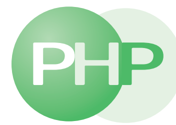

Primary Health Properties PLC (PHP) and the Good Governance Institute (GGI)

Innovative capital solutions to achieving STP goals

A discussion document

September 2017

The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

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.

Primary Health Properties

Primary Health Properties PLC ("PHP" or the "Company") is a UK Real Estate Investment Trust with a 22-year track record of investing solely in the primary care real estate sector. PHP has, over this time, worked in partnership with GP groups, the NHS and specialist developers to provide purpose built, flexible, modern healthcare facilities in the UK. These properties are leased to GPs, the NHS and other UK Government agencies and pharmacy operators.

PHP's deep understanding of primary care real estate and its commitment to the sector goes beyond a property's initial development or acquisition. PHP continues to work closely with its stakeholders and invest in its premises to meet the changing needs of its tenants and facilitate the delivery of the growing number, and ever changing nature, of services that are being provided in the primary care arena.

For its investors, PHP is seen as a beacon of stability in an otherwise volatile market. In each of the 20 years that the Company has been listed on the London Stock Exchange, PHP has paid an increased dividend. The Company is prudently funded and has continued to demonstrate an ability to grow its portfolio adding assets that provide both an attractive initial return and also the scope for further income and capital growth.

PHP has a skilled management team that is experienced in all aspects of the sector. The team combines an appreciation of the needs of its tenants and health care bodies with a track record of delivering original and appropriate solutions to enhance its assets and maintain their key position within local social infrastructure.

What sets PHP apart from other investors?

- *PHP is a pioneering company, the first dedicated investor in UK Primary Healthcare Property on incorporation in 1995;*
- *PHP has provided its investor base with an increased income return in each of its 20 years of paying a dividend;*
- *PHP supports numerous organisations in the sector, working with many specialist developers and advisers, using its financial strength to fund many different projects;*
- *PHP is innovative in funding its business, looking to provide access to as wide a range of investors as possible. PHP was the first listed real estate company to issue a Retail Bond and successfully issued a Convertible Bond as a small cap company.*
- *PHP has established strong relationships with regional and local General Practitioner groups and NHS bodies to input into strategic plans to develop local NHS strategy and meet changing service delivery and patient demand.*
- *PHP is leading the way in targeted investment into the primary care real estate market in the Republic of Ireland, a market which is in its infancy, lending its experience to the assembly and delivery of a series of new, purpose built primary care centres.*

Primary Health Properties PLC (PHP) and the Good Governance Institute (GGI)

Innovative capital solutions to achieving STP goals

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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

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1. Foreword: By Harry Hyman, Founder and Managing Director, Primary Health Properties PLC (PHP)

We are facing a pivotal moment in the history of health and social care in England, as the development and implementation of the 42 Sustainability and Transformation Partnerships (STPs) progresses, a central aspect of NHS England's Five Year Forward View[1]. Instead of an NHS largely centred around care delivered in acute hospitals and the autonomy of, and competition between, NHS organisations, collaboration and integration will now be the key drivers of system improvement.

Central to the STPs will be the development of new models of care, already in train in various parts of the country, including Accountable Care Organisations, Multispecialty Community Providers, Primary Care Homes, and Primary and Acute Care Systems. Bearing in mind a history of primary care and general practice being underfunded in comparison with secondary care organisations, the success of these new models of care will be reliant upon effective estates strategies and investment in community facilities, which too often are inflexible and lack capacity.

However, it is widely recognised that the current central capital investment is simply insufficient to both fund transformation, whilst managing the growing issue of backlog maintenance, as Sir Robert Naylor raised in his recent review[2]. How, then, will STP leaders be able to create an effective estates strategy and capital plan, given the fact that estates make up the fourth biggest expenditure in the NHS?

There is a clear need for STP leaders to embrace alternative, innovative ways of accessing capital. The key to achieving this could lie with Third Party Developer (3PD) schemes, in which private 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 organisations. This includes both financial risk and the risk on property and facilities management. This will be especially important in the development and expansion of general practice facilities, which will require significant capital investment. PHP has a twenty-two year track record of investing in the primary care sector and facilitating the modernisation of NHS facilities, which is more important than ever now as general practice expands to deliver a wider range of services and play a key role in delivering care closer to home.

Although many financing options are available to NHS providers, 3PD schemes can complement NHS England's Estates and Technology Transformation Fund, or drive forward transformation when such central funding is not available.

This paper aims to 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 providers in order to design a balanced development strategy.

1. NHS England, Five Year Forward View (2014)
2. Sir Robert Naylor, NHS Property and Estates: Why the estate matters for patients (2017)

2. Introduction

The successful implementation of the Five Year Forward View (FYFV) will require significant investment in, and transformation of the existing NHS estate, a large part of which, it is acknowledged, is historic and not fit for purpose.

However, given the recognised challenges around finances across the system, it is unlikely that such funding can be delivered centrally. STP leads will therefore need to explore alternative and innovative ways of accessing capital funds whether through rationalisation of estate, the sale of excess assets, or through third parties, to ensure they are able to deliver the vision as outlined within their plans. This includes the fact that the additional revenue costs of servicing the capital that will be more than offset for the system by significant service delivery benefits and savings. These plans propose localised delivery models which synchronise with the FYFV and all will require significant investment in estates and facilities. Working as we do with NHS boards, the Good Governance Institute (GGI) understands the challenges this raises for NHS bodies.

This paper will explore the national policies and governmental bodies which are driving the integration of services in the NHS, before providing an overview of some of the estates challenges to delivering whole system transformation. The paper will conclude by presenting a series of possible solutions to the estates challenge, highlighting some innovative and affordable mechanisms for accessing funding and modernising your property.

3. The national policy background

3.1. The Five Year Forward View (2015)

The NHS is currently grappling with significant financial, operational and quality pressures, along with challenges around workforce and cultural issues. The FYFV, written in 2014 and revisited in 2017[3], is NHS England's (NHSE) response to these, outlining the direction of travel for the NHS in England. This plan focuses on achieving the triple aim of:

1. Closing the health and wellbeing gap
2. Closing the care and quality gap
3. Closing the funding and efficiency gap

In particular, the FYFV envisages improvements in public health, the delivery of patient-centred care, and the integration of services across health and social care.

STPs are intended to be the vehicle for the delivery of this vision, underpinned by a number of national service strategies in support of those areas identified as in need of critical improvement going forward, namely mental health, urgent and emergency care, general practice and maternity services.

STPs are partnerships between NHS providers and commissioners and local councils taking a population-driven, rather than organisational, approach to improving healthcare. A key aspect of the these will be the integration of health and social care services, with the aim of reducing the number of services delivered in acute hospital settings by expanding and upgrading community and primary care facilities. In achieving this, and given the well-documented financial pressures in the system, there will likely be significant roles for third party organisations.

The increasing prevalence of new models of care reflects this shift in thinking, demonstrated through the development of Accountable Care Organisations (ACO) (groups of providers taking responsibility for all care for a given population within a capitated budget), Multispecialty Community Providers (MCP) (expanded general practice providing greater integrated out of hospital care), and Primary and Acute Care Systems (PACS) (the provision of list-based GP and hospital services, together with mental health and community care, in single NHS organisations) demonstrative of this. GGI has been working with variations of the new models of care since their inception.

Crucial to any service transformation will be a behavioural change around how organisations use capital (financial, human, and estates). The Health and Social Care Act[4] created an environment focused on competition rather than collaboration as the key driver to improving efficiencies. Organisations will now have to think in terms of system-wide capital, and this will require a significant shift in mind-set.

3.2. General Practice Forward View (2015)

The General Practice Forward View (GPFV)[5], released in 2016 and corresponding with the FYFV, outlines NHS England's plan to transform general practice, and commits to an additional £2.4 billion funding a year to develop and sustain general practice services by 2020/2021.

Focusing on five key areas (investment, workforce, care redesign, workload, and infrastructure), the GPFV describes a number of initiatives to improve the effectiveness of GP estate. Like the FYFV, it envisages the implementation of new models of care to shift treatment away from expensive acute settings to primary and community, including the use of primary care hubs which through the implementation multi-disciplinary teams are able to deliver a wider range of services. Each necessitates a prominent role for primary care services and GPs. An early example of this is the Modality Connected Care Partnership, one of four GP led NHS vanguard sites in England, developing a new MCP. In Dudley, GGI is working with the Clinical Commissioning Group (CCG) to develop an MCP which includes primary care.

3. NHS England, Next Steps on the NHS Five Year Forward View (2017)
4. Health and Social Care Act 2012. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 30 August 2017).
5. NHS England, General Practice Forward View (2016)

To facilitate this, rapid redevelopment of GP premises will be needed to create new pathways of care, and capital has been provided to achieve this. However, the effectiveness of this is likely to be limited by the fact that many GP practices across the country occupy antiquated estate that is not easily upgraded. Indeed, modelling of nationwide primary care estate carried out by Deloitte, demonstrated that 'the extent of single handed and small GP practices is understood to be inconsistent with the developing service strategies to move care out of hospital into community settings,' with c.30% of practices identified as needing change to fit the future vision of the NHS as set out in the FYFV[6].

3.3. Estates and Technology Transformation Fund

To help accelerate the development of a wider range of services being offered by GP practices, NHS England has introduced the Estates and Technology Transformation Fund (ETTF)[7], a 'multi-million- pound investment (revenue and capital funding) in general practice facilities and technology across England.' The initial phase of this programme of work is focusing on improving and expanding existing GP facilities to incorporate a wider range of services. However, several GP federations that GGI have spoken to have suggested that the money made available through the fund is simply not sufficient with one area of London having only one practice eligible for such funding, and no more practices likely to be eligible for funding in the near future. This GP federation commented that they had a clear strategy as to how they wanted to deliver the proposals of the GPFV, but argued that without additional funding it would be very difficult to facilitate the shift of care away from hospitals using traditional methods of accessing capital.

The use of third party investment may be a mechanism to support the development of services in those practices that are unable to access the fund.

3.4. Next Steps on the Five Year Forward View (2017)

Revisited in March 2017, the Next Steps on the Five Year Forward View reaffirms list based primary care as the bedrock of the NHS, and reiterates the FYFV's pledge to make better use of estates, infrastructure, capital and clinical support services. In particular, it highlights further opportunities within the system to[8]:

- achieve efficiency savings, for example through reducing unwarranted variation in running costs
- improve patient experience, for example by ensuring that premises are safe, warm and clean environments for staff and patients
- use estates productively and effectively, for example by reconfiguring primary care estate to include multi-disciplinary teams, to support the delivery of care out of hospital settings

The extent to which improved efficiencies can be realised in estates management is also made clear in the Carter Review which found that[9]:

- the total estates and facilities costs per area (£/m2) varied across trusts, ranging from £105 to £907. It was argued that, were all trusts nationally able to achieve the median spend this would result in an £11 billion saving annually
- there is unwarranted variation in how trusts utilise their estate, with the review finding that non-clinical space ranged from between 12% to as much as 69%. It was recommended that trusts develop a plan to operate with a maximum of 35% non-clinical floor space, and 2.5% of unoccupied space, to be delivered by 2020

The Next Steps on the Five Year Forward View, although welcome, was criticised by organisations such as the British Medical Association (BMA) which suggested that "the efficiency targets set in this plan are fanciful, given that most hospitals have been pushed into the red"[10], and the King's Fund who have argued that the aims of the FYFV for the NHS estate may not be realistic within the economic environment the NHS is operating in, and considering the limited availability of capital finance, particularly with regard to primary care.[11]

6. Deloitte, Naylor Review Data Analysis – Key Findings (2016)
7. NHS England, Estates and Technology Transformation Fund (2016). Available at: https://www.england.nhs.uk/gp/gpfv/infrastructure/estates-technology/ (Accessed: 30 August 2017)
8. NHS England, Next Steps on the NHS Five Year Forward View (2017)
9. Department of Health, The Carter Report: Reducing Unwarranted Variation in Operational Performance and Productivity in Hospitals in England (2016).
10. British Medical Association, New health service delivery plan sets 'fanciful' targets (2017). Available at: https://www.bma.org.uk/news/2017/march/new-health-service-delivery-plan-sets-fanciful-targets (Accessed: 30 August 2017)
11. The King's Fund, Policy changes to implement the NHS five year forward view: a progress report (2016). Available at: https://www.kingsfund.org.uk/publications/five-year-forward-view-progress-report (Accessed: 30 August 2017)

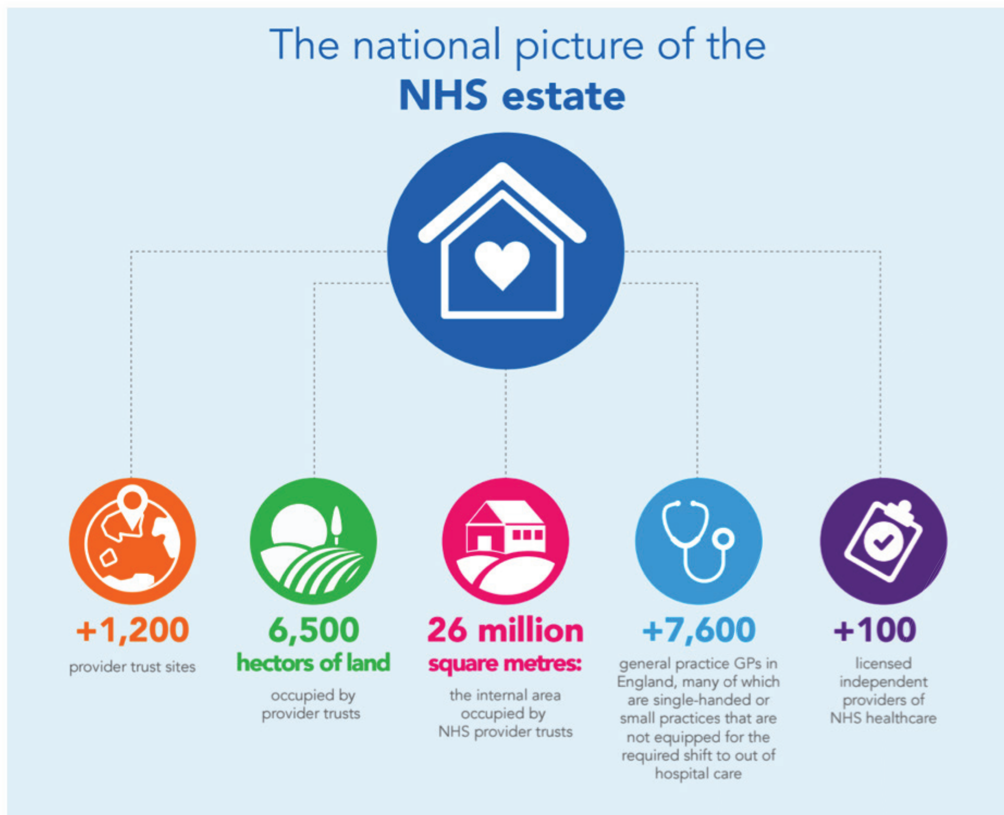
3.5. Healthy New Towns programme

This initiative, launched by NHS England, aims to create ten new housing developments in England, focusing on improving population health and well-being. It will bring together local NHS organisations, technology experts, and designers, with financing coming from council budgets and private partners rather than the NHS. This programme will necessitate a substantial capital investment in new facilities.

The resourcing behind such large-scale development partnerships, although significant, provides unparalleled opportunities to embed the health and wellbeing of inhabitants into the fabric of urban life, ensuring that health provision is localised and centralised into a community setting. An example of this is the Ebbsfleet Garden City which is under development in Kent.

4. Understanding the NHS estate

4.1 The national picture of the NHS estate



NHS provider trusts occupy buildings with a gross internal area of 26 million square metres[12], with the total running costs in 2015/16 amounting to £8.3 billion.[13] This represents the fourth largest cost to the NHS after workforce, clinical supplies, and consumables[14], and is the largest single NHS controlled asset, with a value of £42.6 billion.[15]

Despite its critical importance to the NHS, estates are a somewhat neglected area. The NHS has a historic estate stock which was designed for a fragmented system in which the hospital estate represented the centre of clinical and specialist service delivery – not the integrated system the NHS aspires to - and it is well recognised that existing estate is complex and of variable quality. Notably:

- many NHS properties are under-utilised and a significant proportion are in poor condition and not fit for purpose
- NHS provider trusts occupy significant estate that predates the formation of the NHS (18%) or is more than 30 years old (43%).[16] Although some of this has been upgraded to adhere to modern standards, the rapid pace of medical advancement means that future proofing any estate is challenging

Anecdotal evidence suggests that the condition of primary care estate mirrors that of NHS provider trusts.

Under current arrangements, there is no national overarching strategy for the NHS estate in England. Instead, there exists a central steer for the development of estates strategies at local/organisational level, which are informed by national policy priorities and developed in line with central standards and guidelines. Boards of NHS organisations will therefore need to develop a more strategic approach to the estate and think creatively about how it can be utilised and reconfigured to meet the needs of the system. They will also need to consider how their plans align with the other national estates priorities outlined earlier in this document.

12. Sir Robert Naylor, NHS Property and Estates: Why the estate matters for patients (2017)
13. NHS Digital, Estates and Returns Information Collection, England (2015/16)
14. Arcadis, The 2015 NHS Estates Review: Making the best use of all assets (2015)
15. Department of Health, NHS Premises Assurance Model (2016)
16. Sir Robert Naylor, NHS Property and Estates: Why the estate matters for patients (2017)

4.2. Who owns the NHS' estate?

The NHS estate is fragmented – owned and overseen by a variety of providers and governmental bodies. Although there may be efficiencies to be achieved in the system from the reconfiguration of estates, significant cultural and organisational barriers must be overcome to realise this. A number of STP plans recognise this challenge with most highlighting the necessity of an STP wide estates strategy and implementation group as the primary mechanism for overcoming this.

- **NHS trusts and NHS foundation trusts**

  The majority of the NHS estate is currently owned by individual NHS trusts and NHS foundation trusts. NHS trusts and foundations trusts own the freehold of most of the land that they occupy, although some land and buildings will be leased.

- **NHS Property Services**

  Owned by the Department of Health, the NHS Property Services (NHSPS) 'manages, maintains and improves the NHS properties and facilities within [its] portfolio' on behalf of the Department of Health. 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) were transferred to it.[17]

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

  - health centres and GP surgeries
  - hospitals/hospital-related properties
  - offices

  A BMA report recently found that some 60% of NHS Property Services properties are not fit for purpose, and NHS Property Service contracts have been criticised for being 'not flexible enough' and lacking 'incentive and alignment' to support transformation plans.[18] Although the new NHS lease agreement might support improvement in this regard, providers of NHS care may wish to explore means of acquiring modern, fit for purpose property.

- **GPs and private sector organisations**

  The existing primary care estate is fragmented and, in many instances, not fit for purpose. The ownership arrangements for general practice premises are variable:

  - some of the primary care estate is owned by general practitioners, who own the premises within which they work
  - the remainder (and majority) of the primary care estate is owned by NHS Property Services or by Community Health Partnerships or, primary care estates that are developed under Third Party Development schemes are owned by the private sector

  As mentioned previously, the effective utilisation of GP estate is of paramount importance to the success of STPs. It is therefore worrying that in a recent BMA survey of GPs[19]:

  - 70% stated that their premises are too small to deliver additional services
  - 60% stated that their premises are too small to provide vital training and education
  - 52% stated that their premises had seen no investment or refurbishment in the last 10 years

  To add to this, a review of estate by the British Property Federation found as many as 4,000 of the 7,692 GP practices in England and Wales to not be fit for purpose.[20]

17. NHS Property services. Available at http://www.property.nhs.uk (Accessed: 30 August 2017)
18. Edwina Farrell, Implications of the new NHS lease agreement (2016). Available at: https://www.buildingbetterhealthcare.co.uk/news/article_page/Comment_Implications_of_the_new_NHS_lease_agreement/118858 (Accessed: 30 August 2017)
19. PHP, Investing in the future of integrated healthcare Helping to deliver a 24/7 NHS (2015). Available at http://www.phpgroup.co.uk/~/media/Files/P/PHP/documents/item-pdfs/reports-and-presentation/2015-half-year-results-presentation-v2.pdf (Accessed: 30 August 2017)
20. British Property Federation, Unlocking investment in primary care infrastructure (2015)

4.3. Investing in NHS estate

Whilst transformation of the NHS and social care systems provides an opportunity to 'right size' the estate and make it fit for purpose for future service provision, it is likely that significant capital investment is required to deliver the STPs, and there exists a concern that current levels of funding from the Treasury are insufficient.

The Naylor Review (NHS property and estate: why the estate matters for patients, 2017) argues that an additional £10 billion of capital investment is required to implement the priorities outlined in the FYFV and address the significant backlog of maintenance[21]. The Review estimates that a minimum of £2.7 billion (and up to £5.7 billion) can be raised from the sale of surplus estate, whilst an additional £500 million to £1 billion could be saved annually on estate running costs.

There is, therefore, a clear need for organisations to be innovative with their assets and recycle existing capital infrastructure to develop and sustain estates across the system. This, the Naylor Review recommends, should be facilitated through the development of "affordable estates and infrastructure plans [across STPs], with an associated capital strategy," which should include exploring the use of private capital to overcome the capital funding shortage in the NHS.[22]

Redevelopment of an existing asset can release capital in site-value back to the NHS which can subsequently be utilised to redevelop or upgrade other parts of the estate. Committing to a leasing deal on one asset could therefore unlock a further capital programme within the NHS. In our consultation it was suggested that an estates strategy that balances freehold and leasehold interests provides flexibility and options in terms of keeping the estate modern and fit for purpose.

However, a significant proportion of STPs appear to still be at a high-level stage of planning with regards to how the required capital investment might be secured. Given the cultural barriers that will need to be overcome to ensure a truly collaborative approach to estates management, this is something which should be explored as a matter of urgency.

4.4. Accessing local, risk based financing

Increasingly, NHS organisations are looking to innovative, local risk based finance initiatives to provide the capital to ensure their estate is fit for purpose, and this is something likely to become more commonplace with the development of STPs and new models of care. Examples of this include:

- **The Local Improvement Finance Trust initiative**

  The Local Improvement Finance Trust (LIFT) initiative was introduced in 2000 as a vehicle for partnership between the public and private sectors, with the aim of regenerating and the developing primary care and community facilities to best meet the needs of local populations. The LIFT initiative provides public sector organisations with the means to upgrade existing facilities, and where necessary to develop entirely new premises and estates.

  Under the LIFT structure, LIFT facilities are refurbished or built and maintained by a local LIFT company (LIFTCo) – a joint venture between the public and private sectors, which has the responsibility for leasing facilities back to NHS England and maintaining the premises over the long-term.

  It has been suggested that LIFT has not been as effective as initially envisaged with the scheme described as overly bureaucratic and expensive, and many properties left empty.

- **Community Health Partnerships**

  Similar to NHS Property Services, Community Health Partnerships (CHP) is owned by the Department of Health and is responsible for establishing public-private partnerships to invest in new healthcare facilities in England via the NHS Local Improvement Finance Trust (LIFT) programme. This includes Project Phoenix, launched by CHP, which was designed to investigate and develop thinking around how a future new models could be deployed to meet national strategic estate management objectives

  The Department of Health's (DoH) objectives in developing Project Phoenix were to:

  - increase the pace of delivery of estates transformation across the healthcare estate and provide solutions for a capital constrained system
  - provide a national approach to deliver schemes across the full range of providers to complement other approaches
  - provide innovative solutions to meet identified needs arising from NHS England's five-year view

21. Sir Robert Naylor, NHS Property and Estates: Why the estate matters for patients (2017)
22. Sir Robert Naylor, NHS Property and Estates: Why the estate matters for patients (2017)

- demonstrate Value for Money and provide financially sustainable solutions for the local healthcare economy

CHP aims to deliver savings, increase service integration and drive the optimal use of primary and community health estates.

- **Strategic Estates Partnerships**

Strategic Estates Partnerships (SEPs) offer a new approach to estates management within the NHS and an alternative option for trusts who are wary about entering in to PFI contracts. NHS trusts join forces with private sector organisations in order to form companies that are responsible for the running of the NHS estates, with the aim of improving quality of care in a financially strained environment. SEPs can provide a means of combining the expertise and resources of the public and private sector and support NHS trusts to align their estate and facilities with the clinical strategy and strategic aims of the organisation.

- **Private Finance Initiative**

Private Finance Initiatives (PFI) are a way of creating 'public-private partnerships' by funding public infrastructure projects with private capital – groups of private sector investors pay for the PFI upfront and manage the delivery of public sector projects, bearing the construction risk and the majority of risk associated with the project failing.

In PFIs, the public sector does not own the asset, but leases the asset from private investors, often for around 25-30 years and for which it pays a charge (although, at the end of the PFI, the asset is purchased by the NHS for £1). The government then pays annual payments called "unitary charges", which cover the costs of the services being delivered, plus the costs of interest and repayment of the debt.

The question of whether or not the PFI provides 'value for money' remains controversial. The NHS currently has more than 100 PFI hospitals. The original cost of these 100 institutions was around £11.5 billion, but ultimately, they will cost £80 billion in public money.[23] In 2016/17, the NHS in England paid an estimated £2 billion for past and current PFI projects.[24]

Common criticisms of PFI include a lack of flexibility where the occupier is restricted to one FM provider and has no/limited scope to negotiate on price and therefore the occupier lacks financial control and can find itself with no choice but to pay materially more for relatively small works projects (e.g. moving a non-structural wall) than if it were able to get quotes on the open market.

- **Third party developer (3PD)**

A tried and tested procurement in the primary care arena with a proven record of delivering projects regardless of size on time and on budget and the ability to provide the occupier with greater certainty/control over ongoing costs.

If primary care premises are in need of 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. 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 building to meet local clinical requirements and NHS standards.

Contractors who rent their premises are eligible to receive reimbursement for their rental costs. 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 the District Valuer Services (DVS), an agency of HMRC.

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

23. The Independent, If you think there is no money for NHS funding you'd be right – PFI has sucked it dry (2016), Available at http://www.independent.co.uk/voices/nhs-funding-pfi-contracts-hospitals-debts-what-is-it-rbs-a7134881.html (Accessed: 30 August 2017)
24. HM Treasury Infrastructure and Projects Authority Private Finance Initiative and Private Finance 2 projects: 2015 summary data, Available at https://www.gov.uk/government/publications/private-finance-initiative-and-private-finance-2-projects-2015-summary-data (Accessed: 30 August 2017)

4.5. The STP challenge

Despite many being led by NHS leaders, the STPs that GGI have engaged with regarding the use of assets have said that although it is widely understood that major reconfiguration of services will be necessary, often the creation of an estates strategy has not been the priority and plans are still extremely high level. It is important that adequate strategic focus is given to estates and assets going forward to drive transformation in the NHS. Some footprints appear more advanced in this, for example the Greater Manchester Health and Social Care Partnership, which has recognised health and social care estate as a 'critical enabler' of delivery of the local plans and is creating an effective estates strategy.

That said, the need for the development and implementation of new models of care is recognised in almost all plans. As the Naylor Review has argued, 'given the emphasis on expanding and strengthening primary and out-of-hospital care, it will not be possible for the NHS to achieve its vision without changes in the estate.'[25] This might come from innovative capital solutions or the rationalisation of existing estate.

It is increasingly understood that private partners will likely have a significant role to play in ensuring that estate is utilised effectively and providing access to affordable capital. This point was underlined by Michael MacDonnell, NHS England's Director of Strategy, who has argued that the NHS will need support with capital investment and with "getting to grips with what sort of buildings and other fixed assets we need" as this "is just something the NHS cannot do for, or by, itself."[26] Private partners can support STPs to 'hit the ground running' by providing a modern fit for purpose estate as necessary and appropriate.

25. Sir Robert Naylor, NHS Property and Estates: Why the estate matters for patients (2017)
26. Health Service Journal, STPs offer private sector 'enormous opportunity' (2016). Available at https://www.hsj.co.uk/topics/technology-and-innovation/stps-offer-private-sector-enormous-opportunity/7006369.article?blocktitle=technology-and-innovation&contentid=20694 (Accessed 30 August 2017)

5. Solutions: utilising innovative models of capital finance

There is a growing awareness among STP leads of the capabilities that alternative capital models can offer, especially given that adequate central funding is unlikely to be forthcoming. STPs can make use of private sector investors such as PHP as strategic partners in order to deliver the capital, knowledge and expertise needed in order to modernise estates, as well as sharing the risk burden being taken on by NHS organisations.

In 2013/14, the total costs for GP premises reached c£800m, with around 40% used to pay for older and often unsuitable units.[27] The British Property Federation estimates that there is currently a need to replace approximately 4,000 GP premises with c1,300 new purpose built medical centres.[28] This, they argue could be delivered and funded through the use of the private sector and would result in additional annual rental costs to the NHS of £150 million. Whilst this is a significant amount of money, it is estimated that the efficiency savings that could be accrued through the use of modern, multi-functional GP premises could amount to more than £270 million per annum (through a reduction in non-urgent visits to A&E, reducing pressure on walk in centres etc.) meaning the system would realise substantial savings.[29]

There would also likely be patient, staff and organisational benefits including:

- The use of multi-disciplinary teams (MDTs) would support the delivery of a wider range of services in the community improving access and patient experience, and ensuring that patients are seen by the most suitable health professional
- Premises that support the visitation of specialists and MDTs will support the delivery integrated and holistic care
- Improved and modern facilities will make it easier to recruit

There are clear lessons for STPs as they begin to deliver new models of care that move care out of hospital and focus on the development of community hubs.

In particular, private providers of finance must be viewed as key strategic partners in achieving STP goals. Partnership working and collaboration is central to the delivery of the new models of care, and not just within local health and care economies. Early engagement with private providers of finance will help ensure that commissioners and providers can be certain that all realistic considerations have been taken into account ahead of the design process in order to incorporate existing plans.

This ‘future proofing’ of new estates is vital to the sustainability of the national health and social care system, especially in these times of decreasing budgets, increasing operational pressures, substantial regional variations in quality of service and care across, but also large scale transformation in accordance with the 5YFV and GPFV. In order to provide recommendations on approaching these discussions with all types of finance providers, we set out some key themes that should be considered in any decision-making process, along with a set of helpful case studies from PHP demonstrating how this model can be realistically delivered to optimise the redevelopment of the NHS estate.

- **Engage partners early**

  Finance providers bring a unique perspective to any debate around the development of new estates. Not only can these offer guidance from their experiences of previous development programmes (e.g. what challenges were faced and what mitigations might have helped), they are also able to advise on timelines and budgets ahead of engaging with either architects or construction partners. These providers may also introduce providers and commissioners to other trusted suppliers within the industry with whom they have collaborated with before, helping to limit the risk NHS organisations take on.

- **Prioritise providers with extensive healthcare experience**

  Although there are many providers of capital finance to the health and care sectors, many have little or no experience in providing custom-built properties for NHS organisations. By engaging a provider who has extensive health and care experience at an early phase, NHS organisations can ensure that they receive specialist input in discussions about services, locations and the utilisation of existing assets and infrastructure. This can not only help save costs but also avoid unnecessary design flaws following completion of the project.

27. British Property Federation, Unlocking investment in primary care infrastructure (2015)
28. Ibid.
29. Ibid.

- **Articulate STP priorities early on**

  Although all Sustainability and Transformation Plans are based on addressing the triple aim of the 5YFV, each of the 42 (previously 44) partnerships have a tailored strategy for the delivery of these transformational changes. These may come in the form of new organisational forms, locality/multi-disciplinary teams, the relocation of services, emphasis on community provision, and the incorporation of population health initiatives, with extensive collaboration between wider system partners (local authorities, housing associations, police and fire providers etc.).

  Due to these differences in the plans outlined in December 2016 for STPs across the country, individual STP priorities must be incorporated into the planning of any new assets. An example of this would be the importance of flexibility within estates to factor in the need for community care, community pharmacies, and multi-disciplinary teams without a fixed practice location. These premises may also have to consider the implications of merged corporate functions between providers/commissioners, enhanced patient experience and further opportunities for community engagement within health and care premises.

  Both early engagement with financiers and prioritising those with specific experience will help ensure the STP priorities are thoroughly considered as part of the planning phase

- **Review the shortcomings of existing estates and challenges faced**

  The traditional model of developing large, generalist hospitals (usually in the acute setting) in a central location is no longer viable for addressing the challenges faced by delivering long term, complex care. Challenges with the existing primary care estate (clearly outlined within this paper) also demonstrates the lack of an existing estates infrastructure within a given locality in which to host newly, dispersed services.

  Although there will often be a need for improvement and improvement, partners should review their existing estates infrastructure: the key services and functions delivered, and what the current capacity of these buildings is for sustaining these. This could also include utilising the Naylor recommendation of adopting a principle of prioritising the utilisation of estate capacity for clinical purposes (as opposed to corporate).

- **Engage beyond key partners**

  Key frameworks within the health and social care system advise on the utilisation a wide selection of partners, beyond just system partners. This can include patient groups, public facing organisations, third sector organisations, local enterprises, community groups and many more who will provide valuable insights from the key demographics they represent. These groups should be engaged with at the earliest possible stages of development to ensure adequate buy-in to what can often be significant service change.

- **Consider the implications of all possible options**

  As outlined above, there are many options for raising finance to fund capital projects, each with their own pros and cons. GGI would always recommend conducting a thorough options appraisal of all existing options before taking any decisions around redevelopment of estate and financing of this.

These steps ensure that key stakeholders from finance, construction and development, patient groups, wider system partners, and other third sector organisations can have an input into the asset design approach to ensure it complies with STP goals. Many projects fail to achieve their intended outcomes due to a lack of oversight. Engaging a wider group of stakeholders early on can reduce the chances of this occurring, and increases the chances that any issues are resolved before the commencement of development activities.

6. Case study examples

Here we provide some examples illustrating the impact that such an approach can have on the sustainability and quality of local delivery of care.

This model of strategic partnerships between health and care providers and third party developers, allows providers to readily access capital funding to solve critical strategic issues.

Developers are keen to support health and care organisations to address problems facing the system through better estate development and management.

6.1 Aylesbury

In 2014, Poplar Grove Practice had outgrown their purpose-built premises due to significant housing growth in this part of Buckinghamshire. Nearby Broughton House Surgery were operating out of a listed cottage, and were also struggling with both property compliance issues and space to service the growing population. To ensure the sustainability of both practices, a merger was agreed, and the decision taken to amalgamate the practices at the Poplar Grove site.

As a leasing partner, PHP worked with the practice to arrange concept drawings, land assembly, planning process, business case support and eventual NHS consent. During the process, PHP also assisted the CCG in establishing a new estates strategy, which went onto unlock a number of developments within Aylesbury.

The extended and refurbished facility now provides accommodation for a 19,000-patient practice, creating one of two hub centres for the town. The GP's committed to a new 24-year lease on completion, enabling PHP to invest capital of over £2m.

6.2 Newton Abbot Hospital Redevelopment

In 2006, a new out of town hospital facility was opened to relocate Newton Abbot Hospital. This vacated a large 9-acre former hospital site within the town centre, which was to be sold on and regenerated to partly finance the move.

PHP partnered with the developer, Keyworker Homes Ltd to provide finance for a new 1,600m2 Medical Centre, a 150m2 Pharmacy pre-let to Superdrug and a 350 m2 local store pre-let to Sainsbury on the former hospital site. This enabled PHP to invest capital of c.£4.5m.

The remaining regeneration across the site consisted of:

- 51 new build houses,
- a 75-bedroom extra care facility,
- 48 later living retirement apartments,
- 500m2 D1/B1 accommodation within a Grade II Listed Building.

The development was completed in 2013.

6.3 Central Sutton Health Centre

Robin Hood Lane Health Centre is a modern primary care building housing two GP surgeries together with a Community Services suite, owned and managed by PHP.

There is an adjacent building owned by the London Borough of Sutton, occupied by a number of charitable organisations offering a wide range of services designed to support and enable disabled people encouraging them to have choice and control in their life.

The London Borough of Sutton and PHP, under a joint venture arrangement, and with the support in principle of Sutton CCG, have established a proposal to redevelop the site. The proposal provides for a 3,937 m² (GIA) extension to the existing centre, which will provide:

- all five town centre practices to relocate within one central site
- relocation of the Council charity tenants to a new unit within the centre
- expanded community services to provide a new Elderly Care Hub for the CCG
- a new community pharmacy

In addition to this, apartments will be developed within the upper floors.

This proposal creates a new Health and Social Care Hub for Central Sutton, providing new fit for purpose accommodation for all GP Contractors in Sutton, who combined provide services to over 50,000 patients in Sutton Town Centre.

This particular project was submitted for ETTF program in 2016, achieving a prioritisation rating of 13 out of over 200 projects in London. PHP are able to undertake projects of this scale both with and without capital injections from the NHS.

PHP is assisting the CCG and the council in the engagement program, which is currently ongoing, and project completion is expected in 2020.

7. Conclusion

The challenges facing the NHS in the coming years are well documented and understood, and include increasing population pressures, inadequate funding and workforce issues, particularly around recruitment and retention.

The role of estates in addressing these should not be underestimated. Much of the current NHS and GP estate is not fit for purpose, and will need modernising to meet the vision set out in the FYFV of a truly integrated health service. This will require significant capital investment (as much as £10 billion), which is unlikely to be centrally funded.

NHS organisations are therefore expected to realise efficiency savings and increase financial capital through the rationalisation of existing estates and the release of surplus land. However, the use of third party developers should also be explored as a means of acquiring modern, fit for purpose estate in a cost-effective and sustainable manner.

In the context of these challenges, GGI recommends NHS boards and governing bodies consider the following points in order to determine how organisations and system-wide initiatives should engage with the wide-ranging options for capital and its impact on estates development and optimisation:

1. Does the STP have an effective, sufficiently strategic, estates strategy and, if not, is it going to develop one?
2. Is the estates strategy an integral part of the STP? How can we ensure that it plays a central role and is not simply an afterthought?
3. Do the boards of organisations understand the potential implications on its estate of the STP and its related clinical strategy?
4. Has there been a comprehensive mapping out and modelling of all estate in the footprint? Should this be done?
5. Is there scope within the STP to use assets more innovatively? How could this be facilitated?
6. Does the STP plan include proposals for major secondary care service reconfiguration? Have the consequences of this on the estate and how this will be delivered been thoroughly considered?
7. How can reconfiguration of services that are already ‘running hot’ be delivered?
8. How does the STP propose to deliver new models of care and primary care facilities? How can using assets innovatively help to facilitate this?

The Good Governance Institute is committed to developing a robust body of knowledge in this field.

This evolving landscape across the NHS will require vigilant oversight, and as the plans and partnerships progress, all partners must continue to query both value for money, opportunities for further efficiencies and to what extent boards and governing bodies can remain assured in this challenging context.

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