BPF

BRITISH PROPERTY FEDERATION

UNLOCKING INVESTMENT IN PRIMARY CARE INFRASTRUCTURE

Introduction

The health and care services that we need have changed dramatically since the NHS was founded. We are living longer, our population is larger, and as medicine has advanced our healthcare needs have evolved.

In an era of constrained public finances, private-sector investment in healthcare infrastructure will be vital to meet these challenges, by updating existing property and delivering a new generation of modern, fit-for-purpose healthcare facilities with the ability to realise the vision for 21st century healthcare, improve patient outcomes and generate savings for the public sector.

While we welcome the new Primary Care Infrastructure Fund, set up following the promise in the Autumn Statement of a £1bn investment in primary care, this will be insufficient to tackle the true extent of the upgrading needed, and an increase in revenue funding to allow GPs greater flexibility to claim rental reimbursement would have a significant impact.

In summary:

- Approximately 4,000 of the 7,962 GP surgeries in England & Wales are considered by medical professionals to be unfit for purpose[1].
- Replacing these with larger, modern surgeries offering a broader range of services requires the development of approximately 1,300 new buildings.
- This would result in a capital cost of about £5bn – and our research indicates there is approximately £6bn ready to invest in the sector from UK and global institutions, meaning the capital investment could be borne by the private sector.
- Additional annual costs through rent to the NHS would average about £150m a year, but this revolution in the provision of primary care would more than pay for itself due to the efficiency savings of over £270m that would accrue from reducing the non-urgent use of A&E departments, removing the pressure on walk-in centres, and increasing GP care for the elderly. It would also generate wider economic benefits through an increase in development activity.
- Crucially, it would unlock a range of benefits to patients including better clinical outcomes, a greater range of services provided within the community, and increased co-location of services, allowing primary care to take the lead in improving public health.

The scale of the problem

There are 7,962 GP practices in England[2], and BMA research shows over half of these are too small to deliver the increased level of service provision that NHS England would like to see GPs provide. It is estimated that half of all surgeries have asbestos, and that four out of ten GPs in England and Scotland feel their premises are not fit for purpose[3] – around 4,000 properties.

Many of these are small and could more efficiently be replaced by fewer larger buildings accommodating a number of GP practices. If a ‘hub and spoke’ principle was adopted to allow smaller satellite operations to complement other larger centres, particularly in rural areas, we estimate

around 1,300 new buildings would be required with an average capital cost of £4m. This would require approximately £5bn of capital investment.

Our research estimates that direct institutional investment in UK healthcare real estate is currently around £5bn, with a further £3bn ready to invest from UK institutions and the same again available from global insurers. This means that most, if not all, the capital investment for these premises could be met by the private sector.

Value for money

A significant investment in primary care would offer excellent value for money for the public sector. Research by Deloitte for the Royal College of General Practitioners (RCGP) shows that increased government spending on general practice could lead to a saving of up to £1.9bn to the NHS across the UK by 2020[4], which would go some way towards closing the organisation's projected funding gap of £30bn by 2020/21[5].

Increasing the GP budget would save the NHS £5 for every £1 put in, according to the RCGP research. Spending £72m a year more on general practice across the UK could help save up to £375m each financial year, rising to annual savings of up to £708m by the end of 2019-20.

Benefits and savings

Total GP premises costs were around £800m in 2013/14, of which some 40% is used to pay for these older, often unsuitable units. If substituted in large part by a smaller number of fit-for-purpose buildings, we estimate the additional cost would be around £150m a year – which would be amply covered by the savings elsewhere in the system[6].

There are estimated efficiency savings of over £270m that would accrue from reducing the non-urgent use of A&E departments, removing the pressure on walk-in centres, and increasing GP care for the elderly. Investing in primary care premises construction would also generate wider economic benefits through an increase in development activity.

Crucially, it would unlock a range of benefits to patients including better clinical outcomes, a greater range of services provided within the community, and increased co-location of services, allowing primary care to take the lead in improving public health.

Patient benefits

- GPs can provide, in safety, many services and diagnostics currently unnecessarily delivered in a hospital setting[7];
- Specialists can attend to patients at GP premises, breaking down barriers between primary and secondary care and so delivering service integration;
- New facilities can provide a visible 'medical' location for ambulatory care within communities that, if coupled with longer opening hours and an active local information campaign, will encourage people with non-urgent complaints to attend there rather than A&E;

- A modern, uplifting environment will contribute to primary care taking the lead in improving and providing public health, rather than just providing treatment;
- Providing space for other services which are also highly relevant to public health, such as social care and citizen's advice, would be beneficial in the provision of holistic care.

Organisational benefits

- Modern premises and the improved working environment these offer will help those practices struggling to recruit;
- When primary care practices are run with a broader staffing pyramid, health services can be delivered by appropriately skilled personnel and GPs will be able to handle more complex consultations and manage the overall health and wellbeing of their patients[8];
- With that larger staff pyramid, and through co-location with other general practices as well as pharmacy, dental and community eye care services, the capacity to handle a larger volume of appointments grows and out-of-hours availability becomes easier to manage;

Cost benefits

- There are around 22m A&E attendances each year[9] of which 40% are non-urgent[10], meaning approximately nine million visits could be handled in a lower-cost environment, particularly given that many A&E departments operate expensively with locum staff;
- Recent research has shown that more accessible general practices in England have fewer emergency department visits per registered patient, with some patients self-referring to emergency departments when unable to see a GP within two weekdays and therefore placing an unnecessary burden on A&E[11];
- At least 20% of emergency admissions to hospital could be managed effectively in the community, at a much lower cost[12];
- Increasing GP care for the elderly, either at enhanced premises or in the home, would save money by reducing the number of elderly patients admitted to acute hospitals for lack of an alternative solution: 50% of avoidable bed days at hospital are occupied by patients over the age of 75[13].

A vision for investment in primary care facilities

There is consensus between the Department of Health, NHS England, CCGs and NHS providers that increasing the capability and capacity of out-of-hospital care is vital in order for our NHS to continue to be free at the point of need.

Members of the BPF Healthcare Committee have invested more than £2.4bn in modern primary health accommodation in the UK in the last 15 years. Should this development pipeline be made a priority with Ministerial backing, the industry would be able to increase the pace of delivery so the substantial majority of the required schemes are delivered in the course of the next Parliament.

While the private sector stands ready to play its part, there needs to be further movement of resources from the secondary care system into the primary care system to enable NHS England to be able to increase the amount it spends on rent and rate reimbursement, and we believe the cost saving and patient benefits of the integration of services would far outweigh additional future rent costs. Moreover, most or all the capital investment needed to develop new premises could be provided by the private sector and not from over-stretched Government resources.

Further changes to the structure of organisations created by the Health and Social Care Act 2012 (England) would delay this process. The move from Primary Care Trusts to Clinical Commissioning Groups created paralysis in the commissioning of new healthcare facilities, as well as causing expertise and value to leak from the system. Many CCGs have still to deliver their five-year strategies some 15 months after they were formed, and it would be disastrous to start all over again.

We welcome the £1bn investment and look forward to the publication of NHS England's *Principles of Best Practice*, which will advise on prioritising premises investment decisions. It is vital that decision-makers recognise the opportunities to replace costly, inefficient buildings with modern, purpose-built premises across the whole of the diverse NHS estate, and new primary care facilities have the potential to realise the vision of integrated, whole-person care, and to deliver services at a lower cost while improving patient experience and health.

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References

1 BMA, July 2014

2 Health and Social Care Information Centre, General and Personal Medical Services: England 2002-2013, March 2014

3 BMA, July 2014

4 RCGP, November 2014

5 NHS England analysis, July 2013

6 The incremental costs are estimated at £150 million assuming premises are provided through the current funding model for third party investors and assuming the majority of old stock is retired. This annual cost would be defrayed by efficiency savings and would build up gradually as premises are brought on stream.

7 A good example is the GP practice in Kent referred to in the NHS England Five Year Forward Review, where 20 GPs and 150 staff provide many of the tests, investigations, minor injuries and minor surgery usually provided in hospital.

8 Wirral CCG through St Hilary Group Practice undertook an exercise whereby they developed a multidisciplinary care team to enable the integration of community services and third sector providers to increase capacity in both clinical and social care provision. It found that extended hours with increased professional team could alleviate Out of Hours, Walk in Centre and A&E attendances.

9 NHS Weekly Situation Reports, 2012-13

10 The Keogh Urgent and Emergency Care Review, End of Phase 1 Report, November 2013.

11 Imperial College London, Access to Primary Care and Visits to Emergency Departments in England, June 2013

12 NAO, Emergency Admissions to Hospital: Managing the Demand, October 2013

13 Dr Foster, Fit for the Future?, 2012