

Recycling English town centres - from retail to healthcare: surveys, views, and next steps

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Abstract

Purpose - Many town centres in England exhibit high retail property vacancies and require regeneration. Several alternatives for the replacement of town centre retail have been suggested, one of which is healthcare. The healthcare sector in England is in distress, with the NHS tackling extensive patient waiting lists, whilst operating from an ageing estate. This paper is an introductory study that uses seven carefully selected personalised surveys to raise academic awareness of the importance and potential of integrating healthcare into town centres and calls for large-scale research to establish the statistical validity of the reported observations.

Design/methodology/approach - This study is developed from an interpretative standpoint. Through semi-structured interviews with key stakeholders specific to retail-to-healthcare conversions, it reports their perspectives on opportunities and limitations for such conversions to give direction for large statistical research in the future.

Findings - All participants support the integration of healthcare into town centres and agreed that diagnostic services, mental health support and primary care services are appropriate for provision within town centres. They advocate large-scale change in town centres in England, with integrated healthcare co-located with complementary services to fit with wider regeneration plans. Participants prefer adaptation of existing buildings where technically feasible and emphasise the importance of obtaining the buy-in of other stakeholders while expressing concerns about the uncertainty of capital funding availability.

Originality - The analysis and practice of retail-to-healthcare conversions in the town centres are still rare in England and projects are complex. The market experience is limited and thus the literature is scarce. This paper contributes to filling this void and provides a starting point for future quantitative research in this area.

Keywords retail real estate, healthcare real estate, town centres, conversions

Paper type Research paper

1. Introduction

Once vibrant and filled with shoppers, many town centres in the UK are desolating, and this is well documented (for a detailed account see e.g. Dobson (2015)). This problem is particularly acute and important for smaller English towns where the high street is a unique place of identity for the local community (Hubbard, 2017). It has been largely viewed that town centre regeneration will require major changes away from traditional retail (Grimsey, 2013; Dobson, 2015; Hospers, 2017). Many alternatives have been proposed for the repurposing of surplus town centre retail real estate (TCR), including residential, logistics, and healthcare (Wiejak-Roy *et al.*, 2019).

Like town centres, healthcare in England faces significant challenges, with an estate maintenance backlog of £9.2 billion (NHS Confederation, 2021), and a shortage of at least 62,000 doctors, nurses and midwives (House of Commons, 2022). The Health and Care Act 2022 facilitating a fundamental change in the delivery of healthcare in England (Charles, 2022) may present an opportunity for the reconfiguration of both healthcare and town centres.

This research is introductory in nature to promote large-scale future studies to investigate opportunities for integration of these two economically struggling sectors to improve efficiency in each and thereby enhance aggregate efficiency on the whole. It is introductory because of the small number of surveys (seven) undertaken although this allows us to delve deeper into each participant to explore healthcare's potential role in the repurposing of TCR and the corresponding benefits to healthcare of delivering vital property and infrastructure in town centres, and investigates stakeholders' requirements to facilitate such changes.

We start by looking into healthcare supply and demand trends in England to establish potential for healthcare services in town centres. We then study past international and English TCR-to-healthcare property conversions and highlight investment benefits from healthcare real estate. The main part of the paper reports on seven carefully selected stakeholders who are surveyed for their views. The selection is based on existing international research which identifies stakeholders specific to the economic activity of transforming town centre retail for healthcare purposes (see section 2.5). The responses bring forth the following predominant views: (1) TCR-to-healthcare conversions should

focus on diagnostic services, GP, community nursing services, and wellbeing services; (2) these conversions should be part of wider town centre community-led regeneration supporting co-location of complementary services; and (3) existing facilities should be reused where possible. These views help us provide directions for large-scale future research to make statistically significant conclusions.

The rest of this paper is structured as follows: Section 2 provides an overview of existing literature on demand and supply in the healthcare sector, cases of retail-to-healthcare conversions and the role of stakeholders in facilitating such changes. Section 3 details our methodology, Section 4 provides analysis of collected data, and finally Section 5 summarises our key conclusions and suggests a way forward.

2. Literature Review

We start with an overview of key literature on the current challenges to the UK's town centres and of the issues facing the UK's healthcare sector. This is then followed by international research on conversions of surplus retail real estate into healthcare uses to address the supply-demand imbalance in both sectors. As the international evidence is limited to a few countries only and to large schemes, we then look into the real estate investment in the healthcare sector as an alternative asset class generating superior returns. This is used to gain an understanding of the market trends and potential for smaller-scale investments such as TCR-to-healthcare conversions. In the last subsection, we discuss the role of various stakeholders in facilitating TCR-to-healthcare conversions with a focus on selected groups specific to the economic activity of such conversions.

2.1 Town Centres in England

In the past, shopping in the UK belonged mostly to the high streets, while today high streets account for less than a third of the retail offer (Grimsey, 2013). There are several reasons for this decline with online shopping being the most prominent factor in the decline of TCR. As of Q3 2022 the stabilised online retail sales make up around 25% of the market (ONS, 2022), casting further doubt on the long-term viability of TCR. Traditional retail is a high fixed-cost business (Pilkington, 2019). The poor trading performance resulted in retailers' insolvencies and portfolio restructuring reinforcing the persistent vacancies at around 14% in Q3 2022 (Local Data Company, 2022). Another factor behind the downfall of TCR is the changing UK population, which is

increasing, aging, and diversifying: changing working patterns including working from home resulting in time-constrained consumers also shifting their shopping habits (Wrigley *et al.*, 2015; De Fraja *et al.*, 2021). Several authors have suggested ways for the rejuvenation of the high street. Portas (2011), Distressed Town Centre Property Task Force (2013), Carmona (2015) and Orr *et al.* (2023) recommended the modern high street should include not just shops but a mix of uses such as housing, offices, education, leisure, culture, events, community support, and healthcare. Thus, town centre regeneration requires connecting people and places and developing lasting partnerships of local actors (Hospers, 2017). However, for non-homogeneous communities, no ‘one-size-fits-all’ (Carmona, 2015) and reconfiguration must be considered on a case-by-case basis in accordance with the communities’ needs and respond to global, regional, national and local socio-economic trends (Coca-Stefaniak, 2013). TCR can be changed to healthcare use through adaptation, or demolition and rebuilding (Goodman-Shortall, 2016; Pavlovskis *et al.*, 2017) with adaptation encompassing adjusting, reusing or upgrading a building to change its capacity, function or performance (Douglas, 2006). Adaptation should generally be more cost-effective and environmentally friendlier than other methods (Douglas, 2006; Bullen, 2007; Wilkinson and Remøy, 2017). However, some studies have shown that adaptation costs can surpass a comparable new build, for complex or listed buildings (Wilkinson *et al.*, 2009). Additional challenges to adaptation include high up-front costs and long payback periods (Pardo-Bosch *et al.*, 2019), and being inferior to new buildings in terms of performance, maintenance costs, life expectancy and environmental performance standards (Bullen, 2007; Bullen and Love, 2009). Within this research, the term ‘conversion’ encompasses all of the above. Despite that, adaptation can economically address spatial requirements for the delivery of health and medical services, but a lack of suitable and available buildings in a desired area can be a challenge (Elrod and Fortenberry, 2017) Opportunities for adaptation may therefore be limited, but retail-to-healthcare adaptation may significantly contribute to town centre regeneration alongside other uses.

2.2 The Case for Healthcare in English Town Centres

The Covid pandemic has revealed that the current social infrastructure is not fit for purpose and requires investment, with healthcare properties being on top of investors’ agenda (PwC and ULI, 2022). The National Health Service (NHS), through its ‘national treasure status’ (Berger, 2015) is frequently a topic of political debate (Rimmer and

Iacobucci, 2019) and is subjected to constant political reorganisations (McCartney, 2015). Prior to the pandemic, the NHS missed key national targets for several years, such as on cancer, or planned and emergency care (Alderwick, 2022) with individuals' health conditions fast deteriorating due to obesity, alcohol, blood pressure problems and delayed screening (NHS Digital (2020, 2022); The Office for Health Improvement and Disparities (2022)).

As of March 2022, the NHS faced a backlog of 5.5 million patients in England waiting for tests and treatment, with this potentially reaching 13 million in the next few years (HM Government, 2021). What is key in this is that shortages in staffing do not help this situation (House of Commons, 2022). Further, the NHS estate contributes to the problems. The estate is in poor condition, with a maintenance backlog (NHS Confederation, 2021), resulting partly from funds being transferred from capital budgets to support day-to-day operations (The King's Fund, 2022a). The Government's Spending Review 2021 pledged a 60% increase in healthcare capital spending to £11.2 billion in 2024/25 (House of Commons, 2021). This is to be allocated for transforming diagnostic services through community diagnostic centres (CDC); digital technology; mental health services; new hospitals and surgical hubs (House of Commons, 2021). Poverty, stigma and discrimination, residential segregation, and education inhibit good health (Dean *et al.*, 2013). Improving health in England therefore spans beyond the NHS and the property it operates from and is expected to result in fast-growing outsourcing to private players (Intel, 2022). The built environment can make a significant impact: town centre properties could be the catalyst for rethinking the way in which public and private healthcare is accessed and delivered.

To establish the requirement for healthcare property in town centres, it is vital to determine which healthcare supply and demand trends will be prevalent in the coming years. The NHS in the next decade plans to focus on: (1) improving care and support for mothers and children; (2) improving care and dedicating increased resource to heart attacks, cancer, strokes, respiratory disease, dementia and mental health issues; and (3) improving care and support for the elderly (NHS, 2019). Further, the NHS aims to promote digitally enabled care, with more activities undertaken in patients' homes and via community-based care (NHS, 2019), which is in line with the UK Government's strategy advocating virtual clinics, new ways of working and providing care in the most appropriate settings (HM Government, 2021). This is linked to the 2022 introduction of

‘Integrated Care Systems’ (ICS) to support collaboration on integrated services for patients by the NHS, private healthcare providers, local authorities and other local partners to collectively plan health and care services for the local population’s needs (The King’s Fund, 2022b).

NHS hospital sites can be more effective by separating elective and acute care, ringfencing elective inpatient and day surgery beds from urgent care (Oliver, 2021). However, in the past few decades hospitals have been rationalised to ensure appropriate staffing levels, integrate specialities and maximise access diagnostic facilities (Gandy, 2020) and relocating elective care from general hospitals risks removing access to acute services and specialist acute input (Oliver, 2021).

Immediate opportunities for the NHS to integrate into the high street include running services from vacant property and broadening the range of services provided within diverse town centre communities (NHS Confederation, 2020). People who may not use high streets regularly to shop could use them to access health services, leading to more vibrant community spaces and revitalisation of town centres (NHS Confederation, 2020).

Whilst there is a movement towards shifting healthcare services away from hospitals and closer to communities in town centres, to date there has been little meaningful activity of this nature in England.

2.3 Conversions of Retail Real Estate into Healthcare Property

The medical mall concept originating from Japan has been known for the last 40 years (Ito, 2017; Du and Zhao, 2022). However, these medical versions of a shopping mall, with superior access to medical services, did not replace retail and are not co-located with retail (Ito, 2016). This is different from the US, where ‘demalling’ (Porfirio and Guimaraes, 2019; McCarthy, 2021) created an opportunity for ‘medical malls’ and ‘convenient care clinics’ (Lin, 2008; Laws and Scott, 2008), of which there are around 30 now, are facilities installed in converted shopping malls that include at least five healthcare tenants or units, and can offer a full range of outpatient services, including primary care, mental health and speciality services (Uscher-Pines *et al.*, 2013; Roberts and Carter, 2020; Berry *et al.*, 2021). Uscher-Pines *et al.* (2013), Farnsworth and Shay (2014), and Mason (2015) suggest the rapid growth of healthcare integration into retail real estate in the USA is due to: (1) retail and healthcare property both reflecting

‘experience-based economy’ lifestyles attributes; (2) generational shifts (‘baby boomers’ relocating to urban environments to avoid isolation; ‘millennials’ now in adulthood wanting to live, work and shop in the same location); (3) patients seeking convenience and avoiding travel or using public transportation; and (4) scalability of ‘retail medicine’ due to its ability to connect healthcare delivery to other existing services and products in retail space. Uscher-Pines *et al.* (2013) found primary care and outpatient services to be most prevalent in medical malls, which suggests that these services could be considered for provision in TCR-to-healthcare conversions in England. Outside of the US there are a few examples of retail property being reutilised for healthcare uses, including department stores reused as medical practices in Germany (Junker *et al.*, 2020; Hackelberg *et al.*, 2020; Schrödl *et al.*, 2022) or small units reused as diagnostics centres in Poland (Diag.pl), which seconds the same potential for the UK retail market.

While in the UK the transition from retail to healthcare is well established for e.g. eye medicine (Jones, 2015) or non-NHS ultrasound services (Howard, 2020), there is little evidence of the concept of larger TCR-to-healthcare conversions. Nevertheless, recent examples support such developments in deprived areas, for younger people, young families and the elderly (WBC, 2021; The Live Well Centre, 2022). The Live Well Centre, a *‘one-stop shop for healthy living run by the council’s public health team’*, was launched in 2017 and occupies five floors of the Dundas Shopping Centre in Middlesbrough town centre and is co-located alongside retail, leisure and food and beverage shops (Local Government Association, 2022). In Stroud, the old Woolworth, then Poundland, is now the home of Five Valleys Medical Practice. The relocation triggered a merger of two GP surgeries, which outgrew their previous premises in less prominent locations (Airey, 2021) with the aim to *“bring patients to the town centre who will use the shops and services in the town [...] around 5,000 [patients] a week would visit the Stroud town centre (because of the medical centre).”* (Felton, 2022). Another promising case is the scheduled Warrington Health and Wellbeing Hub (Place North West, 2021) providing a mix of services allowing for synergies with the existing retail and office provision (Healthwatch Warrington, 2022). These facilities, through co-location of health and wellbeing partners, enable clinical teams to support patients closer to their homes; support young people and younger families and elderly; provide lifestyle advice and facilitate access to a range of council health and wellbeing services.

Another example of town centre focused healthcare facilities are CDCs introduced based on the Richards' (2020) report to accelerate diagnosis for cancer, heart and lung diseases by offering tests closer to home, eliminating unnecessary hospital trips. While only 58% of the planned 160 CDCs have been completed (Department of Health and Social Care, 2022b), three notable cases of CDCs are Wood Green (WHNFT, 2022), The Glass Works (Barnsley Hospital News, 2022), and Dorset CDC (UHDNFT, 2022). All are situated in shopping centres, the latter being reconfigured from a department store using reclaimed and reused materials from decommissioned Nightingale Hospitals (BDP, 2021). In line with NHS plans, their diagnostic services include X-ray, breast screening, phlebotomy, ultrasound, and ophthalmology.

2.4 Healthcare Real Estate Investment

In the UK, healthcare infrastructure investment has been subject to a debate suggesting issues around private finance initiatives and other funding mechanisms for large-scale projects (Vecci *et al.*, 2013). Nevertheless, the healthcare real estate investment, while still broadly categorised as alternative asset class, is of particular interest to institutional investors in the US, Europe and Australia (Newell and Marzuki, 2022). Over the last two decades, the UK healthcare institutional real estate investments outperformed all other asset classes, with risk-adjusted returns just below bonds (Newell and Marzuki, 2022). Similar observations were made for the US and Australia (Raudszus *et al.*, 2012; Marzuki and Newell, 2022). Healthcare institutional investors while recognising operational, regulatory and reputational risks, desire to be involved in healthcare operation and thus seek investment opportunities (Mansley and Lizieri, 2015). However, some researchers suggest that this asset class may be riskier than the mainstream classes. Nazlioglu *et al.* (2016) note that the healthcare REITS in Japan were the riskiest sector and Huerta-Sanchez *et al.* (2020) find that while outperforming the other conventional sectors, the US healthcare REITS have been subject to more bubbles than other real estate investment sectors. For UK and US increased investment in healthcare real estate suggests that “*real estate healthcare sector has been underestimated*” (Bachmann *et al.*, 2021, p 8). Aveline-Dubach (2022) based on analysis of UK, French and Japanese healthcare REITS stresses that “*liberal welfare states such as the UK have an especially attractive profile for Healthcare REIT investors*” (Aveline-Dubach, 2022, p. 984). Growth in this sub-sector is underpinned by the lack of fit-for-purpose healthcare

accommodation, medical innovations, increasing demand and superior lease terms (Newell and Marzuki, 2018).

While the above literature focuses on large-scale lumpy projects, the sector's growth and risk profile suggest potential investors' interest in smaller-scale investments such as town centre conversions. The next section elaborates on such opportunities and the relevance of the healthcare provider (including NHS), developers, and local councils in the efficacy of conversion processes.

2.5 Key Stakeholders for TCR-to-healthcare Conversions

To ensure the success of a project, the interests and demands of key stakeholders need to be considered in any decision-making (Schmeer, 1999; Aaltonen, 2011). All redevelopment projects require effective stakeholder management, with consideration of the politics and power dynamics between stakeholders (Eljiz *et al.*, 2022). Key stakeholders relevant for the regeneration of town centres include investors; landlords; local residents; local businesses; local, regional, and central government, financiers, consultants, builders, charities and community groups, amenity, environmental and heritage groups (New Economics Foundation, 2010; Jing-min *et al.*, 2010; Sousa, 2012; Aapaoja and Haapasalo, 2014; Håkansson and Lagin, 2014; Department for Levelling Up, Housing and Communities, 2020; Wills and Harding, 2021; Local Government Association, 2021). As stakeholders of retail-to-healthcare conversions have not been studied systematically, we further address only stakeholders specific to typical healthcare projects and property (re)development projects. Franco-Trigo *et al.* (2020) suggest exponential growth in stakeholder analysis reports in healthcare in the last three decades, yet little consistency in approaches. However, healthcare project stakeholder analyses have identified health authorities and providers (including NHS in the UK), and government agencies as important stakeholders, due to their ability to control funding (Henriksen *et al.*, 2005), their power, legitimacy, and urgency (van Woezik *et al.*, 2016), their leadership role in enacting government policy (Nancy *et al.*, 2016) and their key role in driving strategic change through legislation and regulatory measures (Auvinen *et al.*, 2012). For (re)development and adaptation, Caputo (2013) and Le Feuvre *et al.* (2016) identified several stakeholders. However, in the context of this research, the developers and local government seem to be the key stakeholders. Developers have the power to influence and enforce their demands (Newcombe, 2003) and control all stages of the development process (Olander and Landin, 2005). Local

government on the other hand controls the formal planning stage of the project and influences its shape (Olander and Landin, 2005; Axelsson and Granath, 2018; Zou and Ni, 2022).

3. Methodology

To understand whether an integration of the struggling retail and healthcare sectors can enhance aggregate efficiency of both sectors, we explore healthcare's potential role in TCR-to-healthcare repurposing of real estate and investigate stakeholders' requirements to facilitate such changes.

The revival of town centres is a complex subject, requiring a colossal shift in the status quo and the careful consideration of a myriad of stakeholders. There are several options for the reconfiguration of town centres and plenty of competing uses to take the place of retail property, of which we only consider healthcare. Due to the complexity and lack of detailed research on retail-to-healthcare property conversions in the UK, it is important for us to focus on stakeholders involved in such projects as a valuable source of knowledge. Thus, we developed this research within the interpretive domain. While subjectivity loaded, given the limited experience of successful projects, this approach provides a preliminary picture of the emerging reality and opens avenues for more detailed research.

In line with methods used in comparable studies (Olander and Landin, 2005; Auvinen *et al.*, 2012; Nancy *et al.*, 2016), between July 2021 and August 2022 via Microsoft Teams we conducted seven semi-structured interviews with industry experts, which gave an opportunity to probe responses and collect unconstrained participants' perspectives. In line with Etikan *et al.* (2016), key stakeholders were selected as respondents and were identified via purposive expert sampling based on their recent or current participation in retail-to-healthcare conversions and their influence and authority in facilitating such redevelopments. These stakeholders included: (1) those representing health authorities (Henriksen *et al.*, 2005; Auvinen *et al.*, 2012; van Woezik *et al.*, 2016; Nancy *et al.*, 2016); (2) property developers (Newcombe, 2003; Olander and Landin, 2005); and (3) local government (Olander and Landin, 2005; Axelsson and Granath; 2018; Zou and Ni, 2022), as shown in *Table I*. Note that we have not considered other stakeholders critical to TCR-to-healthcare conversions, such as landlords, large-scale / passive investors, financiers and builders. This is based on the assumption that such

stakeholders would engage only in projects that are supported by the surveyed stakeholders. Thus, they would need to be investigated separately as the next step towards the viability assessment of such projects. Moreover, we have not considered users/patients, NGOs, and other community organisations on the premise that broadly they would benefit from such schemes and as such are not expected to act as “*deal breakers*” for such projects.

Table I - Interview Participant Key

Participant ID	Sex	Organisation	Role
L1	M	Local Authority	Head of Property Management
L2	F	Local Authority	Asset Director
D1	M	Property Developer	Development Director
D2	M	Property Developer	Chief Executive Officer
N1	M	NHS	Estate Director
N2	M	NHS	Chief Officer
N3	M	NHS	Primary Care Director

Source: Author’s own creation.

The entire research has been conducted in accordance with the University of the West of England Research Governance policies and procedures. [1]

In line with Braun and Clarke (2006) and Campbell *et al.* (2021), the interviews were subject to thematic analysis which revealed six themes described in the following section.

4. Results and Discussion

In line with previous literature on institutional healthcare real estate investments (Mansley and Lizieri, 2015; Aveline-Dubach, 2022), research participants are supportive of TCR-to-healthcare conversions and see great potential for such investments. Themes emerging from the interviews included: (1) Suitable Health Services for Town Centres; (2) Town Centre Regeneration at Scale; (3) Building Adaptation; (4) Bespoke to Community Needs; (5) Stakeholder Relationships; and (6) Capital Funding.

4.1 Suitable Health Services for Town Centres

The most frequently referenced health services suitable for town centres were diagnostic, mental health and primary care services. A shift of health activity from acute to community settings was also apparent. All interviewees cited diagnostic services as

suitable for town centres, with emphasis on radiology and imaging (D1, N2), and blood pressure testing (L1). This is in line with the NHS' (2019) aim to diagnose issues earlier and provide improved treatment and rehabilitation, through community-based means. D2 advised they were "*not convinced*" an isolated diagnostic service such as CDCs could work, which supports the potential for healthcare development at scale.

Mental health services were frequently mentioned (L2, N1, N2, N3 and D1), with N3 describing a "*massive pent-up demand for mental health services*" resulting from the Covid-19 pandemic. This supports the NHS' (2019) focus on mental health as a key patient priority. However, it is important to differentiate between the types of mental health care: facilities servicing "*inpatient mental health*" and "*severe mental health illnesses*" are unsuitable for town centres (D1, D2 and N2). The upward trend in premature mortality in adults with *severe* mental illness (PHE, 2022b), and the participants' observations, suggest some proportion of mental health care would need to remain within existing facilities. Mental health was often mentioned by participants in relation to health and wellbeing services (N3, D1, D2).

Health and wellbeing services were cited in the context of a shift away from health services treating people's illnesses, to keeping people well (N1, D2). There is an opportunity for health and wellbeing services to keep people well and to "*reframe health and care away from an illness service, into a service supporting and educating people in staying healthy*" (D2, N3). N1 described a healthcare redevelopment they had undertaken which "*changed the nature of the building from being a place where you went because you were sick to being a place that good things happen*".

The interviews saw an emphasis on reconfiguration of primary care (N1, N2, N3, D1) and community care (N1, N3, L2, D1). Similarly to Uscher-Pines *et al.* (2013), N1 argued for a one-stop-shop noting that "*90% of NHS appointments and contact is through primary and community care. [...] It would make perfect sense to put them in a location where people go to as part of their day-to-day, and make them really accessible*". In line with the NHS's (2019) and HM Government (2021) aim of moving services into the most appropriate settings, N1, N2, N3 and D1 noted the need for a shift of activity from acute to community settings. D1 observed that "*once you start to look at your more primary care type levels of services and certainly GPs, you can definitely*

put diagnostics and all sorts of other complementary health and wellbeing uses in there”.

N1, N3, D1 and D2 all highlighted the importance of integration of services. N3 argued *“an individual patient could have up to a couple of dozen touchpoints to healthcare [...] Why do you need to go to a hospital for an outpatient consultation? [...] I’d always go for wanting it in the community”*. In line with Meads (2016), D1 stressed the need for integration and co-location of services in town centres: *“The patient pathway, where you can access a broad range of health and wellbeing services in a single location where you might have multiple appointments that day [...] you don’t have to leave the building and travel [...] to go and see another consultant”*. D1 also suggested co-location of community-based services (midwives, district nurses, physiotherapy, primary care, GP services, mental health services), which reinforces the aim of ICS to integrate services for patients across geographical areas (Charles, 2022).

Participants were clear that not all services could be provided in the town centre. D2 and L2 both felt the town centre would be unsuitable for bedded or inpatient provision. Specialised care (skill and equipment) or intensive care were also deemed unsuitable for town centres expected to remain in large, acute hospitals (L1, N1, N2, N3, D2). N1, N3 and D1 felt emergency or urgent care would be unsuitable, due to the physical infrastructure they require, with N3 citing *“infection control, the requirements of surgical theatres, the consultants and professionals who operate in those services need to be consolidating on a single site”*. This is in line with Gandy’s (2020) warning that relocating services hosted on hospital sites could cause issues with providing appropriate staffing levels, remove the benefit of speciality integration, and reduce access to key diagnostic facilities. N3 highlighted *“outpatients, diagnostics, therapy, community services”* as activities which could be moved into *“really high-quality smaller hospitals”*. Whilst Oliver (2021) argues that NHS hospital sites could benefit from separating elective care from acute and urgent care, the responses suggest any such split would still need to see elective and acute care within close proximity of one another leaving TCR not attractive for hospitals providing elective operations.

Town centre accessibility must also be considered. D2 warned that *“you’d have to think very carefully about [...] getting people [...], services and paraphernalia they need in and out”*. L1 mentioned that *“anything involving people having to come in through*

specialist transport could be problematic, particularly as we look to further enhance the pedestrianisation and non-vehicularisation of our town centres [...]. The last thing you want is people with mobility, visual issues, etcetera, you know, being sort of lost in the hubbub of the high street”.

4.2 Town Centre Regeneration at Scale

In line with Distressed Town Centre Property Task Force’s (2013), all participants recognised the need for wholesale town centre reconfiguration and moving away from the traditional reliance on retail to a broader mix of uses. L1 emphasised the need for a *“balanced town centre”* whilst L2 acknowledged the need to *“think more creatively around how we use our city centres”*.

Concurring with Dean *et al.* (2013), N1 advised they were collaborating with local authorities on town centre regeneration aiming *“schemes that impact on the wider determinants of health [...] economic wellbeing, environmental wellbeing, even education [and] employment opportunities”*. N1 also noted the importance of *“doing stuff at scale for bigger populations.”*

N2 supported combined town centre developments and felt there were *“real opportunities trying to build and integrate health and care services into broader [...] retail [or] housing development, making sure we’re weaving health and broader public sector wellbeing services, community, leisure and all the rest into it”*.

L1, N1, N2, N3, D1 and D2 all noted the importance of co-locating complementary services together for successful town centre regeneration. L1 and N2 stressed *“cross-pollination”* and complementarity helping the local economy, which seconds recommendations of Portas (2011), Distressed Town Centre Property Task Force (2013), Carmona (2015), and Orr *et al.*, (2023) that the modern high street would draw people back through mixed uses.

No participants questioned healthcare’s role in town centre regeneration. However, in line with Carmona (2015), it was felt that town centre healthcare facilities would need to be of scale to make a meaningful difference. N1 argued health projects must *“be within an integrated regeneration plan for that area”*. Others supported this, suggesting *“the best opportunities are where there is larger scale to that [...] you can bring in a kind of critical mass of services that bring in more footfall to the town centres”* (D1) or *“you’ve got to be able to have a certain level of volume and critical mass within a given*

town centre [to make town centre healthcare work]” (N2). N1 stressed that large footfall volume is primarily why healthcare is suitable for town centre locations.

The co-location of *“like-minded services”* (L1) and healthcare of scale as an anchor (D2) was suggested as a potential driver for users visiting town centres. L1 envisaged visiting a GP surgery and then using a co-located library. Notably, this is now considered for Stroud (Gloucestershire County Council, 2022). D2 felt healthcare could be *“a really important catalyst for regeneration with services acting as an anchor then to draw in other stuff. If you've got that NHS core, it's remarkable how private sector organisations then want to co-locate around that, and then you get all the other ripple effects coming from it”*. Supporting this, NHS Confederation (2020) emphasise the need for recognition of the NHS as a critical anchor institution in many communities and its role in wider issues, such as influencing the social determinants of health and building sustainable communities.

User convenience was identified as a benefit of well-considered co-located services (L1, D1 and D2), with D2 suggesting *“you might do something beforehand, go and interface with the service and go and do something afterwards. It's a more interesting environment for somebody to be in. And everybody benefits from that”*. L1 stated that this could also *“work the other way [...] there's an awful lot of opportunity for people who are in the town centre shopping to then make that incidental health visit”*. In line with Uscher-Pines *et al.* (2013), D1 stressed convenience - *“[In a] department store for health and wellbeing [...] you want to be able to access a lot of different [services] in one location”*.

N2 and N3 stated the need for the NHS to reconfigure services delivery to make the user experience more convenient and accessible and the need to *“reimagine points of [service] delivery in a single integrated care type centre in the community [and develop town centres] as a workplace where people can actually have a positive impact on their health where they come together and actually have support, professional support”* (N3).

4.3 Building Adaptation

New construction vs refurbishing or reconfiguring existing buildings attracted mixed views, with participants suggesting it would be more difficult to support the demolition of TCR and construction of new healthcare buildings than to support the adaptation of existing buildings. D2 concurred with Bullen (2007) and Douglas (2006) and advised

that whilst they were becoming “*accustomed to working from the starting point of reconfiguration*”, “*when something comes to the end of its life, it doesn't matter how much money you spend on it [...] from a sustainability perspective, you're far better off [...] spending money on an appropriately specified building that does meet the purpose, is environmentally suitable, meets the right regulations and policies*”. D2, L2 and N2 in line with Wilkinson *et al.* (2009) felt reconfiguration can often be as costly as building new. N1 felt adaptation was more cost effective and better for the environment than building new. D1, D2 and N1 all stated that for sustainability reasons building new facilities should be avoided where appropriate.

D1 advised “*if you can repurpose, it is the first thing that you should consider before demolition*”. However, L1 and L2 also raised sustainability issues of refurbishment and reconfiguration. L1, like Pardo-Bosch *et al.* (2019) felt it is “*a lot easier to try and build new buildings [...] rather than trying to retrofit them back into old buildings*”, while L2 was doubtful of achieving BREEAM Excellent with an existing building, which is the target for new builds within their organisation. D1 advocated the repurposing of department stores as larger retail units “*lend themselves incredibly well [...]*” and “*there's very little restriction to what you can do.*”

N1, N2, L2, D1 and D2 all acknowledged the complexities of reconfiguring an existing building, with D1 elaborating “*as volumes [of space] get smaller, your opportunity to change them becomes more complex*”. In relation to suitable space for reconfiguration in existing buildings, D2 warned that affordability constraints of health mean that “*you're usually looking at something of a scale that doesn't have a great alternative use*”. This is consistent with Elrod and Fortenberry's (2017) identification of suitable buildings as a challenge.

L1 emphasised the need to consider the “*longevity of the assets*” and future alternative uses for health buildings: “*if the public doesn't take to the concept [...] How then adaptable are these buildings in a high street location? If they're bespoke fitted out for health purposes?*”. When considered alongside Douglas's (2006) statement that the extended life of an adapted building is still only about half of that for a new facility, this raises the question of the reasonability of adapting buildings to health uses.

4.4 Bespoke to Community Needs

All participants stated the need for town centre healthcare developments to consider the specific needs of the community being served, with L1 advising *“it’s certainly not a one-size-fits-all”*. Concurring Coca-Stefaniak (2013), D1 stressed the importance of *“matching availability with demand [...] if those things align, then you’ve probably got a really good opportunity to do something a bit transformative for the community and for the health providers”*. L2 emphasised the importance of engaging with the local community - *“we understand the needs of that local community. We engage [...] we’re not just doing it to them, we’re listening to what they need”*. N1 advised they were *“taking a place-based approach about what’s right for that place, [...] what’s right for that people, what’s right for that community?”*. This supports the ICS approach for local authorities and other local partners to collectively plan health and care services for the local population’s needs (The King’s Fund, 2022b).

As per Goins *et al.* (2005), all participants except N2 cited accessibility as an important aspect of town centre healthcare. N1 questioned: *“I sometimes wonder when people are developing projects if they actually ask questions like ‘what population are they trying to serve?’, and ‘can people access it?’”*. D1 stressed town centres to be most accessible in terms of *“public transport links and parking”*, to which L2 emphasised the importance of public transport, *“because not everybody has a car, and we try to discourage people using the car to access these facilities”*. N1 stated healthcare facilities being accessible for deprived communities, advising *“we’ve been looking at transportation routes [...] because it’s really important people in deprived communities can use and access these things.”* and added that *“we need to be investing in the areas of the deprived communities where the big health issues are, where the health inequalities are, and that’s where we should be doing stuff or at least it needs to be accessible to those communities”*. L2, N2 and D1 also commented on the need for targeting pockets of deprivation.

The elderly were cited by N3, D1 and D2 as a particular group to benefit from town centre healthcare developments, which is conducive to the NHS’ (2019) identification of the elderly as a priority group. N3 stated *“if we develop the focus of a place almost based on a community centre-type philosophy, particularly for the older generation, [...], people who need to be much more social, to come together as a meeting point where it very much is about health and wellbeing [...] you know they’ve got good*

transport links, it means they exercise, [...] they can come together, they've got a facility that allows them to meet safely, where also they've then got access to professionals in terms of their health needs". D1 and D2, recognising aging population, suggested it could be advantageous for town centre regeneration to *"bring in older people into a high street location to live, because they have the time, and the money to spend in the local facilities and services. So that has a knock-on economic benefit as well"*. This agrees with the data of Retail Economics (2022) showing that savings are concentrated across wealthier households and older demographics.

4.5 Stakeholder Relationships

The importance of stakeholders was highlighted throughout the interviews, with N1 stating *"gaining stakeholder engagement and stakeholder support"* was the *"number one challenge"* facing TCR-to-healthcare conversion projects. The most frequently cited stakeholders were local authorities and the NHS, including ICS.

N1, N2, L2, D1 and D2 referenced the importance of working with and gaining the buy-in of local authorities for property development projects, which vindicates their role in property development projects as noted by Olander and Landin (2005), Axelson and Granath (2018), and Zou and Ni (2022). N1 felt that *"working with the local authority, for health, is a really important thing"*, whilst N2 added that *"building strong partnerships between health and local authorities is integral"* to embedding healthcare in town centres. Likewise, L2 described their strong working relationship with local NHS trusts and the ICS as important to overcoming challenges in healthcare development projects, attributing this to being *"as passionate about driving something forward as they are"*. This supports Henriksen *et al.* (2005) and van Woezik *et al.* (2016) identifying health authorities as key stakeholders in healthcare projects. Although the relationship between local authorities and the NHS was identified within the interviews as of particular importance, N2 advised it was *"quite difficult to get the level of traction with some of these developments to meet local authorities' deadlines"*, attributing this to that *"the property side of the NHS is incredibly over-complicated [...] incredibly bureaucratic in many ways"*. ICS, introduced to combine providers and commissioners of NHS services with local authorities and other local partners (The King's Fund, 2022b), may offer a solution to this, and were referenced as key stakeholders by N1, N2, L2 and D2. D2 felt ICS could catalyse achieving a common vision amongst stakeholders, stating *"this is an important moment for the market or the sector to*

capitalise upon, because the ICS should be supporting those various entities to come together to have a common view". L2 advised that they involve the ICS in meetings with GPs regarding integrating healthcare property in town centres.

L1 felt the concept of healthcare in town centres was held back by *"that lack of common vision [...] the multiplicity layers of ownerships within health"*. The common vision was also identified as a key challenge by D1 and D2, with D2 stating that *"you have a myriad of organisations that you have to herd to all pull in the same direction, to share a common vision and it's that level of complexity which is the biggest challenge"*. This supports Hospers' (2017) view that town centre revitalisation requires developing lasting cooperative partnerships between willing local actors.

4.6 Capital Funding

N1, N2, L1, L2, D1 and D2 referenced capital funding as a challenge to healthcare developments, suggesting *"sometimes we get there and then we fall at a particular hurdle, mainly around funding"* (L2) whilst N2 stressed that access to capital is probably one of the most significant challenges. Similar to Vecci *et al.* (2013), L2 felt *"the Government has got a lot to play in this, in terms of the types of grant funding they provide"*. Both developer participants (D1 and D2) referred to the difficulty of the NHS having to respond to limited and fluctuating levels of funding.

D1 agreed with Rimmer and Iacobucci (2019) that the NHS is treated as a *"political football"*, advising the NHS *"never know[s] when funding's going to stop [or] when new funding might come available. If it is available, how quickly does it have to be spent because of its limited budget or limited availability?"*. Despite the pledged increase in healthcare capital spending in the coming years (House of Commons, 2021), The Health and Care Act 2022's removal of NHS foundation trusts' autonomy on capital spending (Department of Health and Social Care, 2022a) may cause additional uncertainty. D2 noted they have *"seen a lot of political money going into the community diagnostic centres. [...] in order to meet the ridiculous timescales that the politicians have put on the capital, NHS trusts have rushed out into the marketplace, desperately looking for some empty space where they could spend some money. Obviously completely unstrategic"*.

These results indicate that opportunities for TCR-to-healthcare conversions exist and are likely to contribute to bringing both retail and healthcare sectors closer to their

equilibria. However, these opportunities are limited to specific health and wellbeing services suitable for town centre locations and need to be considered not as gap-fillers but as part of larger regeneration plans. Notably, the stakeholders focus on NHS and other public funding undermining the private sector opportunities identified by Newell and Marzuki (2022), PwC and ULI (2022) and Aveline-Dubach (2022).

4.7 Summary of the Surveys

Interviews with selected stakeholders established their buy-in for TCR-to-healthcare conversions. All stakeholders saw great potential in the integration of healthcare into town centres and agreed that such schemes should include diagnostic services, mental health support and other primary care services due to enhanced transport accessibility. Interviewed stakeholders, despite their at times uneasy experience with town centre healthcare projects, are supportive of large-scale regeneration in town centres with integrated healthcare alongside other uses to serve the local population. They generally agreed that mutual buy-in from other stakeholders is of vital importance in implementing TCR-to-healthcare conversions. However, they were concerned about the viability of projects where this was not apparent, suggesting that a critical stakeholder mass is needed to boost the support of other stakeholders. Notably, despite project complexities, the interviewees would find it more difficult to support the demolition of TCR and building new healthcare facilities than to support adaptation, reconfiguration or refurbishment projects. Yet, where it is apparent that utilising existing buildings is not possible, or economically or environmentally inefficient, they would accept demolition and rebuilding. Most stakeholders were concerned with the availability of capital and government funding linked to a strong reliance on the public healthcare system. Finally, for assessing the potential for TCR-to-healthcare conversions the interviewees suggest asking questions around:

- Service mix to assess the balance of (1) primary care and outpatient services such as diagnostic services (radiology, phlebotomy, and other screening procedures), GP and community nursing services and (2) wellbeing services (nutritional and mental health support to address growing health deprivation);
- The fit of TCR-to-healthcare conversions in the context of wider town centre regeneration which (1) is community-led, (2) allows for co-location of complementary services and create scale sufficient to generate major footfall and

- support other town centre activities; and (3) is bespoke to the specific needs and demographics of the area they serve; and
- Adaptation of existing facilities versus demolition and rebuilding (considered only as a last resort) and physical accessibility (including public transport).

5. Conclusion

This research studied the prospects of TCR-to-healthcare conversions in the UK. The literature review revealed very few examples of such conversions indicating that this process is still in its infancy. The examples explored focus on providing support services such as mental health, clinical and social services with facilities promoting community wellbeing and aiming to address wider social issues. This suggests a shift toward keeping people well in their communities has begun, whilst it also demonstrates how healthcare can reside alongside retail. Our first policy recommendation is to conduct local investigations in order to assess the feasibility of healthcare alongside local retail. Further, the rollout of CDCs could be considered a major step towards integrating healthcare into town centres in the UK. However, as it is a new phenomenon, it is too early to establish if these new CDCs are successful and relevant for TCR-to-healthcare conversions. Our second policy recommendation is to undertake a full-scale evaluation of the CDC programme.

Expert interviews indicated stakeholders' support for TCR-to-healthcare conversions. However, such conversions are not always possible, as the configuration and technical viability of such projects are dependent on the bespoke needs of the local communities and therefore should be considered on a case-by-case basis.

This research has only lightly touched on the financial feasibility of TCR-to-healthcare conversions, which calls for separate research. As such projects have a great potential for generating wider externalities, their financial feasibility should be considered using cost-benefit analysis tools. Further, the feasibility of TCR-to-healthcare conversions is dependent on other co-located services within wider regeneration areas, which creates uncertainty for those who intend to initiate such projects. Nevertheless, the interviews signalled that the following perspectives should be explored in more detail to gain statistically firm understanding of the TCR-to-healthcare conversion opportunities: (1) service mix including primary care and outpatient services and wellbeing services; (2) fit within wider town centre regeneration and co-location with other uses; (3)

accessibility and building adaptation; and (4) stakeholder engagement, to evaluate wider externalities generated by TCR-to-healthcare conversions, including stakeholders not considered in this study (patients, general public, patient-facing medical staff, landlords, investors, and private healthcare providers). Our third policy recommendation is to promote greater coordination and engagement of wider stakeholders.

Our findings suggest future research exploring the performance of the new schemes to inform policymaking, including local planning, healthcare provision and investment decisions. Finally, we hope that this research will contribute to a systematic discussion on bringing both the retail property and healthcare sectors closer to market equilibria while considering a wider array of stakeholders.

Notes

1. The following statement concerning research governance is in accordance with the University of the West of England standard disclosure requirements: Prior to conducting the interviews, ethical approval was obtained. In advance of the interviews, all participants were informed about the nature of this study via a participant information letter detailing that their consent and participation were anonymous and entirely voluntary. At the outset of the interview, the interviewer explained this again and reminded the participants that the interviews were being recorded and how the data would be stored and used. Following the interviews, the participants were given a two-week window to withdraw from the study (if they desired).

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