NHS Confederation

Accelerating estate solutions for neighbourhood health centre delivery

In partnership with

Community Health Partnerships

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Victoria MacConnachie
George Johnston

About us

NHS Confederation

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

For more information visit www.nhsconfed.org

Community Health Partnerships

Community Health Partnerships is a DHSC owned NHS company working in partnership with local health and care systems to provide innovative and sustainable spaces for patient care. We support neighbourhood health services through partnership working and better use of the NHS LIFT estate.

The NHS Local Improvement Finance Trust (LIFT) programme is a model of public private partnership focused on improving community-based health outcomes. These facilities provide high quality spaces for health and social care services delivered in local communities, especially in areas of high need.

Through joint ventures and working on behalf of the NHS we manage a portfolio of over 300 properties. We manage the buildings on behalf of the NHS through our property and operational team. We lease space to over 1300 health and care providers who support tens of millions of patients and service users.

For more information visit www.communityhealthpartnerships.co.uk

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Contents

Key points

- The government's NHS 10 Year Health Plan sets out an ambitious vision to deliver neighbourhood health, enabled by neighbourhood health centres (NHCs).

- The government has set out that estates and infrastructure strategy and management should be delegated from integrated care boards, with NHS England regions and local providers to have a stronger role to play in estates planning, but several conditions need to be in place to make this happen.

- Void space remains a major financial and operational challenge. More directive commissioning, shared budgets, and using void space for neighbourhood services can reduce waste and improve access.

- Co-location can support integration, but without a robust culture of collaboration, and reduction in complex cross charging, it only delivers proximity, rather than also being a joined-up experience for staff or patients.

- Exploring different funding and ownership models allows healthcare providers and local partners to pool resources and tap into local planning funds.

- Health-led regeneration presents opportunities for healthcare access and economic benefits to local authorities but requires partnership working and streamlined access to planning processes and development funds.

- To support local delivery of NHCs, the Department of Health and Social Care (DHSC) should:

    — allow systems to best plan and fund strategic estate to remove barriers caused by fragmented ownership and complex cross-charging

  - streamline the notional rent reimbursement process in the General Medical Services (GMS) Contract in order to support general practice to co-locate with other providers and partners beyond health

  - allow systems to retain and reinvest funds into NHC development from releasing unused estate

  - continue to remove restrictions on recycling capital from NHS asset disposals and eliminate double counting of NHS funds that currently trigger Capital Departmental Expenditure Limit penalties

  - give areas demonstrating strong partnership working the flexibility to move funding between providers to support NHC development

  - enable cross-departmental coordination, for example DHSC and the Ministry of Housing, Communities and Local Government MHCLG to link NHC funding with other national programmes such as the New Hospital Programme and community diagnostic centres.

- Optimising existing space will accelerate the delivery of many NHCs but in the long term, some will be new builds, delivered under a variety of models explored in this guidance, including leveraging primary care autonomy and a new public-private partnership model.

Background

The government's 10 Year Health Plan (10YHP) reaffirms its commitment to delivering care closer to communities through neighbourhood health centres (NHCs). Modern, multipurpose facilities designed to integrate health and social care services. These centres aim to improve access, reduce health inequalities, and support productivity across the NHS. However, achieving this vision requires overcoming significant challenges that have persisted for over a decade.

The NHS estate is a critical enabler of service transformation, yet it is ageing and fragmented.[1] Today, the maintenance backlog has risen to almost £16 billion, and around 22 per cent of general practice estate predates the founding of the NHS.[2] These issues have constrained efforts to shift care from hospitals into community settings and improve quality of care. In addition, systemic barriers such as contracting and commissioning constraints, misaligned funding flows, and cultural challenges have slowed progress. Current models often fail to incentivise relocation or co-location of services, and fragmented ownership and complex cross-charging discourage optimal use of space.

Delivering the government's neighbourhood health commitments will require bold decisions, innovative solutions and prioritisation of investment at a time when the NHS faces unprecedented financial challenges and pressure to increase productivity. While some interventions will depend on national policy changes, local leaders can also drive improvements. The NHS Confederation, in collaboration with Community Health Partnerships (CHP), has engaged members across the health system to identify barriers, share examples of innovation and highlight scalable solutions that can accelerate NHC delivery.

Accelerating the delivery of NHCs will bring significant benefits to patients and the wider health system. It will make care easier to access, especially for people living in deprived areas where services are often limited. By moving more care into local communities, we can reduce the strain on hospitals and

free up capacity for urgent and specialist treatment. Better use of existing NHS buildings will improve efficiency and help the system get more value from its estate.

This report draws on insights from a national roundtable, engagement across NHS Confederation members, and case studies showcasing successful approaches to estate optimisation, collaborative commissioning and cultural integration. It highlights the need for strategic alignment between service redesign and estate planning, supported by flexible funding models and strong local partnerships.

Insight

By treating estate as a strategic enabler rather than an afterthought, and by embedding neighbourhood health principles into commissioning and investment decisions, the NHS can accelerate delivery of NHCs and realise the benefits of integrated, community-based care.

Introducing the Neighbourhood Rebuild programme

Of the 250 promised NHCs, the government has committed to delivering 120 by 2030. This commitment is best delivered by optimising existing NHS estate, before building new sites. Immediate plans have prioritised existing NHS Local Improvement Finance Trust (LIFT) assets which can be adapted at speed, while the National Infrastructure and Service Transformation Authority, supported by the DHSC, explores funding models for new builds, including a new public-private partnership (PPP) model.

NHCs developed as part of the rebuild plan, will initially focus on improving access to primary care services such as general practice and dentistry. The most deprived areas of the country will be prioritised for these centres, as residents are more likely to experience complex needs and poor outcomes. Priority cohorts will be those with long-term conditions, but as the programme expands, new cohorts will be added and services adjusted accordingly.

Making the most of existing estates

Delivering NHCs quickly and affordably means optimising existing NHS estate, repurposing unused rooms and adapting high-quality assets before commissioning new builds. This is the simplest way to accelerate delivery within current financial constraints.

However, in a complex, multi-stakeholder environment with competing demands for limited capital there are barriers that have historically limited the optimal use of existing high-quality estate. Below, we explore ways these might be overcome, sharing experiences and insight from across the NHS.

Contracting and commissioning

Members identified local changes in contracting and commissioning processes as a key enabler of estates optimisation. Current practices do not incentivise providers to move into new spaces or to assess potential relocation as part of the tender process. This presents a significant barrier to the government's key shift from hospital to community, and results in higher void costs.

Changing commissioning approaches and collaborating with providers has the potential to better enable the effective use of NHS estate, including delivering care closer to patients, co-locating teams which support the same patients, and reducing void costs.

A collaborative approach

Ensuring that NHCs are delivered in the most appropriate locations will rely on a shared decision-making process that engages secondary, community, and

primary care providers, in addition to local organisations beyond the health sector. As the role of NHS England regions and integrated care boards (ICBs) changes, the role of estate leads should be defined by local commissioners and providers to make best use of local expertise and resource. ICBs are ideally placed to convene partners, match services to suitable spaces, and enable innovative solutions with clear roles and shared decision-making. However, cuts to ICB teams and uncertainty regarding the responsibilities which will be included in the final Model ICB blueprint[3] undermines the capacity and efficacy of ICBs in this field. There is a risk that moving estate planning to the regional level could disempower local leaders and promote a 'one-size-fits-all' model for change. Conversely, promoting local collaboration, at a scale determined by system-level partners, would ensure effective alignment of priorities in collaborating communities.

By defining the shared principles and allocating specific organisation responsibilities, systems can determine the simplest and most effective model for their provider and patient needs. In this model, estate leads should be empowered to manage shared estate budgets in line with system and local priorities.

As ICBs delegate more responsibilities, providers are expected to take on a greater planning and commissioning role. The 10YHP names multi-neighbourhood providers (MNPs) as 'responsible for unlocking the advantages and efficiencies possible from greater scale [including] estate strategy, and by providing data analytics and a quality improvement function.'[4] However, the role of the MNP will not become fully realised until the contract is released.

Using data and tools to optimise estate usage

Estate leads need a single view of the entire available estate including locations, conditions, contractual terms, bookable spaces, and how this aligns with population needs and access. As capacity in ICB estate teams is reduced, expanding the use of digital tools would support providers and nominated estates leads to prioritise location in decision-making. Capacity to gather and assess this information should be preserved at system level to support informed and effective commissioning.

STRATA* is an online, interactive, data-mapping, analysis and insight tool that supports service planning and estates strategy development. It brings together data from over 40 trusted sources and can be accessed for free by public sector organisations.

Room booking tools, such as NHS Open Space, encourage flexible use of space, driving up use across a range of NHS buildings. These tools are already available nationally and can be included in upcoming commissioning decisions, as contracts come up for tender and review. For example:

One system shared their experience of including a **portfolio register** in a tender pack for community services, detailing buildings available for service delivery. They worked with NHS Property Services (NHSPS) to assess estate condition, lease flexibility, and indicative costings as well as including indicative costings to facilitate realistic bids from community providers. The purpose of the portfolio register was to ensure that bids were for services to be delivered in the most appropriate estates, and that potential providers could realistically plan for the costs and level of flexibility they were likely to experience.

This process could be replicated in other systems as a permanent part of the commissioning process to ensure that suitable services are commissioned into void space, or community and neighbourhood estates.

Alternative tools include Community Health Partnerships' (CHP) **Productivity Acceleration in Community Estates (PACE) Programme** which provides a framework to support systems to assess their current estate usage and identify opportunities for improvement. By adopting a data-led approach, and supported by CHP's estate productivity leads, ICBs can evaluate, adapt, and optimise use of the LIFT estate, ensuring fully informed commissioning decisions. The programme prioritises the delivery of opportunities to enhance productivity across the LIFT estate and support delivery of neighbourhood health. Opportunities to drive productive use of the LIFT buildings flows into CHP's strategic capital pipeline process where funding is available to adapt and repurpose space.

*Previously known as SHAPE Atlas

Learning from community diagnostic centres (CDCs)

The national CDC programme shows how rapid repurposing of community-based estate can deliver diagnostics at scale and shift activity from hospitals. As of March 2025, 169 centres are in place across the country, hosting a range of diagnostic services in community settings, such as health centres and shopping centres.[5] Many CDCs are embedded in high-quality LIFT estates with minimal maintenance backlogs and appropriate patient facilities, including waiting rooms.

Insight

Ensuring that spaces within existing centres are managed flexibly and are bookable could help deliver NHCs at pace and at lower cost. Where space within centres is not available to host services, digital integration could be used to join up service pathways as part of neighbourhood working.

Case study: **CHP's community diagnostic centres**

As part of the national CDC programme, CHP has repurposed space across the LIFT estate, which has enabled over 600,000 additional diagnostic tests and supported the shift of services from pressurised acute hospitals. Staff and patient experiences are consistently positive.

Site selection and strategic alignment were key challenges creating misalignment in the ambition – to bring diagnostics services closer to people's home – and reality, where CDCs were being co-located on existing hospital sites. Financial and logistical needs of fast programme delivery were resulting in NHS trusts and foundation trusts locating CDCs on their own estate where they had operational control and financial leverage to

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expedite project delivery on familiar ground. This pragmatic approach, while efficient, undermined the core goal of improving access for underserved communities and relieving the pressure on acute sites.

To overcome this issue, early engagement and open communication with national, regional and local teams was essential. Information and data sharing was crucial to support informed decisions. CHP's portfolio information packs identified opportunities with existing community-based estate, the investment needed to adapt and repurpose space, and CHP's ability to deliver CDC capital projects efficiently and cost effectively.

This resulted in collaborative and informed local determination – ICBs agreeing the best place to locate new CDC services and ensuring the strategic intent of the programme was delivered. CHP was also able to influence nationally to secure around £55 million in national funding to deliver ten CDCs in communities across England; around £17 million was spent on building alterations and the remainder on medical equipment. In addition, making best use of existing assets reduced around 1,000m2 of void space creating value for the NHS, further supporting the financial and productivity challenge.

Targeting void space

Estates assessment and a shift in commissioning approach would also help systems reduce the problems presented by void space. Void space in the NHS is empty or underused space within a building owned or leased by providers delivering NHS services. This space can be a mixture of clinical, administrative, or storage space, and currently costs the NHS almost £90 million each year.[6] Reducing void space has been a persistent challenge due to fragmented ownership, entrenched occupancy, and weak incentives to relocate.

While national levers are needed, estate leads can overcome these issues by supporting a more directive approach to commissioning into void space, and exploring options for pooling funds along care pathways, or at system level to support system assets.

Insight

Data and online planning tools, such as STRATA (see page 11) would provide the required information on the location and type of void space available. Commissioners could then prioritise these locations when contracting services, ultimately reducing the drain on estates budgets. Moreover, collaborating with local authorities and the voluntary sector to concentrate services into fewer estates would incentivise co-location through shared savings.

Case study: **St Peter's Health Centre, Burnley**

Financial constraints at NHS Lancashire and South Cumbria ICB necessitated a strategic focus on doing more with the existing estate and reducing costly void space. The ICB brought together partners including CHP, hospital and community trusts, and general practice.

In response to practices struggling to host staff on the Additional Roles Reimbursement Scheme (ARRS), and an expiring lease in one surgery, the ICB has taken the opportunity to begin implementing the findings of the PCN service and estates planning by proposing a health hub at St Peter's Health Centre, Burnley, utilising void space across the building. The proposal brings together three GP practices within the same PCN, to provide a range of integrated services to over 54,500 patients of the Burnley East PCN.

Enabled by the LIFT PPP, CHP is investing £3.2 million capital to enable the development of the health hub through the repurposing of space at St Peter's. This will facilitate the integration of a range of primary care, hospital and community services while reducing pressure on services at Burnley General and Royal Blackburn Teaching Hospitals.

For Lancashire and South Cumbria ICB, optimisation of best accommodation prevents financial losses from underused or unused space and improves value from space the ICB is already paying for. At St Peter's 1,047m² of space will be optimised and void space reduced by 385m². In addition, bringing

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together and integrating services in a health hub enables the release of estate elsewhere in the system, generating potential savings. Patients will benefit from more services in a single, modern health facility.

Designing and delivering a new approach to commissioning and estate strategy is a key lever to deliver savings and progress towards neighbourhood health centres. However, there is a risk that uncertainty around the roles and capacities of ICBs, regions and providers, that this is deprioritised. To support systems to take action, we've summarised the recommendations from members that have already implemented a new, collaborative approach.

Estate and space planning as part of the commissioning process

To include estate and space planning in the commissioning process, NHS and local partners should:

liaise to set up a **portfolio of available estate**

give **detailed information**, including:

- total size of estates
- size of individual spaces
- features to help determine what the space is suitable for
- local infrastructure to inform the patient journey

give **realistic costings**, including:

- leasing arrangements
- flexibility of tenure
- expected running costs

When commissioning community services, commissioners should:

take into account the **local infrastructure** and what **neighbourhood health facilities** are already available

involve local providers in the planning process to ensure estate and space plans are:

- autonomous
- centred on patient needs
- maintain the ability to adapt to future changes

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Sharing spaces

Co-locating with local partners and supporting community regeneration

The 10YHP encourages moving services into community settings co-located with services that can support addressing the wider determinants of health:

> 'NHCs will not only bring historically hospital-based services such as diagnostics, post-operative care and rehabilitation into the community, but they will also offer services like debt advice, employment support and smoking cessation or weight management services.[...] Co-location will not only help ensure convenient access to services, particularly for those with complex needs, but will support more integrated working by professionals.'[7]

The shift to preventative, community-based care naturally positions local authorities and voluntary sector organisations as ideal partners. Including health services in the wider public estate, presents the opportunity to deliver NHCs beyond the confines of NHS buildings.

Insight

As an anchor institution, the NHS can bring benefits to local partners, such as supporting local growth and maintaining population health. Aligning priorities with local partners, through programmes such as Health on the High Street, has shown that embedding health services in council-owned buildings can increase footfall and benefit neighbouring commercial enterprises. Council-owned community venues also offer excellent opportunities to locate health services with council and voluntary sector services that are already being accessed by the same local population. Adding healthcare into these locations allows patients to access support for multiple needs in one visit and facilitates integrated working between services.

Case study: **Finchley and Wood Green**

In 2021, two CDCs, Finchley and Wood Green, began plans for a new hub-and-spoke approach using void estate space creatively to avoid additional costs. The aim was to address diagnostic backlogs, especially in areas like Haringey with no district general hospital and high COVID-19 impact.

Finchley opened as the hub site in August 2021, and services are predominantly delivered by the Royal Free London NHS Foundation Trust which hosts the CDC.

Wood Green was opened as a spoke site in a local shopping centre in 2022 and now delivers 15 diagnostic pathways including respiratory, oncology, cardiology, and novel services like walk-in X-ray to CT for lung cancer detection. An integrated IT system connects both sites to allow results and bookings to be accessed by staff. Space within the CDC has also been repurposed, to suit the changing needs. For example, converting less frequently used X-ray rooms to be suitable for delivering fibroscans. Efforts to bring GP services into the site were delayed by complex rent reimbursement requirements for GMS services, but this has since been resolved.

Since the project was launched, over 770,000 tests have been delivered across both sites, and access has improved for residents of Haringey who had to travel further for diagnostics than other residents in the place footprint. In addition, action on health inequalities because of deprivation has progressed with around 70 per cent of referrals into Wood Green coming from the most deprived areas in Haringey and Enfield. Dedicated engagement teams have worked with GPs to improve referral pathways and reduce DNAs, while community engagement and leaflet distribution has built public trust in the new site.

The shopping centre which hosts the new CDC has also seen benefits. For the six months after the CDC opened, the shopping centre saw a 9.9 per cent increase in visitors, and a sustained uplift of 6.9 per cent into 2024. The initial boost supported a strong post-COVID-19 recovery for the centre,

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and footfall has remained higher than comparable sites, suggesting that the CDC drives steady traffic. Neighbouring retail services have found that appointments bring visitors in earlier and drive activity in cafes and promote longer visiting times in the centre.

The role of culture in effective co-location

While it has many benefits, co-location is not the silver bullet for integration. Relocating teams without considering the culture risks embedding siloed working. By building connections through integrated pathways which support face-to-face collaboration, true integration can be achieved, rather than simply proximity.

When teams are relocated, into new or existing estates, planning must involve leaders from every team that will be working out of that building. By modelling collaboration from the top down, local leaders can embed the culture for wider workforce integration. Moreover, it is vital that teams feel ownership of a space and the service they provide. Engaging leaders from each service gives each team a voice in decision-making and reduces the likelihood of territorialism. No two locations will host the same services and patients, so it is essential that decisions are made locally by the teams who will be based together.

In any partnership estates solution, collaboration requires effective governance and defined responsibilities. Where spaces are bookable or open to new providers moving in, it is important that there is a convening function and lead contact for the space. This would include responsibility for managing booking access or promoting space availability and liaising with existing partners in that building to streamline bookings and relocations. Members were supportive of this coordinating role being held by NHS organisations or local partners from the voluntary sector or local authorities. They stressed, however, that this role would need to be supported by a simple to access funding stream, when needed, and which did not increase service charges.

Integration and co-location have become buzzwords for NHCs, but guidance has yet to establish a framework for successfully delivering this new level of collaboration within a shared space. Following engagement with members across the country, we have collected the critical success factors for successful co-location.

Effectively **integrating estates and spaces**

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Providers should engage local communities and staff in planning neighbourhood health centres. Understanding their needs and barriers is essential for designing effective, accessible services.

Designing a layout that supports integrated care pathways should include:

- a **shared reception area** - this creates a shared hub for staff, and a single point of contact for patients using any of the services within the building
- a **layout that simplifies a patient's journey** between services and makes it **easier for staff to reach out to colleagues** in other teams.

Shared staff spaces are important for:

- **collaborative working between providers** and allowing them to **work across the interface** more effectively
- **reducing the risk of teams working in isolation**
- **supporting staff to develop relationships**, which enhance the feeling of working as one integrated neighbourhood team
- **wellbeing** - this should not be overlooked.

Joint IT infrastructure:

- where possible, a **single Wi-Fi network** should shared by all teams in the space
- **interoperable IT systems**, including bookings, check in and referrals. This would integrate the back-office functions and make it easier for shared operational staff to support multiple services.

Embedding effective communication between teams:

Staff should be supported to **move between shared working spaces** and to **collaborate face to face** with their colleagues on other teams. This can include asking for advice or information about a patient accessing both services and join up each point of contact in a patient's care.

Funding estate improvements

Making existing buildings that have fallen into disrepair suitable for neighbourhood health may require major capital investment. With pressure on capital budgets, many providers cannot fund these projects alone. We heard from members across the country who have found innovative solutions that overcome the challenges presented by financial constraints and unhelpful funding flows and allow them to deliver estate improvements.

- Local estates leads can help by bringing partners together and creating **collaborative agreements to share costs and responsibilities**.

- Refurbishment can take up a large part of a system's capital budget, so this **investment can be protected by agreeing multi-year contracts** with partners. This ensures services stay in the building and rental income flows back into the system.

- **Sharing space** with other organisations also **reduces costs** for each provider and creates **opportunities for integrated services**.

However, co-location brings challenges. Many providers lease space that does not allow flexibility for adding new services or redesigning rooms. For neighbourhood hubs to host both NHS and non-NHS providers, leases must allow mixed use and avoid complex cross-charging.

Insight

Licensing models eliminate cross charging and promote a more collaborative culture. To support this, national contracts should remove rigid notional rent rules that restrict general practice from sharing buildings with non-GMS services, as these can block integration and create greater complexity for patients accessing services.

Case study: **St George's health hub**

St George's hub was developed on the former site of St George's Hospital in South Hornchurch. Recognising the site's historic and symbolic significance in the local community, NHS North East London (NEL) and the London Borough of Havering partnered to transform the old hospital into a modern health and wellbeing facility. Following an options appraisal, 85 per cent of the site was sold for residential development (which gained a capital receipt of £43 million back to DHSC), with the remaining 15 per cent earmarked for healthcare.

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To reduce the risk of void space in the new centre, partners agreed that the building would be considered a 'system' asset, funded by NEL ICB, without the need for cross charging and complex leasing. The licensing approach to sharing space has supported teams to integrate in the building and share ownership of services. Renal and frailty care were relocated from Queen's Hospital to free up acute capacity and joined up to Ageing Well services to improve wraparound care. Additional services on site include general practice, NHS Talking Therapies (IAPT), district nursing, children's services, outpatient dermatology, cardiology, and rheumatology, in addition to Voluntary, Community, and Social Enterprise (VCSE) partners delivering holistic support. Shared IT services have been commissioned for interoperability, and the service model has been developed using system-level population health management data. While the building is new, the licensing over leasing approach can be delivered in existing buildings.

Even where agreements allow flexibility, projects can still take too long. Members shared examples where partnerships delivered good results but took far longer than single-party developments. Long delays increase legal and management costs, increase building material prices, and can even lead to projects being abandoned. Streamlining decision-making, empowering local estate leads to manage shared resources, and releasing central funds quickly would cut costs and make developments more achievable.

Case study: **Barrow Hill Memorial Hall**

Chesterfield Partnerships and Neighbourhood Alliance have been developing a neighbourhood approach to tackling health inequalities for several years. Barrow Hill is a small, deprived area within the combined Chesterfield and Staveley footprint where residents already experience worse health outcomes and struggle to access services due to poor public transport links and the lack of a paved walking route between the village and nearest town. Barrow Hill is home to roughly 1,500 people and has no existing health estate.

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In line with plans to introduce neighbourhood health centres in the 10YHP, Chesterfield Partnerships and Neighbourhood Alliance are working with local community leaders and volunteers to deliver health services into a newly refurbished memorial hall based within one of the most deprived neighbourhoods in Chesterfield, Barrow Hill. The local community and Barrow Hill Community Trust successfully raised the funding required to renovate the centre, with additional support from regeneration funding from the local council, with the intention to establish it as a vital hub for community events and holistic support.

Chesterfield Neighbourhood Alliance is working with a local GP practice, which will take on the lease for two 'health rooms' within the hall and provide general practice appointments. There will be a GP focused on reducing health inequalities as well as rotational services such as public health Live Life Better Derbyshire services and community midwifery. Alliance members and local community leaders have an ambition to include other aspects such as family and children's support and mental health and wellbeing, delivered with resources and staff from across the Alliance membership organisations.

While the Barrow Hill Community Trust trustees and Neighbourhood Alliance partners share the same goals, the complexity of NHS leasing arrangements and access requirements have raised significant challenges and taken 18 months to overcome. Moreover, while a rotational service model for health and care services will benefit the local population, and there is interest from secondary, community and general practice providers to think very differently in terms of how services could be delivered, rents, legal and running costs and risk have made it challenging to implement. In addition, many organisations and services which could address health needs in Barrow Hill are not able to operate from premises where there is a room hire charge. Addressing these challenges will remove this barrier to enable a comprehensive and joined-up service offer to the community.

Discussions are underway to determine the best approach to cover the costs, with options including funding from system level estate sales or subletting for short periods to services as they rotate through the building.

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Ultimately, complex leasing reinforces organisational silos and disadvantages smaller community partners without the funding and experience to navigate the legal requirements in parity with NHS organisations.

For providers that prefer to own their estate, utilising economies of scale, by collaborating with at scale providers such as GP federations and PCNs, or under future neighbourhood contracts, presents new funding solutions. This can include pooling financial resources and leveraging the increased buying power of a larger collaborative.

Case study: **The Hereford Community Health Hub**

The health hub launched in December 2024. Herefordshire General Practice (HGP), a collaborative including 19 PCNs and a GP federation, drew from a range of funding sources to deliver the hub. Using funding from NatWest Bank, Lombard Finance credit and the federation's own reserves, HGP purchased the Nelson House building and carried out extensive refurbishments. This includes the creation of a self-contained clinical unit with eight consulting rooms, conference and training facilities, meeting rooms and social spaces. The hub now houses a wide range of teams, including Wye Valley NHS Trust's Community Response Hub, the Urgent Community Response Service, Healthwatch Herefordshire, GP out-of-hours services, ARRS staff, training hub, diabetic retinopathy screening and the administrative team for HGP.

Larger providers, including foundation trusts and at-scale general practice providers, are already capable of exploring new funding models and avoiding the long waits and red tape which currently hinder refurbishments and expansions in sites owned by other organisations. The emerging MNP model should support more collaboratives to come together and using their neighbourhood mandate, design and finance their own estates solutions in line with system priorities.

Health-led regeneration

However, access to planning discussions and funding varies across the country, with some areas retrofitting inefficient health provision into accepted planning bids.[8] Successful health planning requires both health and local government to engage in proactive collaboration on planning policy and infrastructure delivery plans.

Case study: **Barton Neighbourhood Centre**

Hedena Health delivers primary care services out of space within the Barton Neighbourhood Centre. The centre is owned by the council and space rented by the practice. The centre initially provided three consulting rooms and a waiting area, but following new housing developments in the area, CIL and Section 106 money was used to refurbish and expand the surgery to provide a total of six consulting rooms, one staff room and IT space.

Additional housing developments are underway nearby, and the practice is working closely with the developer and ICB to source additional Section106 funding to further develop the Barton site to increase capacity for new residents.

The co-location with council services – including the advice centre, sports, community classes, and a food bank – has been beneficial to staff and patients, making it easy to access services and refer users between relevant providers. However, GPs have highlighted high levels of bureaucracy and red tape which have made its expansion and development more challenging.

Many patients are affected by the wider determinants of health, so a neighbourhood health model cannot be delivered by the NHS alone. Partnerships between the government and the NHS will be essential to shaping effective services and ensuring that there is access to truly wraparound care for everyone.

Programmes such as One Public Estate (OPE) can support this collaboration by providing technical support and funding to councils or providers to partner on estate solutions. The OPE programme has supported over 800 projects, in 98 per cent of councils, bringing together local partners within a framework that supports the development of shared priorities and local decision-making.

Challenges using development funds for health

CIL and Section 106 can help fund local health services, contributing towards improvements in health infrastructure and facilities. CIL is a charge on new development, set by the local planning authority (LPA), whereas planning obligations are legal agreements between the developer and the LPA.

Insight

Through discussions with members, we found understanding of and access to these funds varies. Here we explain the funding.

- **Section 106**: contributions must be specific to the development proposal, considered necessary and meet statutory tests set out in planning legislation.

- **CIL**: bids must align to the local authority's infrastructure funding plan. Where developments include affordable housing, Section 106 contributions often shrink, reducing money for health services. Future policy needs to balance affordable housing with sustainable health funding.

- To **secure these contributions**, NHS bodies, councils and developers must work together. Early engagement with major planning applications and policy documents is vital – especially Infrastructure Delivery Plans (IDPs), which set out how infrastructure will be funded and delivered.

Building new

The government recognises to deliver its commitment on NHCs, it will need a mixture of refurbishments to expand and improve sites over the next three years as well as new-build sites opening in the medium term. New NHCs will be delivered through a combination of PPPs and public investment.

The NHS Confederation has previously welcomed the government's commitment to explore PPPs to inject capital into the NHS to address the financial barriers to improvement:

> '...a new model of private co-investment, which learns the lessons of the past and has the confidence of the public and private sectors, alongside public investment must play a significant complementary role to public finance in fixing the NHS's capital woes alongside further public investment.'

Modern PPP models are a new approach, different from the old private finance initiative (PFI) schemes from the early 2000s. Lessons learned from that period have shaped approaches like LIFT, which deliver modern, flexible buildings with minimal maintenance issues from the start.

Research by the NHS Confederation has reviewed PFI's impact and identified lessons for future models. While some providers worry about the long-term costs of PPPs, others see private investment as essential for getting new facilities built. With current financial pressures, relying only on public funding would slow progress and could mean the 250 NHCs target is not achieved.

While the new PPP model is established, systems and providers can make use of existing autonomous routes to new development.

Leveraging the GP Partnership Model

The traditional GP partnership model has included estate ownership, giving GP partners full control over use of space and decisions to expand or develop new premises. In areas where a strong GP partnership can lead on developments and act as an integrator for other local services, this model can deliver results faster than partnership builds but requires significant personal investment and risk for the GP partners who fund the project, and any subsequent partners who may later buy into the business. Expanding space to enable co-location, or building new facilities, can generate a return of investment through rents to hosted providers, but without establishing positive working relationships with other local providers and sectors beyond health, and systems increasing notional rent to cover costs, this model is challenging to scale.

Case study: **Whitstable model**

GP partners in Whitstable responded to rising complexity and increasing patient need by rethinking how and where care could be delivered. The team designed, funded and delivered a state-of-the-art, multi-use health centre – Estuary View. The building was purposefully designed to include additional space for non-GMS services, enabling a wider range of providers to share the premises and deliver integrated care.

The new facility supports the expansion of the ARRS workforce and creates opportunities for other services to co-locate, improving access to urgent care, screening and diagnostics, outpatient clinics, long-term condition management, and day surgery. The centre includes an urgent treatment centre (UTC) and minor injuries unit (MIU), providing same-day care for minor injuries and urgent conditions, reducing pressure on A&E departments.

To enhance patient experience, the expansion incorporated newly designed IT infrastructure and robust data-sharing arrangements, allowing staff across different services to collaborate seamlessly and smooth the patient journey between providers. The premises also host East Kent Hospital outpatient clinics, enabling patients to attend secondary care appointments locally rather than travelling to hospital sites.

continues...

Investment for the project was generated by GP partners through a significant mortgage agreement, as notional rent alone was insufficient to fund a facility large enough to accommodate multiple providers. By including space for community pharmacy, ambulance response teams, and secondary care consultations, the practice has broadened the range of services available to meet the growing complexity of an ageing population.

Additional innovations include group consultations for patients with long-term conditions, promoting peer support and efficient use of clinical time. Patient feedback on both the services and the premises has been overwhelmingly positive. Secondary care providers have reported a reduction in bed days as more patients access care within the health centre rather than being admitted to hospital.

Furthermore, the additional space is rented to non-GP providers, creating a supplementary revenue stream to offset the significant investment made by GP partners. This model demonstrates how strategic planning, integrated infrastructure, and collaborative service delivery can transform local healthcare provision.

Release to reinvest

Delivering more purpose-built NHCs would also be supported by a redesign of funding flows which currently disincentivises recycling underused assets. Optimising existing estate can enable the release of underused 'tail' estate. Under current rules, a significant portion of sale funds are returned to the Treasury, reducing the funds available to reinvest in building NHCs.[11] By devolving greater capacity and capability to systems or locally determined estate leads, to manage budgets and existing assets the centre would create greater incentive to release unsuitable and underused space, and fund improvements and developments in the systems which do so.[12] This change would need to be supported by a commitment to preserving capacity for estate management at a scale which supports close working with providers.

Conclusion and recommendations

Key recommendations to NHS, healthcare and local partners

Whether repurposing existing premises or constructing new NHCs, we believe there must be a fundamental reconnection between public service delivery, strategic commissioning, and estate provision. This alignment can be achieved by creating the right incentives and levers for local leaders to maximise the use of their collective assets through pooling estate and resources in support of neighbourhood health. Crucially, this should happen before large-scale investment to avoid repeating the pattern of multiple public-sector assets operating with significant void space.

Historically, estate provision has often been treated as an afterthought, following commissioning decisions. Delivering neighbourhood health centres requires a fundamental reset – enabling local leaders to make strategic estate decisions alongside service redesign.

One local leader noted that in a large private-sector organisation, moving assets and infrastructure was straightforward. In contrast, current departmental expenditure limits and centralised funding pots for specific schemes restrict local leaders' ability to maximise taxpayer value.

Key recommendations to DHSC

- Areas demonstrating strong partnership working across providers and local government should be granted additional flexibility to move funding between organisations to support neighbourhood health.

- Future investment could be strengthened by allowing local leaders to increase refurbishment or new-build budgets by reallocating funds from other national streams.

- Many members have expressed a desire to link new funding for neighbourhood health centres with existing programmes such as the New Hospital Programme or community diagnostic centres.

- Cross-departmental coordination – particularly between the MHCLG and DHSC – will be essential to enable local leadership and stewardship of these centres.

Local leaders have also highlighted that current expenditure limits hinder efforts to move services and workforce into community assets already funded by the NHS. In many cases, organisations cannot relocate services into CHP or NHSPS buildings because entering lease agreements triggers Capital Departmental Expenditure Limit (CDEL) implications. We believe this could be resolved through a national mandate allowing NHS trusts to move services into NHSPS and CHP buildings without incurring these penalties.

Flexibility in national capital allocations is vital, but members also want greater freedom to use revenue allocations more creatively addressing barriers to co-locating general practice within integrated neighbourhood health centres.

Insight

To secure additional flexibility and autonomy over estate capital and revenue allocations, areas should demonstrate a unified approach across public-sector organisations, underpinned by a clear estates strategy. This strategy should bring together expertise from NHS organisations, local government and the voluntary sector, embedding a commitment to resource-sharing and collaborative working. It should empower strategic commissioners to direct how services are delivered through commissioning intentions – reconnecting community service commissioning with the use of refurbished and newly built infrastructure.

National levers to support delivery of NHCs

This report has focused on the challenges to optimising estates for neighbourhood health, and how system partners have overcome them.. However, sole responsibility for delivering the government's neighbourhood health promise does not lie with systems. There are six national levers which DHSC could use to accelerate successful delivery of NHCs through use of the existing estate.

1. **Allow systems to best plan and fund strategic estate to remove barriers** caused by fragmented ownership and complex cross-charging.

2. **Streamline the notional rent reimbursement process for GMS services** to support general practice to co-locate with other providers and partners beyond health.

3. **Allow systems to retain and reinvest funds into NHC development** from releasing unused estate.

4. **Continue to remove restrictions on recycling capital** from NHS asset disposals and eliminate double counting of NHS funds that currently trigger CDEL penalties.

5. **Give areas demonstrating strong partnership working the flexibility to move funding** between providers to support NHC development.

6. **Enable cross-departmental coordination**, for example DHSC and MHCLG to link NHC funding with other national programmes such as the New Hospital Programme and CDCs.

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18 Smith Square
Westminster
London SW1P 3HZ

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