

An illustration of a hospital room. In the foreground, a white hospital bed with grey wheels and a headboard is positioned. To the left, a large window with a yellow sun icon is set into a blue wall. On the right wall, there is a blue medical equipment unit with a black cord and a series of grey rectangular panels. The floor is grey, and the ceiling is white with a rectangular light fixture.

One Programme Three Questions **Twelve Maps**

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INTRODUCTION

One Programme, Three Questions, Twelve Maps

The New Hospital Programme takes a programmatic approach to building hospitals across England. Through its Hospital 2.0 platform, it applies standardised design, manufacturing-led construction, centralised procurement, and shared learning between waves. Its aims to deliver better clinical facilities for patients and staff, delivered faster and at improved value for money.

But the programme’s reach extends beyond individual buildings. It is designed to sustainably deliver critical national infrastructure at scale, while driving enhanced social value at every stage.

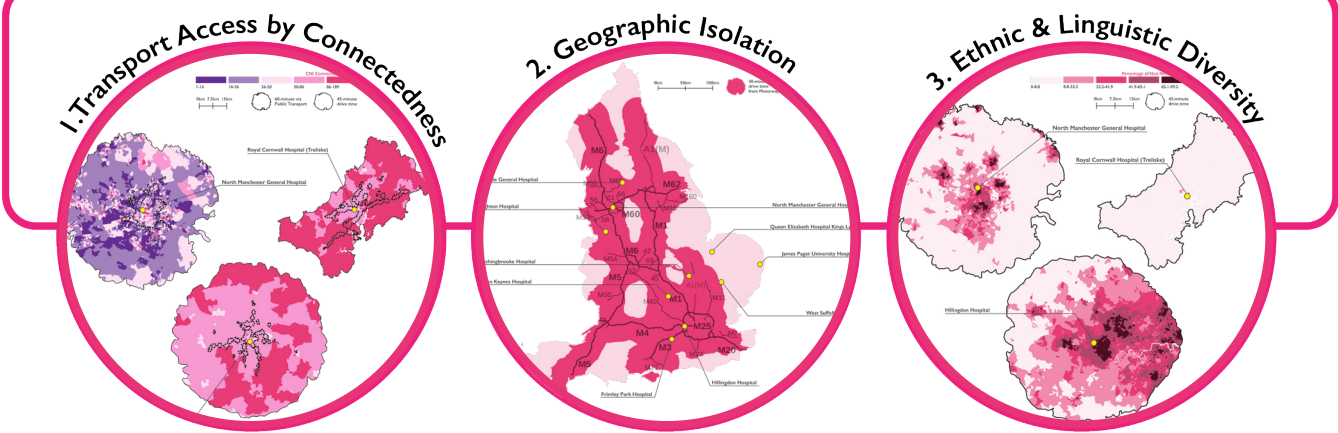
Wave I comprises sixteen schemes entering construction between 2027-30, including seven hospitals replacing buildings constructed from RAAC. Hospitals, though, are delivered in places, and places differ. These schemes serve distinct catchments with different age structures, disease burdens, deprivation patterns, transport networks, labour markets, and community infrastructure. A standardised programme meets unstandardised geography.

The maps that follow give a snapshot of eleven Wave I schemes currently at Outline Business Case stage or earlier, organised around three questions:

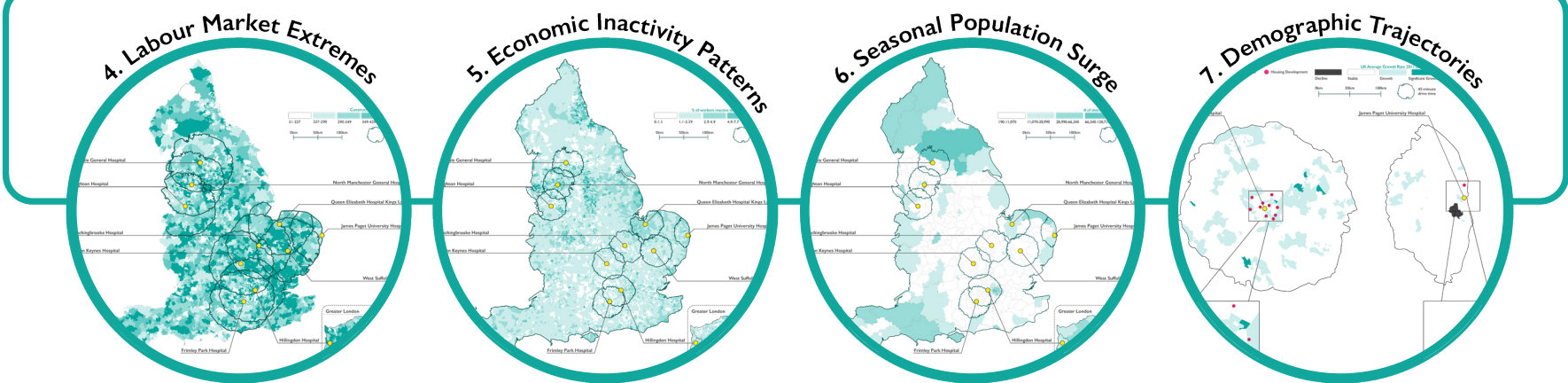
- 1. Who can the hospital reach, and who is excluded?
- 2. Who will build and staff it?
- 3. What does the hospital catchment actually look like?

Each dimension reveals a different aspect of local context that shapes how a standardised hospital programme delivers social value on the ground.

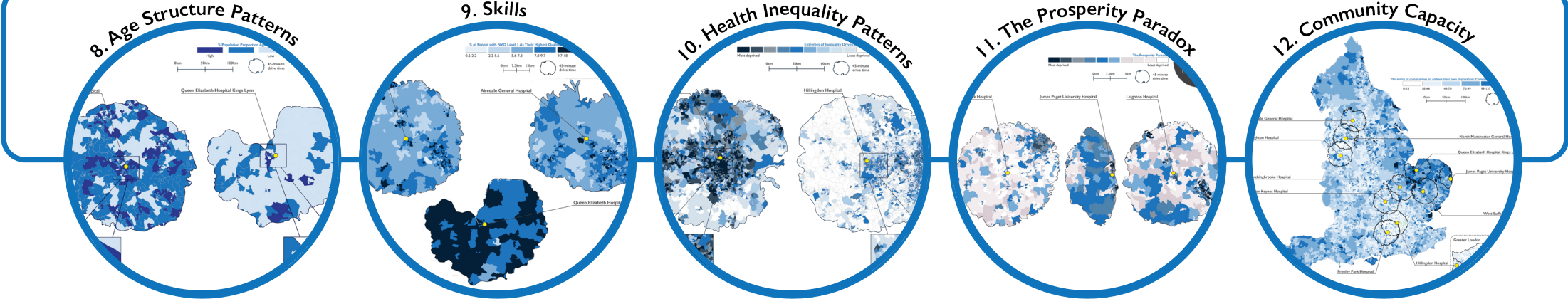
WHO CAN THE HOSPITAL REACH?



WHO WILL BUILD AND STAFF IT?



WHAT DOES CATCHMENT ACTUALLY LOOK LIKE?



WHO CAN THE HOSPITAL REACH?

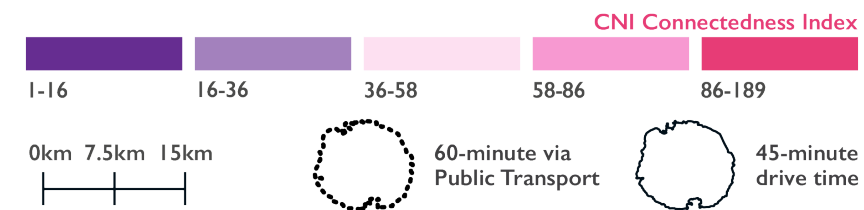
I. Transport Access by Connectedness

North Manchester serves a population where 39% of households have no car, relying heavily on public transit and walking. West Suffolk represents the rural opposite: 57.6% of workers are entirely car-dependent. In Cornwall, the hospital is the only Emergency Department in the county, yet bus services are hourly at best and 15.1% of households lack vehicle access.

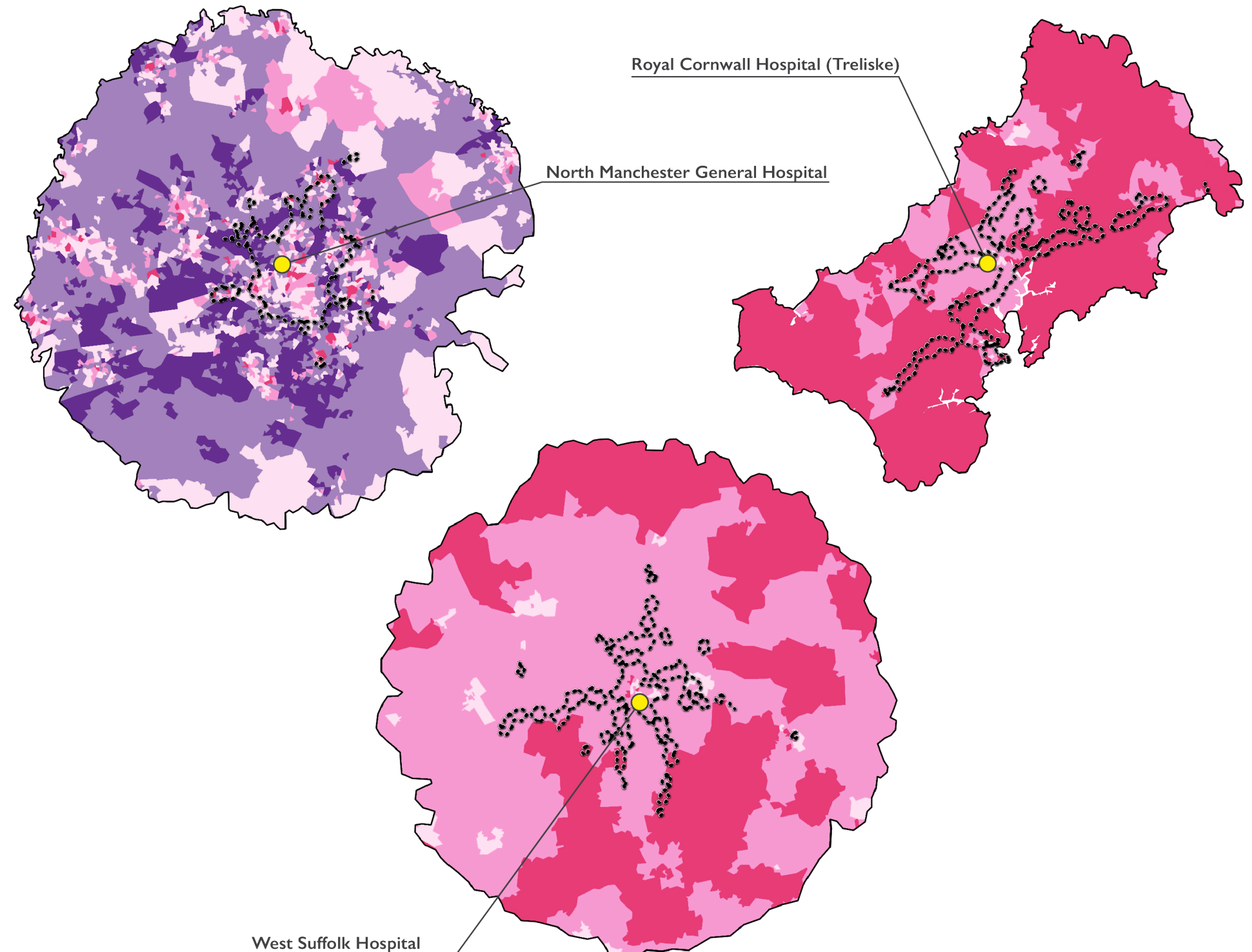
The maps opposite show these catchments against the Community Needs Index connectedness domain, which measures isolation through travel times, service access, and digital infrastructure provision. Higher scores indicate greater disconnection. Viewed in isolation, the map highlights where physical access is most constrained. But when read alongside the Index of Multiple Deprivation, a more complex picture emerges: in some catchments, poor connectivity compounds existing deprivation; in others, it masks a form of disadvantage that is not conventionally captured.

North Manchester is well connected but deeply deprived. Public transport reaches across the catchment, but the communities it serves include some of the most disadvantaged in the country. Cornwall compounds both: pockets of significant deprivation sit within a catchment where public transport barely extends beyond the hospital itself. West Suffolk presents a different challenge again. Whilst overall deprivation is low, the minority of households without vehicle access face isolation from clinical services and employment opportunity alike.

Local employment strategies will need to account for these dynamics. Whether potential recruits can physically reach construction and operational roles, and how that aligns with shift patterns, public transport schedules, and accommodation availability, will determine whether “local” means the wider catchment or only car-owning households within it.



TRANSPORT
ACCESS BY
CONNECTEDNESS



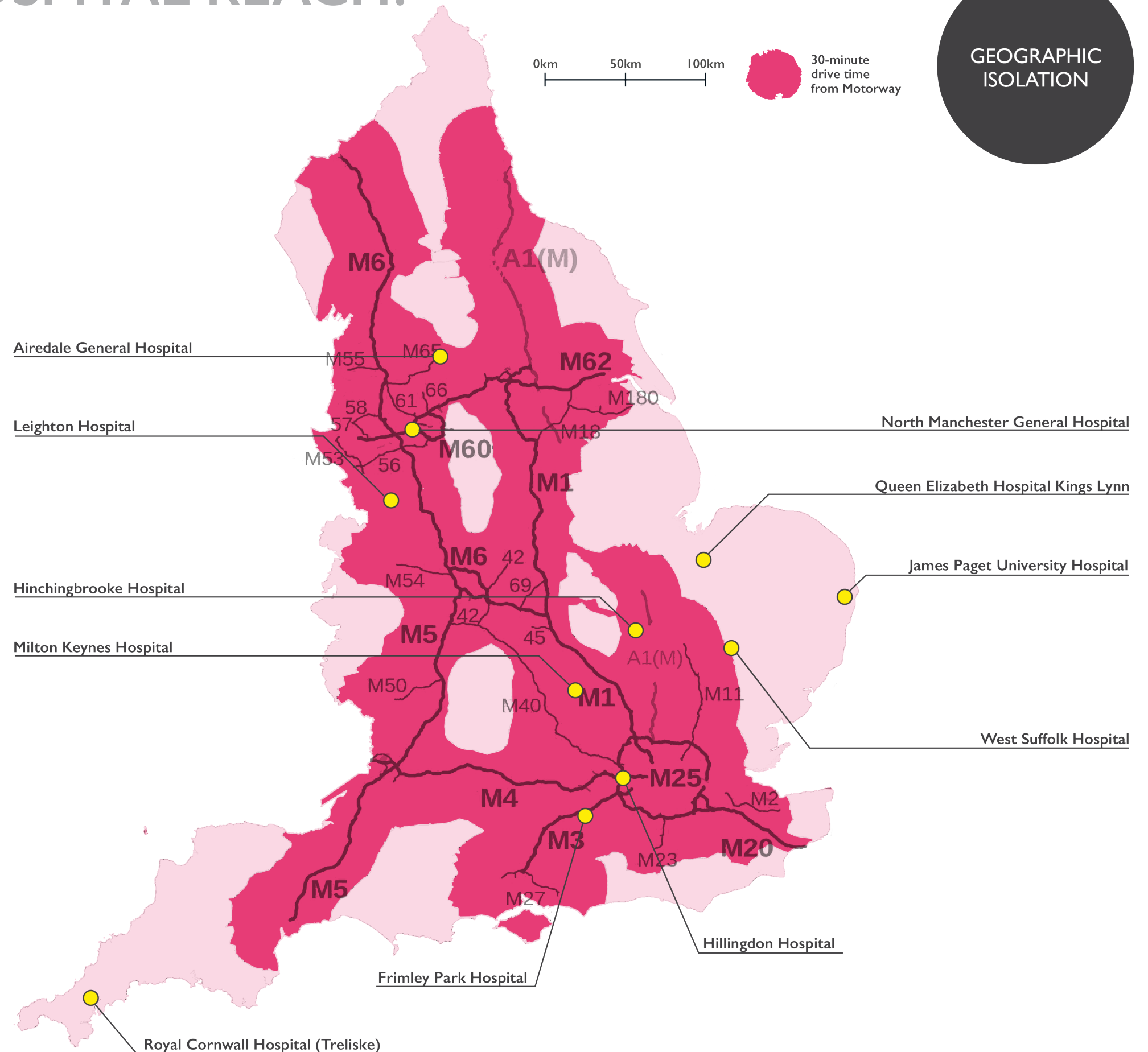
WHO CAN THE HOSPITAL REACH?

2. Geographic Isolation

Royal Cornwall manages mainland England's most geographically isolated acute catchment, providing the only Emergency Department for a county of 474,000 people, within a county of 570,300 - a population that doubles during tourist season. The nearest alternative acute hospital is over 50 miles away, and the entire county sits outside a 30-minute drive of any motorway.

Cornwall is not alone. QEH King's Lynn and James Paget occupy similarly disconnected positions on the Norfolk coast. Urban sites like North Manchester and Hillingdon sit within dense motorway networks. Hinchingbrooke occupies middle ground: a market town hospital with Addenbrooke's and Peterborough City Hospital as regional alternatives, but 40% of public transport journeys to site exceed 60 minutes.

Any hospital of this scale is a significant institution in its community. But where it is also the only acute facility for an entire county, sitting outside the motorway network with no nearby alternative, its significance compounds. Social value carries disproportionate weight in these contexts, but so does dependency risk.



WHO CAN THE HOSPITAL REACH?

3. Ethnic & Linguistic Diversity

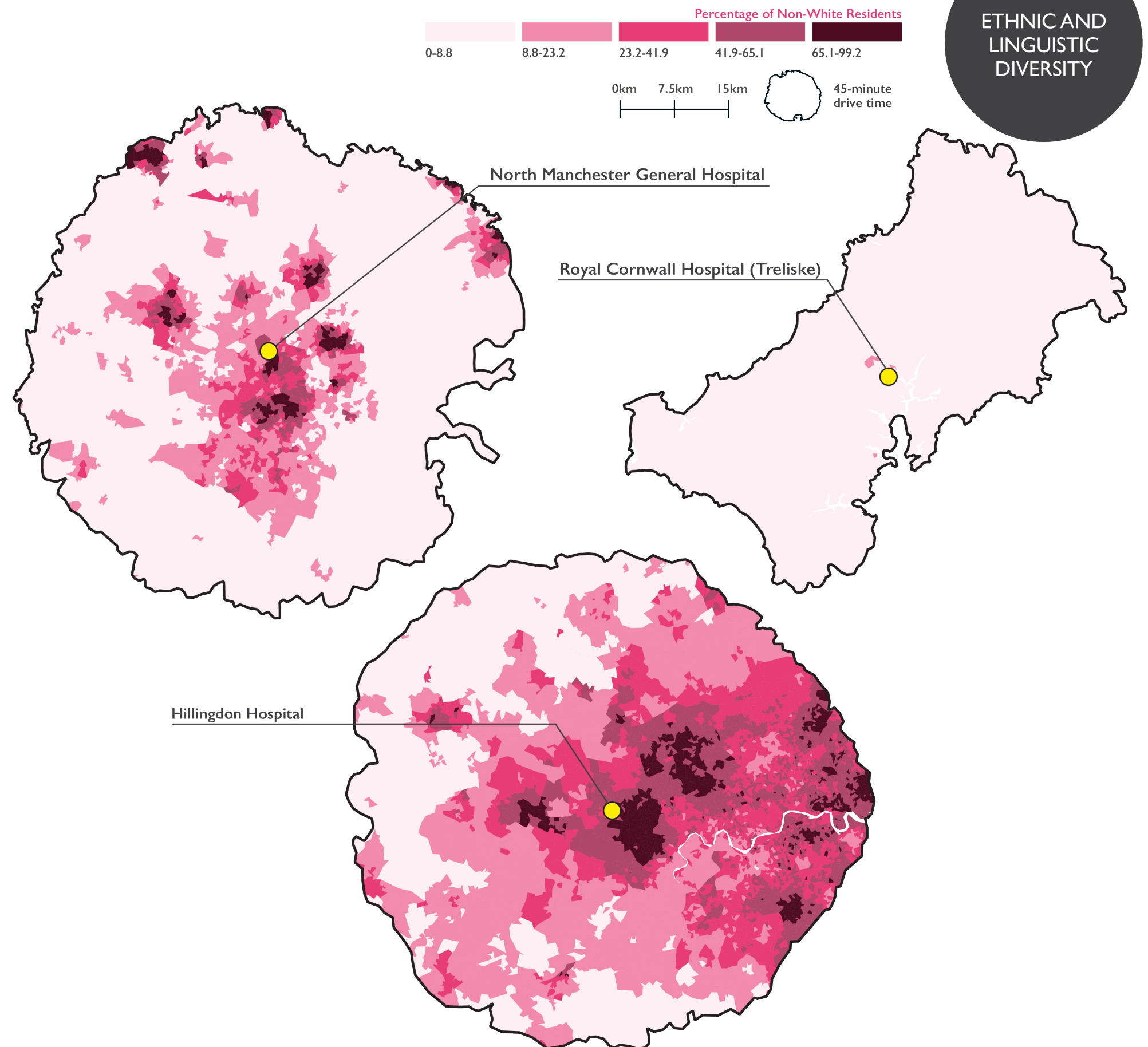
Hillingdon is a majority-minority borough: 51.8% of the population identifies as non-white, with significant South Asian, Black African, and Eastern European communities. North Manchester has 18% non-English main speakers, with over 150 languages spoken across the city.

In stark contrast, Royal Cornwall is 97% white and largely linguistically homogeneous.

This diversity matters most for healthcare planning and clinical service design. Culturally appropriate care pathways, health literacy strategies, community engagement approaches, and language provision all look fundamentally different across these catchments.

A standardised building programme can deliver consistent clinical space. The services delivered within it, and the communities those services need to reach, require local calibration.

Where 18% of a catchment doesn't speak English as a main language, translation and ESOL provision are essential for equitable access to the services the hospital exists to provide.



WHO WILL BUILD AND STAFF IT?

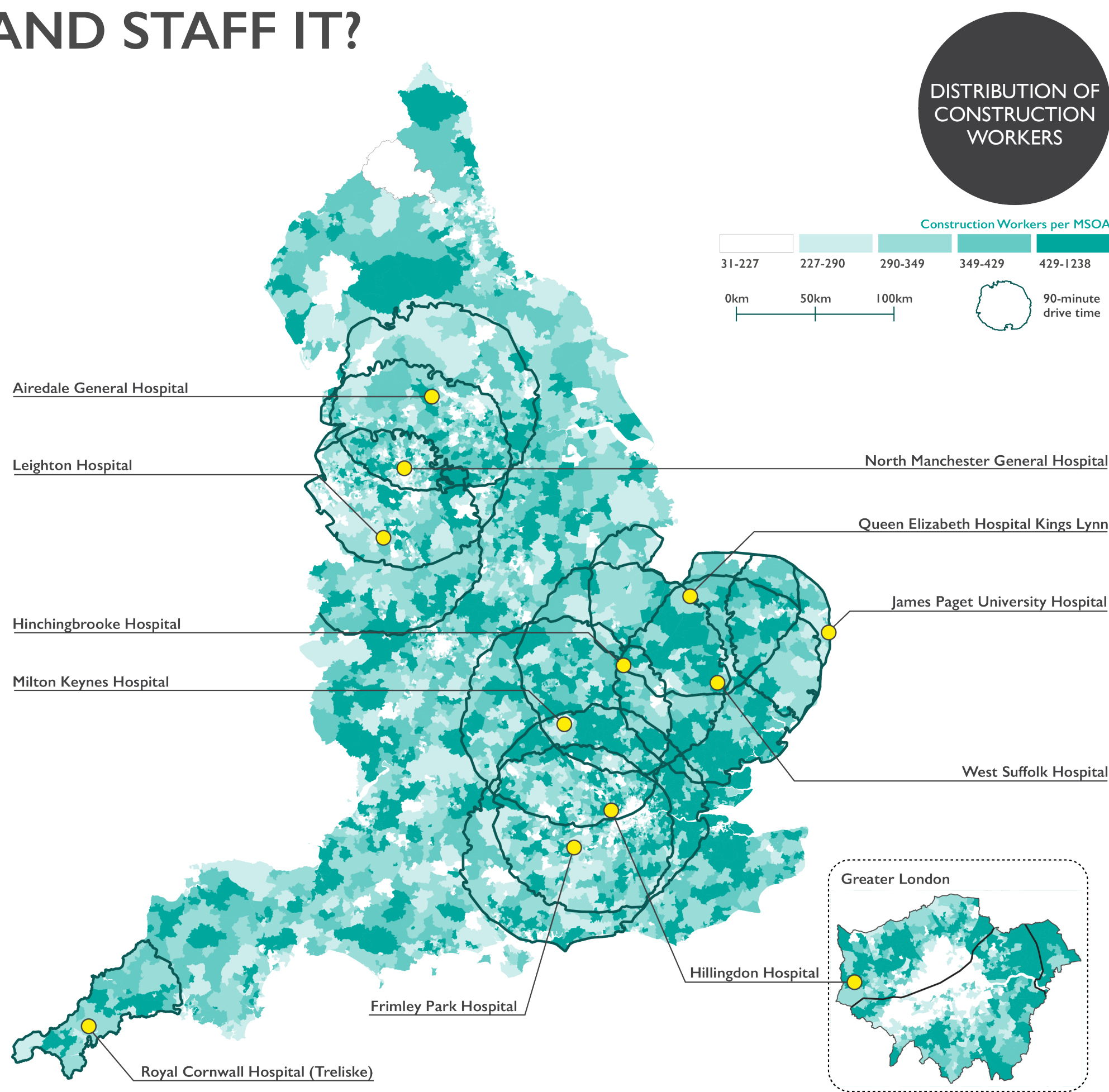
4. Labour Market Extremes

North Manchester’s construction and engineering sector reports an 82% recruitment difficulty rate. Frimley’s wider South East region needs 10,400 additional construction workers by 2028. Royal Cornwall faces a shallow local labour pool constrained by peninsula geography.

The workforce to build these hospitals must be recruited from somewhere. The question is where construction workers actually live, and how many are within realistic commuting distance of each site. For most Wave 1 schemes those catchments are largely distinct. As major infrastructure programmes from Sizewell C to the Lower Thames Crossing mobilise concurrently, they will shift.

This leaves strategic choices: how much does each Trust invest in growing local capacity, and how much does it acknowledge a transient, mobile labour force and plan around it? Most schemes will need both. But the RAAC safety imperative compresses the timeline. Pre-employment programmes need two to three years to deliver meaningful impact. For many sites, the transient workforce is not a fallback. It is a structural reality.

The scale of the programme creates opportunities through shared frameworks, collective procurement, and cross-site intelligence that no single Trust could build alone. The challenge however will be leveraging that scale locally.



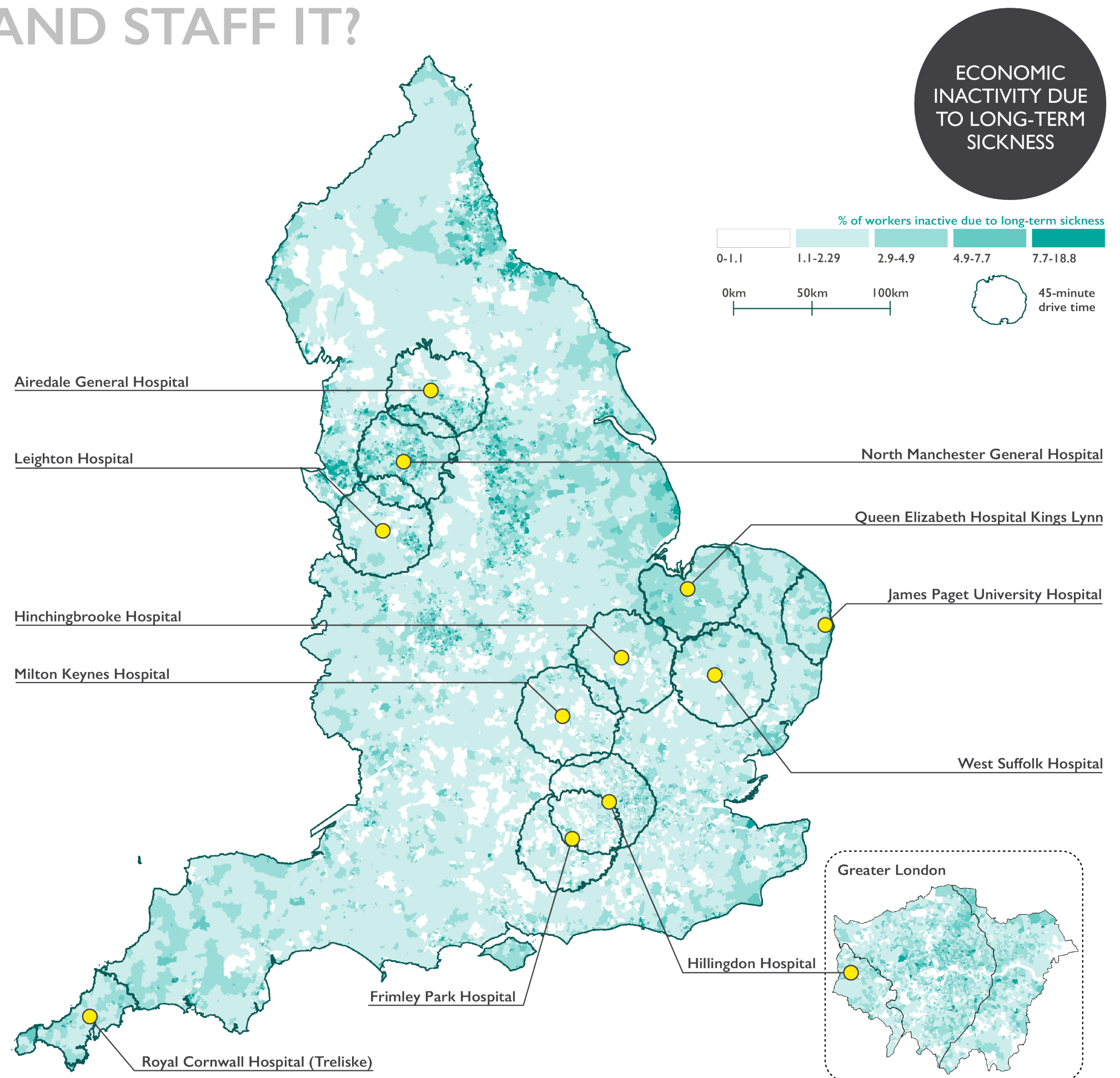
WHO WILL BUILD AND STAFF IT?

5. Economic Inactivity Patterns

2.8 million people in England are economically inactive due to long-term sickness. But it's not evenly distributed.

North Manchester sits within a local authority with an economic inactivity rate of 25.5%, with nearly a third of that group out of work due to long-term illness. Adjacent to Airedale, Bradford would need 20,000 additional people in employment just to match the national average. Great Yarmouth has 29.3% economic inactivity. These hospitals are not simply being built in deprived areas. They are being built in places where large populations are out of work specifically because of poor health.

Where a quarter of the working-age population is inactive through ill health, the distance between “local resident” and “employable candidate” is significant. Pre-employment support becomes less of a social value aspiration and more of a prerequisite for meeting local hiring targets. These hospitals are being built to treat the conditions driving the economic inactivity. The construction programme and the clinical mission are, in some of these catchments, addressing the same problem from opposite ends.



WHO WILL BUILD AND STAFF IT?

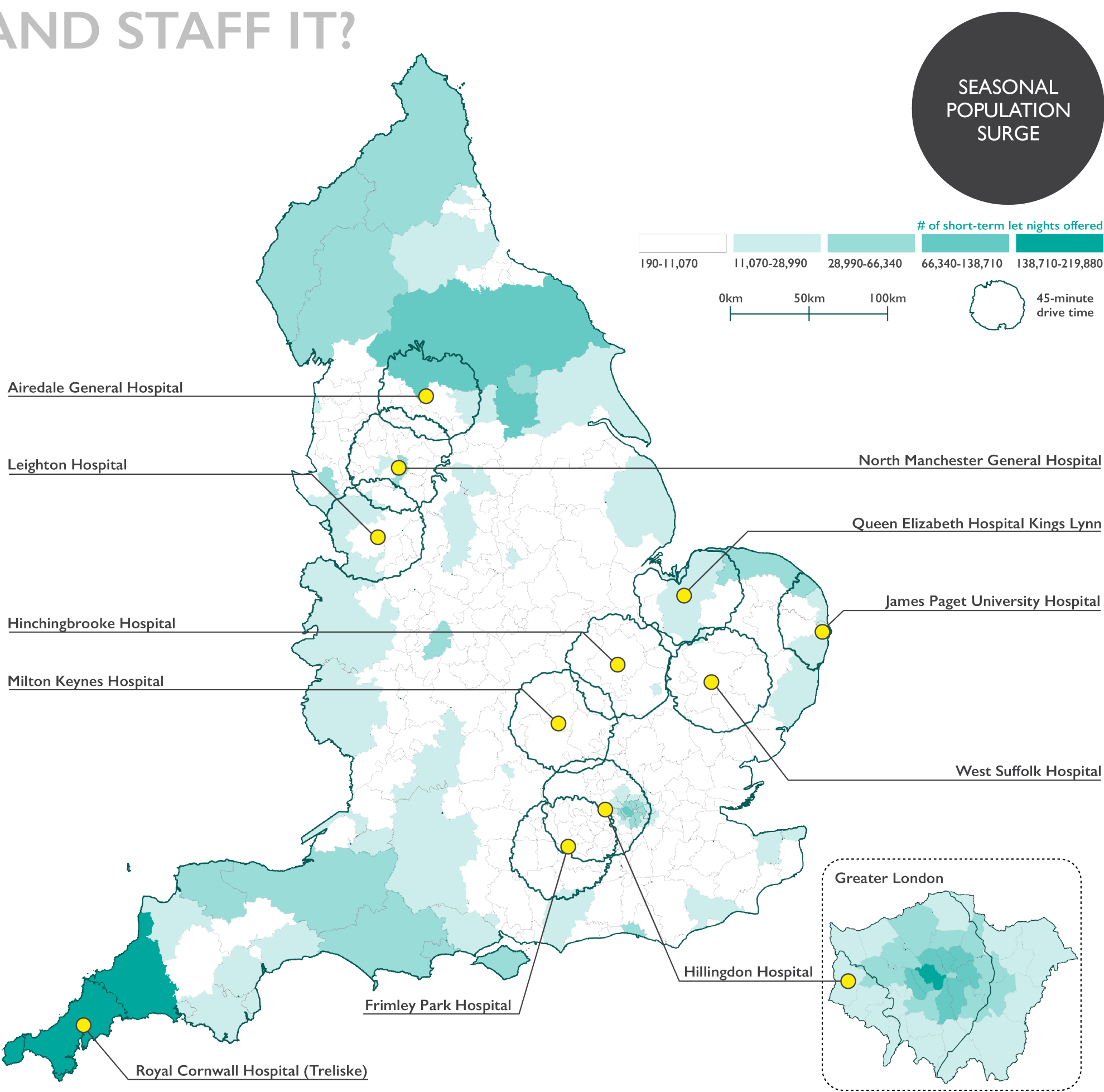
6. Seasonal Population Surge

Royal Cornwall’s catchment increases significantly in summer; the Trust and CQC describe the population as “more than doubling” during peak holiday periods, though independent estimates suggest increases of 35-60%. Great Yarmouth faces similar dynamics as a traditional seaside resort.

The same properties that attract seasonal visitors remove housing stock from the local market, inflating rents and pricing out the clinical and construction workers these hospitals need to recruit. A recruitment offer that holds in winter may not survive the summer rental market. But the relationship runs both ways. A transient construction workforce arriving during off-peak months can support local accommodation and hospitality businesses when tourism is quiet.

The balance of that dynamic varies by site. In Cornwall, where median earnings sit at 80% of the national average, directing construction workers into seasonal accommodation during quieter months could provide genuine economic benefit. In Airedale, where income deprivation is the highest indicator and significant numbers are in work but in low-paying jobs, the same influx of construction workers competing for low-cost rental property could directly harm the communities the hospital is being built to serve.

Understanding these dynamics in advance is what allows Trusts to direct demand rather than simply absorb its consequences.



WHO WILL BUILD AND STAFF IT?

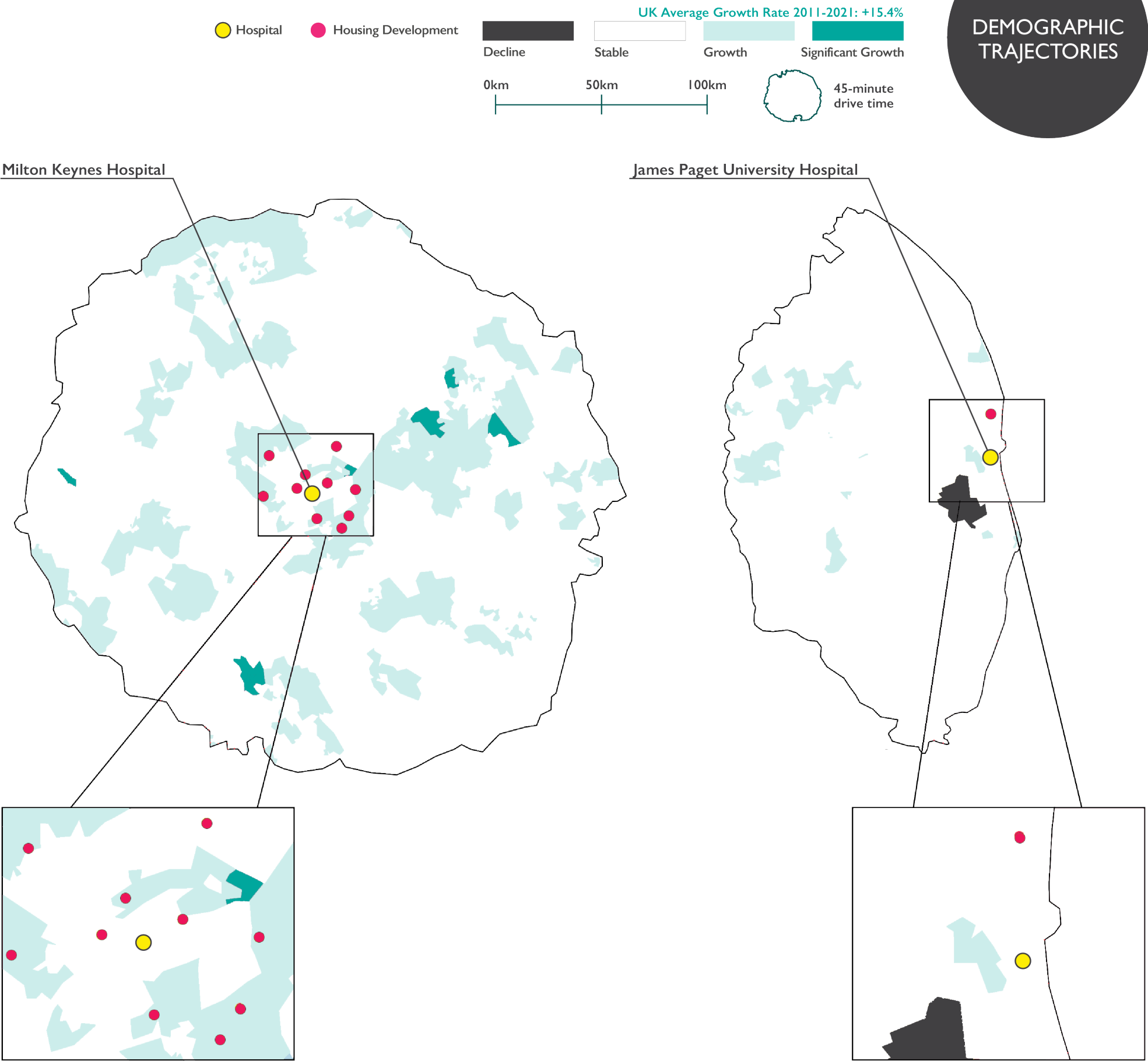
DEMOGRAPHIC
TRAJECTORIES

7. Demographic Trajectories

Milton Keynes is a national growth outlier, expanding at 15.4% over a decade, more than double the national average, with the council's Strategy for 2050 targeting approximately 410,000 residents. That growth is accompanied by significant planned housing development across the catchment, meaning the hospital construction programme enters a local market already competing for labour.

James Paget serves the opposite. Great Yarmouth's population is in natural decline at roughly 522 people per year, sustained only through net international migration.

A growing population potentially offers a growing local labour pool alongside growing demand. A population in natural decline offers neither. Where growth depends entirely on migration, the composition of that labour pool, its skills, its language needs, and its settlement patterns, becomes a workforce planning question in its own right.



WHAT DOES CATCHMENT ACTUALLY LOOK LIKE?

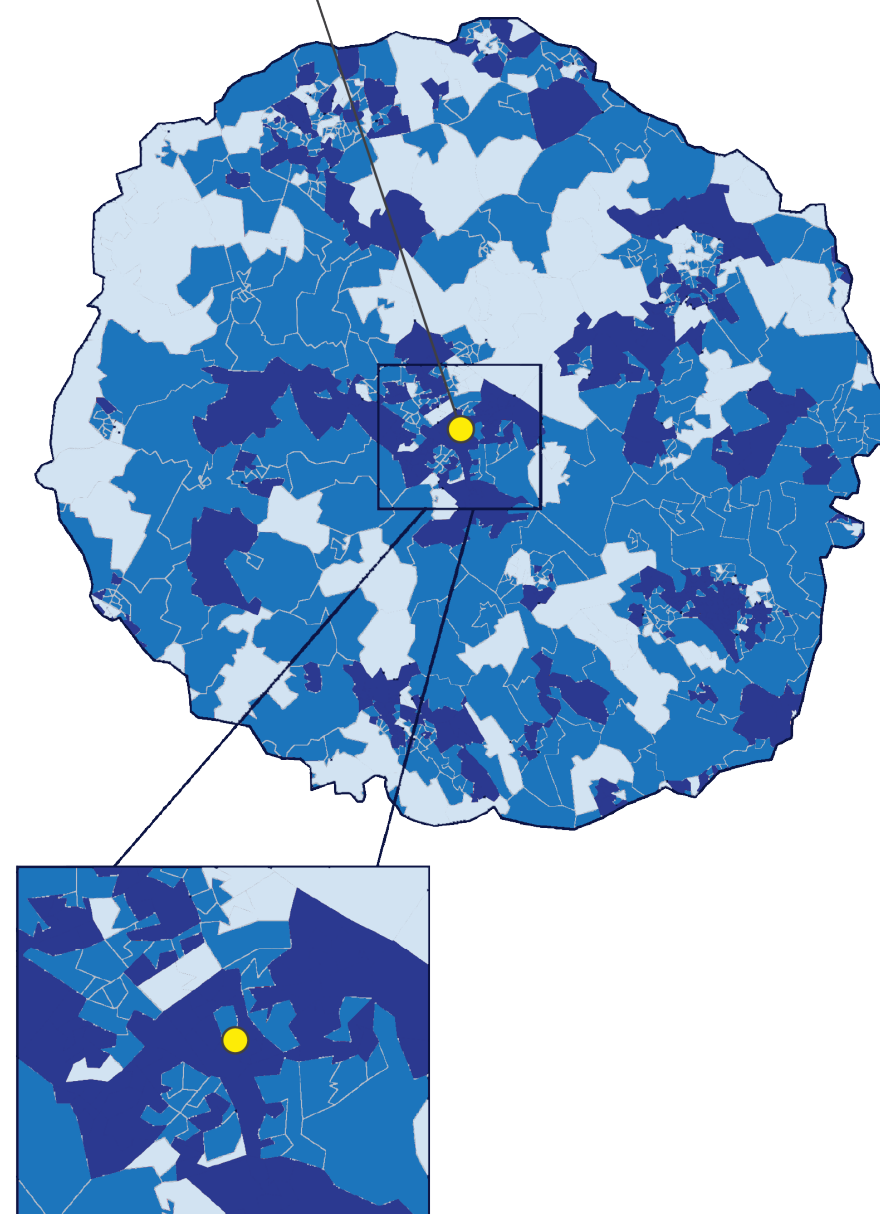
8. Age Structure Patterns

Milton Keynes has a median age of 37, with nearly 28% of the population under 19 and a maternity unit delivering approximately 3,800 births annually. Demand growth is projected to continue as the population expands towards 2037.

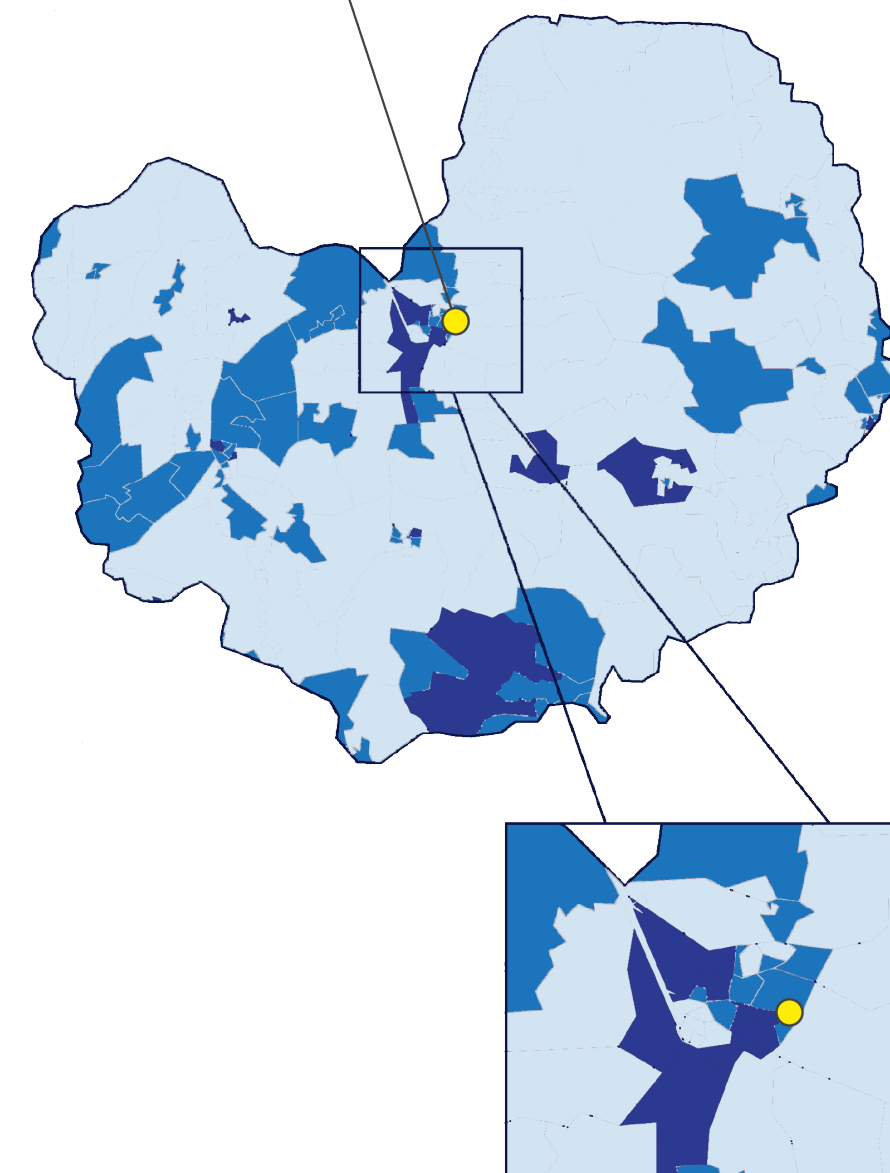
QEH King's Lynn serves the opposite: a median age of 47, seven years above the national average, and one of England's highest dementia prevalence rates at ICB level, jointly recorded at 0.97% alongside Dorset and Lincolnshire ICBs. Across Norfolk, the 65+ population is projected to grow 36.7% by 2040.

In ageing catchments, the population generating clinical demand and the population available for local employment, volunteering, and community partnership are increasingly the same people.

Milton Keynes Hospital



Queen Elizabeth Hospital Kings Lynn



POPULATION
PROPORTION
AGED UNDER 19

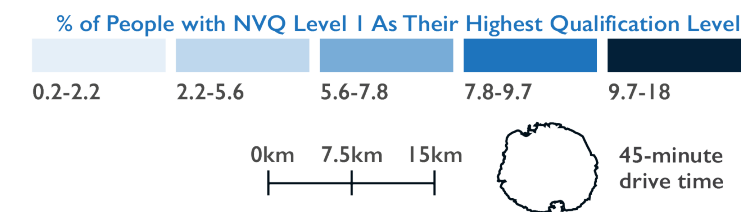
WHAT DOES CATCHMENT ACTUALLY LOOK LIKE?

9. Skills

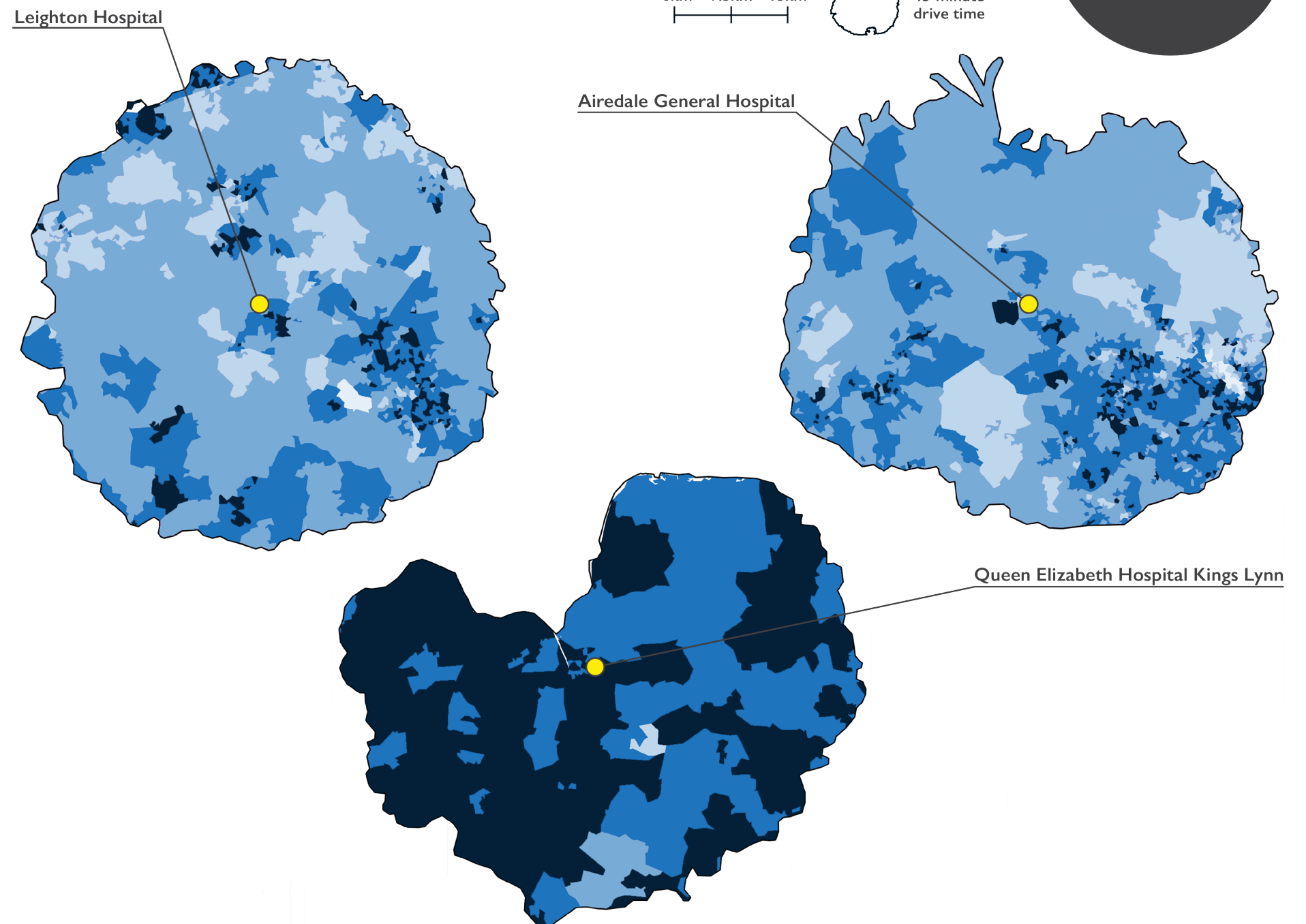
Local employment targets assume a workforce with the right skills, or at least the capacity to acquire them. Qualification data across these catchments challenges that assumption at its foundation.

This map shows the proportion of residents whose highest qualification is NVQ Level 1. In King's Lynn, the concentration is pronounced. Across much of the catchment, between 10% and 18% of the adult population hold no qualification above this level, with a third of neighbourhoods falling in the most deprived 20% nationally for education and skills. Around Airedale, the pattern fragments: pockets of urban Bradford show similarly elevated figures, set against a backdrop where only 51% of adults hold NVQ3+ qualifications compared with 60% nationally and where the proportion holding no formal qualifications is the highest in West Yorkshire. Leighton's catchment appears more moderate in aggregate, but aggregates mislead. Cheshire East averages 45.5% degree-level attainment; in Crewe, where the hospital actually sits, the figure drops to roughly 15%.

These are not communities with a skills gap that recruitment alone can resolve. They are communities where formal educational attainment has remained persistently low across a significant share of the working-age population. The distance between current qualification profiles and the workforce requirements of a major hospital construction programme represents a structural deficit. Closing it will require sustained investment in apprenticeships, pre-employment training, and foundation skills programmes, all initiated well before a spade goes in the ground.



HIGHEST QUALIFICATION LEVEL



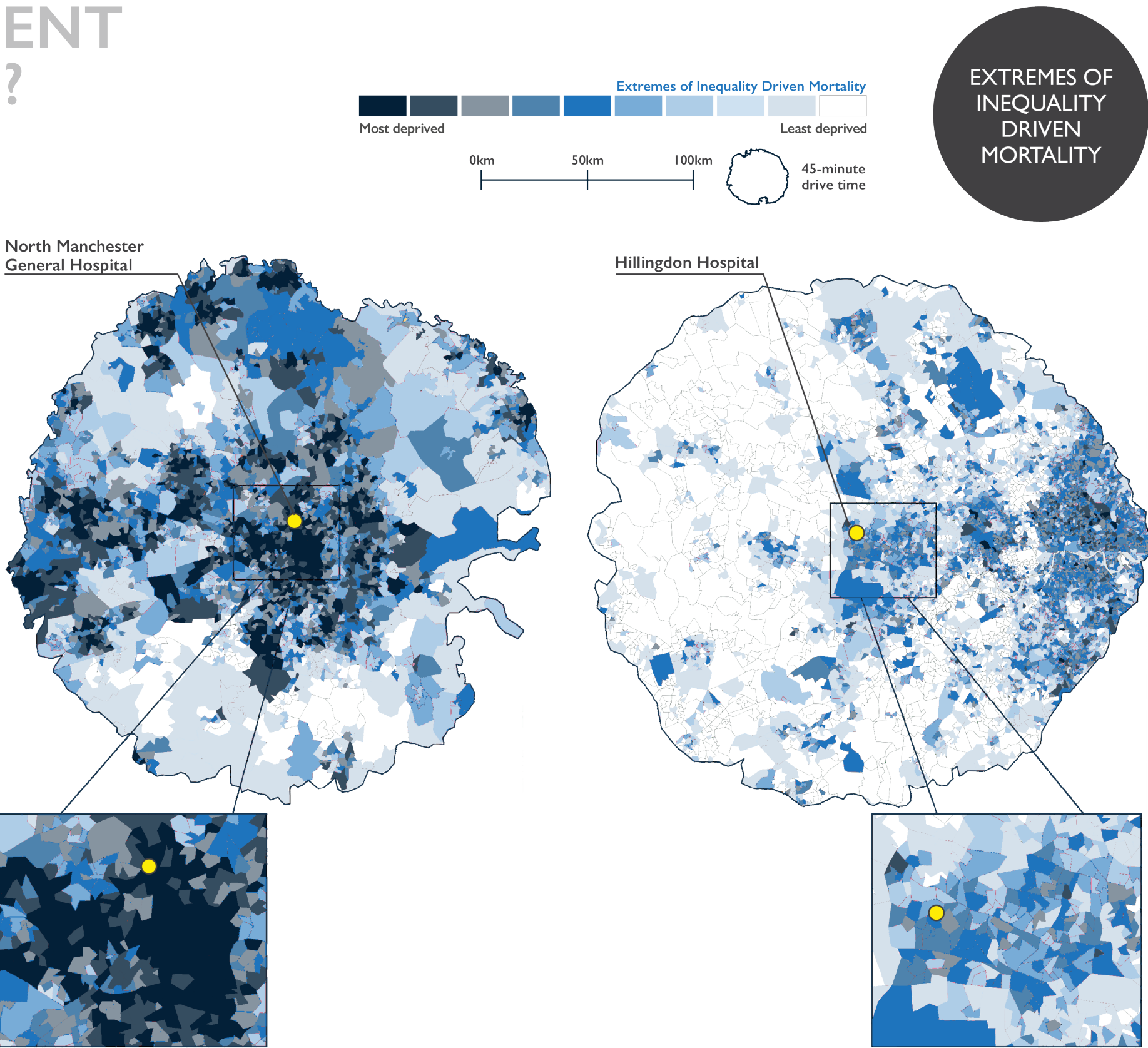
WHAT DOES CATCHMENT ACTUALLY LOOK LIKE?

10. Health Inequality Patterns

North Manchester records 58% of premature deaths attributable to socioeconomic inequality, the highest proportion in England. Manchester ranks among the most deprived local authorities nationally, placed 6th on the Index of Multiple Deprivation's average score measure.

Hillingdon appears to be the opposite: a positive outlier that has achieved the largest increase in healthy life expectancy in the country since 2017, up 6.3 years for women. Yet it simultaneously reports a Severe Mental Illness mortality gap 496% above the general population. Aggregate improvement and acute crisis coexist in the same catchment.

Where over half of premature deaths are attributable to deprivation, who the hospital employs, what it pays, which suppliers it uses, and how accessible it is all intersect directly with the health outcomes it exists to improve.



EXTREMES OF
INEQUALITY
DRIVEN
MORTALITY

WHAT DOES CATCHMENT ACTUALLY LOOK LIKE?

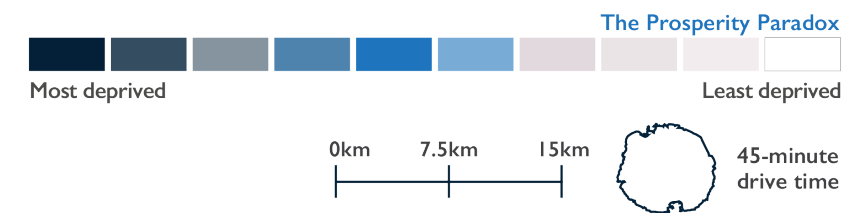
11. The Prosperity Paradox

Frimley Park serves a distinctive prosperity paradox: Surrey Heath ranks as less deprived than 98% of England, yet the catchment includes Old Dean ward, more deprived than 94% of the country, with 22% child poverty and male life expectancy 8.2 years below the district's affluent areas.

Leighton faces a similar pattern: Cheshire East is one of England's least deprived upper-tier authorities, yet Crewe contains 13 of the borough's 18 most deprived neighbourhoods, with a 10.9-year male life expectancy gap.

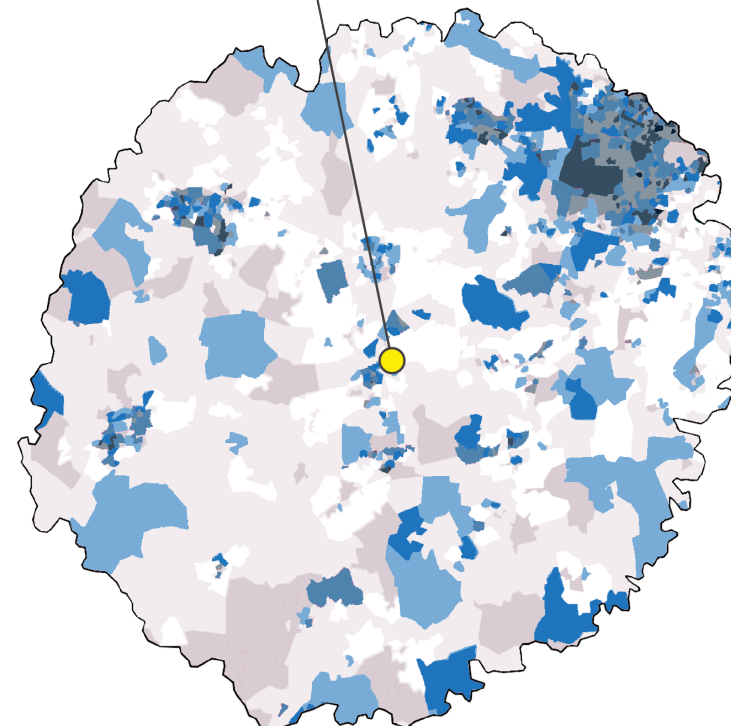
James Paget presents the inverse: uniformly deprived, with 40% of the entire borough population living in the most deprived 20% nationally.

Borough-level deprivation data can mislead in both directions. Where extreme affluence and acute deprivation sit within the same catchment, average indicators understate need and overstate capacity. Where deprivation is uniform, the headline scores are accurate but the scale of the challenge, and the absence of local wealth to offset it, can still be easily underestimated.

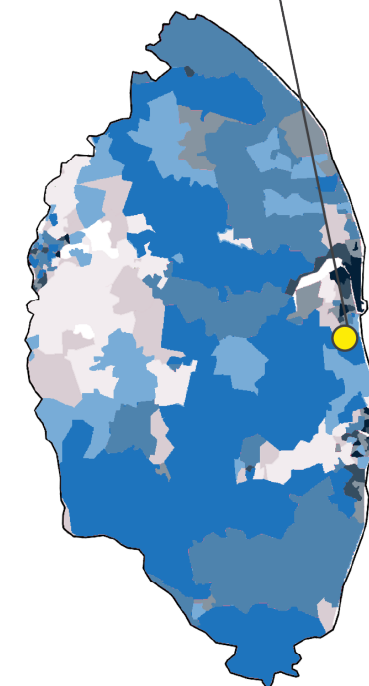


THE PROSPERITY
PARADOX:
UNEVEN
DEPRIVATION

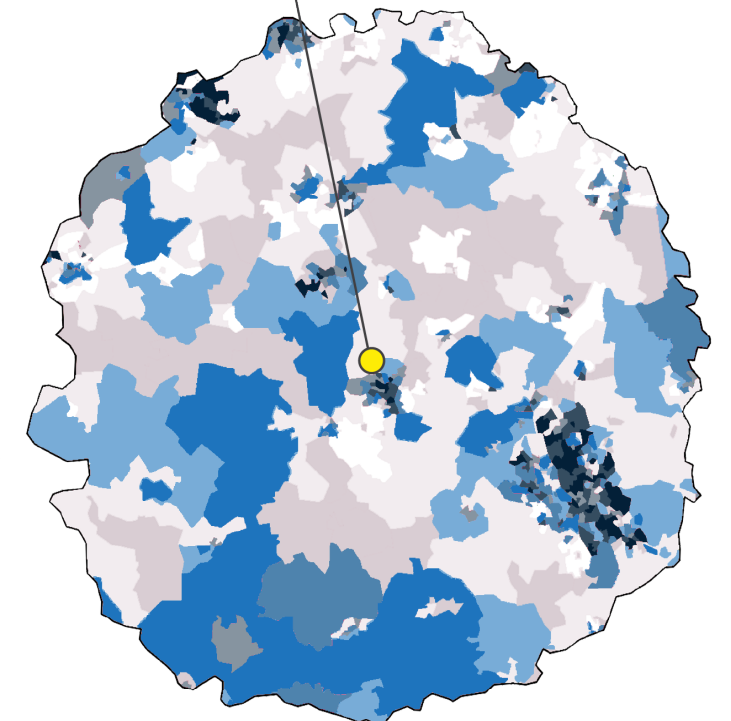
Frimley Park Hospital



James Paget University Hospital



Leighton Hospital



WHAT DOES CATCHMENT ACTUALLY LOOK LIKE?

12. Community Capacity

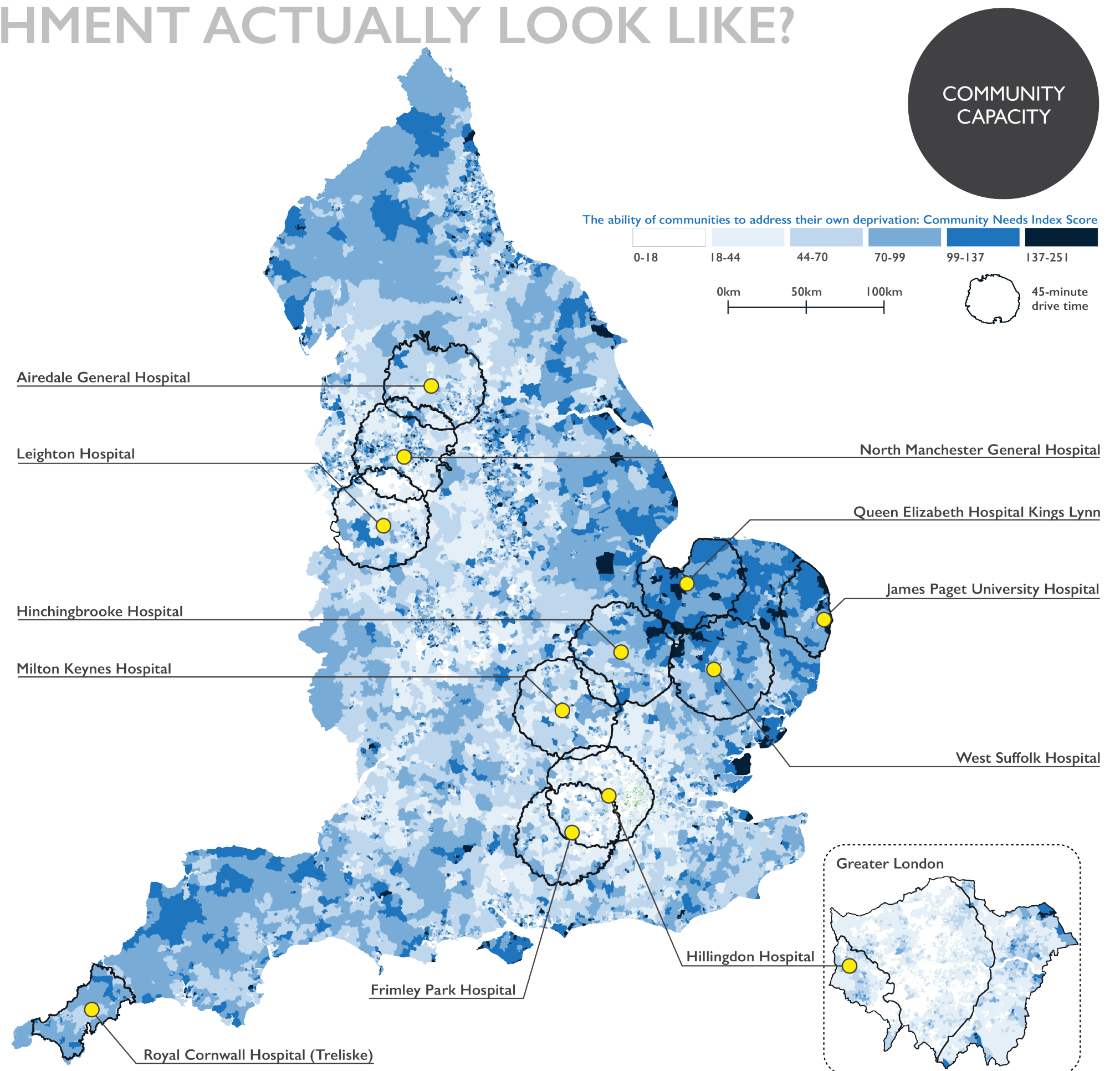
Every NHP business case commits to social value: local employment, community partnerships, VCSE engagement, social prescribing links. But they assume community infrastructure exists to deliver them.

Some areas have dense networks of charities, community centres, and engaged civic institutions. Others lack the spaces, organisations, and networks that make social value partnerships possible. The Community Needs Index reveals where those gaps are most acute. High scores signal not just deprivation, but structural fragility: communities where the infrastructure to absorb and sustain social value commitments is thinnest.

That variation is visible across the Wave 1 sites. James Paget and North Manchester General sit in catchments with some of the highest community need in England. Frimley Park and Hillingdon do not. The social value opportunity, and the risk of overpromising, is not evenly distributed.

Where community infrastructure does not exist, building capacity takes time and investment that needs to be recognised at an early stage. The hospital's construction phase is a finite intervention. The Trust's presence in its community is permanent. Aligning the two is how medium-term construction commitments translate into lasting local impact.

With thanks to Oxford Consultants for Social Inclusion for the use of their data for this map.



COMPOUND EFFECTS

These dimensions do not operate independently, they compound.

Royal Cornwall faces geographic isolation, a shallow labour pool constrained by peninsula geography, seasonal housing inflation, and a super-aged population with limited public transport. Each dimension is individually manageable. Together, they describe a delivery context where standard assumptions about recruitment reach, workforce availability, community partnership, and social value delivery all require fundamental adjustment.

North Manchester faces a different dynamic: transport poverty, high economic inactivity driven by ill health, extreme health inequality, and significant linguistic diversity. The hospital will serve a population that is geographically close, but simultaneously hard to reach, hard to recruit from, and hard to engage through conventional channels. The investment represents one of the most important interventions available to address the conditions driving the key social challenges.

Hinchingbrooke, Frimley, and Milton Keynes face less visible, but no less real compound effects: prosperity masking pockets of acute deprivation, rapid growth outpacing infrastructure, or apparent accessibility concealing poor public transport connections. Where these projects can be interlinked with wider built environment interventions, the potential to create sustained and inclusive economic growth increases exponentially.

What this means for planning, delivery, and measurement

The NHP's programmatic approach is an asset. It frees local teams from reinvention, allowing effort to concentrate where it matters, which in our view is in understanding the place, building the right relationships, and directing social value commitments where they will create the greatest impact. However, that potential only converts into local impact if the teams applying it, both at a Trust and Alliance Partner level, carry two things simultaneously: fluency in the programme's technical requirements and the capability to read and respond to local context with precision. Generic social value planning, applied without that dual lens, will produce commitments the supply chain cannot honour and partnerships communities cannot sustain.

At delivery stage, the risk is not ambition, but dependency. Construction creates a temporary, intensive pulse of activity in communities that often have fragile infrastructure and limited absorptive capacity. The schemes that leave a lasting legacy will be those that invest in building community partnerships and structuring their supply chain and employment commitments to strengthen local provision over time, rather than create a boom that retreats when the programme moves on. This will require relationships with community organisations, training providers, and local anchor institutions that are built ahead of need, not as the site breaks ground.

Measurement adds a further layer of complexity. The NHP's scale and standardisation create an opportunity to aggregate social value evidence in a way the sector has never managed before. That aggregation across schemes will only be meaningful if it rests on measurement that is locally calibrated at scheme level. What good employment outcomes look like in North Manchester, is not what they look like in West Suffolk. Community benefit in a fragile rural catchment with limited VCSE infrastructure is a different proposition to community benefit in a dense urban setting with established, but potentially fragmented networks. The programme needs a measurement framework flexible enough to capture context-specific outputs, outcomes, and impact at scheme level, while still being capable of rolling up to the core programme benefits in a form that satisfies Treasury and NHP reporting. That is a technical and strategic challenge, and it needs to be resolved now, not after the contractor gets onto site.

These maps offer a snapshot. The deeper analysis sits with each scheme, its partners, and the communities each Trust serves. The schemes that invest early in sound analysis, and carry it through planning, delivery, and measurement with the right community partners, will be the ones that show what programmatic delivery, based on collaborative partnership models, can really achieve in terms of long-term, sustained economic growth and social impact.

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