deliver optimum capacity and provide resilience (locally and regionally), adaptability, future proofing and sustainable waiting lists	17.5%
Clinical Configuration	The extent to which schemes improve multiple services, deliver optimum configuration and adjacency of services, foster models of care and implement clinical pathways	12.5%
Statutory & Professional Standards	To meet standards laid down in legislation and law by DHSC (eg HBN/HTM/Ockendon) and/or clinical standards (eg Clinical networks and standards) and/or enforceable by outside agencies (eg CQC).	12.5%
Staffing	Does the scheme improve the deployment, recruitment, retention, cost and critical mass of all necessary staff for patient treatment	10%
Physical Condition of Buildings	Eradication of sub-standard accommodation, elimination of high/significant backlog maintenance, bringing the physical condition of health care buildings up to at least condition B. Appropriateness and attractiveness of the physical environment and the personal safety of patients, visitors and staff	10%
Teaching, Research and Development	The need to meet requirements for teaching, research and development - recognising its long-term impact on quality but not predominating over criteria which have immediate impact on patient requirements	6.25%
Deliverability	A judgement concerning the complexity of the capital scheme and the challenge which it will present in being brought to fruition. Understanding of site complexities, phasing and planning constraints	6.25%
Sustainability	The extent to which the scheme contributes to 'Delivering a Net Zero NHS', improving population health by reducing carbon emissions, improving air quality and enhancing biodiversity. The scheme enables the rapid decarbonisation of health services and support multiple stakeholders to reduce their environmental impact	5%

Our Investment Requirements*

We **currently have 13 schemes** , to the **value of £514.1m** that are already **funded via existing National Programmes** such as the New Hospital Programme. Below we have set out a snapshot of these schemes - top 5 in remaining value (highest). This snapshot does not include all our projects and programmes of work and values have been inflated to 2034.

Maternity Replacement

James Cook Hospital
South Tees Hospitals NHS FT

Value

£310.12m

Shotley Bridge Hospital

County Durham &
Darlington NHS FT

£56.81m

Childrens Heart Centre Freeman Hospital

Newcastle UT Hospitals
NHS FT

£61.23m

Medicines Manufacturing Unit

Seaton Deleval
Northumbria Healthcare
NHS FT

£30.32m

Theatres & Critical Care - The Friarage

South Tees Hospitals
NHS FT

£16.13m

*The financial information provided within this Strategy is based upon our current ambition and is not constrained by our current financial limits. Please note all figures used have been inflated to reflect 10-year horizon of the strategy.

Our Investment Requirements

We have **identified 95 schemes**, to the **value of £3,803m** that are **yet to be funded via any National Programme**. Below we have set out a snapshot of these schemes – top 5 in value (highest). This does not include all our projects and programmes of work that require funding such as the replacement of **North Tees Hospital**, and we will be updating this as projects are identified. Our investment requirements will be further shaped as we develop and refine our system and local needs and the associated capital requirement and values have been inflated to 2034.

Adult & Paediatric Cardiothoracic Services	**New Specialist Hospital Building**	**Hub/ Spoke Sites North East and additional EOC resilience**	**Patient Safety Works**	**EV Fleet (Transition to Electric**
Royal Victoria Infirmary Newcastle UT Hospitals NHF FT	Royal Victoria Infirmary Newcastle UT Hospitals NHF FT	Ambulance Service NHF FT	Roseberry Park Hospital Tees Esk & Wear Valley NHS FT	North East Ambulance Service NHF FT
Value				
£452.86m	**£387.63m**	**£86.21 m**	**£153.03m**	**£143.92m**

*The financial information provided within this Strategy is based upon our current ambition and is not constrained by our current financial limits. Please note all figures used have been inflated to reflect 10-year horizon of the strategy.

Delivery Timeline*

The timeline below provides a snapshot of our top 5 schemes by value, with project values ranging from £16 million to over £310 million and are due for completion between years 29/30 and 33/34, including a new specialist hospital building and upgrades to primary care facilities.

Year	Scheme	Location	Value
24/25	**Theatres & Critical Care**	The Friarage	**£16.1m**
25/26	**Medicine Manufacturing Unit**	Seaton Deleval	**£30.3m**
26/27	**Shotley Bridge Hospital**	County Durham & Darlington	**£56.8m**
28/29	**Childrens Heart Centre**	Newcastle Hospitals	**£61.2m**
28/29	**Maternity Replacement**	James Cook Hospital	**£310.1m**
29/30	**Hub/Spoke Sites**	NE Ambulance Service	**£86.21m**
31/32	**New Specialist Hospital Building**	RVI	**£387.6m**
32/33	**Patient Safety Works**	Roseberry Park Hospital	**£153m**
33/34	**Adult and Paediatric Cardiothoracic Services**	RVI	**£452.9m**
33/34	**Primary Care Estate**	NENC	**£160.3m**

Timeline years: 24/25, 25/26, 26/27, 26/27, 28/29, 29/30, 30/31, 31/32, 32/33, 33/34

Top 5 - Existing Funding Schemes – £474 million (24/25 to 29/30)

Top 5 New Funding Schemes – £1,340 million (29/30 to 33/34)

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Please note all figures used have been inflated to reflect the 10-year horizon of the strategy.

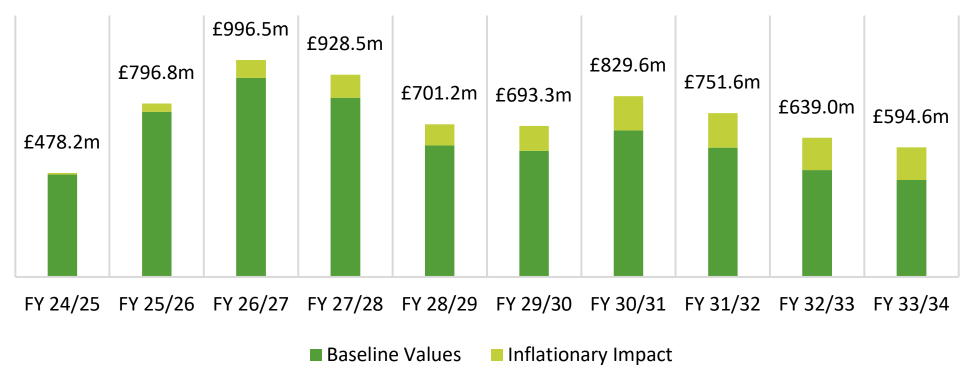
Investment & Funding Sources*

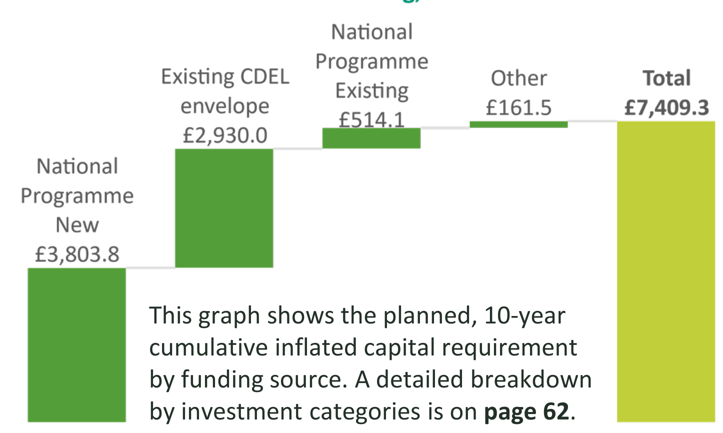
The table below shows the expected cumulative system capital spend over the next 10 years and is valued at £7.4bn. The information has been developed and prioritised by our Provider Collaboratives (Secondary, Mental Health, Ambulance Service and Primary) and is based on the current understanding of investment need.

	FY 24/25	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	FY 30/31	FY 31/32	FY 32/33	FY 33/34	Grand Total
Baseline Values	£469.6m	£757.8m	£914.0m	£823.0m	£604.4m	£579.4m	£673.4m	£593.5m	£490.8m	£444.7m	£6,350.6m
Inflationary Impact	£8.6m	£39.0m	£82.5m	£105.5m	£96.9m	£113.9m	£156.2m	£158.1m	£148.2m	£149.9m	£1,058.7m
Capital Including Inflation	**£478.2m**	**£796.8m**	**£996.5m**	**£928.5m**	**£701.2m**	**£693.3m**	**£829.6m**	**£751.6m**	**£639.0m**	**£594.6m**	**£7,409.3m**
of which											
Existing CDEL envelope	£266.69m	£291.09m	£318.91m	£290.77m	£256.10m	£263.41m	£273.71m	£288.27m	£336.18m	£344.84m	**£2,929.97m**
National Programme Existing	£61.95	£121.89m	£125.77m	£104.17m	£93.98m	£1.2m	£1.23m	£1.27m	£1.30m	£1.34m	**£514.10m**
National Programme New	£125.77	£366.31	£532.72	£519.73m	£334.17m	£413.43	£538.99m	£444.31m	£285.75m	£242.60m	**£3,803.79m**
Other	£23.76	£17.50m	£19.12	£13.85m	£16.98m	£15.24m	£15.70m	£17.75m	£15.75m	£5.84m	**£161.49m**

Please refer to Appendix 17 for further information.

Note: There may be slight discrepancies up to 0.1 between the sum of individual figures and the total amount displayed in financial tables. This is due to rounding applied within calculations.





This graph shows the planned, 10-year cumulative inflated capital requirement by funding source. A detailed breakdown by investment categories is on **page 62**.

*The financial information provided within this Strategy is based upon our current ambition and is not constrained by our current financial limits.

NHS
North East and
North Cumbria

Investment & Funding Sources*

10 year Planned Cumulative Inflated CAPEX per Category

Of the **£7,409m** total investment required, **the top three** investment categories that reflect our Infrastructure Strategy objectives are:

- New build (£3.684bn),
- Backlog maintenance (£1.190bn) and
- Equipment (£799m)

Top 3 investment categories accounted for nearly **75%** of total capital expenditure in 10-year investment plan

Funding, £m

£8,000
£7,000
£6,000
£5,000
£4,000
£3,000
£2,000
£1,000
£0

Fire Safety £9
Plant and machinery £21
Fixtures & Fittings £60
Intangible Assets £115
Fleet, Vehicles & Transport £184
Routine maintenance (non-backlog) £236
Other £508
IT £603
Equipment £799
Backlog Maintenance £1,190
New Build £3,684
Total £7,409

Increase Decrease Total

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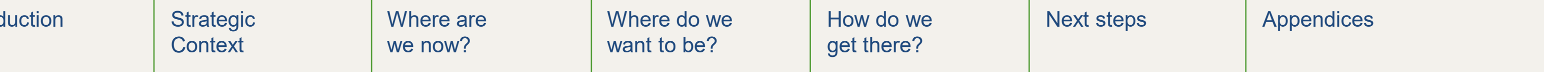

Source of Funding*
Existing CDEL Envelope

Existing CDEL Envelope

- 40% of funding requirement over ten-year plan is assumed from existing CDEL envelope.

	FY 24/25	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	FY 30/31	FY 31/32	FY 32/33	FY 33/34	Grand Total
Existing CDEL envelope	£266.69m	£291.09m	£318.91m	£290.77m	£256.10m	£263.41m	£273.71m	£288.27m	£336.18m	£344.84m	**£2,929.97m**

Note: There may be slight discrepancies up to 0.1 between the sum of individual figures and the total amount displayed in financial tables. This is due to rounding applied within calculations.

2024/25 CDEL allocation, excluding 5% planning tolerance, breaks down as follows:

Capital Allocations	2024/25
Providers:	
Baseline allocation (incl. Aseptic and UEC ambulance)	£172.159m
Indicative prior year revenue performance allocation	£4.261m
UEC Performance Allocation	£7.00m
Surplus £ for £	£4.00m
Total provider capital allocation	**£187.420m**
Total ICB capital allocation	**£5.447m**
Total ICS capital allocation 2024/25	**£192.867m**

Category	CAPEX, £m
Backlog Maintenance	**£687.4m**
Equipment	**£591.0m**
New Build	**£585.4m**
IT	£402.1m
Other	£373.7m
Fleet, Vehicles & Transport	£232.4m
Routine maintenance (non-backlog)	£171.9m
Intangible Assets	£4.0m
Fire Safety	-
Fixtures & Fittings	-
Plant and machinery	-

- As can be seen from the annual break down of assumed CDEL usage in the NENC ICS Capital template, CDEL envelope assumed to increase year on year.
- Largest areas of expenditure is focused on **backlog maintenance, equipment replacement and New Build**.

Note: There may be slight discrepancies up to 0.1 between the sum of individual figures and the total amount displayed in financial tables. This is due to rounding applied within calculations.

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Source of Funding*
National Capital Programme

National Capital Programme

- 6.9% of funding requirement over ten-year plan assumed from existing National Schemes.
- 51% assumed from new National Programmes.

National Programme	FY 24/25	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	FY 30/31	FY 31/32	FY 32/33	FY 33/34	Grand Total
Existing (e.g., NHP)	£61.95m	£121.89m	£125.77m	£104.17m	£93.98m	£1.20m	£1.23m	£1.27m	£1.30m	£1.34m	**£514.10m**
New	£125.77m	£366.31m	£532.72m	£519.73m	£334.17m	£413.43m	£538.99m	£444.31m	£285.75m	£242.60m	**£3,803.79m**

Note: There may be slight discrepancies up to 0.1 between the sum of individual figures and the total amount displayed in financial tables. This is due to rounding applied within calculations.

More than half (51%) of the capital required is to be sourced through **new national capital schemes**.

This includes the systems ambition for capital schemes over the next 10 years that currently have no funding source but would require either further national funding, or other sources of funding.

In Primary Care for example a further **£134m** could be spent across the ten-year plan period in improving primary care estate, in addition to the assumed level of business-as-usual CDEL cover.

The most significant requirement is around new build, with over 50 schemes requiring more than **£2.7bn** of funding that is yet to be identified.

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Vast majority of expected national capital is to support new build schemes, as shown in tables below:

Category \ Programme	Existing	New
New Build	**£514.10m**	**£3,803.79m**
Backlog Maintenance	£5.39m	£385.25m
New Build	£495.32m	
Equipment	£0.08m	£207.52m
IT	£13.14m	£187.82m
Fleet, Vehicles & Transport	-	£69.13m
Other	-	£134.2m
Intangible Assets	-	£110.65m
Fixtures & Fittings	-	£60.07m
Plant and machinery	-	£21.42m
Routine maintenance	£0.2m	£18.69m
Fire Safety	-	£5.89m

In total **£3,803.79m** of National Capital Programme Funding over next 10 years is required to support new build schemes.

Source of Funding*

Other Sources of Funding

The remaining **2%** of capital is to be sourced from other funding routes that are not yet fully identified; this will be picked up within our 'Affordable' objective as we set ourselves up and deliver this strategy.

	FY 24/25	FY 25/26	FY 26/27	FY 27/28	FY 28/29	FY 29/30	FY 30/31	FY 31/32	FY 32/33	FY 33/34	Grand Total
Other	£23.76m	£17.5m	£19.12m	£13.85m	£16.98m	£15.24m	£15.7m	£17.75m	£15.75m	£5.84m	**£161.49m**

Note: There may be slight discrepancies up to 0.1 between the sum of individual figures and the total amount displayed in financial tables. This is due to rounding applied within calculations.

Category	CAPEX, £m
Backlog Maintenance	£112.33m
Routine maintenance	£45.63m
Fire Safety	£3.53m
Equipment	-
Fixtures & Fittings	-
Fleet, Vehicles & Transport	-
Intangible Assets	-
IT	-
New Build	-
Other	-
Plant and machinery	-

In total
£161.49m
to be funding via other sources not yet identified.

*The financial information provided within this Strategy is based upon our current ambition and is not constrained by our current financial limits.

Capital Departmental Expenditure Limits (CDEL)*

Discussions regarding the North East and North Cumbria approach to application of CDEL allocations have been undertaken by Estates and Finance Directors ahead of the 2024/25 financial planning round, with the following assessment:

- There is varying ability amongst Trusts over the extent to which they can internally fund capital schemes with their existing cash reserves and known CDEL limits.
- This means it is possible to specify a range of scheme capital values within which a Trust might be expected to self-finance a scheme.
- There is a ‘middle ground’ of proposed capital schemes that are too expensive for Trusts to self-finance but too small to bid for national capital funding, unless they fit within the definition of specific initiatives with earmarked capital allocations.
- Whilst conceptually a ‘Regional’ fund could be created to be managed by the ICB to allocate to such prioritised schemes, there is a consensus amongst Trusts that there is currently insufficient overall CDEL allocated to the ICB for this to be top sliced for this purpose. To do so would compromise business as usual and exacerbate backlog maintenance and critical infrastructure.
- Consequently, there is a risk that these mid-range schemes (typically in the tens of millions) will remain in limbo.

The following approach has therefore been adopted re allocation of CDEL across the North East and North Cumbria ICS for 2024/25 and beyond:

- ICS core CDEL has been allocated to provider Trusts following the national formula with an adjustment for PFI.
- Additional performance related CDEL relating to financial outturn will be added to the core CDEL and allocated in the same way.
- Additional performance related CDEL relating to Urgent Emergency Care will be allocated to the Trusts that earn it.
- The CDEL allocation was not top sliced for specific projects other than those agreed by the NENC Infrastructure Board, being only for exceptional projects supported by all members of the Infrastructure Board and then agreed by the Provider Collaborative CEOs (For example for 24/25 and 25/26 the only currently agreed top-slice was for the ICS wide Aseptic Programme).
- Trusts will therefore manage to CDEL and IFRS 16 allocations.
- Any deviation from allocations must be agreed by the NENC Capital Collaborative group. Any brokerage in year will be adjusted the following year for individual organisations involved.
- Trusts will over programme to 105% each year with the assumption that each Trust will manage back to 100% in year, this is to allow for slippage.
- Trusts will commit to a Month 9 financial review to reallocate any slippage in line with the brokerage principle.
- Individual Trusts will manage the cash implications of the capital spend.

*The financial information provided within this Strategy is based upon our current ambition and is not constrained by our current financial limits.

Funding Risks

We have developed an informed 10-year investment plan valued at £7.7bn to address our critical infrastructure risks, backlog and RAAC and to invest in our accommodation to create more capacity where it is needed in support of our health and care needs. We are, however, aware of the consequence of not receiving funding at the scale required and the impact upon the management of our key risks. The list below further illustrates our case for funding:

Critical Infrastructure Risks – currently valued at £223M, and without investment, the value and risk to patient safety will continue to grow and require additional management.

Backlog Maintenance – the total outstanding backlog is currently valued at £514m (incl. critical infrastructure risks), and as above, without investment the value and risk to patient safety will continue to grow.

Net Zero – our target is to be the Greenest region by 2030 and without investment we will not fulfil this ambition and our progress towards the NHS 2040 target for carbon net zero will be limited.

Health and Care Service Transformation – we need to invest in our infrastructure to support the transformation of health and care services and to address our evolving health and care needs . Without investment, our infrastructure will struggle to support future service demand and respond to changing models of care.

Digital Transformation – we need to invest in our digital infrastructure to enable a joined up response to our digital healthcare strategy and enhance patient care and operational efficiency. Without this investment, our infrastructure will not support the changing models of care and citizen expectations.

Aging Infrastructure - nearly 14% of our health buildings pre-date the NHS, increasing to 51% of the Gateshead Health estate. We require investment to bring our stock consistently up to current standard and support our changing service needs.

Section 5.
Next steps

Key priorities to progress during Q3 and Q4 24/24

Next Steps – Short Term

These are the initial recommendations agreed by the Infrastructure Board for focus over the coming year:

Governance

Undertake a review of our Governance Structure. While the Infrastructure Board is functioning well, we recognise the need to increase our connection to place based governance and decision making and to align better with our local authority colleagues. We also recognise a need to place this strategy under the wider governance structure of the Integrated Care Partnership, in order that we can better align and realise the ambitions in this strategy

Clarity on System Wide Health & Care requirements across the next 10 years

The ICB and its aligned collaboratives continue to develop a longer-term clinical model/direction of travel. As this develops, and as we increasingly align our thinking at place and with local authority partners, we will work to align our long-term infrastructure requirements with our future model for health and care.

As a minimum we will develop an infrastructure blueprint up to 2034, which sets out our best view of the future quantum and type of infrastructure required to support future system need and ways of working.

End of Term Planning

Develop a plan to manage all 6 LIFT handback opportunities, and options to buy NHS Property Services and Community Health Partnership freehold assets into System ownership and control.

Resource

Build on our existing collaboration to formally establish an infrastructure Programme Management Office to support the mobilisation, ownership and delivery of the infrastructure strategy.

Data and intelligence

Collate and own (at a System) our data and existing intelligence beyond that which has been collated in the development of this strategy and agree how we are going to maintain and update this moving forward in the short term.

Update this ICB Infrastructure Strategy to include a full profile of our core, flex and tail assets and our future investment requirements plans.

Consider how we adopt and use the 'Core, Flex and Tail' approach across the full system.

Workforce

Undertake a system wide mapping exercise of our infrastructure workforce, to understand our current baseline against the skills, expertise, knowledge and ways of working required to deliver on this strategy.

Our investment requirements

Continue to identify alternative funding sources to reduce the gap in our 10-year investment plan. We will investigate opportunities for collaboration across the system, including our local and combined authorities, and with commercial and industry partners to develop innovative ways of funding our future in partnership with National Government.

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*Appendices to be linked to an NHS SharePoint site

Abbreviations

A&E	Accident and Emergency
AI	Artificial Intelligence
ARP	Ambulance Response Programme
BAU	Business As Usual
BMS	Building Management System
CDC	Community Diagnostic Centre
CDDFT	County Durham and Darlington NHS FT
CDEL	Capital Departmental Expenditure Limit
CEDAR	Care Environment, Development and Re-Provision
CEX	Chief Executive
CHP	Community Health Partnerships
CIL	Community Infrastructure Levy
CNTW	Cumbria, Northumberland Tyne and Wear NHS FT
CT	Computed Tomography
EoL	End of Life
EPR	Electronic Patient Record
ERIC	Estate Return Information Collection
EV	Electric Vehicle
FBC	Full Business Case
FM	Facilities Management
GH	Gateshead Health NHS FT
GIA	Gross Internal Area
GNCR	Great North Care Record
GP	General Practice
HBN	Health Building Notes
HTM	Health Technical Memoranda
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IFRS	International Financial Reporting Standards
IMD	Index of Multiple Deprivation
LIFT	Local Improvement Finance Trust
LTP	Long-Term Plan
NCA	Northern Cancer Alliance
NCCC	Northern Centre for Cancer Care
NCIC	North Cumbria Integrated Care NHS FT
NEAS	North East Ambulance Service
NENC	North East and North Cumbria
NHC	Northumbria Healthcare NHS FT
NHP	New Hospital Programme
NHS	National Health Service
NHS FT	NHS Foundation Trust
NHS PS	NHS Property Services
NUTH	Newcastle upon Tyne Hospitals NHS FT
OBC	Outline Business Case
OHID	Office for Health Improvement and Disparities
OPE	One Public Estate
PCN	Primary Care Network
PFI	Private Finance Initiative
PMO	Programme Management Office
POD	Pharmacy, Optometry, Dentistry
PSDS	Public Sector Decarbonisation Scheme
RAAC	Reinforced aerated autoclaved concrete
S106	Section 106
SEND	Special Educational Needs and Disabilities
SME	Subject Matter Expert
STS	South Tyneside and Sunderland NHS FT
STP	Sustainability and Transformation Partnerships
TEWV	Tees, Esk and Wear Valleys NHS FT
VCFSE	Voluntary, community, faith and social enterprise