# HEALTH AND SOCIAL CARE SELECT COMMITTEE INQUIRY

## DELIVERING THE NEIGHBOURHOOD HEALTH SERVICE: ESTATES

## BRITISH PROPERTY FEDERATION EVIDENCE

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## British Property Federation Evidence

### ABOUT THE BRITISH PROPERTY FEDERATION

The British Property Federation (BPF) represents the UK real estate sector, an industry that invests in communities across the UK, providing a wide range of high-quality homes, workplaces, health, education, and warehousing facilities which people and businesses rely on every day.

The BPF's Healthcare Committee is comprised of companies across the healthcare sector, from investors to developers and advisors, all motivated to increase the quality and supply of healthcare estates, and we drive best practice and policy change to achieve this.

1. What is needed from the NHS estate to allow it to deliver the Neighbourhood Health Service?

It has long been a priority of parties across the political spectrum to address issues facing the NHS, including through a focus on moving more care into the community. While discussion around NHS reforms to date have centred around funding, resourcing, and staff pressures, estates are increasingly recognised as part of achieving the Government's vision for the NHS – as the Fuller Stocktake notes, estates are key to achieving the accessible care and integrated teams required to ensure a strong primary care system. To deliver on this vision, the estate must receive sufficient investment and benefit from a supportive development and financial system.

One such area of support estates provide is in workforce recruitment and retention. Reports have found that 42% of GPs are likely to leave general practice in the next five years, and subsequent governments have committed to increasing the number of trainee doctors. However, it is not clear how these additional places will be accommodated; in a 2023 Royal College of General Practitioners survey, 66% of respondents said limited space was making it difficult to train new GPs and 75% said it was restricting the number of trainee GPs that they can take on (this was further reinforced in a 2025 BMA survey). Estates will provide the space to enable a larger workforce, but only with sufficient investment.

More and higher quality facilities and better utilisation of existing estates will also support increased productivity, more patients being seen (alongside additional workforce capacity), and better outcomes. We welcome the Government's announcement in the 10-Year Health Plan of a Neighbourhood Health Centres (NHC) programme, delivering 250 NHCs in part through a capital commitment of £426m over the 4 years of the 2025 Spending Review, with up to half supporting delivery of 40 to 50 NHCs this Parliament through refurbishment of existing buildings. As we will discuss below, delivery on the NHC programme will require increased investment and flexibility beyond that already committed.

a) How does this compare to the current NHS estate?

It is well known that the current NHS estate is ageing and not being sufficiently upgraded, with Lord Darzi's report finding that 53% of the primary care estate is over 30 years old, and over 50% of primary care premises unsuitable for current needs, according to GPs.

b) Do DHSC and the NHS hold sufficient data on the condition and utilisation of NHS estate?

Sufficient data is essential to identifying and addressing opportunities for investment and support. As noted in our response to part A of this question, the age of the overall estate is well-documented; however, we are not aware of any data held or available on the maintenance requirements and cost for the primary care estate; unlike the secondary care estate, data for which is published through the Estates Returns Information Collection (ERIC). Despite this lack of data, the Government has committed that 40% of NHCs will be in existing NHS buildings.

Further, there is no central NHS published dataset that comprehensively reports on detailed utilisation rates for every clinical room or building across the estate in the same way that, for example, hospital bed occupancy is reported. According to ERIC data, in 2022/23 under-utilised space was reported at 1.9%, and non-clinical space 33% of all NHS estate (trusts are targeting less than 30% non-clinical space). However, as we note above, ERIC does not report on the primary or community care estate.

c) Are there opportunities to better utilise the current NHS estate to support delivery of the Neighbourhood Health Service?

While there is very little centralised data on the utilisation of the primary care estate, we have identified three areas through which the estate can be better leveraged to support delivery of the Neighbourhood Health Service: design, utilisation, and opening hours.

On design, our members have excellent examples of where they have refurbished existing and developed new facilities designed to better integrate care and allow for more patients to be seen, alongside delivering sustainability benefits – these are noted below:

Integration of primary and urgent care in Birmingham

Over 45,000 patients are benefiting from the integration of a community diagnostic centre into an existing primary care building in Birmingham. Commissioned via LIFT partnership, the project refurbished underused space to add modern diagnostic equipment, improved ventilation and energy-efficient lighting.
The Centre now operates seven days a week and brings together outpatient diagnostics, two GP practices, an Urgent Treatment Centre, a Primary Care Hub, mental health services and community physiotherapy. Patients can access appointments more quickly and closer to home, while the scheme has increased lettable space and reduced occupancy costs for the ICB.

Delivering modern primary care on the south coast

One BPF member has worked with GPs and the ICB on the south coast to develop a new primary care centre to deliver more care in the community. The purpose-built facility enabled the merger of three separate GP

practices, which had been operating from converted residential properties. The area has seen significant housing growth and the new medical centre now offers a range of additional services in the heart of the community. There are 15 GPs able to offer face to face and online appointments. More than 100 staff operate from the building offering physiotherapy and occupational therapy, minor operations and procedures, social prescribing and mental health support. The centre also has space for training GPs, nurses and paramedics and contains a pharmacy. For the merged practice the new working environment has brought financial stability and significantly improved the ability to attract new staff and retain existing staff.

Regarding utilisation – again, there is very little data available on the primary care estate and the ratio between clinical and non-clinical space, let alone how much of this non-clinical space could be better utilised. Anecdotally, we hear from our members and stakeholders that there is a wealth of opportunities for better utilisation within the primary care estate that support better productivity and additional appointments – examples we are aware of include converting excess waiting room and retail space into clinical space.

Finally, the existing estate may be restricting the ability of GP surgeries to extend their opening hours, and train staff to support any extension. Improved access to primary care through extended opening hours has been pursued by successive governments, but a 2015 study found that GP surgeries were open on average 8.8 hours a week less than was recorded on the NHS Choices website. The success of initiatives to extended opening hours depends on the premises that support them – and, according to the BMA's most recent GP Premises Survey, 83% of GPs consider their premises unsuitable for future needs, with 74% reporting insufficient space to train new GPs.

All three elements here would free up more space and/or time for clinical staff to see patients, increasing the reach and effectiveness of the Neighbourhood Health Service and supporting successive governments' ambitions to deliver more care closer to home. For this to be effective, there must be an accompanying drive to increase the numbers of clinical staff working in primary care.

2. What criteria should be used to prioritise the investment in the estate to enable it to deliver the Neighbourhood Health Service?

As a wealth of research has made clear, public capital alone will not be sufficient to deliver the scale of investment needed to address current maintenance needs, improve productivity, and support additional capacity within the Neighbourhood Health Service. Many reports note the importance of a different approach to estates, and this must include a central role for private capital support, which BPF members are already providing.

While we welcome public-private partnerships as a mechanism to deliver NHCs, it is essential that any framework for private capital support facilitates meaningful delivery of improvements to the estate. As such, we believe that the following should be prioritised in estates investment:

- Flexibility – As we note below, current financial and accounting frameworks for NHS trusts and Integrated Care Boards (ICBs) can restrict the ability of organisations to deploy funding efficiently or work creatively with the private sector. Greater flexibility is needed to enable innovative delivery

models that reflect local circumstances, unlock underused assets and provide value for money over the long term. Primary care estates must be able to respond to changing demand, workforce, and service integration, recognising that each community, NHS organisation and facility will have distinct priorities and constraints.

- Pragmatism – Alongside flexibility, a pragmatic approach is essential in acknowledging the realities of delivering primary care estates, including workforce pressures, existing estate condition, planning and capital constraints. This means prioritising solutions that are deliverable and timely, such as new development, refurbishment, and co-location. Pragmatism also requires openness to a range of delivery and ownership models where these better support service continuity and speed of delivery.
- Localism – Planning and decision-making should be rooted in local communities. Centralised approaches can limit responsiveness and slow delivery, particularly where they fail to reflect local population needs, service configurations and existing assets. Empowering ICBs and place-based partnerships to lead estates planning, in collaboration with local government and community partners, enables more integrated and accessible facilities that align with wider infrastructure.
- Sustainability – Sustainability must be embedded into primary care estate development if the NHS is to meet its commitment to become the world's first net zero national health system by 2040. This includes prioritising low-carbon design, retrofitting, and improving energy efficiency.

a) What lessons should Government take from previous private investment models when using Public-Private Partnerships?

Currently, private capital is principally deployed in primary care through two models:

1. Third party development – where a private developer builds and owns the asset and the NHS, general practice, or other public body take a long-term lease; and
2. Public-private partnerships – which involve a joint venture between the public and private sector to deliver a new estate with private equity funding and debt.

Both models are struggling to be effectively deployed. Public-private partnerships have struggled due to barriers to NHS LIFT use (a model that specifically supported public-private partnership), or an equivalent partnership structure, a result of a 2018 ban on PF12. Third party development is subject to two key investment constraints:

Accounting barriers - For third party development, in some cases there can be accounting barriers to making progress. An international accounting rule (known as IFRS16) requires NHS Trusts that take on a multi-year lease to capitalise the entire cost in the year the lease is signed. On its own this requirement may not cause an issue, but NHS Trusts have a legal obligation not to breach the NHS's annual capital spending limits (CDEL). In many cases, the capitalised leases mean that Trusts will breach their CDEL limits. This is preventing the development of new estates, even when a third-party developer is investing in the project.

Market rents and viability - Some third-party developments – for example GP surgeries – are 'off-balance sheet' as GPs are independent contractors to the NHS, and so hold the leases directly and are reimbursed for their premises costs. However, even here there are challenges due to uncertainties over market rent levels. To ensure the NHS gets value for money from its estates, current market rents are assessed by the

District Valuer Service. However, changes in the cost of construction and interest rates, as well as fluctuations in property values, are not being reflected in the assessments of current market rents, meaning projects are being put on hold because a viable rent cannot be agreed. For example, there is insufficient support for additional building costs relating to environmental measures – this means developers will need to show a net financial benefit of such measures to the NHS before the cost can be included in any financial assistance, such as a higher market rent valuation.

b) What are the non-financial barriers to more effective estate development and utilisation and how can they be addressed?

We have identified several non-financial barriers to more effective estates development, including:

Over-centralisation – many experts point to the centralisation of strategic estates planning as a barrier to effective reform. As noted earlier in our response to Question 2, we would support local decision-making, guided by clear national objectives and frameworks that allow for flexibility and strategies that best cater to individual communities. For example, capital envelopes that are managed through ICBs at system level, which play a key role in financial planning and capital prioritisation and are well placed to perform this role.

Lack of facilitating public sector partnerships – working together across public sector organisations can be challenging but can maximise investment for the public sector and bring other shared benefits. For example, locating community diagnostic centres on university campuses opens the campus to the community and offers opportunities for training collaboration for the students. ICBs and Trusts should work with local authority partners to identify opportunities for delivery of new primary care schemes as part of regeneration plans being developed by local authorities who are bound to meet housing delivery targets. Known examples of such collaboration have seen such schemes become anchor community assets around which the wider regeneration is centred.

Lack of support for additional infrastructure needs – through planning requirements (including possible ringfencing of financial contributions under planning obligations) and joined-up thinking between bodies such as Homes England and the ICBs at early stages of housing development. Premises Cost Directions envisage a cost saving for ICBs for development where the funding has come through public funds, whether from the health service, or section 106 grants or Community Infrastructure Levies from local authorities, and this should encourage public bodies to work together to maximise this potential source of additional funding. NHS organisations should engage in the preparation and ongoing review of Local Plans providing an evidence base to help inform strategic planning policies on the location of future health infrastructure schemes. This will become of growing critical importance if the Government's ambitions to get Britain building are realised, and the consequential strain on health services increases due to demand created by new housing developments.

3. What lessons can be taken from pilots of Neighbourhood Health Centres for the development of an NHS estate that supports the delivery of the Neighbourhood Health Service?

While we cannot speak to specific NHC pilots, our response draws on the collective and broad expertise across our Healthcare Committee and their experience in delivering healthcare estates. As we have noted above, members consistently highlight the need for clear investment avenues that support delivery of private capital alongside public investment, providing long-term certainty for development and refurbishment. These investment avenues should not impose a rigid, centralised model, but enable local decision-making and flexibility to meet local needs, recognising that economies of scale are not necessarily achievable at a neighbourhood level. Progress in delivering estates is also constrained both by financial and non-financial barriers that fail to align service provision with wider community infrastructure needs and sustainability. Further, NHCs must be planned with sufficient, flexible space to maximise productivity and accommodate the workforce and expanded range of services required to safely shift care out of acute hospital settings and into the community.

4. How could non-NHS settings or infrastructure be used to support the delivery of care in neighbourhood settings, and what arrangements would be needed to facilitate it?

    a) What are the challenges of delivering care services in these settings and how would they be addressed?

No response.

5. How can local communities and the workforce best be involved in the planning and design of estate transformation for the Neighbourhood Health Service?

Local communities should be involved from the outset through early and sustained engagement with local government and wider public services – including, of course, the NHS. As we note above, working across public sector organisations can be challenging, but it is imperative to ensure that the Neighbourhood Health Service is delivering for local communities.

    a) How should the estate be designed to meet the needs of different communities, including those based in rural or coastal settings?

We would reiterate here our answer Question 2 on the need for flexibility, pragmatism and localism – NHS organisations, the private sector, and local government must be given the tools and freedom to develop estates that support their communities and local needs, with planning and coordination at a strategic level that incorporates service and infrastructure provision across areas.