BPF

DELIVERING PRIMARY CARE

Healthcare

How third party development can help meet the primary care infrastructure challenge at better value for money to the public purse

Executive summary

- The primary care system continues to face funding challenges, and new development of GP premises should be a priority within Sustainability and Transformation Plans (STPs).

- With a new NHS property organisation set to be established, Sir Robert Naylor's new report on NHS property highlighting that without investment in estate, the Five Year Forward View cannot be delivered, recently-announced funding for STPs and a new delivery model set to be launched, it is critical that those involved recognise that no single investment model is likely to act as the silver bullet to solving the UK's primary care infrastructure challenge.

- LIFT can be used to great effect on large, strategic projects and there are successful examples of its use.

- However, the third party developer (3PD) delivery model is often more suitable for GPs, particularly on more straightforward projects.

- When used, research carried out by BDO and commissioned by the BPF proves the 3PD model provides better value for money than LIFT over the life cycle of a development.

- 3PD also provides a secure, low-risk and flexible option to doctors

The need for investment

The primary care system acts as the heart of our NHS, operating as most patients' first point of call when unwell. Despite its critical function, its proportion of the NHS budget has decreased every year since 2005/06 (General Practice in England, Briefing Paper 07194, House of Commons Library, October 2015), while patient demand has increased significantly. During the same period the primary care estate has also faced underinvestment, with approximately 4,000 of the 7,962 GP surgeries in England & Wales considered by medical professionals to be unfit for purpose.

The NHS Five Year Forward View emphasises the need to shift more care away from the acute sector towards primary and community settings, meaning the demand for appropriate facilities will grow further by 2020 as NHS England's new models of care embed. The recent follow-up 'Next Steps on the Five Year Forward View' reiterates that shift, setting out targets for growth in the primary care workforce, expansion of access to general practice and the need for improved primary care premises.

While the General Practice Forward View is a welcome blueprint to put primary care on a sustainable footing, its commitment of an additional £900m investment in facilities over the next five years, and £400m extra over the subsequent three years, falls short of what we have estimated to be the true cost of bringing the primary care estate into the 21st century – a capital cost of around £5bn.

The level of investment needed means that no single investment model is likely to act as the silver bullet to solving the UK's primary care infrastructure challenge. We welcome thinking from the Department of Health and CHP while developing Project Phoenix on how they can maximise value for money in new procurement models while ensuring a high level of service, and look forward to continuing to discuss with both parties how this can be achieved. On larger projects incorporating a range of services, this model will prove a very attractive option and the engagement from those involved has been very effective.

However, it is critical that Government does not limit the potential contribution that could be made by private sector investors by favouring one procurement model which could stymie much-needed growth and development of primary care premises.

Our research shows using third party development (3PD) as a funding model is consistently better value for money to the public sector as a whole than an NHS LIFT structure – this is the case whether covering the lease cost, residual value, or the first full year cash outgoings for the occupier.

This briefing sets out the need for further investment in the UK's primary care infrastructure, and the benefits of using the 3PD model to deliver this where appropriate and in line with other public sector approaches.

3PD

3PD is a system that provides GPs with private sector development expertise and capital to construct modern purpose built premises, which they then lease back from the private sector partner. Since 2000, the three major providers of primary care premises have delivered over 500 schemes, which have an average occupancy rate of nearly 99%. Crucially, 3PD offers an off-balance sheet solution to the need for capital investment in primary care estate and for the delivery of the vision set out in STPs, whilst ensuring value for money to the taxpayer - with subsequent rental rates set independently and approved by the NHS.

Secure and flexible offers

One of the key benefits of 3PD is the flexibility and security it offers to tenants, who have the right to renew leases upon completion or to move into alternative premises at the natural end of the lease.

As independent agents, the GP partnership or NHS tenant is not exposed to financial risk through fluctuation in property values or changes in interest rates or lending terms, or any liability in the unlikely event of a project being aborted before a lease is agreed.

Experience in construction

From initial bid stage through to project completion, the 3PD model is an efficient and quick procurement option. The third party developer takes on responsibility, and risk, for development costs and project delivery – often this will include identifying and securing appropriate land site.

The design and build process is streamlined, as responsibility rests with the developing and requires minimal input from the commissioning body. Responsibility for external and structural repairs is borne by the developer, while the tenant maintains internal liability.

Value for money

A competitive market place within the 3PD sector ensures the tendering process is rigorous and provides value for money. A variety of competing developers within the market allows GPs and commissioners to choose the most suitable, and cost effective, option for them. This helps prevent a single developer dominating the market in any given area, stimulating choice and competition.

Because lifetime construction costs and interest payments on the debt used to finance the project are not borne by the tenant, as is the case in other models, the GP partnership or head tenant is not exposed to this financial risk

As the private sector development partner sources 100% of the capital for the project, there is no burden on the GP partnership or NHS to produce any share of the capital requirement.

Financial savings

We engaged BDO to produce comparative research examining the value for money of funding health facilities through NHS LIFT and through 3PD. The below sets out the key findings, and the full analysis is available upon request.

The purpose of the research was to present a quantitative assessment of the relative value for money to the public sector of:

- A lease with a third party developer;
- A Land Retained Agreement (LRA) with the local LIFT company; and
- A Lease Plus Agreement (LPA) with the local LIFT company

BDO calculated the Net Present Values for the funding options identified above for three example projects. The model was populated with the following information:

- Sudbury Community Health Centre, which opened in December 2014;
- North Caerphilly Resource Centre, which opened in December 2012; and
- A sample scheme based on a floor area of 2,000 m2 and current benchmark costs and rental charges.

These tables set out the comparative life cycle costs of developments using 3PD and LIFT, and show the cost benefits to the tenant over the lifetime of a typical lease. For each of the three examples, the 3PD structure proved better value for money.

	SUDBURY		
ALL £'000	**LPA**	**LRA**	**3PD LEASE**
UC / Lease cost	11,028	12,089	8,957
Life cycle costs			271
FM costs			596
Residual value	1,450		1,450
Returns from LIFTCo to CHP	(662)	(547)	
Total	**11,816**	**11,542**	**11,274**

	CAERPHILLY		
ALL £'000	**LPA**	**LRA**	**3PD LEASE**
UC / Lease cost	12,929	14,116	9,077
Life cycle costs			347
FM costs			763
Residual value	1,820		1,820
Returns from LIFTCo to CHP	(834)	(707)	
Total	**13,915**	**13,409**	**12,007**

	SAMPLE		
ALL £'000	**LPA**	**LRA**	**3PD LEASE**
UC / Lease cost	8,012	8,835	5,898
Life cycle costs			164
FM costs			360
Residual value	1,001		1,001
Returns from LIFTCo to CHP	(409)	(395)	
Total	**8,604**	**8,440**	**7,423**

We also compared the first full year cash outgoings for the occupiers, and again found the 3PD model to provide better value:

	SUDBURY		
ALL £'000	LPA	LRA	3PD LEASE
UC / Lease cost	840	921	590
Life cycle costs			39
FM costs			18
VAT on lease			118
Total	**840**	**921**	**765**

	CAERPHILLY		
ALL £'000	LPA	LRA	3PD LEASE
UC / Lease cost	1,014	1,107	611
Life cycle costs			51
FM costs			23
VAT on lease			122
Total	**1,014**	**1,107**	**807**

	SAMPLE		
ALL £'000	LPA	LRA	3PD LEASE
UC / Lease cost	608	670	388
Life cycle costs			24
FM costs			11
VAT on lease			77
Total	**608**	**670**	**500**

Conclusion

The research above, coupled with the qualitative benefits set out, show that the lifetime lease costs, low financial risk, and speed of project delivery of the 3PD model offer GPs and commissioners a highly competitive development solution.

The primary care infrastructure market is comprised of a range of financing and delivery options, each with their advantages. Constrained capital flows within the NHS mean value for money assessments and access to capital are increasingly important when GPs consider the development options that are most suitable to them, and it is critical these different options remain open to those involved.

Third party developers take risk away from tenants, while maximising the capital available for modernising the NHS estate. This provides a cost effective financing option that does not indebt NHS organisations or GP partnerships. Its flexibility, cost effectiveness and attractiveness to investors means 3PD is helping to transform the primary care estate as it prepares for a shift towards community-based models of care.

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 at no cost to the public purse.

The Government recognises the need for investment, but is constrained by tight capital controls within the NHS budget. The primary care sector has an established and mature relationship with private sector developers and investors, putting it in a strong position to access capital and expertise to modernise the estate.

We would seek to discuss the impact of these findings with Government and NHS bodies as they move forward with their construction of new procurement models.

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