NHS Confederation

Briefing

Transforming the NHS estate to enable a neighbourhood health service

This briefing explores the issues affecting the shift to neighbourhoods and what it will take to overcome them. Informed by discussions with NHS leaders, it considers the challenges of transforming estates and how to improve the process.

It will be of interest to all those involved in neighbourhood health and estates transformation, including GPs, directors of strategy, transformation and estates, and chief operating officers.

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In partnership with

assura

Key points

- To realise the vision of a neighbourhood health service set out in the government's 10 Year Health Plan, the underlying NHS estate needs to change rapidly and radically.

- While areas of good practice exist, many leaders cannot deliver transformation within their estates at the scale or speed needed due to financial and procedural obstacles.

- Local leadership is vital to ensure that neighbourhood working (including the proposed rollout of neighbourhood health centres) accurately reflects the needs of their populations.

- NHS leaders believe that the planning system does not adequately account for the needs of the NHS – neither in terms of providing funding to enable services to match population and housing growth nor to allow the NHS to transform its own estate as required.

- The current methods of estimating the NHS's needs for capital investment are inconsistent and do not cover the whole country or capture the full range of services that neighbourhood working will include.

- Actions that could help transform the NHS estate include: more clarity around leases; more capital and a simpler capital allocation process; changes to the planning system; a single means of estimating NHS capital investment requirements; and learning from services that are already moving into more community-based settings.

Background

Central to the 10 Year Health Plan is the shift to a neighbourhood health service. Moving to this model of care – which is more preventative and better equipped to manage multiple long-term conditions, particularly for those most in need – will in part require large-scale change to the buildings and facilities where patients receive care.

Nationwide, the NHS estate covers more than 27 million square metres and costs over £13 billion per year to run – with GP premises contributing a further 4 million square metres. Transforming this vast portfolio at pace to meet the needs of a neighbourhood health service will require vision and cooperation at scale, and at every level. In partnership with Assura, a specialist healthcare property investor and developer, we convened NHS leaders to discuss challenges to transforming their estates and how to improve the process.

This briefing outlines how these issues are affecting the shift to neighbourhoods across the NHS and what it will take to overcome them. It will be of interest to all those involved in neighbourhood health and estates transformation, including GPs, directors of strategy, transformation and estates, and chief operating officers. In transforming its estate, the NHS can improve the care that patients receive as part of a more sustainable health system: one rebuilt on a neighbourhood footprint.

While already struggling to renew their existing estates, our members are faced with significant obstacles. NHS organisations need the right tools to radically and rapidly reshape their facilities so that they are fit for the future.

The problems are diverse. They range from inflexible leasing arrangements in certain types of buildings and issues of

engagement with local government, to historic underinvestment in the NHS estate and the need to respond to population growth in many areas.

Now is the time for change. Not only has the 10 Year Health Plan set the direction for the NHS over the next decade, but the government is also pursuing reforms to planning law, aiming to cut through red tape and boost development. This is the ideal opportunity to introduce the changes needed to transform the NHS estate for the future.

What are the current obstacles to transforming the NHS estate?

Putting the 10 Year Health Plan into practice will require the NHS to radically reappraise its estate, with facilities needing to expand, change or be reconfigured to meet a raft of new challenges. Current obstacles include:

- the condition and inflexibility of the existing estate
- a lack of capital funding (and the sheer complexity of securing this investment)
- flaws in the planning system
- uncertainty around the rollout of neighbourhood health centres (NHCs).

Moving care out of hospitals will rely on greater clinical space within other sectors of the health system, such as primary and community services. Yet half of all GPs' premises, for example, are unfit for purpose, including many older buildings (often former residential properties) with large maintenance backlogs – unsuitable locations for additional or more specialised clinical space in the community.

The ambulance sector too is struggling with an ageing estate unsuitable for a reformed service model. The 10 Year Health Plan recognises that "ambulance trusts will play a key role in supporting neighbourhood health" through a fundamental rethink of the facilities from which they operate, which will boost their overall productivity.

Inflexibility is another complicating factor. Some buildings developed under previous public-private partnership models are underused but bound by complex leases, leading to inter-organisational disputes over matters as fundamental as shared use of rooms or corridors. This legal issue creates physical barriers and encourages tribal behaviours between local teams who should be integrating and working as one.

Those same leases often count against a system's allocated share of Capital Departmental Expenditure Limit (CDEL), impeding opportunities to invest and transform their estates. This is exacerbated by the historic lack of capital investment throughout the NHS, which has led to the current maintenance backlog and further complicates plans for large-scale transformation of the estate.

Although recent announcements of some additional capital funding are welcome, the overall amount available is only part of the picture. NHS leaders have outlined seemingly never-ending processes to access and be granted permission to spend capital funding, with delays often undermining business cases as costs spiral while awaiting sign-off from above.

Securing capital investment from outside of the NHS is also difficult. Section 106 (s.106) and Community Infrastructure Levy (CIL) payments – made by developers to support public services to cater for population growth – theoretically could cover some of the gap between limited NHS budgets and the vision of a neighbourhood health service. But with many stakeholders (including education and policing) seeking to

access a limited pot, health leaders report significant shortfalls versus projected needs. Development of health infrastructure must compete with other needs, such as transport infrastructure and social housing, for a limited source of funding.

Even where developers offer contributions in kind (such as dedicated space on a new development), size is often an issue. These can amount to small 'shop fronts' rather than the bigger footprints that larger neighbourhood hubs – which can include more complex services currently based in hospitals – may need. This stems from a lack of alignment between agreements made by developers and planning authorities with local NHS infrastructure strategies. NHS leaders also highlighted 'shell and core' agreements, which provide buildings but not the funds needed to fit them out to clinical standards.

In addition, developers are often able to escape the requirement to fund or provide health infrastructure altogether. Viability requirements allow many developers to receive planning permission even without offering sufficient s.106/CIL payments, on the grounds that this would prevent them from making a large enough profit. Indeed, some providers – such as ambulance trusts – have reported almost never being able to secure s.106/CIL monies at all.

Equally, with no nationally accepted model for calculating the health sector's need for capital investment within the planning process, councils can contest or reject outright bids made by the NHS. Existing frameworks – such as the Rapid Health Impact Assessment tool – rely on London-based valuations and costs based on traditional GP surgery spaces. Not only does this limit the model's acceptance outside of the capital, it also may need reform to encapsulate the demands that neighbourhood working could place upon the NHS estate.

In addition, councils' capacity both to engage with the NHS and approve planning applications swiftly have shrunk since 2010 due to falling budgets. NHS leaders have reported how this has impeded partnership working with local authorities for a lack of specialist staff or funding.

How can the NHS estate fulfil its role in achieving neighbourhood working?

Faced with the need to transform at speed given financial and operational pressures, NHS leaders are already innovating and demonstrating ways forward within the confines of the current system. For example, Romford's St George's Neighbourhood Health Centre has shown how flexible leasing arrangements can enable different providers to work together under one roof and thereby better join up patients' care. Using a 'head lease' model minimises the cost of redundant space, while also avoiding the complexity of a multi-organisation partnership which would require negotiating with a landlord and between providers at the same time.

The move to neighbourhood working also offers the chance to maximise the role the NHS can play as an anchor tenant within economic regeneration. One NHS leader reported how repurposing a vacant floor in a local shopping centre had allowed them to leave their previous, unfit premises, ultimately supporting local regeneration plans and improving patient access and satisfaction. With the landlord funding the fit-out and the tenant paying a stable, reliable rent, this allows the NHS to play a central role in place-making on a neighbourhood level through health on the high street.

Improved relationships with local authorities could also empower the transformation of the NHS estate for neighbourhood working. Co-locating with financially constrained councils can both offer savings through a shared public sector estate and improve cooperation with local government's public health duties.

Aligning integrated care board and council infrastructure plans – including aligning resourcing schedules for health with periodic local plan reviews – can also ensure engagement with the planning process at the earliest possible opportunity. This can help to ensure that the right scale of facilities is available to the NHS while also increasing public support for development, as per polling carried out by Assura earlier this year.

A reformed planning process is also a key lever for reshaping the NHS estate. A universally accepted methodology for calculating the NHS's requirements for s.106 and CIL purposes could make the amounts available more reliable – as already exists for education. Including ambulance facilities (alongside their fellow emergency services) within the scope of developers' contributions would also render the process more equitable.

Lastly, neighbourhood health centres (while requiring significant investment) have a wealth of good practice upon which they can draw. NHS leaders across the country have shared examples of bringing services together to co-locate care outside of hospitals – even where existing facilities have been adapted rather than new space built afresh. By learning from these success stories – alongside the support of a dedicated investment stream – the promised NHC programme can revolutionise the NHS estate and how patients receive care.

Conclusion and recommendations

The 10 Year Health Plan has set out the vision for the future of the NHS. Transforming the estate is essential to achieving its goal of a neighbourhood health service, with outpatient hospital care becoming the exception rather than the rule.

NHS leaders across the country are already pioneering the way forward. Their insight and experience, along with that of our partner Assura, has informed the following recommendations:

- A **simpler process for accessing capital funding** from both the public and private sectors, designed specifically to achieve the new model of care set out in the 10 Year Health Plan and **without the current restrictions of CDEL at a system level** impeding local leaders.

- **Expansion of the 'head lease' model** to enable organisations to share facilities and eliminate void space more easily as part of systems' role as strategic commissioners.

- One **nationwide formula to calculate NHS capital requirements** which can accommodate local land values and the costs of different types of clinical space. This should be **endorsed by the Ministry of Housing, Communities and Local Government (MHCLG)** and **integrated as standard within the s.106/CIL process** for planning applications.

- Changes to the **Planning Act 2008** and the **Town and Country Planning Act 1990** to include "facilities and equipment for emergency and rescue services" (including ambulance trusts) within the remit of s.106/CIL developer contributions.

- **Incorporation of current examples of good practice** into the developing neighbourhood health centre programme, which should also offer a **descriptive, rather than a prescriptive**, blueprint. Decisions about **which services to include, where to locate the NHC, and how to leverage the investment required** are best made by local leaders rather than centrally.

Some of the above recommendations will require legislative change. However, most can be progressed as part of the 10 Year Health Plan's implementation. Combined with these systemic changes, access to greater capital funding for the NHS – including via existing and new models for private sector investment – would enhance its ability to transform its estate to meet the demands of neighbourhood working.

To shift to neighbourhood working, the NHS estate needs to transform at pace. The facilities and buildings within which staff care for patients are an essential factor in improving both the quality of care and the outcomes for local communities. The scale of the change necessary is significant – but the potential benefits are even greater.

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NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales, and Northern Ireland.

The members we represent employ 1.5 million staff, care for more than one million patients a day and control £150bn of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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Assura

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