Good Governance Institute

Primary Health Properties

Primary Care Estate

delivering value and improving care

September 2020

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Good Governance Institute

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We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

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Primary Health Properties

Primary Health Properties PLC ("PHP") was founded 24 years ago by entrepreneur, Harry Hyman. The purpose of the company is to own and invest in primary care properties in the UK. GPs provided services from their own premises, receiving reimbursement from the NHS, as contractors, for doing so. As practices grew and partnerships formed, the premises needed to grow too and this often created a large financial burden for GPs. PHP was therefore created to provide the capital to do this, with GPs entering into a LTP , traditional property lease of the premises instead.

This model has proved successful and grown over the intervening 24 years. PHP is now a listed FTSE 250 company, owning 511 buildings with a combined valued of in excess of £2.5bn and over 1,200 different occupiers. A majority of the tenants are GP practices though there are many pharmacies, dentists, physiotherapists and opticians, as well as NHS bodies including NHS PS, Foundation Trusts and other parts of the NHS, that call PHP properties their home. The model has also been successful in Ireland, where PHP has been active is participating in Slaintecare, a ten-year programme to transform and build a world-class health and social care service for the Irish people. PHP has also invested over EUR 200m of capital in Ireland alone to create buildings housing the wide variety of integrated services provided by the HSE in Ireland, as well as GP's, Tusla, pharmacies and other state and private health care providers.

Simply put, PHP's mission is to be a leading provider of modern, primary care, premises.

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Primary Care Estate: delivering value and improving care

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Foreword from Harry Hyman

Would it be over the top to say that Covid-19 has changed everything? Yes and no. Yes, the rapid rise in the adoption of remote consultations looks to be a lasting change, as technology facilitates new ways for patients to access the system and for the system to deliver treatment. No, in that follow up face to face consultations with still be required, and no, in that we still have an ageing population that will probably live for longer with more incidence of chronic illness.

It is also still the case that the primary care estate remains, in part, obsolete in satisfying current demands, let alone meeting the NHS Long Term Plan for more services to be provided in a primary care and community setting. It also remains widely recognised that the current central capital investment is simply insufficient to fund both the integration of services as well the upgrading that the estate will inevitably require.

PHP has therefore commissioned GGI to assess the options available to health system leaders in creating an effective primary care estates strategy and capital plan to deliver it. Could the key to achieving this lie with Third Party Developer (3PD) schemes? Private sector partners act as both contractor and developer, as well as taking on the role of a long-term strategic partner and sharing the risk associated with the venture with NHS commissioners and organisations.

This includes both financial risk and the risk on property ownership and management. This will be especially important in the development and expansion of general practice facilities, which will require significant capital investment. PHP has a 24 year track record of investing in the primary care sector and facilitating the modernisation of NHS facilities, which could now be more important than ever as general practice expands to deliver a wider range of services and play a key role in delivering care closer to home.

This paper aims to build on and re-iterate the current policy regime and offer insights into the capital financing options available to providers, commissioners and GPs and how those looking to develop new estates can utilise the experience of 3PD providers in order to design a balanced estates strategy that meets the long-term needs of local communities.

Harry Hyman
Founder and Managing Director of Primary Health Properties PLC

September 2020

Contents

A paper to explore the commissioning of primary care premises by Clinical Commissioning Groups (CCG), Primary Care Networks (PCN) and trusts and the influence of healthcare integration and digital access to primary care, post-Covid-19.

Key messages

- The NHS LTP Plan (LPT) makes clear an ambition to "boost 'out of hospital' care, and finally dissolve the historic divide between primary and community health services".[1] In particular, General Practitioners (GP) will continue to have a fundamental role in reducing health inequalities and driving preventative care, especially through newly established primary care networks. Doing this will require investment within primary care to improve estate - ensuring that a range of services can be accommodated under one roof - and boost access.

- Primary care and other parts of the NHS have had to make significant alterations in the way care is provided as a consequence of the Covid-19 pandemic. One of the most visible changes has been the transition away from the face-to-face GP consultations, with various estimates suggesting that c.85% are currently being conducted remotely. This has also, arguably, had the effect of shifting public expectations around how health and care should be delivered and, in turn, what fit-for-purpose estate might constitute.

- We know that primary care will also be under increasing pressure as phase three of Covid-19 recovery begins to address the significant backlog of patient appointments that have built up.

- It is acknowledged that, at present, access to, and the quality of, primary care varies across the country. Recent polling and reviews indicate the significant need to improve the quality of primary care estate. For example, the Naylor Review indicated that the quality of primary care estate largely mirrors that of the overall NHS estate - 42% of which is over 35 years old and 62% of which is over 25 years old. Recent polling by the General Practitioners Committee England (GPC) has reinforced this view, revealing that as many as 50% of GPs regarded their premises to be 'inadequate'.

- There are several barriers to the modernisation of primary care estate.

    - Firstly, GPs are contractors of the NHS rather than employees meaning that they are independent to the NHS and that they own much of their estate that their services are run from. Primary care estate is therefore owned by a range of bodies which means that commissioners have relatively few levers they can use to facilitate the procurement and development of modern premises. During our engagement activities, we were also told that there has been an exodus of primary care estate expertise away from commissioning bodies, compounding this issue.

    - Secondly, GP contracts do not necessarily incentivise GPs to maintain or modernise their estate, with GPs largely guaranteed reimbursement for their premises regardless of their condition. Moreover, GPs can be reluctant to invest in their estate because of concerns around being the 'last partner standing' and also an increasing desire to pursue more varied portfolio careers, and for younger GPs to be salaried doctors.

    - Finally, it is not always apparent from where funding for primary care estate programmes will be made available from. The Government recently announced a £2.7 billion fund to support the development of new hospitals at six NHS trusts but has been comparatively quiet on primary care estate. Previous capital programmes such as the Private Finance Initiative (PFI) based Local Improvement Finance Trust (LIFT) initiative have now ceased and there is currently no other dedicated government programme in place to fund primary care infrastructure.

- In this context, third party development (3PD) is a viable and attractive option that should be considered by GPs and commissioners to help facilitate rapid improvement in primary care estate. PHP, for example, has indicated that an annual rental revenue commitment of £200-300 million could unlock private investment of £3-5 billion, enough money to build or upgrade 750 primary healthcare properties. PHP buildings can contribute to the delivery of key service targets in the response to Covid-19, such as the plans for community diagnostic hubs to tackle surging NHS diagnostic waiting lists.[2]

Third Party Development (3PD) and PHP

3PD is a widely used term to refer to private sector real estate companies, though the name masks that once built, many are in fact many long-term institutional owners of real estate, providing a stable base for the provision of healthcare services. Many third-party developers have a proven record of delivering projects, regardless of size, on time and on budget, demonstrating the ability to provide occupiers with greater certainty/control over ongoing costs.

It is important to note the 3PD is not the same as a Private Finance Initiative (PFI). Within the 3PD model, and in return for a revenue commitment from Commissioners to reimburse rent for General Medical Services (GMS) services, contractors can offer simple property lease contracts with the rent adjudicated by the Her Majesty's Revenue and Customs (HMRC) agency, District Valuer Services, on behalf of the NHS, based on the lower amount of the current market rental value or the actual lease rent. Counter parties such as PHP and other 3PD companies are stable financial institutions, not subject to the same risks faced by contractors, and as Listed companies are subject to robust scrutiny and governance.

Introduction

The challenges facing the UK's health and care system are well understood: how to safely and effectively serve an ageing population with multiple and long-term health needs within the context of financial and workforce constraints. In tackling these challenges, the long-term ambition is for more integrated care for patients to be delivered away from large, acute hospitals and closer to the community in primary health settings where health and wellbeing outcomes can be improved.

As part of this ambition, GP practices have been encouraged to form Primary Care Networks (PCNs), typically covering 30-50,000 people within larger integrated care systems (ICSs), to deliver more joined-up services at scale. Practices are funded to work together and create genuinely integrated teams of GPs, community health, social care and other primary care professionals.

Over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget, with a ringfenced fund worth at least an extra £4.5 billion a year in real terms by 2023/24. This is desperately needed as NHS estate and many GP premises in the UK remain unfit for their current purpose, let alone this expanded role, which requires significant change, flexibility and collaboration.

The Naylor Review, for example, suggests that anecdotally primary care estate is in a similar condition to that of the overall NHS estate - 42% of which is over 35 years old and 62% of which is over 25 years old.[3] And recent polling by the General Practitioners Committee England (GPC) found that as many as 50% of GP practices deemed their premises to be inadequate.[4]

Common challenges include a lack of space in waiting rooms and consultation rooms, growing list sizes and a lack of disabled access. There are many reasons for the variable quality of the primary care estate, including how GPs are incentivised for maintaining or modernising premises, as well as the significant complexity in how funding is accessed and where accountability for improvement lies.

Alongside these issues, the Covid-19 pandemic has intensified focus on how primary care is provided. This includes acceleration of the intended transition away from face-to-face GP consultations, with various estimates suggesting that c.85% are currently being conducted remotely.[5] Many of those engaged in the development of this report questioned whether this level will be sustainable over a longer period, with implications for continuity of care, equity, and waiting times. Nonetheless, it creates an opportunity to meet the aspiration for more services to be provided in primary care centres. This will be explored further in section 3.

High-quality primary health estate will undoubtedly be vital in alleviating some of the immediate consequences of the pandemic. This includes the delivery of some of the backlog of treatments, diagnostics, urgent treatment, testing and, potentially, vaccination as well as the resumption of more, but not all, consultations in a face-to-face format.

In the longer term, development and flexibility within the primary care estate throughout the UK will be crucial if opportunities for addressing health inequalities and improving population health and wellbeing outcomes are to be realised.

However, while all of this is acknowledged, it is not always apparent that funding for primary care estate programmes will be made available from within the NHS. The government recently announced a £2.7billion fund to support the development of new hospitals at six NHS trusts but has been comparatively quiet on primary care estate.[6] Moreover, the pandemic has driven up the UK's national debt has above £2 trillion for the first time, meaning that there may be a need to reduce public sector funding.[7]

Unlike large hospital builds, which take many years, improvements to primary care premises can be delivered at a much faster pace. New and enhanced modern primary care estate has a significant bearing on the quality of care that patients receive. PHP analysis demonstrates that visible results could be quickly demonstrated all over the country, with schemes of around £5m deliverable in two years or less. Such developments would form a major contribution to unlocking the benefits of integrated care for local communities.

This report is a collaboration between the Good Governance Institute (GGI) and Primary Health Properties (PHP) and is based on a range of interviews conducted with health care professionals and property experts throughout the UK. It explores the current state of primary care estate and makes suggestions for how opportunities can be embraced to deliver more modern and flexible premises, with clear immediate and long-term benefits for communities. The report also usefully sets out prompts for leaders to consider throughout health and care systems including PCNs, CCGs, NHS trusts, and the evolving integrated care systems. Case studies of PHP's 3PD solutions are presented in Section 5.

New purpose built premises and consultation rooms, Richmond Medical Practice, Kew, London. Owned and funded by PHP PLC.

1. What is primary care?

NHS England (NHSE) defines primary care as:

The first point of contact in the healthcare system, acting as the 'front door' of the NHS.[8]

In the UK, there is a common perception that primary care is the same as general practice. While general practice is a significant aspect of primary care, the full scope is much broader, including clinical pharmacists, physician associates, allied health professionals and paramedics among others (see functionality diagram page 25). The multidisciplinary nature of primary care is important, helping to reduce demand pressure elsewhere in the NHS and other care providers, while also ensuring that patients receive high-quality joined-up care closer to home.

Despite this, the current primary care model in the UK has been criticised for inconsistencies in access and quality for patients. For example, there are often fewer GPs in deprived areas, resulting in reduced access for certain populations.[9] The reasons for this are myriad but include recruitment, retention and funding challenges, which mean GPs have to cope with ever-growing demand and increasingly complex care.

1.1 What is the vision for primary care?

Sustainable primary care is a core enabler of more effective and efficient health and care delivery. Building primary care at scale is a recognised ambition of the NHS LTP Plan, and a central focus of ICS ambitions throughout England, with recently introduced primary care networks playing a principal role in this.

It is recognised that developing new models that draw together elements of primary care through pharmacists, nurses, social prescribers and others can reduce the burden on GPs and deliver better care for communities.[10] We also know that primary care is frequently cheaper than care delivered in secondary or tertiary care settings.[11]

This broader approach to primary care requires care provision to larger populations of patients in order to achieve the economies of scale required to drive investment in longer opening hours and a more diverse service offering of integrated care.[12] Unleashing the potential of population health management also requires GPs and primary care colleagues to be able to lead as experts in the health and care needs of local communities through population health management approaches.[13]

What is population health management?

"Population health management is the health outcomes of a group of individuals, including the distribution of such outcomes within the group.[21] Population health management aims to optimise the health of populations over individual life spans and across generations. It is the nexus that brings together an understanding of population need (public health) through big data, patient engagement and healthcare delivery to embrace the triple aim of experience of care, the health of populations and cost savings."[22]

As such, single-handed independent general practice is increasingly viewed as being at odds with this vision. In particular, smaller practices can be hampered in both scope and flexibility, offering consultation appointments with relatively rigid availability, potentially in outdated and sub-optimal premises, and without the multi-disciplinary teams that can provide access to the wider range of primary care services.

1.2 Population growth and primary care

Aging is a strong risk factor for chronic illness - one in every four people living in the UK is comorbid rising to two thirds in those aged 65 years or more. The Office for National Statistics (ONS) has predicted that in 50 years-time there will be 8.2 million more people aged over 65 years old in the UK[14] and, with this, we will likely see a commensurate increase in those living with a chronic illness.[15]

The cost of caring for older patients with complex needs can be significant as they typically require more holistic and integrated care delivered through a multidisciplinary team, often with a GP as the central member. As such, it is estimated that comorbidities cost £8-13 billion per year in England at present, including more than 50 per cent of primary care costs.

The LTP highlights that primary care must play a central role in meeting demand, as well as in reducing future health issues in the population through prevention and health promotional work.

Indeed, the National Association of Primary Care has suggested that a stratified population health management approach, with a particular focus on three population groups could be effective:

- People who are generally well
- People with LTH conditions
- Older people with complex needs

However, it is also acknowledged that realising this will require investment in primary care to ensure that recognised workforce, estate and technology challenges can be met.[16]

1.3 Social and health inequalities and primary care

Many areas of the UK experience stark health inequalities, with a significant body of evidence suggesting that these have widened in recent times.[17] For example, between 2015-17, those living in the country's least deprived areas could expect to live 19 more years in good health than those in the most deprived.[18] This has led to many bodies, including the Care Quality Commission (CQC), decrying the existence of a postcode lottery which means that:

> *"Some people can easily access good care, while others cannot access the services they need, experience 'disjointed' care or only have access to providers with poor services."* [19]

Primary care has a central role to play in addressing some of the key determinants of health inequalities.

As the Royal College of GPs has highlighted:

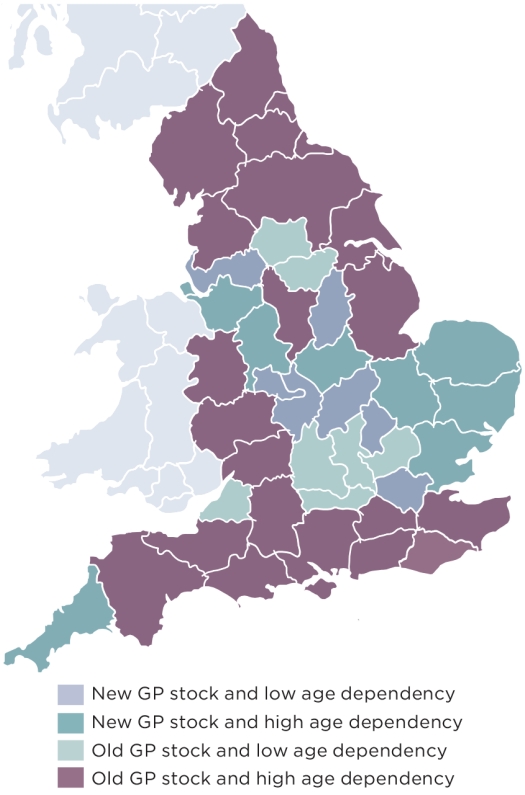
> *"General practice is unique as the only part of the health service that provides whole-patient care, through the GP's role as an expert medical generalist providing individualised care to patients in the context of their wider social environment. General practice is also the only part of the service that is truly universal in that the vast majority of patients are registered with a GP practice, and GPs do not 'discharge' patients from their care. As such, continuity of care and preventative care — two important tools in combating health inequalities — form a fundamental part of the work of a GP and their team."* [20]

However, this cannot be realised whilst access to primary care is varies across the country. Mirroring other parts of the system, the more deprived areas in the UK typically have fewer GPs per head of population than less deprived areas, despite often having a higher burden of disease.[23]

As the UK population grows and ages, it will be important that primary care is appropriately funded and supported to meet this need and help prevent widening health inequalities – this includes the development of fit-for-purpose estate.

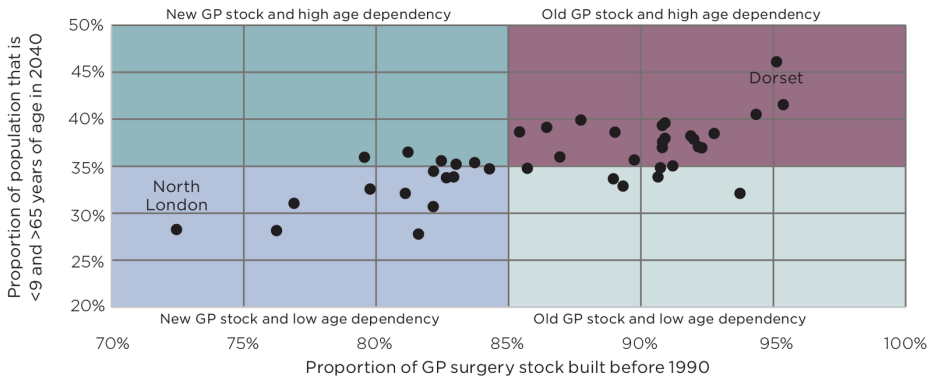
A need for new GP practices with high age dependency

These diagrams below demonstrate the dearth of new GP premises where they are most needed including areas with large ageing population.



Source: NHS England, ONS
(as referenced in Market in Minutes:
UK Primary Healthcare Real Estate, Savills, 2020)

Age of GP building stock versus age dependency



Source: NHS England, ONS (as referenced in Market in Minutes: UK Primary Healthcare Real Estate, Savills, 2020)

1.4 The role of Primary Care Networks

It is hoped that PCNs can help to resolve some of the aforementioned challenges. In particular, PCNs are tasked with tackling inequalities and providing anticipatory care (linking with community services) and will receive specific funding for clinical pharmacists, social prescribing, and paramedics.

PCNs will use population health methods, applying local data to gain a deeper understanding of inequalities in healthcare pathways, and an ability to target health and care services to deliver improved outcomes for communities.[24] While this has been made possible in some areas, workforce and capacity challenges are evident, and data are still often collected in silos with cultural and systemic challenges limiting effective sharing.

Change in primary care has been stimulated and catalysed through the Covid-19 pandemic. Primary care and other parts of the NHS have had to make significant alterations in the way care is provided which presents an opportunity for PCNs.

2. Primary care estate and the wider health system

2.1 What is the current state of primary care estate?

The NHS operates from the largest property portfolio in Europe, including 1,200 sites across 6,500 hectares of land across the UK.[25] This remarkable portfolio is owned by many different types of organisations, with a wide range of legal arrangements.

The NHS collects data about NHS provider trusts' premises through the Estates Return Information Collection (ERIC), which has the most comprehensive estate information available. However, this does not include primary care estate data.

Indeed, the Naylor Review demonstrated we still do not have a complete or comprehensive picture of the quality of current primary care estate. Anecdotally, we are told that it is similar to NHS owned estate, 42% of which is over 35 years old and 62% of which is over 25 years old.[26] Unfortunately, this means that much of it is unlikely to be fit for purpose to meet the ambitions of the NHS LTP.

2.2 Improving primary care estate – system working

"If you think competition is hard, you should try collaboration"[27]

It is important to recognise that a relatively piecemeal and uncoordinated approach to primary care estates development has historically been pursued. Premises provision has, from the commencement of the NHS in 1948, been the responsibility of GPs; by contrast, premises commissioning is a function of the NHS, currently in the hands of CCGs.

This means that, today, relatively little of the primary care estate is owned by the NHS. GPs own a substantial proportion of the property through which their 7,600 GP practices are provided from.[28] NHS Properties owns around 1,500 practices and leases the space back to GPs. Some primary care estate is also held by other independent but linked NHS organisations such as Community Health Partnership. Third-party developers also own a large amount of primary care estate, with PHP, for example, owning 500 premises in the UK.

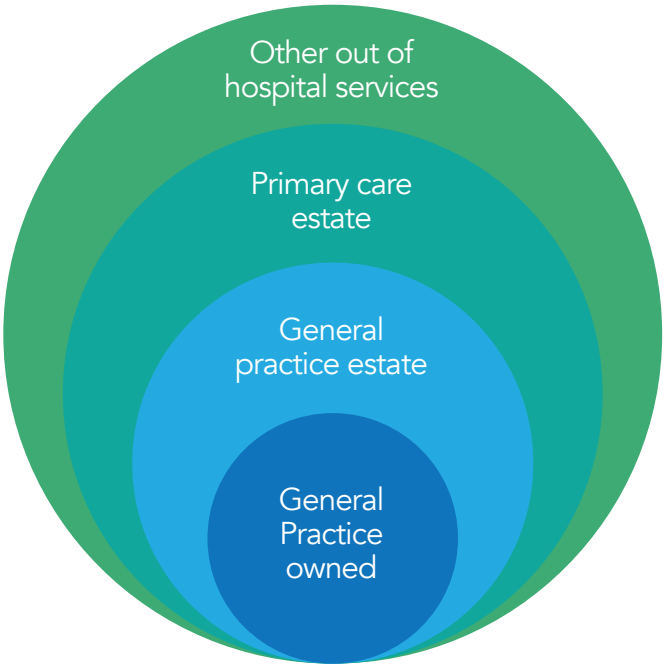


Diagram demonstrating ownership of estate out of which primary care is provided.

Estates planning and development can be compounded by these various players, often working at different levels and with competing interests. The NHS LTP acknowledge this, arguing that "if we were starting from scratch, there are…aspects of the way the NHS works that we'd now design quite differently," reinforcing the importance of integration and collaboration that was set out in the NHS Five Year Forward View (5YFV) and subsequent planning guidance.[29] It makes clear an ambition to "boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services" with primary care networks at the heart of this vision.[30]

Covid-19 has demonstrated how partners can collaborate to deliver positive change at pace, establishing innovative and novel solutions. It is therefore timely for partners to address ways in which modern health and care buildings can be delivered to support the aims of integrated care. Here we outline different levels health and care systems, describing some of the key players and their various accountabilities and the opportunities presented with regards to modernising primary care estate.

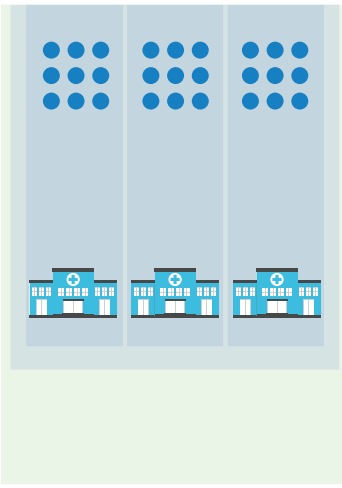
2.3 System: Integrated Care Systems

At a system level, planning for the commissioning and delivery of healthcare for populations of one million people or more will take place.

Groups of providers and commissioners are coming together as an ICS to:

- Hold system accountability
- Implement strategic change
- Take on responsibility for operational and financial performance
- Manage population health

GPs are primarily represented at this level through the clinical directors of PCNs.



Level	Pop. Size.	Purpose
Neighbourhood	**~50k**	- Strengthen primary care - Network practices - Proactive & integrated models of care
Place	**~250-500k**	- Borough/council level - Integrate primary, community, council and hospitals services
System	**1+m**	- System strategy & planning - Implement strategic plan
Region	**5-10m**	- Hold systems to account - System development - Intervention and improvement

Diagram showing the breakdown of health system levels, their corresponding population size and purposes.[31]

Structure of an Integrated Care System

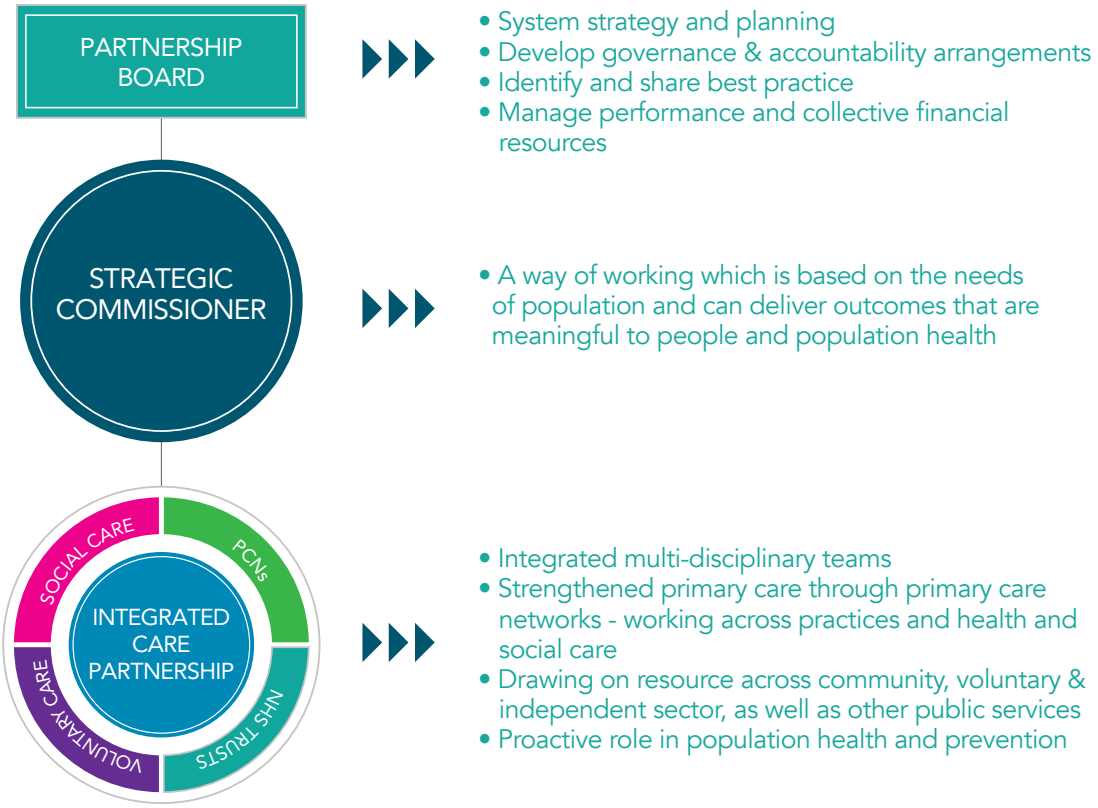


Diagram demonstrating the breakdown of roles in an ICS

The NHS LTP has made clear the requirement that ICSs are in place everywhere in England by April 2021, and NHS England has used the language 'system by default' to describe how they see care being organised and delivered in the future.

At their most basic, ICSs are a way of planning and organising the delivery of health and care services. It is unlikely that, in practice, this will mean the same thing in all health systems. ICSs across the country are in very different stages of maturity, and a variety of approaches are already being adopted.

It is acknowledged that plans developed at a system level are unlikely to be effective without stable and effective primary care. In the future, system-level capital and estates plans will become the main basis for capital planning, and NHSE/I has made clear that system-wide primary care estates plans will be expected to reflect the planned shift of activity out of hospitals and into primary and community care, to align with amended and improved clinical pathways, as well as making progress on the digital agenda.[32]

Importantly, and as reiterated at a recent NHSE/I board meeting, access to half of the Financial Recovery Fund will be linked to the financial performance of the whole system, meaning that NHS organisations are being increasingly incentivised to think "system".[33] GPs will have a key role in shaping these, particularly through the establishment of primary care networks, as described below.

Furthermore, The King's Fund has recently reported that "national bodies said that systems would have a (carefully managed) opportunity to move capital investment between NHS trust budgets and commissioner budgets for primary care business-as-usual capital investment." This has the potential to increase both the availability and flexibility of capital funding within systems.

2.4 Place: NHS trusts and commissioners

At this level, a set of health or care providers will typically serve a population of 100,000 to 500,000 people. It will normally include clusters of PCNs connected to broader services including those provided by local Councils, community hospitals or voluntary organisations.

Changing how primary care is perceived and utilised will be crucial in meeting the demand challenges of the future, with investment in and development of primary care estate a key enabler for this.

It is often argued that local commissioners and NHS providers have few levers at their disposal to bring GP-owned or leased properties into local or system estate plans.[34]

CCGs do not hold a budget for primary care capital but do have strategic planning responsibility and expertise that can be brought to bear on local estates management. An example of how this might manifest is in prioritising practice bids to NHSE in support of capital applications.

Both commissioners and NHS trusts are also exploring innovative opportunities to invest in GP premises, or even hosting them on existing hospital sites. This has several possible strategic benefits, including increased alignment and integration of GP services with the wider system as well as potentially helping to address recruitment and retention challenges within general practice.

Examples of this can be seen in:

1. **Royal Wolverhampton NHS Trust**, which has vertically integrated with nine GP Practices as of 2019. As part of the deal, the practices ceased to be independent contractors and work as part of the Trust. The GPs were subcontracted to the Trust and all staff, including partners, became salaried employees. This included the purchasing of the GP Practice premises, some of which they bought for market value. On purchasing the primary care premises, Royal Wolverhampton NHS Trust assumed the responsibility of upkeep and costs of the premises, which it incorporates into its estates plan.

2. **North Staffordshire Combined Healthcare Trust** followed in Royal Wolverhampton NHS Trust's footsteps, applying a similar model to vertically integrating four GP Practices with a tally of over 30,000 patients alongside its secondary care. North Staffordshire holds operational responsibility for the Practices but, learning from Royal Wolverhampton, allowed the GP partners to remain owners of the buildings that services were provided from. GP partners act as landlords, renting the buildings out from a limited company, leaving them with the rental income stream. This means that the partners held the responsibility and cost of building maintenance, and when the property is sold the GP partners will receive the equity.

3. **Northumbria Healthcare NHS Foundation Trust** created Northumbria Primary Care, a wholly-owned subsidiary of the foundation trust, in 2015. It is reported that this helped multiple GP practices, preventing their potential closure. GPs are named on their provider contracts, which they hold. Practices can choose the extent of the support they would like from NPC, with services including estates maintenance, quality, governance and compliance and HR being offered. NPC covers a similar number of patients to PCNs across Northumberland in various towns and villages. GPs have reported that being part of a big organisation brings benefits, such as pharmacy technicians working in practice and saving them time. It can also enable more flexible GP working patterns, with practices reporting cost-saving and high quality standards – all practices being CQC rated 'Good'.

4. **Dudley Integrated Health and Care Trust**. The first integrated care provider established in the country in April 2020 has begun to provide primary care services such as first point of contact mental health services. Dudley's model allows it to integrate with general practices, absorbing the PMS contract and create a single point of access, with the ICP running the operations and the option for practices to release practices assets, in line with some younger doctors' preference to be salaried.

2.5 Neighbourhoods: Primary Care Networks

Operating at a neighbourhood level, PCNs have been identified as one of the foundations of an ICS. It is hoped that bringing together GP practices to work at scale will improve their ability to recruit and retain staff, maintain and improve estate, address financial challenges, and improve access to and quality of care for patients. They are required to deliver a set of seven national service specifications, and in time will also play a key role in strategic planning through PCN clinical directors. Delivering the service specifications will require GPs to work in new ways, alongside multi-disciplinary teams.

It is anticipated that this will also address several of the underlying issues with primary care estate. For example, it is expected that, through PCNs, practices will increase the service offer at the neighbourhood level. This has the potential to help Practices with their existing workload and future demand.

To support this, NHS England has negotiated the new Network Contract Directed Enhanced Service (DES).[35] This revised package includes:

- An increase in funding for the core practice contract.
- A £94 million investment to address recruitment and retention challenges.
- A £173 million investment to expand the primary care workforce, including up to 20,000 additional posts in five specific different primary care roles (clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics).
- An access review which will develop the offer that PCNs will make for both physical and digital services.

There are also plans, from April 2021, to use new funding to support the co-location of mental health practitioners within practices.

PCNs are at variable states of maturity and influence throughout the country. Many clinical directors deliver essential system leadership roles and are being recognised within emergent ICS governance. PCNs have a core role to play in making the ambitions of place-based improvements a reality for health and care systems. Coordination and scale are fundamental to this aim, including opportunities to embrace more strategic and innovative approaches to primary care estate in the interest of improving care for communities.

2.6 General Practice

At a practice level, ownership arrangements vary across the country:

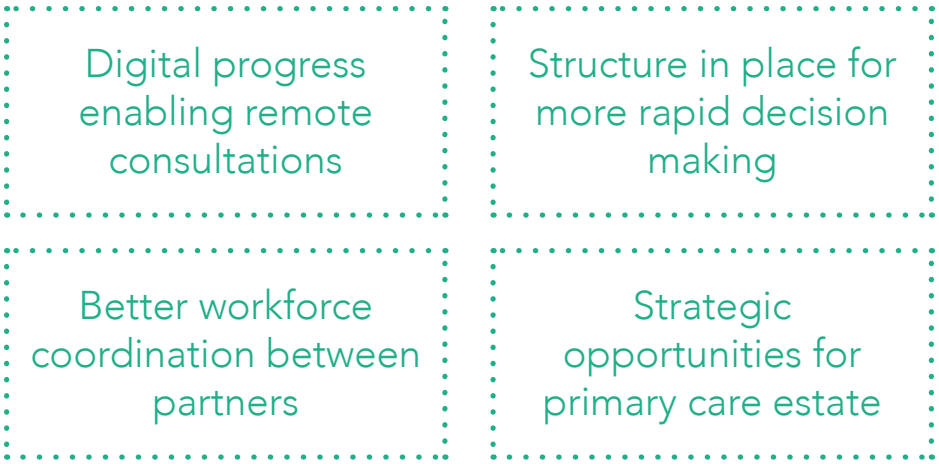
- Some of the primary care estate is owned by general practitioners.
- A minority of primary care estate is owned by local authorities or NHS trusts.
- The rest, and the majority of the primary care estate, is owned by NHS Property Services (NHSPS) or by Community Health Partnerships, or primary care estates developed under 3PD schemes and owned by the private sector.

Where GPs do own their properties, they can be reluctant to invest in maintaining and modernising them. This is typically because of the perceived risks of doing so, and also a lack of incentivisation within contracting mechanisms. For similar reasons, GPs can also be reluctant to enter into long-term leases with 3PDs, the NHS or local councils.

Indeed, research shows a declining interest on the part of GPs to enter into partnership arrangements, which are typically tied to premises ownership.[36] Particularly strong concerns persist around the risk of being the 'last partner standing', as well as around entering into lengthy lease terms, which, it is commonly assumed, will have implications for GPs upon retirement.

3. Impact of Covid-19

The delivery of primary care has seen rapid changes in response to Covid-19, as technology-enabled care has been employed to ensure patients can be seen from the confines of their homes and reduce the risk of cross-infection.



These four boxes demonstrate some of the key impacts that Covid-19 has had on primary care.

The almost immediate shift to remote consultations has been well-publicised, with NHS England reporting that "general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely."[37]

This adjustment has been remarkable. The majority of Practices now have video consultation capability and, although recent reports indicate that telephone and messaging remain the favoured methods of remote access, many see these changes as permanent.

Such changes have highlighted the question of what fit-for-purpose primary care estate will look like in the future. It is important that this is not only classified as a primary care issue, but rather is addressed through a whole-system approach by boards and governing bodies across health and care organisations.

The definition of primary care continues to be expanded through a population health approach that seeks to address root causes and improve outcomes for communities. This vision still requires high-quality primary care buildings and flexible and modern healthcare facilities that contribute to effective integrated care for communities.

The pandemic will create pressure over the longer term to reinforce primary care centres, as more NHS services are moved out of hospitals, and with the need for sites to deliver testing and, perhaps eventually, to vaccinate communities against coronavirus.

The backlog of appointments for regular health issues created by Covid-19 is also putting a strain on the system, further highlighting the need for mature and flexible primary care in delivering sustainable care.

Covid-19 has prompted innovation and change in how primary care is delivered, which in turn has highlighted strategic opportunities for the role of primary care estate in contributing to improved health and wellbeing outcomes. Issues identified by those interviewed as part of the development of this report included:

Digital progress

- Rapid adoption of remote consultations.
- Implications for GP work-life balance and continuity of care.
- Remote consultations are not evidence of full-scale digital maturity.

Structures in place for more rapid decision making

- Improved system-wide communication and coordination in response to Covid-19.
- Improved escalation routes and rapid problem solving involving primary care.
- More visible role of PCNs and involvement of clinical directors in system decisions.

Better workforce coordination between partners

- Improved identification of pressure points in primary care.
- Coordinated approach to recruitment.
- Support and improvements delivered in care home settings.

Strategic opportunities for Primary Care Estate

- Opportunities for more flexible shared facilitates delivering high-quality local care.
- Embracing the next steps in digital maturity and population health management.
- Building on coordinated approaches to achieve modernised estate.

Implications for primary care estate:

Diagram courtesy of Dr Arvind Madan

COVID-19 has demonstrated the ability of general practice to change working practices.[38] It is now clear that remote consultation is here to stay though it is yet to be determined whether it will continue at the very high rates seen during lockdown.

The response to the pandemic has also served to significantly advance the agenda for integrated care, which commissioners are likely to further embed in ICS models. A clear ambition of integrated care is to use primary care to undertake outpatient activity, as referenced in Section 2 above. Such activity can only be facilitated through the development of appropriate space in primary care, including more flexible clinical space in primary care. As highlighted in the diagram above, there is thus a tension between responding to changes in consultation (potentially less space) and the need for integrated services (potentially more space). Whilst such a balance will ultimately need to be determined by the commissioner, on a scheme by scheme basis, it underlines the need for change in primary care estate.

4. How can improved primary care estate be realised?

Many organisations have a stake in the development of primary care estate. These include NHS trusts, third-party developers, and GPs themselves.

4.1 NHS Property Services

Owned by the Department of Health, NHSPS 'manages, maintains and improves the NHS properties and facilities within [its] portfolio' on behalf of the Department of Health and Social Care.[39]

NHSPS took over the ownership of approximately 3,600 NHS facilities in April 2013, when all properties previously owned, leased or managed by either primary care trusts or strategic health authorities that were not passed on to clinical commissioning groups (CCGs) or trusts were transferred to it. The investigation into NHSPS by the National Audit Office recognised that the body is constrained in its contract management abilities and has faced a number of operational challenges in the past.

The vast majority of NHSPS sites are used for clinical, local healthcare and fall into one of three categories:

4.2 Third-party development (3PD)

A tried and tested procurement model in the primary care arena with a proven record of delivering projects of all sizes on time and on budget and providing occupiers with greater certainty and control over ongoing costs.

If primary care premises require significant new development or refurbishment, the occupants may wish to engage with a 3PD to provide the finances to facilitate construction costs. In such instances, the GP will lease the building back from the 3PD under a traditional property lease contract. This should be a 3PD with a relevant track record of working with GPs, NHS and other health providers and local authorities as these organisations can demonstrate the understanding required of NHS processes, as well as property investment and development to work collaboratively to design buildings to meet local clinical requirements and NHS standards.

GPs who rent their premises are eligible to receive reimbursement for their rental costs, a process covered by the well-established Premises Costs Directions. The level of leasehold rent that may be granted is determined by the current market rental (CMR) value of the premises, or the actual lease rent, whichever is lower. This is adjudicated by District Valuer Services (DVS), an agency of HMRC. [40]

3PDs are also increasingly proposing innovative solutions for capital development. PHP has estimated that an annual rent commitment of just £200-300 million could unlock private capital investment of £3-5 billion, enough money to build or upgrade 750 primary healthcare properties.

Importantly, risks would be minimised as the counterparties would be stable and Listed financial institutions, subject to significant regulatory and shareholder scrutiny.

Other benefits of engaging with a (specialist) 3PD include being able to utilise expertise and skill, risk transfer (in terms of pre-development expenditure delivery to time and budget), and cost efficiencies for procurement. Not only does this provide a professional platform for investment into primary care but it also provides an investor that can support the management of the estate, allowing GPs increased capacity to run their businesses.

4.3 Other options

There are also other funding routes for health facilities, such as privately sourced investment, and other public sector funding routes that have been brought out over the years, each of which has different requirements and restrictions for how they are used and developed in the future. Previous government-led initiatives such as PFI and LIFT schemes have now ceased and, at present, there is no other dedicated government programme in place to fund primary care infrastructure.

Health Infrastructure Plan (HIP) – A 2019 investment plan for the NHS including capital for 40 hospitals being developed by 2030 and improving primary care estate.[41]

Section 106 is a section of the Planning Act where conditions are placed on developers to contribute to the local authority in order to allow it to make aligned improvements connected with the development improvements, for example, local road infrastructure connecting to the new health facility.

Community Infrastructure Levy (CIL) – A condition of planning approval for health facilities introduced in 2008 to enable wider infrastructure improvements, CIL operates on the basis of a percentage contribution in proportion to the type and scale of development. The Planning Authority will then determine how those CIL monies are spent, within the statutory regime.

4.4 Navigating the financial routes to new premises

Complex mechanisms and disparately owned properties across primary care have led to LTP consequences, with estate in different positions and requiring different strategies to maintain.

It is worth noting that NHS capital is charged internally at 3.5% [42] and that, due to the technicalities of accounting regulation, NHS trusts are discouraged from taking leases as they incur capital charges on the balance sheet, and CCGs are legally prohibited to take on or hold leases of premises for third parties.

Capital investment as a means of improving the estate is effective but it is in short supply within the context of public sector financial constraints. Even if the availability of capital were to improve, delivery times are long and the extant Health Infrastructure Plans (HIPs) have a strong focus on hospitals. Section 106 and CIL schemes tend to be site-specific in nature and relatively limited in scope.

As outlined earlier, through 3PD revenue can be deployed quickly and it has the additional benefit of shifting risk to the private provider. Unlike large hospital builds, which can take many years, improvements to primary care premises in this way can be delivered at a much faster pace and larger scale. PHP experience indicates that tangible results can be quickly demonstrated all over the country, with schemes of around £5 million deliverable in two years or less. Such developments would form a major contribution to unlocking the benefits of integrated care for local communities using health and wellbeing centres outside of hospital.

5. Achieving the integration agenda

Optimal estate for NHS services to be run from not only meet the daily clinical quality and safety needs of patients, but also meet the strategic needs of the NHS, only then will it be considered 'fit for purpose'.

What is fit for purpose estate?

Fit for purpose is when a building enables and enhances the functionality to be performed within the estate.

Features of 'fit for purpose estate' in health provision:

- premises must facilitate the agreed form of healthcare service delivery.
- aesthetically pleasing and not distracting, uncluttered, accessible, comfortable.
- minimises the risk of incidents and potential litigation, supports infection control
- secure, private but not isolated.
- compliant with General Data Protection Regulation (GDPR) and patient confidentiality.

Features of 'fit for purpose estate' in primary care:

- meeting the vision of wider NHS strategy such as 5YFV and LTP. e.g. colocation.
- flexibility, for example, a building structure has a 60-year cycle, whereas internals are thought to have a roughly one 15-year life cycle before needing to be reconfigured.

Integrated primary care under one roof keeps more patients out of hospitalis

Built to a standard that will reduce the carbon emission of the NHS

Helping to facilitate a more integrated digital offer for patients

Reduces the need for government debit for new primary care centres

The very best primary care estate allows all primary care services to co-locate, becoming a one-stop-shop for communities to access health and wellbeing resources – without having to go to the hospital. This estate enables integrated services and multidisciplinary working out of the hospital, both headline commitments in the GP Forward View, 5YFV and the LTP.

Primary care organisations will need to provide more joined-up care with smooth patient pathways, shared data and strong multidisciplinary teams to achieve integration out of the hospital. This care for patients will look different to how it does now and requires the estate to enable that change.

Co-location is an important factor in achieving this new way of working, and primary care estate can be a fundamental enabler. A GP interviewed for the report, who worked in a health centre with a range of community services on-site, such as podiatrists, eye services, physiotherapists and occupational therapists, said:

"I think a building should house all the relevant primary care agencies. We can easily organise multi-disciplinary teams as we are based in the same building. It's a great place to work, surrounded by professionals who can help and support you."

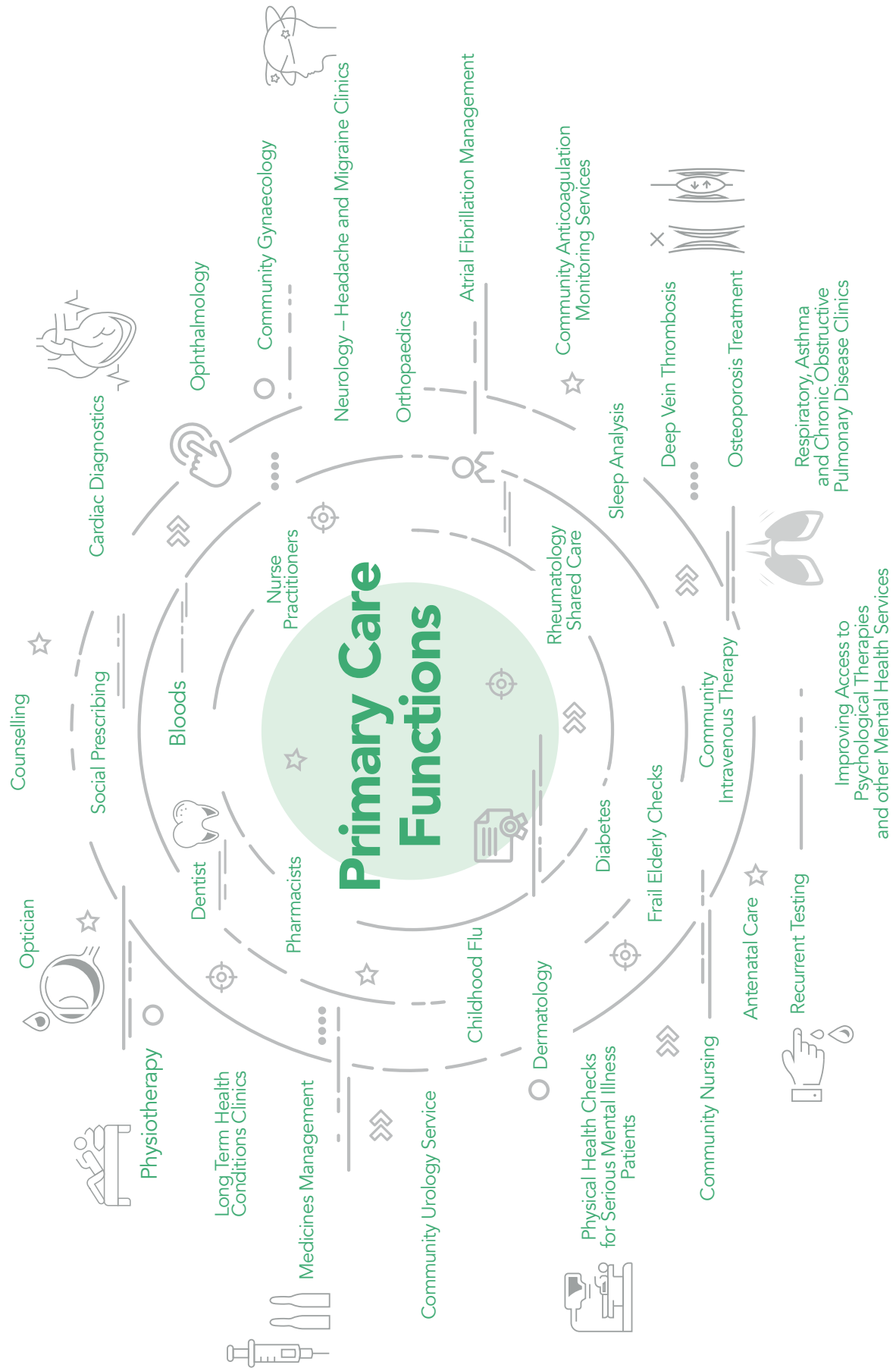
Positive aspects of the co-location of primary care services:

- Create a one-stop-shop of services for patients which is convenient and time saving.
- Supports health professionals to build relationships and work together better sharing their expertise.
- Out-of-hospital changes help the prevention agenda and match the need of the ageing and chronically ill population by enabling them to retain their independence for longer in a comfortable setting and preventing patients from entering a crisis.
- Can help local health economies better manage health care capacity.
- Cost-effective treatment in the LTP and avoiding potential future costs term (although often not cost saving in the short term).
- Can address hospital and GP flow challenges by improving triage before going to hospital or primary care.

However, there are still barriers in many areas before this can be achieved:

- Complexity in primary care estate space and flexibility that requires significant planning, investment and commitment from multiple organisations.
- Financial barriers with clashing incentives and budgets. The LTP includes an incentive for service integration and population health working approach through 'shared saving' schemes that will financially benefit PCNs.
- Requires strong leadership.
- Organisational culture has not been collaborative in the past and staff require leadership to build the necessary relationships with other services.
- Primary care and community care alliance needs to be built.

5.1 Examples of wider primary care functions that can co-locate



5.2 3PD in action - Eastbourne case study

3PD company, PHP, is developing a modern primary healthcare facility in Eastbourne, East Sussex. The new PHP property will provide modern facilities for several merged GP practices to deliver primary care services for a patient list of over 27,000. The demographics of the local population make the need for well-considered and accessible primary care particularly necessary, with an above-average elderly population.

Case for change

The GP practices all currently operate from converted houses. Whilst the premises have been converted and extended they are not capable of compliance with current NHS standards and the Equality Act 2010 and are incapable of expansion to meet the needs of their patients, to become training practices, or to take on additional Partners or even to provide some services that are considered a prerequisite for a modern GP surgery.

PHP analysis demonstrates that the previous estate at this site is typical of c. 50 per cent of the UK's current stock of GP practices; highlighting the potential for modern primary care estate to be rapidly realised for the long-term benefit of communities throughout the country.

One major challenge of the old premises is the layout of the buildings which, in order to use all available space, is impacting on functionality, putting pressure on the capability of staff to work efficiently and to continue providing quality healthcare. There are occasions where the practices had insufficient rooms to conduct all scheduled clinics; this has resulted in the cancellation and rescheduling of patients or the use of a Meeting Room/Staff Room which is unsuitable for clinical appointments.

Should patients not be able to negotiate the stairs, clinics are disrupted to allow for room swaps to accommodate the situation. This often results in extended waiting times and delays for subsequent clinics.

Assessment showed that one of the practices had the smallest sized net internal area per 1,000 patients of all surgeries in the local CCG.

Delivering fit for purpose premises

The new purpose-built premises will provide an integrated primary health setting for thirty thousand patients in a safe, well-connected and central location. The centre will accommodate a single Primary Care Network under one roof and has acted as a catalyst for change in enabling truly integrated care where patients can access a wide range of services. This not only delivers better local patient outcomes but accelerates the NHS's policy drive towards primary care providers operating at scale through PCNs.

This integrated primary care model fits within the wider strategy of the local STP towards between integration of hospital and community care. By working closely with local NHS leaders, the building is an integral part of the NHS's Local Estates Strategy, and an example of how more planned and considered estate is transforming the way care is delivered locally.

Even with the expected shift to more remote consultations in general practice, the majority of patients will still require face-to-face care, especially those with more complex and long-term chronic conditions. Multidisciplinary teams collaborating in purpose-built premises make this a reality and reduce the need for hospital care for many patients.

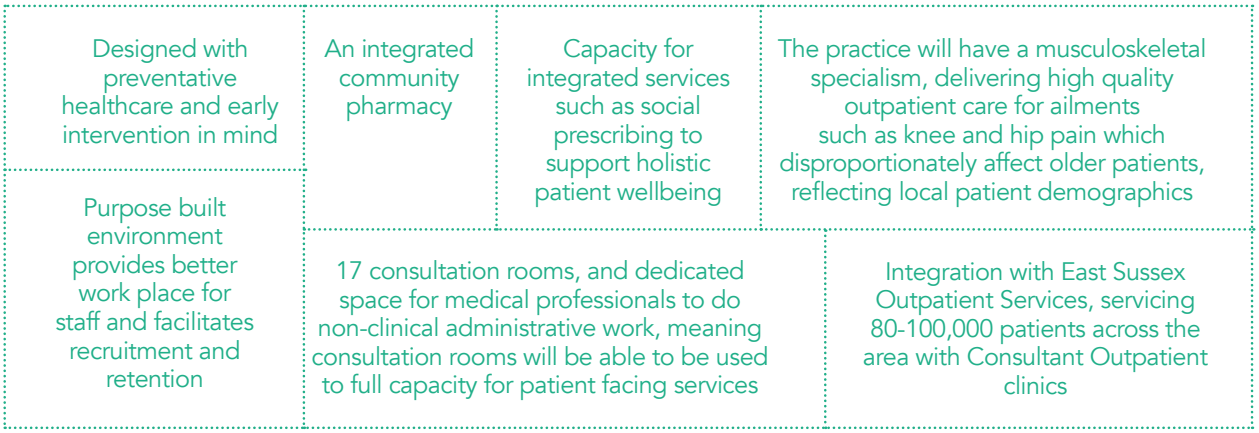


Diagram demonstrating features of modern 'fit for purpose' primary care premises

The new facility will deliver a flexible primary care centre, with open waiting areas, modern treatment rooms, regular layout, and lifts to the upper floor. The first floor has a multipurpose space which can be used for a range of services and activities including social prescribing and other direct enhanced services that CCGs wish to commission to serve population need.

The second floor has an open-plan hotdesking space for staff to work at and provide services from when they are not consulting. There are also modern purpose-built staff amenity areas that ensure a positive physical working environment, with support for staff recruitment and staff retention. The building will also be much more environmentally friendly, built to BREEAM Excellent standard, meaning it uses less energy and emits less CO2.

This illustrates how the PHP collaboration is delivering a modern flexible primary care centre, which is a major improvement for service users, staff, and the CCG.

The improvements can be seen in the below images of existing practices, and the modern design of PHP's forthcoming new buildings.

Rendered images of the new Eastbourne primary care premises

Most modern GP practices require premises of between 750 sq m and 2,000 sq m. On occasions, where a number of services are co-located it is a significant undertaking for a practice to lease larger premises. In these situations, such as the St Catherine's Health Centre in the Wirral or the Moorgate Health Centre in central Bury shown below, it may be more appropriate for an NHS body to enter into the lease.

Two further examples of 3PD in action

St Catherine's Health Centre, Wirral Community Health and Care NHS Trust

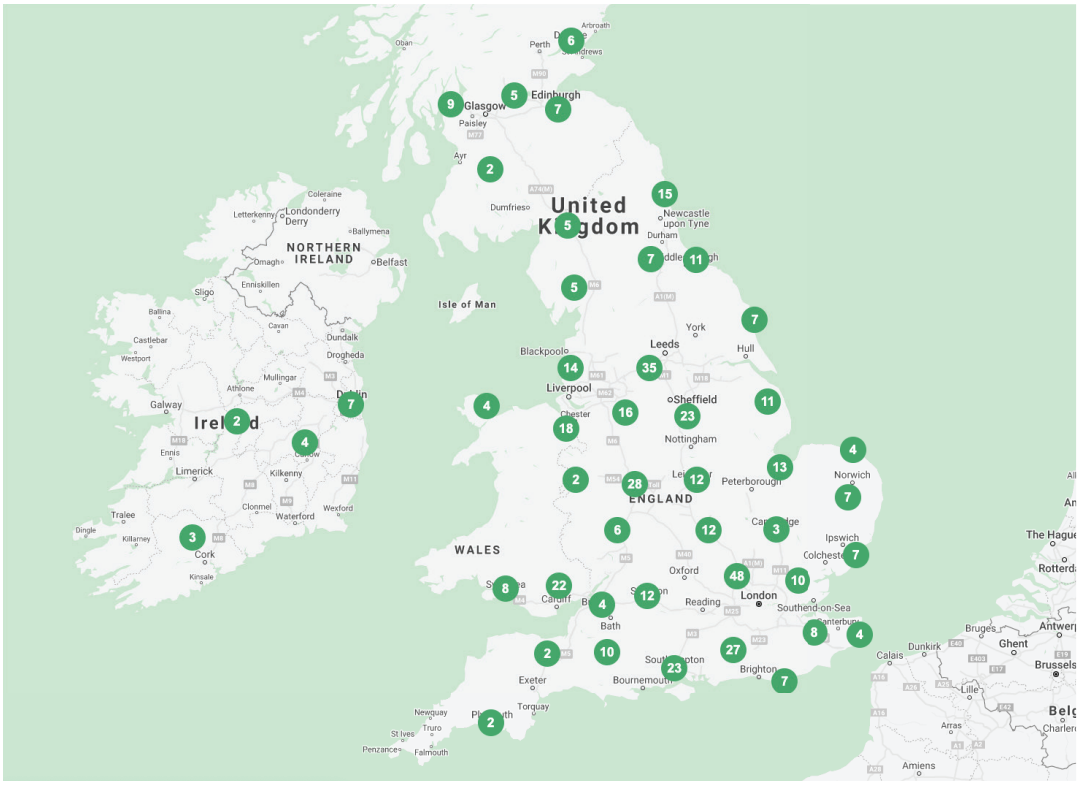
Moorgate Primary Health Centre, Bury

5.3 Integrated primary care centres – existing buildings

In the previous case study, the existing premises were converted, dated properties. However many primary care premises were purpose built in the last 20-30 years and remain fundamentally fit for purpose. 3PD owners, including the likes of PHP, have portfolios totalling over £5bn of primary care properties across the UK that, with ongoing CCG support for the practices in them, can provide ongoing suitable, stable, secure bases for the provision of primary care services to the local population.

PHP has a portfolio over c. 500 such properties in the UK, which range from [300] sq m in size to c. [8,000] sq m. These buildings are purpose built and leased, using a traditional property lease, primarily to GP's that are providing classic GMS services. They receive rent reimbursement from their CCG / the NHS, the level of which is signed off by the District Valuer, an agency of HMRC.

In recent years, these buildings have also been adapted and extended in order to provide services such as endoscopy, scanning and imaging, urgent treatment and a variety of other uses traditionally found in acute hospitals. Other occupiers also include NHS Trusts and Foundation Trusts, NHSPS and other NHS entities, as well as users such as pharmacies, physios, dentists and even some coffee shops. These buildings are located close to the populations that they serve, from Bournemouth to Blackpool, from Cobham to Grimsby.



Map of PHP portfolio
https://www.phpgroup.co.uk/portfolio

In return for additional revenue commitments from CCG's, PHP has invested over £50m in refurbishing, extending and expanding these buildings over the last few years. This includes investing in the environmental sustainability of the buildings, enhancing and providing continuity of services to the local populations they serve.

Some examples of recent projects are set out below:

Derby Road, Nottingham

Extension to provide 7 new consulting rooms increasing floor space by 20% to meet local demand. Energy efficiency improvements being made to the enlarged building.

Completion date:	March 2021
Capex:	£0.8m
Additional Rent:	£42,000 pa
New Lease:	21 years
Size:	1,016 sqm
Patients:	12,000 Number
of GPs:	7

Buckley Medical Centre, Buckley, North Wales

Void space fitted out to provide further clinical space for the GPs and additional rental income for PHP. LED light fittings utilised throughout the refurbishment

Completion date:	May 2020
Capex:	£0.1m
Additional Rent:	£5,000 pa
New Lease:	15 years
Size:	2,544 sqm
Patients:	10,500
Number of GPs:	7

Prospect Medical Group, Newcastle

Refurbishment to include a first floor extension to increase the usable floorspace and provide 3 additional consulting rooms. Work includes the installation of LED energy efficient lights.

Completion date:	October 2020
Capex:	£0.38m
Additional Rent:	£3,000 pa
New Lease:	25 years
Size:	907 sqm
Patients:	16,000
Number of GPs:	11

Stokewood Surgery, Eastleigh

Surgery extended to meet local population growth. The energy performance has been improved through investment in green initiatives.

Completion date:	April 2020
Capex:	£0.1m
Additional Rent:	£5,000 pa
New Lease:	19 years
Size:	620 sqm
Patients:	18,000
Number of GPs:	13

6. Conclusion and next steps

Flexible and modern purpose-built buildings have a significant contribution to make to the realisation of the ambitions to improve health and wellbeing outcomes for local communities. 3PD offers a viable and proven method for such premises to be delivered throughout the UK in relatively rapid timescales.

Recognising that PCNs, boards and governing bodies operate within highly complex environments, the following strategic questions are intended to promote thought and engagement. The right questions can support health and care leaders to strengthen their understanding of the primary care estate landscape, and to test the appetite for proven and innovative solutions such as 3PD.

We encourage you to reflect on these questions and discuss them with colleagues at system, place, and neighbourhood level.

System

i. Is there a clear picture of the quality of primary care estate within the system? If not, how will we gain one?

ii. Will the current estate successfully fulfil the need for our population in 5 and 10 years' time?

iii. Have we developed a system-wide primary care estates strategy (as part of the system's estates strategy) and are we prepared to commit to investment to deliver modern and flexible premises?

Place

i. Is there a clear picture of local primary care capacity and capability linked to patient need?

ii. Have we explored all opportunities to develop or repurpose existing estate to meet future primary care needs?

iii. How are we engaging with external partners with expertise to advise on primary care premises opportunities?

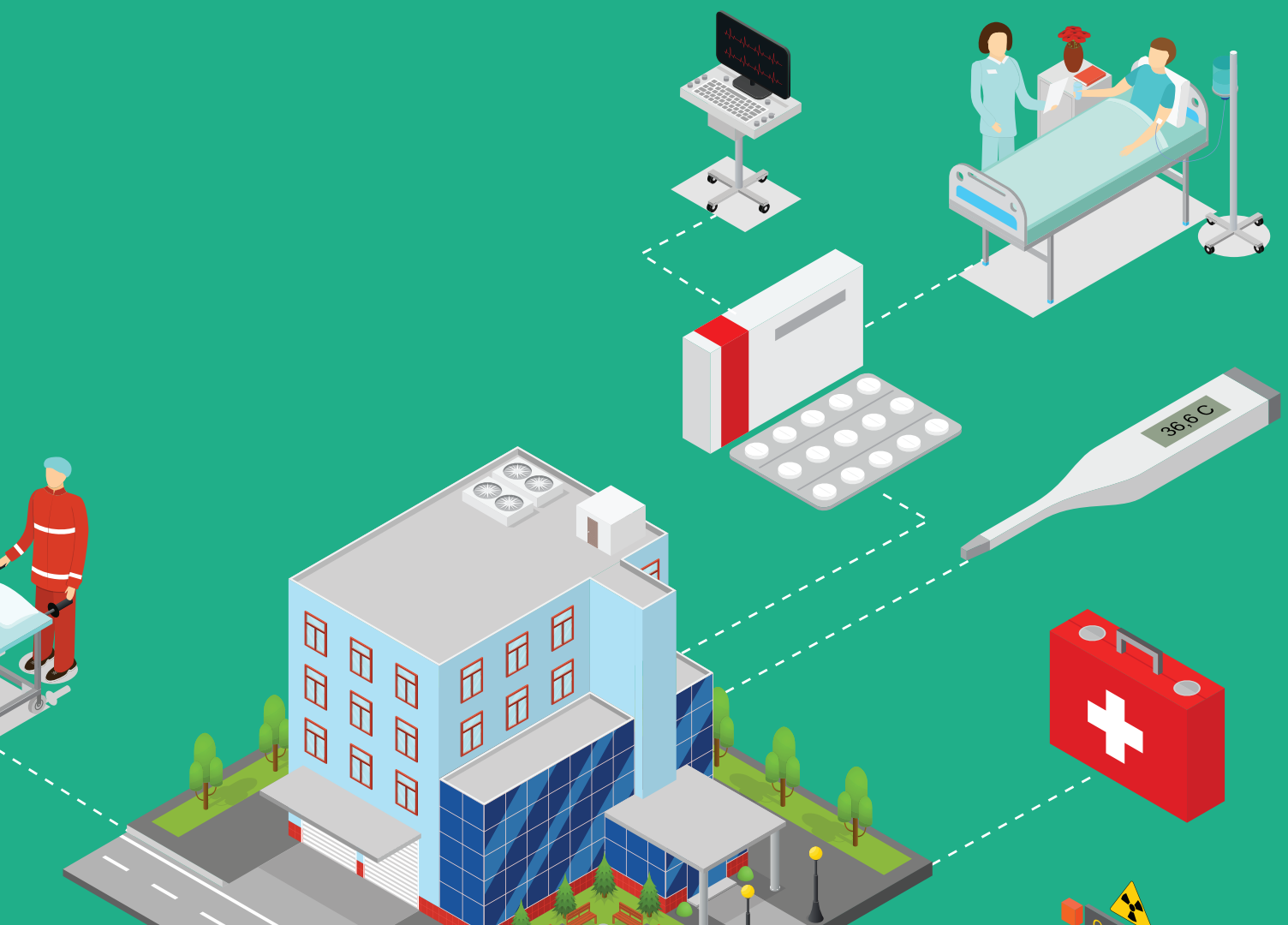
Neighbourhood

i. Have we identified areas of deprivation and inequality in outcomes which may benefit most from improved primary care provision?

ii. Are the PCN roles and responsibilities clear and understood at all levels, particularly around estates and workforce?

iii. What feedback and insight are we accessing from local communities about their experience and requirements of primary care?

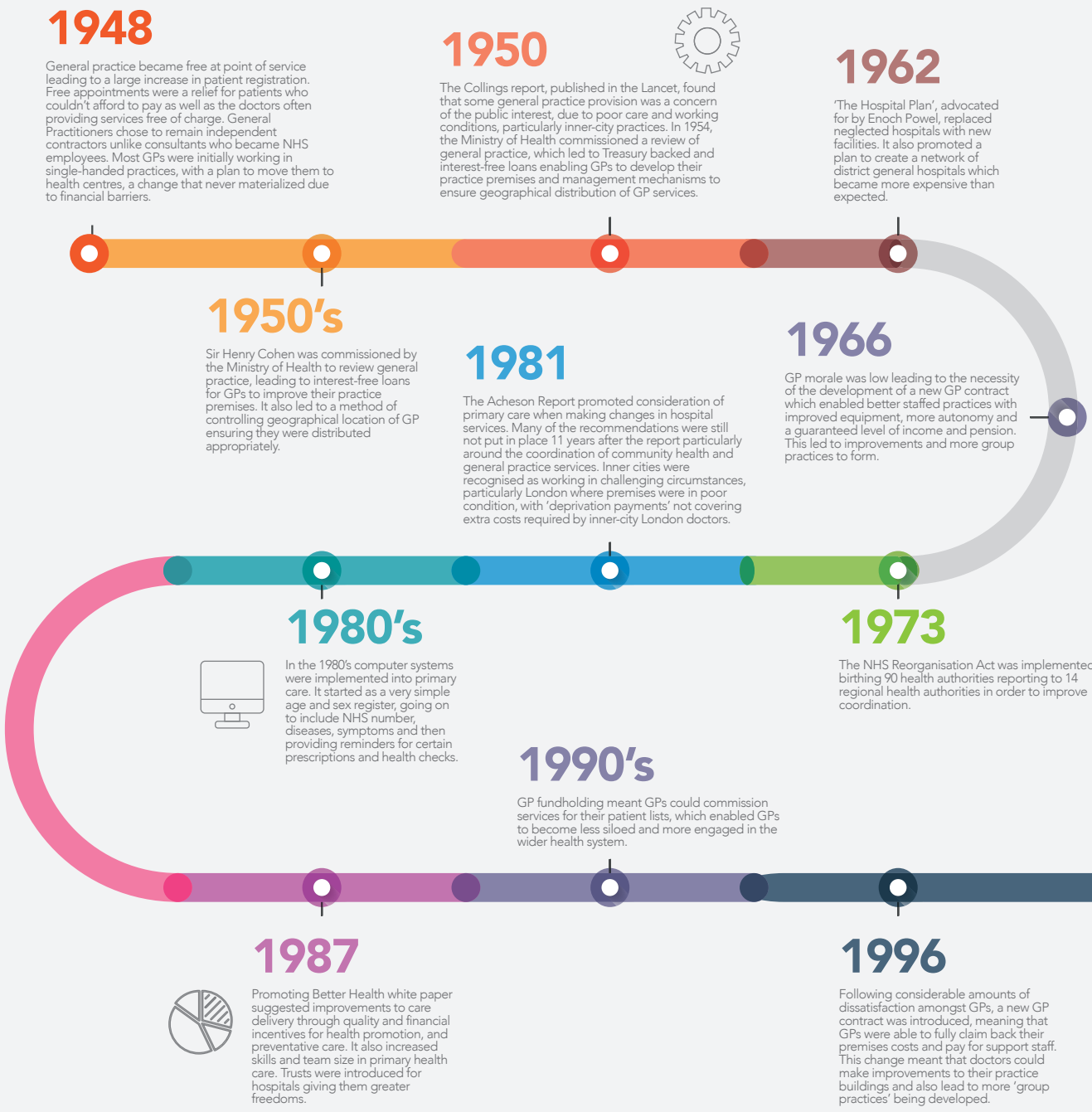
APPENDIX

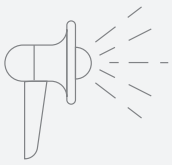


I. History of primary care and its premises

Primary care has existed since before the NHS was formed in 1948. General practice and primary care in the NHS has experienced many changes over the last 70 years. The changes demonstrate GPs' adaptability and resilience in the system as well as the trends and patterns, some of which are still familiar today. Below is a brief history of general practice and primary care.

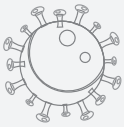
Key changes in Primary Care





2017

Naylor Review of NHS Property and Estates describing a new strategy to rebuild NHS infrastructure to inform and reform service provision according to modern and future health needs, Naylor referenced the Hospital Plan in 1962 as the only time a similar estate reform with capital injection happened, which shaped the hospitals we have today. Naylor also describes the need for incentives for providers.



2020

Impact of COVID-19 pandemic resulting in rapid adoption of remote consultations

2016

'GP Forward View (GPFV) described the direction of GPs with more network style primary care provision including GP Federations and single large organisations.

2019

PCNs are born as part of the Long-Term Plan.

2010's

A trend of less GP partners, and more salaried GPs in the workforce with more primary care professional roles becoming part of practices such as pharmacists, nurse practitioners and therapists.

2012

Clinical Commissioning Groups were established as part of the Health and Social care Act 2012, giving GPs power to contribute to larger commissioning decisions in local primary care and replacing PCTs.

Darzi report published a high-level vision and plan for healthcare estate. Darzi emphasised quality of care in London and introduced of the concept of polyclinics as community facilities which provide a wider range of primary care services, closer to home.

2000

2000 NHS Plan introduced a new programme to build 100 hospitals and private funding schemes such as Private Funding Initiative (PFI) and NHS Local Improvement Finance Trusts (LIFTs) to increase investment in primary care premises.

2004

Foundation Trusts were established with increased power to determine how they use their budget and developing services.

2002

Primary Care Trusts were launch overseeing GPs, dentists and controlling a large proportion of the NHS Budget, only to start being dismantled in 2011, which anecdotally led to a loss of specialised commissioning skill including that of estates commissioning.

2008

Patient choice was introduced in the NHS in England meaning that patients had more power to choose their preferred provider rather than the GP deciding which hospital a patient would go to.

II. Future-proofing and best practice

Future-proofing means designing buildings in a way that anticipates and accommodates the potential change of purpose or needs of those buildings in the future. The future-proofing of new or updated estates is vital to the sustainability of the UK health system. This could include putting in building foundations that can cope with more floors being added at a later date. From the current situation, we can see that any estate developments need to be able to last for a long time. This includes being adaptable to changes in population size or demographic, and transformational policy changes in health and social care provision in the UK, currently in accordance with the LTP.

It is important to approach the decision-making process for future property development with a skilled team in a considered way, engaging all appropriate stakeholders. Our 2017 paper[43] set out a framework for decision-making in estate redevelopment. Here is an adapted version of the key factors decision-makers should consider:

1. Engage possible funding partners early

a. In order to achieve the best outcome for all stakeholders including primary care providers, commissioners or financers, ICS and PCN and patient groups, as well as economic and social value.
b. Through engaging potential financer options early on, as experts, they will be able to advise on key timelines, and budgets, as well as being able to introduce providers or commissioners to trusted suppliers within the industry to limit the risk that NHS organisations take on.

2. Engage beyond key partners

a. Health and social care frameworks advise engagement with a wide selection of partners in estate decisions. This may include patient groups, public-facing organisations, third sector organisations, local enterprises, community groups, social care organisations and more. This will help provide key insight into the demographics they are part of or engage with. This engagement should be done as early as possible in the development process to ensure buy-in and also opportunity for their ideas to be incorporated. Engaging beyond key partners is now even more important considering the integration agenda and direction of the LTP, where a wider selection of primary care and community-driven services may be co-located or intentionally close by to each other.

3. Articulate STP, ICS and PCN priorities early on

a. Each STP/ICS has tailored strategies for delivering transformational changes in their locality, such as the location of services or emphasis on community provision. It is important for asset planning and development in the locality to be aligned with these strategic differences. Wider system partners such as housing associations, local authorities, emergencies services and community organisations should be engaged as part of the NHS population health approach.
b. This strategic alignment is the same for PCNs who, as part of the LTP, have a responsibility to pool their neighbourhoods' resources, feeding into their place strategy. Should there be collocation of multiple primary care or community services and organisations, it is important to review all estate available in the area, and make decisions in conjunction with other GP practices, opticians, pharmacists and physiotherapists in the area.

4. Prioritise providers with extensive healthcare experience

a. Estate is a complex environment – as is its financing. There are many providers of capital finance to the health and care sectors, however, they have varying levels of experience, some have none. NHS organisations can benefit from the specialist input into discussions about services, locations and the possible utility of current infrastructure and assets. This can help save costs and ensure a future-proofing methodology is applied and reduce potential design flaws.

5. Review the shortcomings of existing estates and challenges faced

a. Due to the changing demographic of our population with increasing numbers of people with comorbid chronic conditions and new health strategies to meet the growing need. The NHS owns a significant amount of estate in the UK, however much of it is not fit for purpose or suited to current health provision needs. Challenges within the current primary care estate demonstrate a need to review current assets and prioritise developments to bees meet the long-term needs of communities.

6. Consider the implications of all possible options

a. GGI would always recommend conducting an options appraisal to fully understand the options available before deciding redevelopment or building of estate. This should include headings such as sustainability, value and cost-effectiveness, legal arrangements with occupiers, patient and other stakeholder input.

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