

## **LONDONWIDE LMCs' RESPONSE : Commons Health & Social Care Select Committee**

### **Call for Evidence: Delivering the Neighbourhood Health Service: Estates**

#### **ABOUT US**

Londonwide Local Medical Committees (Londonwide LMCs) is the representative, elected, clinically led, independent voice of general practice in the capital. We aim to secure the future of general practice in London through our work with all partners in the health and social care sector and beyond, and by supporting and representing over 7,000 GPs and 1,100 practices in London through the 27 locally elected committees that we serve. We ensure that London's GPs and their practices have access to the information and support they need to help them provide the best possible service to their patients.

Local Medical Committees (LMCs) are made up of practising GPs and practice staff elected by local GPs.

#### **OVERVIEW**

Evidence shows that primary care is best delivered by expert generalists working with registered lists in defined geographic communities. Capacity in general practice is the major issue affecting patient access and GP morale, along with their staff. And this is as much about premises and estates capacity as the workforce.

It is our hope that ICSs will consider local need and depart from the increasing reliance on quantitative data to drive service improvement; considering on a case-by-case basis the value of aspects of care that are less easily measured, such as the doctor patient relationship, continuity of care and relationship continuity. There is significant risk that, without GP leadership, the full complexity of general practice and the value to patients is not understood and lost to the significant detriment to patient care and community health and all other elements of the quintuple aim if not adequately considered during service design/ procurement.

To that end we hope that any premises or estates discussion and procurement considers contracts within general practice/ primary care/ community care settings about the needs of practitioners and their teams, and patients and their communities.

#### **QUESTIONS POSED BY THE COMMITTEE**

##### **What is needed from the NHS estate to allow it to deliver the Neighbourhood Health Service?**

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

Rather than beginning with the physical and matching service to it, we believe that the starting point is to determine what the new model of care looks like, and what buildings are needed to deliver it. At present there is not a clear model of care for neighbourhood working. Clinicians and patients alike do not know what a neighbourhood health services actually means and how this will be different to the existing model of care. It could mean an illness rather than disease model, which would potentially bring care into the community and could include working more effectively across the

system and removing the contractual, perverse, provider incentives and other constraints that limit neighbourhood working now; or it could mean a tier two services which would require additional estate. Until this is articulated, it is impossible to effectively determine what the physical/ estate needs are/ will be in future.

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

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

GP practices need estate that is fit for purpose to deliver modern GP access, and large enough to cater for the patient populations and future growth (including hosting allied health professionals and such neighbourhood services as are commissioned/ coordinated in a given locality. And that given locality must be a part of the community they serve. A core element, not an add on. Being a fundamental “community anchor” is important for access and trust. The further away practices move from local communities the greater the challenges for patients, the more access and travel issues that are experienced, and the more trust and confidence is eroded. The current estate across general practice, on the whole, does not meet these requirements to deliver core general practice, let alone future plans for enhanced neighbourhood health.

With regard to the estate utilised by general practice and what we understand about the needs of the wider primary care estate, there is neither the finance, space or flexibility to accommodate multi-disciplinary teams or related providers under a neighbourhood structure. Whilst we concur that there will be a need for much closer working with community and secondary care and a more integrated, flexible estates approach to support this, it remains the case that the retention of local, accessible, community based general practice is critical.

Much is already known about the premises and estates challenges being managed across general practice in London. We have been through numerous premises surveys and had professionals audit the estate across general practice over the years - this data is held by ICBs, NHSE and the Department of Health and Social Care and its agencies. It is unclear how and where consideration of this data factors into the current Neighbourhood Health Service proposals, and what is being done with the data which has been gathered.

What is clear is that without significant increases in capacity and functionality/ repair it is unlikely much of the current estate would be large enough to support delivery of increased or scaled co-located activity as outlined in relation to the aspirations and goals set out for the Neighbourhood Health Service (<https://www.gov.uk/government/news/government-takes-action-to-deliver-neighbourhood-health-services#:~:text=In%20addition%20to%20the%20neighbourhood,we%20know%20affect%20people's%20health.>).

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

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

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

The investment should follow the patient.

If the Neighbourhood Health Services is to deliver services closer to home, out of hospital in the community, in an integrated way, primary and community care premises will need to be updated and maximised, and all void space appropriately utilised and funded. There will also need to be changes to the Premises Cost Directions and the rent reimbursement framework for use of premises by providers other than GP practices. Cost efficiencies will need to be realised, with specific attention to service charges, repair and maintenance costs.

If GPs hold risk for service charges and unfunded rent increases in any new proposals, there are concerns that this risk will be too great for them to bear alongside other contractual and financial uncertainties.

Premises funding needs to be sustainable and manageable and, where necessary, supported/subsidised to maintain access to high quality and safe local services in areas of need due to poor or lacking current estate.

**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?**

We know that co-location of teams can support cohesive joined up working and better patient outcomes. Relationships between professionals are key and co-location can help to develop these relationships and the necessary trust for them to work effectively, but this is only one enabler. General practice, GPs and other professionals working at a neighbourhood level will need the time and headspace to develop effective, collaborative relationships. And time is not simply a longitudinal measure - we know that co=locating services in the same building doesn't build collaboration without the time and ability to develop and grow those relationships of trust and partnership. Changed ways of working aren't organic – we need the time to meet others.

**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?**

Local Authority premises could be utilised and potentially other public service estate. NHSE and the London Estates Delivery Unit will have more specific information on this. The key factor for general practice is sustainability and management of financial and other risk so that they can focus on the provision of patient care.

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

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

Noting messaging that general practice is at the heart of neighbourhood working, we should never lose sight of the fact that GPs and practices are already core elements of neighbourhoods – firmly embedded in the communities they serve. They could be enabled, funded and released to run community-based events and staff-led events, in conjunction with other providers.

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

**a. How does this compare to the current NHS estate?**

**b. Do the Department of Health and Social Care and the NHS hold sufficient data on the condition and utilisation of NHS estate?**

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

Effective delivery of the Neighbourhood Health Service estate needs is dependent on clearly analysing and articulating whether the estate supports delivery or inhibits it – based on information which could be provided on request. We are aware of many examples of GPs operating in shared rooms with limited examination space, surgeries on multiple floors without adequate lifts for the less mobile etc. Some of these issues might be addressed via access to capital funding, but others stem from physical limitations intrinsically linked to the premises from which they operate.

Listen to what practices say they need. Premises have to be affordable. There is little point in building new premises if practices (and others) cannot afford to move into them because of high management or running costs.

Keep practices informed about the plans for their premises (flex/tail) allow them to be part of the premises development in their area. Practices often feel siloed. ICBs, NHSE and the Department of Health and Social Care and its agencies might have data on estates and practice populations but not the development plans for the practice.

Estates need to be affordable – whether new or old - and fit for purpose. We need a thorough review of what premises are currently being utilised; including an assessment of whether any can be expanded/reconfigured to provide services and what is required to make existing and future estates fit for purpose now, and in years to come.

Can changes be made to make current premises more cost efficient? Increasing service/facilities charges could become a barrier to development and desire to move into new or expanded premises

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

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

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

Understanding practices future plans and ensure that there is a robust implementation plan that meets the needs of local communities for those practices identified as “tail premises”. Developing flex premises to become core, where these meet practice plans, and addressing concerns that any premises development policy does not leave tail premises to further decline/ decay. Clarifying available void space asap with costings. Simplifying occupation and charging arrangements, and recognising that whilst tail premises might not be ideal, they are often a part of local communities, embedded as local community anchors, and relied on by many of our patients.

Affordability & standardisation are key, with recognition that flexibility be available when required, such as enabling out of hours usage at no penalty to the occupier.

Pre investment considerations must include a thorough review of current premises regarding viability for the future. Look at other options than new builds eg large empty high street premises that could become Neighbourhood Health Centres or a group of smaller premises next to/opposite each other to collaborate on the provision of a broader range of services, still within their local practices; providing services for which function fits that scale in a centralised location and building on practices core role as community anchors understanding the needs of the communities they serve working collaboratively.

Priority should be given to local practices in local areas, be-spoking services to local communities and having a relationship with patients and local communities rather than aggregating primary care into at-scale buildings. And any application or consultation process should be mindful of practicalities such as timely responses to business case submissions.

#### **4. 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?**

Function should determine scale: supports weekend reach out; supports health campaigns through high volume pass through; integration within communities. There’s a need for practice level delivery but there are also functions that are best delivered at-scale through a centralised neighbourhood premise - different to core general practice. The level of scale should be dependent on/ determined by patient demographics and need. And we must retain the established value of collaborative working between individual relationships at practice level in local communities and not seek to replace.

#### **5. 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?**

Vacant high street shops to be used as neighbourhood ‘health hubs’ utilised for low risk (but often high volume) areas of work - health promotion, social prescribing, Health Checks, smoking cessation/weight management. Supporting weekend reach out and health campaigns through high volume pass through. This increases the visibility of general practice, normalises the importance of our health (and hopefully encourages more self-management) so reduces “white coat syndrome”.

Long term education and carer support similarly builds community/relationships. Time limited pilots can be run from them. Lower overhead costs. Can be short term and potentially scaled up/down depending on demand.

Agree look into vacant high street premises of all sizes smaller = hubs larger = local health centres

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

### **a. How should the estate be designed to meet need of different communities, including those based in rural or coastal settings?**

Engagement at grass roots to gain ownership and support change management processes on how, when, why, and where services need to be developed and changed to maximise health gain. Multi agency engagement recognising the broader determinants of health and wellbeing on health gain.

Do not assume you know what the local community wants, talk to local people to find out what they want, where they want it and if delivery is possible. Don't promise what cannot be delivered.

Operate openly and transparently. Remember one size will not fit all areas.

## **7. Are there any other comments you would like to add?**

## **HEALTH INEQUALITIES**

There is a critical need for ICS Boards to appoint a board-level executive with clinical and primary care knowledge and experience as a channel for assessing clinical impact, risk:benefit analysis and escalation of concerns about potential harm resulting from decisions on issues such as estates. Consideration of the impact of changes to place and service access on groups with protected characteristics or higher need for adaptation, underpinned by robust governance and processes, is needed to ensure that specific concerns at a locality or place-based level do not get lost within the large structures being created at the ICS system level. GPs and general practice teams are located within communities, as a part of them, and are best placed, in partnership with their patients and communities, to advise on the impact of service changes on their patients.

This area will require the bodies involved in providing joined-up care to work together differently through a new model of care in which all providers have responsibility for reducing inequalities in and between our local communities, and in monitoring and assessing efficacy on an on-going basis. Many people with the greatest need are those who need their GP surgery as part of their local community – eg people who struggle with public transport, can't drive, poor mobility, need greater trust in services that gained through relationships and the practice being trusted – (maybe due to frailty, significant mental health, poverty). Centralising premises could increase health inequalities.

## **SUMMARY**

Function must be considered before scale and form. We will likely need multiple levels of scale to meet complex need – one solution will not fit all. The development of innovative and agile practice is

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an area in which GPs and their teams excel, and from which patients benefit hugely. It is critical that any move towards increased at scale working and the need/ pressure for innovation to improve does not adversely impact care. There is a clear need for any such moves to be clinically led. Innovation is needed and neighbourhood working offers opportunity, but to focus on innovation irrespective of impact would be to ignore the skill and value of general practice. Lack of appreciation for the place of practices as part of the local community can all result in negative outcomes for those with the greatest need. Wider structural changes must be cognisant of these needs and supportive and mindful of existing relationships that underpin and deliver that care.

**Londonwide LMCs**  
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