

HEALTH POLICY

Reforming the NHS: The Case for Polyclinics across Britain

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Abstract

The NHS is facing a sustained patient flow crisis driven less by rising demand than by a structural gap in diagnostic access at the primary care level. This leaves Accident & Emergency as the default gateway for patients who need imaging and assessment but not emergency care. This paper argues that polyclinics - larger, integrated community health centres combining GP services, same-day diagnostics and multidisciplinary teams, is the most structurally coherent response. It combines a model-based economic evaluation with a United Kingdom Singapore comparative analysis and an implementation framework. Three linked models were developed: an infrastructure cost–benefit analysis (Model A), a Type 2 diabetes early detection budget impact model (Model B) and a screening and productivity cost–benefit analysis (Model C). Judged against A&E deflection alone in Model A, the infrastructure is cash-negative over five years; this is shown to be a feature of a deliberately conservative appraisal rather than a verdict on the policy, since polyclinics would enable further benefit streams: earlier chronic disease detection and population screening, that carry no incremental capital cost. Together, models show polyclinics present a platform which even with only a few benefits considered can have a net positive impact for patient outcomes and bring great value for the NHS. The Singapore comparison demonstrates that the model's core operating principles, though not its financing, are transferable to the NHS. The paper recommends a targeted 5 centre pilot in areas of high deprivation and high A&E utilisation, evaluated over five years against both economic and equity metrics.

Reforming the NHS: The Case for Polyclinics across Britain

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Policy Recommendations:

- 1. Target the Pilot Using Core20PLUS5:** The pilot programme should not be distributed randomly across England. It should be targeted explicitly at the most deprived 20% of the population as defined by the Index of Multiple Deprivation, the same population identified by NHS England's Core20PLUS5 framework as the priority cohort for reducing healthcare inequalities. Three of Core20PLUS5's five priority clinical areas chronic respiratory disease, early cancer diagnosis, and hypertension case-finding map directly onto the diagnostic and management capabilities a well-equipped polyclinic delivers. A 5-centre pilot in Core20PLUS5-identified areas, evaluated over five years against inequalities metrics as well as A&E deflection rates, produces a dual evidence base: economic and equity.
- 2. Position Polyclinics as Parallel Provision, Not Displacement:** The most frequently raised objection to polyclinics is that they will cannibalise existing GP practices. This concern rests on a misreading of the current workforce landscape: the UK faces a documented bottleneck at the FY2 level, a significant cohort of doctors who have completed foundation training but cannot secure specialty or GP training posts. Polyclinics offer a direct solution salaried, clinically meaningful, supervised roles that absorb a workforce cohort currently underutilised by the system. Existing surgeries retain their registered lists and their role as the longitudinal point of care, while polyclinics absorb the episodic, diagnostically driven demand that GP practices currently cannot handle.
- 3. Expand Practitioner Roles at Manageable Pilot Scale:** A polyclinic staffed exclusively by doctors would be both expensive and unnecessary. The multidisciplinary model GPs in a supervisory and complex-case role, supported by advanced nurse practitioners, clinical pharmacists, physiotherapists, and on-site radiographers substantially increases centre capacity without proportionally increasing medical staffing costs. A pilot of 5 centres requires approximately 15–25 advanced nurse practitioners nationally in the first phase, entirely manageable within existing Health Education England frameworks. The five-year evaluation period is sufficient to grow into the full multidisciplinary model rather than requiring it to be fully formed at launch.
- 4. Deliver Community Engagement Through Existing Infrastructure:** NHS engagement with deprived communities has historically underperformed when delivered through top-down channels that fail to reach populations already disengaged from formal health services. Voluntary sector organisations embedded in deprived areas food banks, community centres, faith organisations, housing charities, and social prescribing link workers carry the community trust that NHS communications frequently lack. NHS England's Core20PLUS5 Community Connectors programme is specifically designed to facilitate exactly this kind of partnership. PPIE embedded from the outset, with community representatives involved in pilot governance structures, is the mechanism through which trust is rebuilt with the 20% of A&E attendees who reported attending because they did not trust their GP practice to deliver effective treatment.



Introduction

The NHS is under-sustained and is suffering from worsening pressure. In early 2026, 7.29 million people remained on the hospital treatment waiting list (NHS England, 2026), while A&E attendances reached 27.4 million in 2024-25, a record high (NHS England, 2025). This crisis cannot be explained by the increasing demand alone, but rather the current unsustainable health system. The NHS is a fragmented care system in which patients cannot access timely diagnostics at primary care level, leaving A&E as the default diagnostic gateway for conditions that do not require emergency treatment.

General practice, being a primary care setting, should be the front door of the NHS. However, it lacks the diagnostic infrastructure to manage a significant proportion of the presentations it receives. While GPs can refer patients for imaging, the standard target of six weeks wait is routinely breached. In November 2024, 15.9% of patients were waiting six weeks or more for an MRI alone. In 2024, 976,000 scans exceeded the 28-day reporting target, the highest number ever recorded. For a patient with an acutely painful soft tissue injury, a suspected minor fracture, or an urgent chest query, a 6–18-week imaging wait is not clinically acceptable. The rational response, both for the patient and the clinician, is to attend A&E, where imaging is available on the same day. This is not misuse of emergency services but rather is a predictable consequence of diagnostic inaccessibility at primary care level.

The consequences are visible in A&E activity data. Of 27.4 million attendances in 2024-25, 13% were classified as general or minor cases (NHS England, 2024), and 68% of patients attending stated they had been directed there by another service (NHS England, 2026). A further 20% reported attending because they did not believe their GP could deliver effective treatment (Peart, 2024).

A&E is therefore absorbing a substantial cohort of patients who require diagnostics but not emergency care, patients who are consuming emergency department capacity, extending waiting times, and contributing to a situation in which 25% of all A&E patients spent more than four hours in the department in 2025 (Nuffield Trust, 2025). The Darzi Report (2024) confirmed that the effectiveness of NHS care declined during the pandemic and that recovery has been slower than in comparable healthcare systems, with urgent and emergency care among the worst-affected areas.

This is not a problem that will resolve through demand management alone. It requires structural intervention at the primary care level: expanding the diagnostic capability of community-based services so that patients with non-emergency needs can be assessed, imaged and treated without recourse to A&E. A proposed mechanism for achieving this is the polyclinic, a larger, integrated community health centre combining GP services, same-day diagnostic tools including X-ray, and multidisciplinary clinical teams (Nuffield Trust, 2007).

Though previously piloted under the Darzi reforms and subject to inconclusive early economic analysis (Bienkowska-Gibbs et al., 2015), the model has since been implemented at scale in Singapore, where it demonstrably reduced pressure on emergency services. This paper argues that a targeted polyclinic programme, deployed first in areas of high deprivation and high A&E utilisation, represents the most structurally coherent solution to the NHS's current patient flow crisis. It draws on a UK-Singapore comparative analysis, a cost-benefit assessment of polyclinic deployment, and an implementation framework for a phased pilot programme.

The Diagnostic Gap

As mentioned previously, general practice is the intended first point of contact for most NHS patients but its unable to adequately diagnose patients in a timely manner simply due to lack of diagnostic infrastructure. The result is a predictable and measurable displacement of patients toward A&E, not because their conditions are emergencies, but because the diagnostic tools required to assess and discharge them do not exist at primary care level.

In 2024-25, 49.9 million imaging tests were performed in England, up 5.9% from the previous year, with plain radiography (X-ray) accounting for 23.5 million procedures alone (NHS England, 2025). This data is significant not because of the volume but the referral source and the associated wait times. For patients referred via A&E or admitted as inpatients, imaging is effectively immediate, the median request-to-test period for X-ray is zero days across all referral sources, but for GP direct access referrals, MRI waits a median of 24 days and ultrasound 31 days (NHS England, 2025). This gap is not marginal; it is the structural difference between a patient being assessed and discharged within hours versus waiting over a month for a result. For a patient presenting with acute musculoskeletal pain, a suspected minor fracture, or a chest query, that wait is not clinically tolerable.

The consequence of this disparity is well-evidenced in-patient behaviour. GPs requested only 26.6% of all imaging tests suitable for diagnosing cancer under direct access arrangements in 2024-25, a figure that has fallen from 27.7% the previous year (NHS England, 2025). The most common GP-referred test was chest X-ray at 2.2 million requests, yet GP chest X-ray referrals actually fell 2% year-on-year, while A&E and inpatient-driven imaging volumes continued to rise. This is not a reflection of lower diagnostic need at primary care level; it reflects the barriers GPs face in accessing imaging and the rational patient response of bypassing a service that cannot deliver timely results. NHS England has itself acknowledged that variability in testing capacity and access to referral mechanisms has limited GP use of direct imaging referral in many parts of the country (NHS England, 2024).

The NHS standard states that patients must be seen within 6 weeks but in November 2024, 15.9% of them were waiting six weeks or more for MRI alone (Ezra, 2024). In 2024, 976,000 scans exceeded the 28-day reporting target, the highest number ever recorded (Doctorum, 2025). For GP-referred cases specifically, the Diagnostic Imaging Dataset (DID) confirms that waits are consistently longer than for any other referral source: a GP-referred brain MRI takes a median of 24 days to reach the scanner compared to near immediate access for A&E attendees (NHS England, 2025).

This is the mechanism that drives inappropriate A&E utilisation. A patient with a clinical need for imaging who cannot obtain it through their GP within an acceptable timeframe faces a binary choice: wait weeks through the GP pathway or attend A&E where same-day imaging is available. For many patients, particularly those in pain, with young children, or without the health literacy to navigate referral systems, the A&E pathway is the rational choice. It is not a failure of patient behaviour but rather of primary care infrastructure. The 13% of A&E attendances classified as minor or general cases in 2024-25 (NHS England, 2024) and the 68% of attendees who reported being directed there by another service (NHS England, 2026), are in significant part a downstream consequence of this diagnostic bottleneck.

Establishing local polyclinics equipped with X-ray, ultrasound and other diagnostic tools, staffed by GPs and allied health professionals, would eliminate the referral delay that currently pushes ambulatory patients into emergency care. The patient with a suspected soft tissue injury, an acute chest query, or an abdominal complaint requiring imaging can be assessed, imaged and discharged within a single polyclinic visit, without consuming emergency department capacity or waiting weeks for a GP referral to resolve. The international evidence for this model and its applicability to the NHS context, is examined in the following section.

Methodology

Model A: Infrastructure Cost-Benefit Analysis

Our analysis consists of qualitative comparison of UK and Singapore healthcare systems and model based economic evaluation of the polyclinic proposal. Three linked cost benefit and budget impact models were built. Model A estimates the net present value (NPV) of building and operating a pilot network of 5 polyclinics with a 5-year evaluation period. It also tests it against one of many benefits of building out such infrastructure. In this case, A&E diversions of minor, ambulatory presentations were chosen. The model is deliberately conservative, as it does not monetise wider clinical or productivity benefits which are quantified separately in Models B and C. The analysis follows the structure of HM Treasury’s Green Book, using discounted cash-flow (DCF) over a defined appraisal period, a social discount rate of 3.5%, and low/base/high scenario ranges on the principal cost driver.

The pilot is modelled as five polyclinics, each serving a defined catchment, appraised over five years:

Parameter	Value	Basis
Pilot centres	5	Programme design assumption (pilot scale)
Catchment population per centre	45,000	Programme design assumption
Total covered population	225,000	= 5 centres × 45,000 (shared with screening model)
Evaluation period	5 years	Appraisal horizon (pilot evaluation window)
Asset useful life	20 years	Estimated economic life of clinic building/fit-out
Discount rate	3.50%	HM Treasury Green Book social discount rate

Capital cost per centre is modelled as a low/base/high range to reflect uncertainty in site acquisition, construction and equipment fit out. The base case is £7.5m per centre (£37.5m across five centres). The low and high bounds are £5.0m and £10.0m respectively.

Capital is annualised as straight-line depreciation over the 20-year useful life: *annual depreciation* = *capital cost* ÷ *useful life*. For the base case this is £7.5m ÷ 20 = £375,000 per centre per year (£1.875m across the programme).

Scenario	Capital / centre	Programme total	Annual depreciation / centre
Low	£5,000,000	£25,000,000	£250,000
Base	£7,500,000	£37,500,000	£375,000
High	£10,000,000	£50,000,000	£500,000

Comparator Facilities

Recent NHS community diagnostic and primary-care builds bracket the modelled range. The most directly comparable single-site new build, Corby Community Diagnostic Centre (opened June 2025), cost £11.7m, marginally above the high case, indicating the range is, if anything, conservative for a full new build. Larger acute-adjacent multi-site programmes (e.g. the Norfolk & Waveney diagnostic centres at c.£28m per site, and the £73m West Middlesex ambulatory centre) lie well above this model's scope, while refurbishment of existing estate (e.g. the £1.3m Ingol Healthcare Centre, Preston) lies well below it.

Comparator	Capital cost	Relevance to model
Corby CDC (new build, 2025)	£11.7m	Closest single-site analogue; just above high case
Norfolk & Waveney DACs (3 sites)	£85.9m (≈£28m/site)	Large acute-adjacent; above model scope
West Middlesex ambulatory centre	£73m	Large acute-site facility; above model scope
Ingol Healthcare Centre (refurb)	£1.3m	Refurbishment route; below low case

Sources: Building (2025–26); LSI Architects / DHSC; Chelsea & Westminster NHS FT; NHS Property Services.

Bottom-up Derivation

The base case is independently reconstructed from per-square-metre healthcare construction benchmarks. A polyclinic serving 45,000 residents is assumed to require c.1,500–2,500 m² of floor area (for reference, the Ealing CDC occupies c.2,000 m²). Applying 2026 UK benchmarks for community hospitals and clinics of £3,200–£4,500/m² , the clinic band rather than the lower GP-surgery band, since diagnostic facilities carry elevated mechanical-and-electrical cost (35–50% of build cost for medical gas, enhanced ventilation, backup power and infection control), reproduces the modelled scenarios:

Floor area × rate	Construction cost	Maps to
1,500 m² × £3,200/m²	≈ £4.8m	Low case (£5.0m)
2,000 m² × £3,750/m²	≈ £7.5m	Base case (£7.5m)
2,500 m² × £4,500/m²	≈ £11.3m	High case (£10.0m) + margin

Sources: RapidQS UK construction cost benchmarks (2026); NWL Acute Provider Collaborative (Ealing CDC).



Limitations of the model include: the per-m² benchmarks above are construction-only and exclude land, professional fees, planning and finance; large diagnostic equipment (CT/MRI) is also additional, so the modelled figures are best read as build-plus-fit-out estimates and the all-in comparators (Corby, Norfolk) appropriately sit higher. Second, NHS practice favours lower-cost delivery: most active CDCs were established in pre-existing buildings or as additions to existing structures rather than new builds, large new-build projects being approved only where no other viable option existed. A new-build base case is therefore conservative relative to a realistic refurbishment-led rollout, which would push capital below the low case and improve the NPV.

Each centre is staffed with a fixed multidisciplinary establishment. Annual cost per role is headcount multiplied by a fully loaded salary assumption:

Role	Headcount	Cost per post (£/yr)	Annual cost (£)
Salaried GP	4	£ 110,000.00	£ 440,000.00
Advanced Nurse Practitioner	4	£ 65,000.00	£ 260,000.00
Radiographer / Allied Health Practitioner	4	£ 55,000.00	£ 220,000.00
Administrative	3	£ 35,000.00	£ 105,000.00
Total	15	-	£ 1,025,000.00

Non-staff running costs (equipment, consumables, IT and facilities) are modelled as a proportion of staffing cost, set at 25%. For the base establishment this is $0.25 \times £1,025,000 = \textbf{£256,250}$ per centre per year.

Total annual operating cost per centre is the sum of staffing and running costs: $£1,025,000 + £256,250 = \textbf{£1,281,250}$ per centre, or £6,406,250 across the five-centre programme. Depreciation is held separately and combined with operating cost only in the depreciation-based NPV.

The modelled benefit is the avoided cost of treating minor/ambulatory presentations in a Type 1 A&E department when they are instead managed at the polyclinic. This is built up in three steps.

National A&E attendances are scaled to the catchment by population share, then the minor/ambulatory fraction is applied:

Parameter	Value	Basis
England population	£58,620,100.00	ONS mid-year estimate
Total annual A&E attendances (England)	£27,400,000.00	NHS England A&E attendance statistics
Proportion minor / ambulatory	£0.13	Share of attendances judged deflectable
Attendances per catchment	£21,034.00	$= 27.4m \times (45,000 \div 58.62m)$
Deflectable cases per catchment	£2,734.00	$= 21,034 \times 13\%$

Applied at national scale, the same minor/ambulatory fraction implies a pool of approximately **3.56 million** potentially deflectable attendances annually ($27.4m \times 13\%$). This national figure is reported for context only; the NPV calculation operates exclusively on the per-catchment volume of 2,734 cases, since actual deflection is bounded by each centre's catchment.

Each deflected case avoids the Type 1 A&E unit cost (£250, covering imaging and discharge) and instead incurs the polyclinic contact cost (£50). The net saving per deflected case is therefore **£250 – £50 = £200**. The £50 contact cost assumes 25 clinical contacts per clinician per day across 230 working days.

Three deflection rates are applied to the deflectable population to give gross annual savings per centre. The rate represents the share of deflectable cases captured by the polyclinic:

Scenario	Deflection rate	Cases deflected	Gross saving / centre / yr
Conservative	5%	137	£27,344.00
Moderate	10%	273	£54,688.00
Optimistic	15%	410	£82,032.00

Gross and net savings are derived as: *gross saving* = *cases deflected* $\times$ £200; and *net saving* = *gross saving* – *annual operating cost*. Programme net cash flow is the per-centre net saving multiplied by the five centres.

The model reports a primary and a secondary tier of outputs:

- **Primary Outputs:** annual gross savings from A&E deflection; annual net financial impact per centre; and annual net financial impact across the five-centre programme.
- **Secondary Outputs:** net present value (NPV) and discounted cash flows over the five-year evaluation period, under each capital-treatment convention.

Net annual saving per centre is gross deflection saving less operating cost. Because operating cost (£1.28m) vastly exceeds gross deflection savings (£27k–£82k), the net figure is strongly negative in every scenario, the expected result given that only one narrow benefit stream is counted. Programme net cash flow is five times the per-centre figure.

The model reports NPV under two conventions, because the choice materially affects the result over a five-year window:

● **Upfront-expensing:** The full base (£37.5m) is charged in Year 0, with operating net cash flows in Years 1–5. This is the conservative, cash-based view.

● **Depreciation-based:** capital is charged as an annual depreciation flow (£1.875m programme-wide) spread across the years it is used, with no Year 0 capital spike. This reflects the Green Book treatment of assets whose useful life (20 years) substantially exceeds the evaluation period (5 years), so that charging the whole asset against a five-year window would overstate the cost attributable to the appraisal horizon.

In the depreciation-based view, annual programme net cash flow becomes the operating net saving less programme depreciation. For the conservative scenario this is –£6,269,531 – £1,875,000 = –£8,144,531 per year.

Each annual net cash flow is discounted to present value using the standard factor $I \div (I + r)^n$, with r = 3.5% and n the year index. NPV is the sum of discounted cash flows across Years 0–5.

Sensitivity is handled through scenario analysis on the two parameters carrying the most uncertainty: the A&E deflection rate (5% / 10% / 15%) and the capital cost per centre (£5m / £7.5m / £10m). The deflection rate is shown to have only a marginal effect on NPV, the spread between conservative and optimistic is roughly £1.2m, because deflection savings are small relative to fixed operating cost. Capital cost and capital-treatment convention are the dominant drivers of the headline figure.

Model B: T2DM Early-Detection Budget Impact

Model B estimates the longer-term NHS budgetary impact of using polyclinic infrastructure to detect and manage Type 2 diabetes mellitus (T2DM) earlier than under usual care. Where Model A appraises the cost of the physical infrastructure against acute-care deflection, Model B quantifies one of the principal benefits that the infrastructure is intended to enable: improved access to preventative care, routine screening and chronic-disease management.

It is presented as a worked single-disease pathway, a demonstration of the mechanism by which one chronic-disease stream running on the polyclinic platform can become net-positive over time, rather than as a complete account of the platform's multi-disease value.

The model is a budget impact analysis (BIA) implemented as a simple Markov-style cohort projection in Microsoft Excel over a ten-year horizon. It follows a single cohort of people whose T2DM is detected earlier than it otherwise would have been, costs the screening and incremental management required to achieve that, and offsets these against the value of diabetes-related complications avoided when earlier glycaemic control is achieved. Costs and effects are discounted at 3.5% in line with the NICE reference case.

Two design features distinguish the model. First, the additional management cost of early detection is treated as genuinely incremental: it applies only during the lead-time window before usual care would have caught up, rather than being charged in perpetuity. Second, the prevention benefit is treated as persistent: earlier metabolic control is assumed to continue lowering complication risk after usual care catches up, decaying gradually over time rather than ceasing abruptly. These two features are what separate short-run cost from long-run value and drive the timing of break-even.

The model starts from the national pool of undiagnosed T2DM and applies a sequential cascade of conditional probabilities. Each stage multiplies the previous one, yielding the cohort that achieves glycaemic control and is therefore eligible for risk reduction. Base-case values are shown below; the starting pool is modelled across a scenario range (700,000–1.3 million).

Stage	Rate	Cohort	Basis
Undiagnosed T2DM pool	-	1,000,000	ONS / Diabetes UK (c.30% of cases undiagnosed)
Screening uptake	50%	500,000	NHS Health Check-style uptake (around half)
Positive screening rate	25%	125,000	Model assumption (share needing review)
Diagnosis confirmation rate	80%	100,000	Model assumption (positives confirmed)
Treatment uptake	80%	80,000	Model assumption (diagnoses starting management)
HbA1c control rate	60%	48,000	Model assumption (treated achieving control)

The controlled cohort of **48,000** carries the entire benefit calculation. The 32,000 treated-but-not-controlled patients are deliberately assigned no risk reduction in the base case, a conservative choice that avoids crediting benefit to patients who do not achieve control.

This avoids the error of charging £1,000 per patient in perpetuity for care that usual practice would have funded anyway.

Combining the elements, the Year 1 net NHS impact is gross complications avoided less incremental management (screening having fallen in Year 0): £18,543,360 – £48,000,000 = **–£29,456,640**. The early years are deliberately net-costly; the value accrues later as management cost falls away while prevention benefit persists.

The cohort is projected over ten years. Three mechanisms govern how the annual net impact evolves:

● **Cohort attrition:** the treated and controlled cohorts shrink by 2% per year (a simple mortality/attrition proxy), reducing the population generating benefit over time.

● **Usual-care catch-up:** early detection brings management forward by a defined lead time (base case two years). The incremental managed share steps down from 100% (Year 1) to 50% (Year 2) to 0% (Year 3 onward); once usual care has caught up, the early pathway no longer incurs an additional management cost.

● **Benefit persistence and decay:** the prevention benefit does not cease when usual care catches up. Instead it persists and decays gradually, in the base case an absolute decay of approximately 5 percentage points per year applied to the effective prevention cohort, reflecting the continuing effect of earlier glycaemic, blood-pressure and renal-risk control on future complications.

Each year's net impact (gross savings less any incremental management and any Year 0 screening) is discounted at 3.5% and accumulated. Break-even is the first year in which cumulative discounted net impact turns positive.

Model B carries no capital cost. Screening and management are assumed to run inside polyclinic infrastructure already costed under Model A, so its incremental capital is zero. The two models are therefore complementary and are reported side by side rather than summed, since Model A is an NHS cash-flow appraisal while Model B is a budget impact projection of a single disease pathway.

For each diabetes-related complication, the model computes the events avoided in the controlled cohort as the product of cohort size, baseline annual event risk, and the relative risk reduction (RRR) attributable to earlier glycaemic control. Events avoided are then valued at an acute event (or state) cost:

$$Events\ avoided = cohort \times annual\ risk \times RRR;$$
$$Annual\ cost\ avoided = events\ avoided \times cost\ per\ event$$

Event	Annual risk	RRR	Cost / event	Annual cost avoided
MI	2%	14%	£4,300.00	£577,920.00
Stroke	2%	12%	£5,600.00	£483,840.00
CKD / dialysis	3%	37%	£32,000.00	£17,049,600.00
Amputation	0%	25%	£18,000.00	£432,000.00
Total	-	-	-	£18,543,360.00

The MI and microvascular RRRs (14% and 37% per 1% HbA1c reduction) are drawn from UKPDS 35; the remaining RRRs and several event rates are model assumptions pending export of National Diabetes Audit rates and are flagged as such in the Inputs sheet. The CKD/dialysis line dominates the gross saving (£17.0m of £18.5m), reflecting its high state cost and large relative risk reduction; this concentration is the model's single most important sensitivity and is examined in the sensitivity analysis.

Screening costs are incurred once, at programme outset, and applied as the Year 0 cost:

Component	Quantity	Unit cost	Cost
Invitation / admin	1000000	£2.00	£2,000,000.00
HbA1c screening	500000	£10.00	£5,000,000.00
Confirmatory review	125000	£40.00	£5,000,000.00
Total screening cost	-	-	£12,000,000.00

Invitation cost is applied to the whole target pool, HbA1c testing to those screened, and confirmatory review only to positive screens.

Earlier detection brings forward the cost of diabetes management. This is charged at £1,000 per controlled patient-year, but **only as an incremental cost during the lead-time window** before usual care would have detected the same patients. In Year 1 the full controlled cohort (48,000 × £1,000 = £48.0m) is incremental; as usual care catches up the incremental share falls (see Section 3.2), and once catch-up is complete the management cost is no longer incremental and falls out of the calculation.

Model output measures are:

- **Primary outputs:** annual net NHS impact and cumulative (undiscounted and discounted) net impact across the ten-year horizon; and the break-even year.
- **Secondary outputs:** ten-year cumulative net impact and ten-year cumulative discounted net impact, used to summarise overall budgetary value.

Model C: Screening & Productivity

Model C estimates the value generated by delivering population screening through the polyclinic platform, capturing two benefit streams that the infrastructure enables but which Models A and B do not: the health gain from reaching people who would otherwise avoid or delay contact with primary care, and the productivity (time) saved when screening is delivered through a faster point-of-care pathway rather than a conventional laboratory pathway. Like Model B, it assumes the screening activity runs inside infrastructure already costed under Model A and therefore carries no incremental capital cost.

The model is a cost–benefit analysis (CBA) implemented in Microsoft Excel over a five-year horizon, with parameters reconciled to Model A (same five centres, same 45,000 catchment, same 3.5% discount rate). Benefits are monetised in two ways, health gain valued in QALY terms at the NICE reference threshold, and time saved valued at the median wage, and set against the cost of the screening pathway itself. The result is reported alongside, not added to, Model A, because the two are denominated differently: Model A is an NHS cash-flow appraisal, whereas Model C monetises QALY value at a willingness-to-pay threshold.

The model distinguishes two screened groups within each catchment. The first is reached through standard NHS-pathway uptake; the second is an additional group, people who typically delay or avoid GP contact, captured specifically by the polyclinic model. Reach is expressed over a full five-year screening cycle and then annualised.

Group	Rate (% catchment)	Full cycle / centre	Annual / centre
NHS-pathway uptake	50%	22,500	4500
Avoidant population captured	20%	9,000	1800
Total screened (polyclinic)	70%	31,500	6300

The 50% NHS-pathway uptake is anchored to observed NHS Health Check uptake (52.6% in 2012–17; 45.9% in 2018/19). The 20% avoidant-capture rate is informed by survey evidence that a large share of the public delays or avoids GP contact, with around a fifth citing access barriers the polyclinic model is designed to remove. The two cohorts are treated differently in the benefit calculation: **health gain is credited only to the avoidant cohort**, while productivity gain is credited only to the NHS-uptake cohort, to avoid double-counting.

Two distinct, non-overlapping benefit streams are monetised, each assigned to a different cohort so that no person is counted in both.

Health gain is attributed only to the avoidant cohort, on the basis that these are the people who would not otherwise have been screened and for whom screening therefore represents genuinely additional health benefit. The benefit is valued as QALY gain per person, monetised at the NICE reference threshold: *annual benefit = annual avoidant cohort × QALY gain × QALY value*. In the base case: $1,800 \times 0.02 \times \pounds30,000 = \pounds1,080,000$ per centre per year.

Model C was specified as both a scenario analysis and a breakeven analysis rather than as a single deterministic estimate of screening benefit. The key uncertain parameter is the QALY gain per additional patient reached through the polyclinic screening pathway. Because this value is not directly observed, the model does not treat the base-case QALY gain as a fixed empirical estimate. Instead, it estimates the QALY gain required to achieve different economic thresholds and then reports results across a plausible range of QALY scenarios.

The threshold calculation is based on the relationship:

QALY gain required = required net benefit ÷ (additional screened cohort × QALY value × discount factor)

In the base specification, the five-centre programme captures 9,000 additional avoidant patients per year, and QALYs are monetised at £30,000 per QALY, consistent with the upper bound of the NICE cost-effectiveness threshold range (£20,000–£30,000).

Productivity benefit and screening cost are retained separately. Across the programme, annual productivity benefit is £885,150 and annual screening cost is £536,760, giving a non-QALY net benefit of £348,390 per year. The five-year discounted annuity factor at 3.5% is 4.515. Under these assumptions, the QALY gain required for Model C to generate a five-year NPV of £20m is approximately 0.015 QALYs per additional screened patient. The QALY gain required to reproduce the base-case NPV of £25.95m is approximately 0.020 QALYs per additional screened patient. A QALY gain of approximately 0.029 would be required for Model C alone to offset the depreciation-based Model A deficit of approximately £36.8m.

The base-case value of 0.020 QALYs is therefore not presented as a directly observed outcome. It is used as a calibrated scenario, anchored to the most directly comparable real-world programme: the NHS Health Check, a general cardiovascular and diabetes risk-screening programme delivered in primary care to a broad adult population. Published evaluation of the NHS Health Check estimates a QALY gain of approximately 0.05 per participant, with an incremental cost-effectiveness ratio of around £900 per QALY (Crossan and Godfrey, 2017); independent Department of Health modelling placed the programme at £2,480–£2,866 per QALY, well within the NICE £20,000 threshold. The base-case assumption of 0.020 QALYs is thus deliberately conservative, less than half the observed per-participant gain for the closest comparable programme.

This is reinforced by an independent threshold back-solve: at the polyclinic point-of-care screening cost of approximately £17 per person, a 0.020 QALY gain implies an ICER of roughly £850 per QALY, closely matching the published NHS Health Check figure and lying around 24 times below the NICE threshold. The two approaches, a conservative discount on observed health-check QALYs, and a back-solve from the cost-effectiveness threshold, are mutually reinforcing and place the base case on firmer ground than a single assumption.

Both nonetheless carry uncertainty: the 0.05 health-check figure is itself driven largely by modelled cardiovascular risk reduction and has been contested, and transferring a per-participant value assumes broadly comparable case-mix between the health-check and polyclinic populations.

Productivity benefit is attributed only to the NHS-uptake cohort and is valued as the difference in patient time lost between the conventional laboratory pathway and the faster point-of-care pathway, priced at the median hourly wage: annual benefit = annual NHS cohort × (hours saved) × wage. In the base case: $4,500 \times (4 - 2) \times \pounds19.67 = \pounds177,030$ per centre per year. The hourly wage is taken from ONS ASHE (2025); the time-lost figures (4 hours conventional, 2 hours point-of-care) are working assumptions, as no UK-specific evidence for total attendance time could be identified.

The only cost in the model is the screening pathway itself; incremental capital is zero by assumption. Screening is costed at the point-of-care unit cost applied to the full annual screened cohort (both groups): *annual cost = annual total cohort × LPI screening cost*. In the base case: $6,300 \times \pounds17.04 = \pounds107,352$ per centre per year.

Parameter	Value	Basis
NHS pathway cost (laboratory)	£21.67	Gillett et al., NHS Health Check cost-minimisation (laboratory)
Polyclinic cost (point-of-care)	£17.04	Gillett et al., NHS Health Check cost-minimisation (point-of-care)
Incremental capital cost	£0.00	Runs inside infrastructure already costed under Model A

The point-of-care unit cost is lower than the laboratory cost, so delivering screening through the polyclinic pathway is cost-reducing on a per-test basis as well as timesaving. Per-centre annual net benefit is the sum of the two benefit streams less screening cost: $\pounds1,080,000 + \pounds177,030 - \pounds107,352 = \pounds1,149,678$ per centre. Across the five-centre programme this gives an annual net cash flow of **£5,748,390**, treated as a constant Years 1–5 flow (no Year 0 outlay, since capital is zero).

Each annual flow is discounted at 3.5% using the standard factor $I \div (I + r)^n$, and summed over the five-year horizon. Capital and discounting are reconciled with Model A so the two models are directly comparable in their treatment of time and cost.

- Model output measures include Primary outputs: per-centre and programme annual net benefit; five-year discounted NPV (QALY-monetised).
- Secondary outputs: the decomposition of benefit into health-gain and productivity streams, and the per-test cost saving of the point-of-care versus laboratory pathway.

Comparative Analysis, Methodology

The international evidence base for this paper draws on a structured comparative analysis of healthcare systems in Singapore and the United Kingdom, conducted through a review of publicly available policy documents, government health statistics, peer-reviewed literature, and think tank publications. The comparative framework was organised around three analytical dimensions: funding models, workforce structures, and polyclinic characteristics and function. These dimensions were selected because they directly correspond to the structural failure modes identified in Section 2, inadequate diagnostic infrastructure, workforce retention pressures, and the absence of an intermediate care tier between GP and A&E.

Singapore was selected as the primary comparator for three reasons. First, it operates a mature, government-run polyclinic network at scale, making it the most directly analogous international model to the proposal advanced in this paper. Second, its healthcare system achieves comparable or superior outcomes to the UK at substantially lower GDP expenditure, 4.9% against 11.1% in 2022 and 2023-24 respectively, suggesting systemic efficiency gains that warrant examination (World Bank Group, 2025; Office for National Statistics, 2024). Third, existing UK facing literature, most notably Thilo (2024) for the Social Market Foundation, has already begun mapping Singapore's primary care model onto the NHS context, providing an established analytical foundation to build upon rather than starting from first principles.

The comparison was not conducted as a direct equivalence exercise. Singapore and the United Kingdom differ substantially in population size, healthcare financing mechanisms, cultural context, and the role of private insurance, differences that constrain direct policy transfer.

Singapore operates a co-payment model incompatible with NHS values, and its polyclinics function within a broader tiered financing system that has no direct UK equivalent.

These structural differences are acknowledged throughout and inform the analysis: the paper does not argue that the UK should replicate Singapore's system, but that the core operating principles of its polyclinic model, salaried multidisciplinary staffing, same-day diagnostic access, and positioning as an intermediate care tier, are transferable within the NHS framework.

Data sources for the UK side of the comparison included the House of Commons Library briefing on general practice in England (Gajjar, Powell and Stiebahl, 2025), the Institute for Government's performance tracker on local GP services (2025), and NHS England's Hospital A&E Activity data for 2024-25. Singapore-side data was drawn from the Singapore Ministry of Health's published statistics on primary care services and doctor retention strategies (2024), and the peer-reviewed primary care system analysis by Khoo, Lim and Vrijhoef (2014). The Darzi reform pilots were included as a UK-specific precedent for polyclinic implementation, drawing on Haidar (2015) and the original Darzi review documentation.

The comparative analysis was conducted thematically rather than statistically. No quantitative equivalence testing was performed across the two systems; the analytical contribution is the structured identification of transferable design principles and the mapping of those principles onto the specific NHS failure modes identified in Section 2.

Results

Model A: NPV under both capital treatments, base capital cost, five-year horizon

Scenario	Upfront-capital NPV	Depreciation-based NPV
Conservative (5%)	-£65,807,259.00	-£36,772,983.00
Moderate (10%)	-£65,189,965.00	-£36,155,688.00
Optimistic (15%)	-£64,572,670.00	-£35,538,393.00

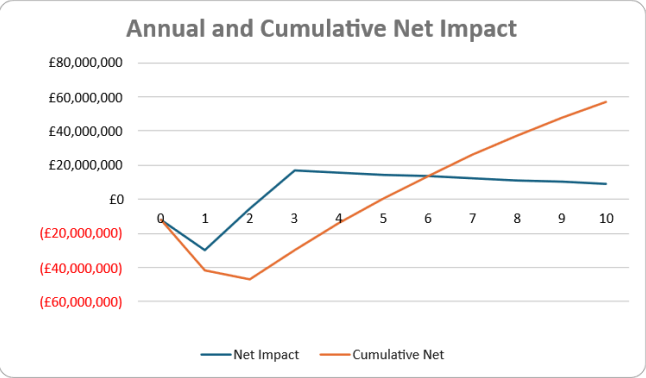
Note: figures in parentheses are negative. The depreciation-based treatment roughly halves the apparent five-year cost by not loading the full 20-year asset onto a five-year window.

Across all three deflection scenarios Model A returns a negative net present value over the five-year horizon. On the depreciation-based treatment the programme NPV ranges from approximately (£36.8m) in the conservative scenario to (£35.5m) in the optimistic scenario; on the upfront-expensing treatment the equivalent figures are (£65.8m) and (£64.6m). The narrow spread across deflection scenarios (roughly £1.2m) confirms that A&E deflection volume is not the principal driver of the result: fixed operating cost dominates the modest gross savings in every case. The choice of capital treatment, by contrast, changes the headline figure by approximately £29m, identifying it as the single most material methodological lever in the model.

Model B: T2DM Early Detection

On the base case, the programme is net-costly in its early years and turns net-positive thereafter. The annual net NHS impact is (£12.0m) in Year 0 (screening cost) and (£29.5m) in Year 1, reflecting the concentration of incremental management cost during the lead-time window. As usual care catches up and management cost falls away while prevention benefit persists, the annual net impact becomes positive from Year 3 onward (£16.9m), declining gradually thereafter as the benefit decays. On a cumulative discounted basis, the programme breaks even in Year 6, and the ten-year cumulative net impact is £56.9m (£39.0m discounted). The result is dominated by the CKD/dialysis complication line, which contributes £17.0m of the £18.5m Year 1 gross saving.

Figure 1: Model B annual net NHS impact and cumulative net impact over the ten-year horizon (undiscounted)



The early years are net-costly as screening and incremental management costs are incurred; the position turns cumulatively positive from around Year 5 as management cost falls away and the persistent prevention benefit accumulates.

Model C: Screening and Productivity

Delivering screening through the polyclinic platform produces a positive annual net benefit of £1,149,678 per centre (£5,748,390 across the five-centre programme), comprising £1,080,000 of QALY-monetised health gain to the avoidant cohort and £177,030 of productivity (time-saved) benefit to the NHS-uptake cohort, less £107,352 of point-of-care screening cost, per centre.

Discounted at 3.5% over five years, the programme NPV is £25.95m. This figure is QALY-monetised at NICE's reference threshold and is reported alongside, not added to, Model A's cash NPV of (£36.8m).

Scenario	QALY gain per additional screened patient	Five-year discounted NPV
Lower bound	0.002	£4.01m
Low	0.006	£8.89m
Moderate	0.015	£19.86m
Base (conservative)	0.02	£25.95m
Observed (NHS Health Check)	0.05	£62.53m

The scenario range is anchored at both ends by evidence rather than supposition. The 0.05 case is not a speculative best-case but the QALY gain per participant observed for the NHS Health Check, the closest comparable real-world programme (Crossan and Godfrey, 2017); at that empirically observed value the programme returns £62.53m. The base case deliberately adopts 0.02, less than half the observed figure, so that the headline result rests on a markedly conservative assumption.

Critically, Model C remains strongly net-positive across the entire range: even at the lower-bound 0.002 QALY gain, one-twenty-fifth of the observed value, the programme still returns £4.01m. The screening benefit of the polyclinic platform is therefore robust to even severe pessimism about its health impact, and the central estimate understates rather than overstates the likely value.

Singapore-United Kingdom Comparative Lens

Singapore offers a useful case study in examining how polyclinic systems can reduce pressure on General Practitioners (GPs) and Accident and Emergency (A&E) services. This section uses a comparative framework to analyse the funding and workforce models of Singapore and the United Kingdom, before considering the characteristics and functions of Singapore's polyclinics and the extent to which they apply to the British context. Funding Models: United Kingdom and Singapore A common trend that can be seen between the UK and Singapore is the comparison of GDP spending on healthcare, which demonstrates a disparity in spending.

On the one hand, the Office for National Statistics (2024) reported that the rate was 11.1% in 2023-24, whereas in Singapore, it was 4.9% as of the most recent data reported in 2022 by the World Bank Group (2025). Singapore's lower expenditure relative to the UK stems from the application of efficiency. Despite the charges involved with using A&E services and the use of private insurance that are involved in seeking A&E services within Singapore – which are incompatible with the NHS's values – it does not explain Singapore's lower need for A&E services. Rather, as Thilo (2024) argues, it reflects a greater investment in primary care access: by expanding GP services and polyclinics, Singapore reduces the demand for A&E attendance, which patients use only when necessary.

The UK's comparatively high healthcare spending provides a financial basis for establishing pilot polyclinic centres. A targeted allocation of funds toward these facilities could reduce pressure on A&E services and support a more structured three-tier system comprising A&E, GP services, and polyclinics. Workforce Models: United Kingdom and Singapore The workforce structures of the two countries differ in significant ways. GP clinics within Britain are independent contractors that work in partnership with the NHS (Gajjar, Powell, Stiebahl, p.5, 2025).

In Singapore, GPs remain private, but a dual system also exists with polyclinics employing salaried doctors under public ownership services, working with other teams in a multidisciplinary manner (Singapore Ministry of Health, 2024). The partnership model in the UK has faced some criticism, though it continues to serve local communities effectively when bridging healthcare (Sherifi, p.218, 2022).

However, the Institute for Government (2025, pp.18–22) recorded that there has been a sharp decrease in GP partners, which fell 27.5% between 2015 and 2024, with new cohorts of doctors seeking part-time roles instead. In contrast, the Singaporean Ministry of Health (2024) reported that polyclinic attrition rates for doctors remained at 3-5% in recent years, demonstrating a consistent platform of ensuring doctors remain within the services.

These trends suggest that salaried jobs, as offered by polyclinics, may be better suited to current workforce preferences than the traditional partnership model. Retaining GP practices in their existing forms while also introducing polyclinic roles could attract doctors who prefer more flexible and salaried arrangements, potentially producing retention outcomes like those seen in Singapore. The workforce benefits of polyclinics are not without precedent in the UK. Haidar (2015) notes that polyclinic pilots introduced under Gordon Brown's government demonstrated benefits for multidisciplinary working under Health Minister Darzi, including expanded opportunities for nurses to take on practitioner roles alongside doctors.

This experience suggests that the model has a degree of established credibility within the British healthcare context with controlled implementation. Singapore's Polyclinics Characteristics and Function: Applicability to the United Kingdom? Singapore's polyclinics are mainly characterised as being “one-stop” centres which carry an assortment of equipment: health screenings, vaccinations, and X-Ray machines.

This is also paired with the additional information that doctors who work within these clinics remain as the primary and first point of contact patients attend to, which usually encompass 20% of the primary health care services being used. (Khoo, Lim, and Vrijhoef, 2014, p.2). The primary function of polyclinics, therefore, is not emergency care but accessible intermediate care. The function of the centre itself is to provide immediate care and alleviate burden on A&E and GP services by providing services with the multitude of equipment offered, filling the gap of having to seek the extreme option (A&E) for issues or waiting for a referral. In England, A&E services accounted for 27.4 million in attendance, with 79.3% being resolved within four hours, with a 1.9x likelihood increase in deprived areas (NHS England, 2025).

The Institute for Government (2025, p.31) has also identified a shortage of approximately ten GPs in deprived areas relative to more affluent ones. This suggests that patients in these areas who seek A&E services may be attending partly due to limited access to primary care – a gap that polyclinics could reasonably address, as they have in Singapore. Introducing polyclinics in the UK, particularly in underserved areas, could reduce misuse of the A&E services by providing timely, team-based care for conditions that do not otherwise require emergency treatment. Polyclinics fill the gap of having specialised staff members equipped to deal with needs on standby, which would resolve the UK's fundamental problem of non-targeted care for patients.

Discussion and Limitations

Model A includes the following limitations and assumptions:

- Only minor A&E deflection is monetised. Avoided ambulance conveyances, reduced four-hour-breach penalties, GP appointment substitution and downstream admission avoidance are excluded. The negative NPV is therefore a lower bound on the platform's value, not a complete account of it.
- Staffing establishment and running-cost ratio are held constant across scenarios; the model does not flex capacity to demand.
- Deflection rate is the principal behavioural uncertainty and is handled by scenario range rather than a fitted estimate.
- Wider clinical value, QALY gains from earlier diagnosis and productivity gains from reduced waiting, is deliberately out of scope here and is quantified in the companion screening and T2DM models, which should be read alongside Model A and reported side by side rather than summed (the numeraires differ: NHS cash flow versus QALY-monetised value).

Model B includes the following limitations and assumptions:

- Several event rates (MI, stroke, CKD, amputation) and several relative risk reductions are model assumptions pending export of National Diabetes Audit data; outputs should be read as illustrative until these are replaced with audited rates.
- The result is highly sensitive to the CKD/ dialysis line, which alone contributes most gross savings; conclusions should be stress-tested against lower CKD risk-reduction and dialysis-cost assumptions.

- The annual management cost (£1,000/patient-year) is a proxy derived from aggregate UK diabetes-care spend rather than a costed care pathway.
- The cascade probabilities (positive-screen, confirmation, treatment-uptake and control rates) are largely assumption-based and jointly determine the size of the benefiting cohort.
- Attrition is modelled as a flat 2% proxy rather than age-specific mortality; the persistence and decay parameters are assumptions tested in sensitivity analysis.
- As a single-disease model it captures only T2DM value; the wider multi-disease benefit of the polyclinic platform is addressed qualitatively in the discussion and is not quantified here.

Model C includes the following limitations and assumptions:

- The QALY gain per additional screened patient is the dominant parameter in Model C. It is therefore treated through scenario and breakeven analysis rather than as a directly observed empirical estimate. The base-case value of 0.020 QALYs is a calibrated scenario, anchored to the observed NHS Health Check per-participant QALY gain of approximately 0.05 (Crossan and Godfrey, 2017) and cross-checked by a threshold back-solve (implied ICER ≈£850/ QALY at a £17 screening cost); the base case is deliberately set below half the observed value, and the headline NPV should be interpreted as conditional on this assumption.
- The productivity time-lost figures (4h vs 2h per patient) are working assumptions, no UK-specific evidence for total attendance time having been identified; the productivity stream should be treated as indicative.

- The 20% avoidant-capture rate is inferred from survey evidence on access barriers rather than from observed screening data and determines the size of the health-benefit cohort.

- Crediting health gain only to the avoidant cohort and productivity only to the NHS-uptake cohort is a deliberately conservative anti-double-counting choice; it may understate total benefit if, for example, NHS-uptake patients also gain health value.

- Productivity gain is valued at the median wage and represents patient time rather than direct NHS expenditure, consistent with the model being a societal-value rather than cash-flow appraisal.

- Incremental capital is assumed zero on the basis that screening uses Model A infrastructure; this is appropriate only if read jointly with Model A, which carries that capital in full.

Synthesis across the three models

Read together, the three models describe a platform rather than a single intervention. Model A shows that the polyclinic infrastructure does not pay for itself on A&E deflection alone: judged against that single benefit stream, it is firmly cash-negative over five years. This negative result should be read as a feature of the appraisal rather than a verdict on the policy. Model A deliberately monetises only one of many benefits the infrastructure enables, so its NPV is a lower bound on the platform's value, not a complete account of it. Models B and C then quantify two of the benefits that run on top of that infrastructure, earlier chronic-disease detection and population screening, each of which carries no incremental capital cost precisely because the platform has already been paid for under Model A.

Reading the results by side

The three NPVs are denominated differently and must not be summed. Model A is an NHS cash-flow appraisal; Model C monetises QALY value at NICE's willingness-to-pay threshold; Model B is a budget-impact projection of a single disease pathway. Adding a cash figure to a QALY-monetised figure would conflate actual NHS expenditure with the societal value of health gain and overstate the combined position.

Presented side by side, however, they tell a coherent story: a platform that costs roughly £37m in cash terms over five years (depreciation basis) simultaneously generates QALY-monetised screening value of around £26m over the same period and enables a single chronic-disease pathway that itself turns net-positive within six years and returns £39m discounted over ten. The cash cost of the platform is therefore plausibly outweighed once even a small number of the benefit streams it enables are counted.

From one disease to many

Model B is a worked example, not a ceiling. It demonstrates the mechanism by which one chronic-disease stream running on the polyclinic platform becomes net-positive over time, but T2DM is one of many conditions for which earlier diagnosis and structured management avoid downstream acute cost. The same logic, incremental management cost during a lead-time window, set against persistent prevention benefit, applies in principle to hypertension, cardiovascular risk, COPD, chronic kidney disease and other long-term conditions managed in primary and intermediate care.

The single-disease result should therefore be interpreted directionally: if a comparable net benefit were achievable across several analogous pathways, the platform's negative standalone NPV would be outweighed by a margin that grows with the number of pathways delivered. This is offered as an illustrative argument about the direction of value, not as a quantified multi-disease estimate, which the present models do not attempt.

Capital treatment and the appraisal window

The five-year evaluation window understates the value of an asset with a twenty-year useful life. Charging the full capital cost against five years of benefit, as the upfront-expensing treatment does, attributes to the appraisal period costs that properly belong to a far longer horizon; the depreciation-based treatment, which roughly halves the apparent five-year cost, is the more faithful representation of the resource actually consumed within the window and is adopted as the primary basis here. A longer appraisal horizon, or a refurbishment-led rollout using existing NHS estate rather than new build, would each improve the headline position further, conservative choices that the present analysis does not exploit.

Patient Referral and Awareness Pathways

A reasonable objection to the preceding analysis is that building polyclinic capacity does not, by itself, guarantee that patients who currently default to A&E will redirect to it. The primary mechanism for this redirection already exists within the NHS and requires no new patient-facing infrastructure: NHS 111.

NHS 111 call handlers triage using NHS Pathways software, which selects a disposition from a live Directory of Services (DoS) covering all services available in a caller's area, urgent treatment centres, out-of-hours GP, pharmacy, and A&E among them. Listing polyclinics as a defined DoS service means 111 can systematically direct callers with ambulatory, non-emergency presentations, the same soft-tissue injury, suspected minor fracture, or urgent imaging query profile identified in Section 2, to the polyclinic rather than defaulting to A&E.

This is not a new behaviour change being asked of patients; it relies on a triage pathway they already use, and 68% of current A&E attendees already report having been directed there by another service (NHS England, 2026), evidence that the routing mechanism is active and simply needs the polyclinic added as a destination.

This is reinforced by three secondary channels: GP direct booking or e-referral into the polyclinic from a patient's own practice; self-referral once the polyclinic appears as a listed service on the NHS App and website; and the community engagement pathways set out in Section 7.4, which reach the population less likely to navigate any digital or telephone triage route in the first place. Together, these mean the polyclinic does not depend on patients independently discovering or choosing it; it is reachable through the same referral infrastructure that currently channels patients toward A&E by default.

Conclusion

The root cause of the NHS patient flow crisis is lack of timely diagnostic access. A&E has become the default gateway for a large cohort of patients who require imaging and assessment but not emergency care, because the primary care tier lacks the infrastructure to serve them within a clinically acceptable timeframe. This paper has argued that polyclinics is the most structurally coherent response to that failure.

Economic analysis of costs to establish the pilot, judged against A&E deflection alone, is cash negative over five years. This is a feature of a conservative appraisal that monetises only one of many benefits, not a verdict on the policy. Once the broader value the platform enables is shown, such as the screening and productivity gains of Model C and the chronic disease pathway of Model B, the cash cost of the platform is plausibly outweighed. That conclusion only strengthens with every additional pathway the infrastructure supports. The single disease result is not a ceiling for the overall benefits of polyclinics.

The international evidence reinforces the case. Singapore demonstrates that a salaried, multidisciplinary, same-day-diagnostic polyclinic tier can relieve pressure on emergency and primary care at substantially lower system cost, and that the core operating principles of that model, though not its financing, are transferable to the NHS.

The implementation framework set out here shows how a phased pilot can be delivered without destabilising existing provision: targeted at the most deprived communities through Core20PLUS5, drawing on an underutilised workforce cohort rather than cannibalising GP supply, and introduced through the trusted community networks that NHS communications routinely fail to reach.

The proposal is therefore modest in its immediate ask and significant in its potential. A 5-centre pilot, targeted at areas of high deprivation and high A&E utilisation and evaluated over five years against both economic and equity metrics, would produce the evidence base needed to judge polyclinics at scale. The structural logic, the international precedent, and the directional economics all point the same way: the question is not whether the NHS can afford to build polyclinics, but whether it can afford to continue without them.



View of NHS Nightingale Hospital (Wikimedia Commons)

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