



NAPC | National Association
of Primary Care



Primary care networks: critical thinking in developing an estate strategy



#primarycarenetworks #primarycarehome

March 2020

Contents

1. Introduction	04
2. Primary care landscape	08
3. Estate landscape	13
4. Framework for estate planning	23
5. Step 1 – Build a picture of current services and estate	26
6. Step 2 – Outline future health and care models based on population health approach and assess estate needs	32
7. Step 3 – Produce key elements to begin to form your estate strategy	42
8. Considerations and next steps	48
9. Case studies	50
i. Case study – St Helens North Primary Care Network (pilot)	50
ii. Case study – St Helens Newton and Haydock Primary Care Network (pilot)	52
iii. Case study – Click Primary Care Network (pilot)	54
iv. Case study – Yeovil Primary Care Network (pilot)	56
v. Case study – Frome Primary Care Network	58
vi. Case study – Granta Primary Care Network	60
10. References	62
Appendix A	65
Appendix B	65
Appendix C	66

Foreword



This guide aims to help primary care networks (PCNs) and primary care homes (PCHs) gather the evidence and insight to inform an estate strategy for integrated community-based health and care consistent with the vision of the NHS Long Term Plan.

Many GP practices across England struggle to provide essential services because of inadequate premises. There are considerable challenges not only to deliver the PCN contract but also to expand services to reach what is expected as a mature network.

This guide is designed as a starting point – its purpose is to stimulate ideas and the critical thinking to begin estate planning for the future. As every network has potentially different premises needs, it has been written to enable PCNs to do some of the groundwork as they build their estate knowledge and expertise.

We encourage networks alongside their partners to consider their future estate needs as early as possible in their development, to look at the bigger picture across the health economy and not be put off with the scale of the task but to start gathering information.

The guide includes practical tips on how to build a picture of the current estate, how this can evolve in line with service developments as well as plan for future models of care and ensure buildings are in the right place to deliver them.

The PCN estate can act as a catalyst for changing the way services are delivered locally. There is evidence that buildings have an impact on staff morale, retention and patient experience. All are vital as we strive to deliver care differently to make our estate fit for the future.

We would like to thank the four primary care networks in St Helens and Somerset who worked with us on this guide, helping us to identify the questions that networks need to ask and for sharing their insights into the challenges they are facing.

Dr Sue O'Connell
*Chief Executive Officer and Executive Director
 Community Health Partnerships*

Professor James Kingsland OBE
*National PCH Clinical Director
 National Association of Primary Care*

1. Introduction

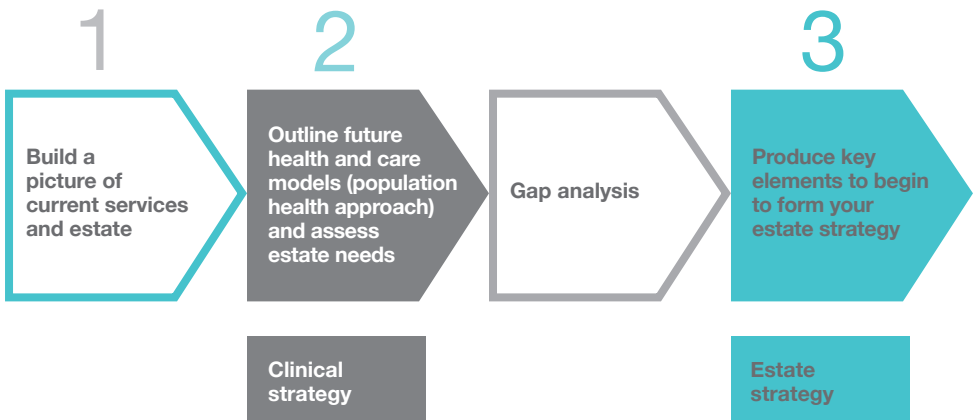
How to use this guide

Integrated primary care providers need modern, efficient buildings, equipped with the latest technologies, to enable their practices to develop and expand patient services. They also need buildings that are reliable and well maintained with the capacity to cope with future demands.

Often estate issues are debated after service redesign discussions have concluded and the limitations of unsuitable premises not recognised early enough. This can lead to the primary care estate being a blocker rather than an enabler to moving more care out of hospital.

To support the ambitions of the *NHS Long Term Plan*¹, a clear strategy for the development of the primary care estate is needed to deliver a range of extended community-based services in optimal care settings. Working with partners, PCNs need to respond to the changing needs of their local population and to continually improve patient outcomes. This presents PCNs with questions about how well they understand and optimise their existing estate and consider what is needed in the future.

This practical guide, from Community Health Partnerships (CHP) in collaboration with the National Association of Primary Care (NAPC), is designed as a starting point for networks embarking and grappling with future estate needs. It may help to unpick complex issues, offering tips, key questions and an initial framework to begin to plan the future PCN estate.



Assessing future estate needs with partners crucial to success of PCNs

The infrastructure implications of developing PCNs in line with the NHS Long Term Plan can be significant. It is important that the productivity of the estate is maximised, waste eliminated, and funding released to develop transformation projects. To achieve this, networks should avoid planning in isolation, instead bringing everyone to the table across the system and consider the art of the possible.

Impact on patient care and staff wellbeing

There is considerable evidence that the healthcare environment, particularly new and refurbished buildings, improves patient experience, outcomes, staff recruitment, retention and morale. The environment can also be linked to the quadruple aim – improving the experience for those providing care and bringing further enjoyment at work.

According to the British Property Federation's report *Quality buildings, quality care – How buildings contribute to improved patient care and staff wellbeing*², investments in new build healthcare premises in England have had a significant, measurable impact on the quality of care provided to patients. New buildings are also associated with reducing staff sickness and turnover, patient harm (particularly falls) and reducing mortality.

Maggie's centres have revolutionised cancer support and redefined the relationship between architecture and wellbeing. There are 20 centres across England attached to major NHS cancer centres where architecture is vital to the care they offer – each warm, welcoming and full of light and open space, providing an uplifting and calm environment.



Maggie's Dundee (Ninewells Hospital)

Inclusive design

All buildings should ideally be designed to be inclusive for all users whether patients, visitors or staff. One of the core values of the NHS is that everyone should have equal access to high quality healthcare³. Research shows people with disabilities often struggle to access primary care services housed in poorly designed buildings which haven't been adapted to meet their needs.

In simple terms, inclusive design is about making places that everyone can use. Inclusivity was a key design principle from the offset at the Finchley Memorial Hospital, built in 2010. Design features included:

- building colour zones to simplify orientation and allow users to easily give directions
- feature walls to mark destination points
- open plan layouts and floors without stepped access to ease navigation
- Braille and picture signage to identify rooms



Finchley Memorial Hospital

The Commission for Architecture and the Built Environment (CABE) states that the aim of inclusive design is “to remove the barriers that create undue effort and separations” and so enable “everyone to participate equally, confidently and independently in everyday activities”.⁴

Making facilities accessible for as many people as possible is critical within healthcare environments that are commonly used by people with a wide range of motor, sensory and cognitive abilities. Later in the guide in chapter 7, we give more information on the CABE principles of inclusive design and how to address it early in the development process.

Digital considerations

More insight is needed into the relationship between primary care estate and advances in technology, for example, the need to understand the implications of online GP services. The Naylor Review recommends that it is vital that future estate is flexible and can adapt to the new opportunities that technology brings.⁵

Flexibility is vital too as new ways of providing care evolve to meet the growth in demand including the rise in group consultations, trial of standing appointments and online consultations to improve access. A project sponsor should look to design digital needs around current and future service delivery models. For more information on digital considerations and primary care, see pages 11 and 45.

*Maggie's Dundee
(Ninewells Hospital)*



2. Primary care landscape

Background to primary care networks

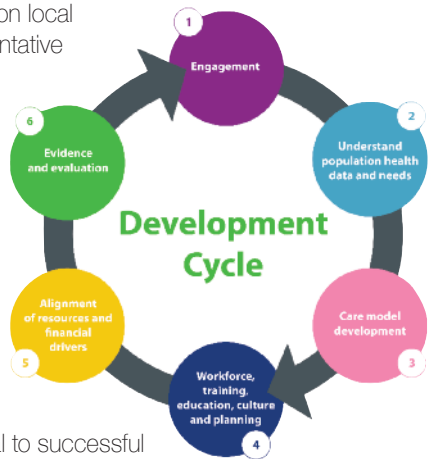
NHS Chief Executive Sir Simon Stevens launched the primary care home (PCH) model – the original PCN developed by the NAPC – in 2015 with an initial 15 rapid test sites.

Under the model, a range of health and care professionals come together as a complete integrated care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide personalised and preventative care closer to patients' homes.

There are now more than 240 PCHs* across England, representing 11 million patients and covering a fifth of the health and care system.

Experiences of PCH sites informed the development of national PCN policy as set out in the *NHS Long Term Plan*¹ and *Investment and evolution: the five-year framework for GP contract reform*⁶.

NAPC's organisational development approach for PCNs is based around six enablers. The six are crucial to successful network development, to achieving the broader vision of integration and align to NHS England's PCN maturity framework. The PCN development cycle should be used alongside the framework for PCN estate planning as outlined in chapter 4.



Four key characteristics make up the primary care home:

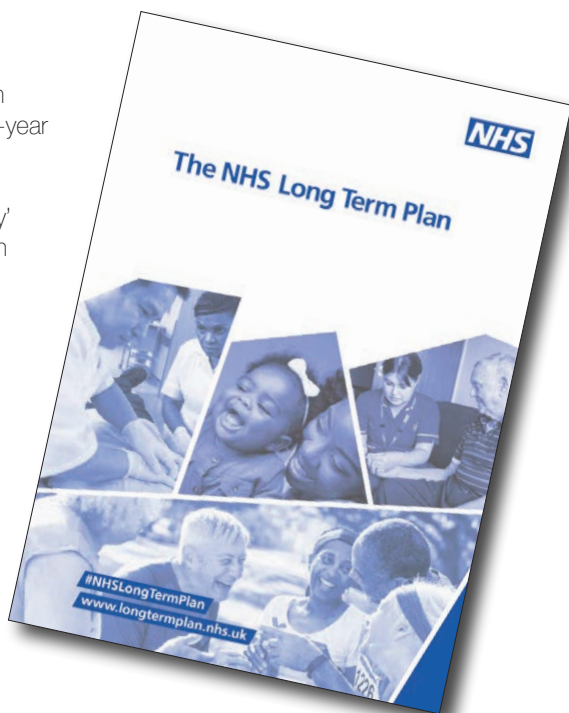
- A combined focus on personalisation of care with improvements in population health outcomes
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- Aligned clinical and financial drivers
- Provision of care to a defined, registered population of between 30,000 and 50,000

* 247 primary care home sites as of 26 February 2020

NHS Long Term Plan

The *NHS Long Term Plan*¹ published in January 2019 set out an ambitious 10-year agenda for change across the NHS in England. The key aim was to deliver 'a new service model for the 21st century' and to strengthen the NHS contribution to prevention of illness and addressing health inequalities.

The proposed new service model – which provides more coordinated primary and community care – offers patients more choice, better support and properly joined-up care at the right time and in the optimal care setting. The plan included an aspiration to avoid up to a third of outpatient appointments, saving patients 30 million trips to the hospital.



The plan set out how GP practices – typically covering 30-50,000 people – would be funded to work together as PCNs to cope with the pressures in primary care and extend the range of local services, creating integrated teams of GPs, community health and social care staff.

New expanded community health teams would be required to provide fast support to people in their own homes as an alternative to being in hospital, and to ramp up NHS support for people living in care homes.

Under the Long Term Plan, digitally enabled primary and outpatient care would go mainstream across the NHS. Local NHS organisations would increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs).

Estate transformation is an integral part in delivering the Long Term Plan. Having the right estate is a key enabler to providing multidisciplinary health services across primary and community sectors.

The GP five-year contract

NHS England and the BMA General Practitioners Committee (GPC England) agreed a five-year GP contract in January 2019, designed to deliver many of the commitments made in the NHS Long Term Plan. A major part of the GP contract was the creation of primary care networks (PCNs) through the Network Contract Directed Enhanced Service (DES).

In February 2020 GPC England negotiated an update to the GP contract in response to feedback over the draft DES specifications. Doctors felt they were too prescriptive and overly burdensome for practices and networks alongside their existing workloads.

The revised package offers additional investment to practices and PCNs including £94m to address recruitment and retention, a one-off £20,000 incentive for new partners, 100 percent reimbursement for all additional staff and £173m for networks to employ a broader range of professionals. The new contract equates to seven full time equivalent staff for the average PCN in 2020/21, in cash terms this is £344,000.

There were also considerable changes to the seven DES specifications. Initially five were to be introduced from 2020/21 and a further two from 2021. Now only three are required to be started from 2020.⁷

From April 2020

- Structured Medication Reviews (SMRs) and Optimisation (volume of SMRs now to be determined by PCN clinical pharmacist capacity)
- Enhanced Health in Care Homes
- Supporting Early Cancer Diagnosis

From April 2021 (to be revised and negotiated with GPC England)

- Personalised Care (postponed from April 2020)
 - Anticipatory Care (postponed from April 2020)
 - Cardiovascular disease (CVD) Diagnosis and Prevention
 - Tackling Health Inequalities
-



Digitalisation and primary care

The NHS Long Term Plan places technology at the centre of several of its commitments. It sets out that every patient will have the right to be offered digital-first primary care by 2023/24, where they can easily access advice, support and treatment using digital and online tools. To achieve this, the GP contract has laid out a number of digital primary care requirements, including:

- All practices will ensure at least 25 percent of appointments are available for online booking. Practices that are encouraging online consultations and offering non-triage appointments online (for example cervical screening, health checks, travel and flu vaccinations), including those available for direct booking by patients on the phone or in person, will be recognised as working towards the 25 percent target. A quality framework is being developed by NHS England and NHSX to support practices with online appointments.
- All patients will have the right to online consultations by April 2020 and video consultation by April 2021.

Primary care networks will play an essential role in supporting practices and other partners to deliver a comprehensive digital offer for their patients and integrating these services across a local area. More information on the implications of digitisation of the primary care estate can be found on page 45.



Kensington Neighbourhood Health Centre, Liverpool L7

3. Estate landscape

Background

The estate strategy in primary care has mirrored policy and technical advances through the decades. Historically GPs were employed by the NHS on individual contracts and many practised in their own homes. Investment programmes encouraged them to form bigger practices and the NHS began to pay GPs' rent and business rates. By the 1970s local authorities began to build health centres which co-located GPs with other health services such as dentists and health visitors.



Credit: Wellcome Collection.
Attribution 4.0 International (CC BY 4.0)

In the early 2000s, it was acknowledged that primary care estate needed investment and a strategic approach to be fit to deliver the healthcare of the future. There was also a move towards establishing primary care hubs called polyclinics in some parts of the country. These were one-stop shops for primary care, advocated by Professor Lord Darzi in his *Healthcare for London: a framework for action*⁸. These were designed to create larger groupings of primary care professionals, exploit economies of scale and help alleviate pressure on the acute sector by taking some services out of hospitals and placing them in community-based centres.

The Local Improvement Finance Trust (LIFT) programme was created in 2000 to attract private investment into the primary care estate as it became clear that updating premises would be expensive and general practice had to explore models to reduce upfront costs. The scheme grew and over the next two decades helped deliver integrated primary care facilities in areas of need.



Springhead Health – a Darzi Centre which opened in 2012

In 2014 the Government established the Primary Care Infrastructure Fund to accelerate improvements in GP premises and infrastructure. This included the Estates and Technology Transformation Fund (ETTF), a multi-million programme to modernise infrastructure and facilities, including the better use of technology, in general practices across England which was launched in 2015/16.

Naylor Review

Despite investment, there remain concerns over the ability of the current primary care estate to meet the challenges of the future – more care out of hospital, better integration and digital advances in how healthcare is delivered.

An independent report by Sir Robert Naylor published in 2017 stated that, without investment, the NHS estate would remain unfit for purpose and unable to support an NHS of the future. *NHS Property and Estates, Why the estate matters for patients* examined how the NHS could develop its estate to support the delivery of the *Five Year Forward View*⁹ – the NHS's strategic plan that preceded the NHS Long Term Plan.

It highlighted poor buildings, a backlog of maintenance and estimated Sustainability and Transformation Partnerships (STPs) required capital funding of £10bn. It recommended that NHS England and the NHS Property Board should ensure primary care facilities meet the vision of the Five Year Forward View, including potentially linking payments to the quality of facilities and greater use of 'fit for purpose' standards.

Reform Report

The findings of the Naylor Review were echoed in a report by Reform *A design diagnosis: reinvigorating the primary care estate*¹⁰ in 2018. It cited a BMA 2014 survey which found that 70 percent of GPs who responded regarded their premises as too small to deliver more services. The report also highlighted that small practices had specific challenges with many operating from buildings with limited and outdated facilities. It said there had been a history of responding to urgent need rather than thinking strategically about estate in partnership with other parts of the system, including the acute sector.

The Reform report found that, even where investment had been found to expand primary care estate, this was too often done in a siloed way which meant increasing the capacity of primary and community care but not taking any pressure away from the acute part of the system.

“ There is an urgent need for additional capital to address backlog maintenance and deliver the 5YFV.

Naylor Review ”

“ Small practices had specific challenges with many operating from buildings with limited and outdated facilities.

Reform report ”

In its latest report *A primary care estate fit for the future*¹¹ published in February 2020, Reform calls for the need for Government plans to have greater focus and prioritisation on the primary care estate alongside further investment and a new approach to funding digital initiatives in primary care.

The General Practice Premises Policy Review (GPPR)

NHS England and NHS Improvement published the *General Practice Premises Review (GPPR)*¹² in June 2019. The review, conducted in collaboration with key stakeholders, recognised ongoing issues around general practice premises and published some policy conclusions.

It highlighted that primary care premises in many places were not fit for purpose and cited the *BMA GP Premises Survey 2018*¹³ which reported that 50 percent of respondents felt that their premises were not suitable for present needs and only just over two in 10 practices thought their premises were fit for the future.

The review encouraged PCNs to begin working on their future estate needs straightaway considering joint working and the estate of their community partners. Some policy conclusions are listed below.

- Assign existing practice leases to NHS bodies where they are of strategic importance

- Package of support for primary care engagement for STPs' and ICSs' capital strategies and the capital allocations process

- Pilot alternative premises reimbursement arrangements to minimise networks' estate costs

- Encourage networks to start working out their future estate needs now

- Pilot simpler models of premises provision where the NHS directly bears the cost of premises in multi-use new build premises

- Best practice guidance developed for property-owning GPs

Finance and ownership models

Investment options

Primary care infrastructure investment in recent years has been through different financing and ownership models. The key programme are listed below.

Estates Transformation and Technology Fund (ETTF) **(£800m)**

Formerly the Primary Care Transformation Fund, the ETTF is a multi-million pound investment in general practice facilities, both revenue and capital, provided to accelerate development between 2015/16 and 2020/21.

NHS Local Improvement Finance (LIFT) Programme **(£2.5bn)**

Now in its 20th year, this is the Department of Health's sponsored partnership between the private and public sectors. Community Health Partnerships (CHP) delivers the programme through 49 LIFT companies. Under the scheme, LIFT design, build, finance and maintain with CHP operating the estate.

Third party development **(3PD – £3bn+)**

Private investors build new surgeries for GPs to lease over a fixed period. Under this model, the private sector designs, builds and finances the estate, with GPs mostly responsible for internal maintenance.

GP owned

GPs can, and always have been able to, invest in their own estate. The NHS reimburses costs through a range of premises' payments. GPs are increasingly becoming unwilling to invest.

Development partner (e.g. local authority)

Under this model primary care works with a partner for external development expertise who design and build the facility. Local authorities fund (or ETTF fund) and retain ownership. Primary care occupy under lease arrangements.

Historic NHS funding and delivery route (PCT)

Using internal development experience, the public sector is responsible for all the delivery design, build, finance, operation and maintenance and has all the risks associated with the build. Public capital funding is used and the building is leased.

In August 2019, the Government announced a further £1.8bn for the NHS to upgrade outdated healthcare facilities and equipment as well build 20 new hospitals. This included primary care investment in South Norfolk and South Yorkshire and Bassetlaw.

Further significant investment to support primary care estate development and the implementation of the Long Term Plan is expected to be announced at the next Spending Review. The government has committed to a new multi-year capital settlement for the NHS which will include capital for primary care to modernise diagnostics and technology¹⁴.

Data gathering on primary care estate

While it is estimated that £800m is spent annually on reimbursed primary care premises across England, there is limited system-wide understanding of how this cost compares to asset size, condition and related ownership models.

In response, NHS England and NHS Improvement have commissioned a programme across the primary sector to collect estate data for every GP practice across England, through Community Health Partnerships, which includes location, building condition and ownership. It is due to be finished by March 2021.



Newport Pagnell Medical Centre

Ownership models

Primary care estate is owned or leased by different organisations making estate planning complex.

Historically, the sector has adopted multiple ownership, funding and risk transfer models, for example, NHS, GP, joint venture and private sector owned. These different partners have designed, built, funded, delivered and maintained the primary care estate in a variety of ways.

The changing appetite for GP ownership adds to the complexity with GPs becoming less willing to take the risk associated with property ownership or long leases, preferring to occupy non-GP owned or leased buildings.

A summary of the different delivery models and the different parties' responsibilities are set out below.

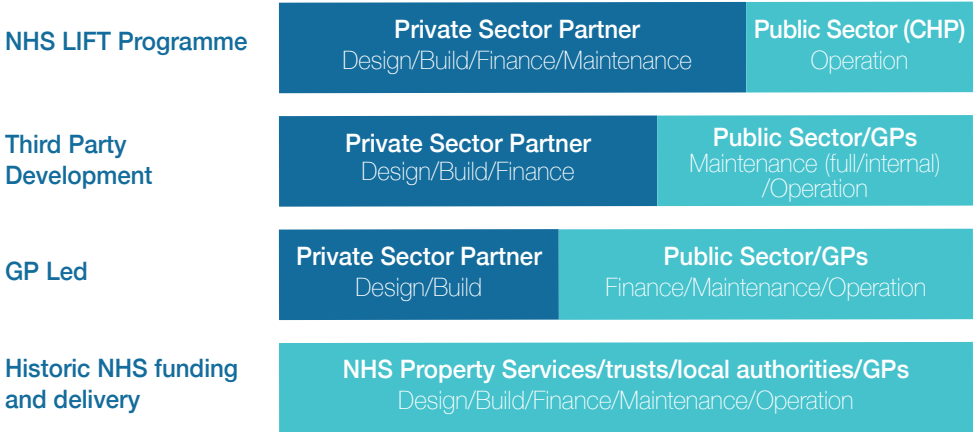
DELIVERY MODELS		ROLES AND RESPONSIBILITIES
Design	D	Responsibility for design of facility from inception to practical completion based on brief provided by an NHS organisation
Build	B	Employment of contractor to build new facility and acceptance of associated build risk
Finance	F	Provider(s) of capital for construction of facility
Operation	O	Day-to-day running of facility including provision of soft service
Maintenance	M	Provision of hard facilities management services including life cycle replacement

These delivery models have resulted in a range of ownership models. A summary of the different models is explained opposite.

OWNERSHIP MODELS	DESCRIPTION
Private sector	
Third party development	Typically these consist of a small number of large players in the healthcare investment market. GPs lease via commercial/ specialist healthcare landlord.
GP owner occupier	Approximately half the current market consists of GP-owned estate.
Retired GP owned	Within the GP-owned estate is an element where retired partners of a practice still retain ownership of premises and lease to other GPs.
GP property company/joint venture	A number of GP practices are looking at separating premises from their healthcare contract and forming property holding companies. These are more prevalent in recent developments.
Public sector	
NHS Property Services	Department of Health and Social Care (DHSC) owned or leased, with GPs/tenants leasing space.
Community Health Partnerships (CHP)	DHSC and private sector part-owned with CHP holding the head lease and GPs/tenants leasing space.
NHS trusts	NHS owned or leased with GPs/providers leasing space.
Local authority	Local authority owned or leased with GPs/tenants leasing space.

For information about lease options see Appendix C on page 66.

The relative risks of different ownership models can be seen in the diagram below which shows the different levels of risk transfer between public and private sector bodies.



As the NHS Long Term Plan is implemented and PCNs continue to develop, having a fit for purpose estate to enable transformational change in line with population health needs may need new ownership models – models that are not a barrier to service redesign and are less fragmented. They are likely to reduce the reliance on the estate being commissioned and held at GP level with an increase in wider or independent ownership models.

PCNs' role in climate change

The government in 2018 made a legal commitment to reduce the UK's CO₂ emissions to net zero by 2050. This is a key consideration for all PCNs looking at their estate and how they operate most effectively both now and in the future.

According to different estimates, the NHS accounts for between four and five percent of all the UK's greenhouse gas emissions¹⁵. A significant proportion will be associated with the primary care estate. An accurate assessment of the current carbon intensity of the primary care estate is difficult because of the wide variation in building age and quality. The implications for primary care include requirements to formally assess the current emissions of local primary care estates (for the purposes of a baseline assessment). PCNs are required to:

- Make a net zero estate a part of transformation plans
- Understand the emissions associated with the travel that staff and patients make to access services and include these secondary emissions in planning

- Provide as much energy as possible from the new primary care estate (PV, heat pumps etc) to mitigate against the likely increase in energy costs as the carbon impact is increasingly priced in.

Primary care networks cannot ignore the net zero agenda. Further guidance is mentioned in chapter 7.



Photo by Science in HD on Unsplash

Case study: *Frome Primary Care Network*

Frome Primary Care Network (a primary care home) had an exciting vision of a new health park where medical facilities would be co-located in a new community hub and offer a more multidisciplinary and collaborative approach. In 2012, Frome opened a modern building which co-located Frome Medical Practice and Frome Community Hospital. When designing their new site, the network worked with Frome Town Council to put in place plans for electric car charging points and solar panels. Since opening the new site, Frome has won several awards for its sustainability achievements (see page 58 for full case study).



Frome Medical Centre



4. Framework for PCN estate planning

NAPC's experience with the primary care home programme has shown that success is dependent on building strong relationships and trust among its stakeholders. This is crucial before embarking on assessing future estate needs.

The way organisations engage patients, carers and their communities, and co-design integrated services from the very beginning plays a critical part in their overall success – setting the foundation for cultural change, empowering colleagues, listening and working in partnership with patients and ultimately leading to better outcomes.

A guide is available on the NAPC website¹⁶ which highlights best practice to support stakeholder engagement. This includes the importance of creating a shared high-level vision with PCN practices and other partners. This should be built with as wide engagement as possible with a range of colleagues, managers and clinicians across all the organisations or partners involved.

Three-step approach

After PCNs have defined their vision with partners, CHP and NAPC recommend a three-step approach to help networks embark on estate discussions and work towards the development of an estate strategy.

Working through steps one and two will help map out key aspects, challenges and gaps that PCNs will need to consider and face to realise their vision as they redesign their care models.

Step three helps consider the case for change informed by the service and estate stocktake and the proposed development of new health and care models.

It is often the case that service delivery is shaped and constrained by the estate. Both NAPC's development cycle and the vision of the Long Term Plan is that population health needs are determined first before services are designed and new estate developed. Estate planning cannot be done in isolation, it should be an integral part of the process.



PCNs in the early stages of forming with no previous history of working together will first need to get to know each other and build relationships before embarking on estate discussions. For groups of practices that have collaborated for several years, it will be easier to start these discussions.

Be prepared for challenging discussions

In most cases, it is likely to be new territory for practices to have complex estate discussions. Before embarking on these three steps, it is important that a PCN has achieved a comfortable environment to start the conversation acknowledging that some of the discussions may be challenging and decision-making may be difficult.

Networks should ideally work with their health system as one cohesive force which will ensure that the estate and the ownership models that emerge are able to respond and deliver services locally as one united system.

To inform these discussions, specialist resource may be required to help the PCN team to understand their current estate and the future options. This was recognised by pilot site St Helens North PCN which, after completing their population health analysis to look at the services which required further development, acknowledged that they didn't have a detailed enough knowledge of the PCN's estate to inform their decision making. Their local clinical commissioning group (CCG) was able to help with commissioned support from Renova Developments, an NHS Local Investment Finance Trust (LIFT company) which is a joint venture public-private partnership. This included a study of the estate's use and gave the PCN a much clearer picture of the full estate and the way it was being used.

In the next chapter, step one is outlined: building a picture of current services and estate. This is designed to give PCNs ideas on how to start to gather information about the services that are currently provided across the network and the existing estate landscape.



Frome Medical Centre

5. Step one: build a picture of current services and estate

1

Build a picture
of current
services and
estate

The first stage is to consider current service provision. To begin, PCNs should look at all the services that are provided by the practices individually and collectively.

To build a full picture, PCNs should try to capture what else is provided in their locality, from where and by whom. Everything is relevant from community services to third sector support.

5a. Current services

Below are some key questions to ask about current services, response to population health needs and levels of integration.

Population health needs

Q *What are the population health and demographic needs we are currently responding to?*

Services within the PCN

Q *What services (under GMS, PMS and other contracts) do we offer individually and collectively as a PCN?*

Q *What services are we currently offering from external premises?*



“ **The estate is a critical enabler for PCNs to develop their services in the future. The development of an estate strategy focuses PCNs on their current estate portfolio across their network, not just in GP premises but all health and care assets or public estate.** ”

Julie Ashurst, Executive Lead, Primary Care, St Helens CCG

Other providers

- Q *What services do other providers deliver within the PCN footprint either co-located in our practice buildings or in other locations (community pharmacy, opticians, physiotherapy, district nurses, community mental health teams etc.)?*
- Q *What is the current profile (and percentage) of acute services (NHS services or others) being delivered through the primary care sector?*
- Q *Do we have a picture of all the third sector and voluntary services available?*



Integration and communication

- Q *What is the current level of integration and communication between PCN services and secondary care services?*
- Q *Considering existing service delivery, can we see opportunities for enhanced PCN integration and working?*



5b. Current estate

To accompany the information about current services, PCNs will need to collate information about where these services are delivered both in terms of location and building type. The information about practice buildings may be easily accessible with support from practice managers, managing partners and CCG colleagues.

It is important not be restricted to the traditional general practice estate. There may be opportunities to place some services out in the community for example or use space in other NHS or local authority buildings.

When gathering information about existing estate, it is useful to split into the three levels as outlined below.

1

Build a picture
of current
services and
estate

LEVEL 1
PCN buildings

LEVEL 2
**Assets in local health
and care system**

LEVEL 3
Local public estate

Here are some key questions to ask about your current estate.

Level 1 – PCN buildings

Q *What buildings are within the PCN?*

One possible source for this data is the national data gathering programme which is underway with pilot sites in 2020/21. This will capture an agreed list of 58 data fields. The data is intended to gather a national baseline for the primary care estate which PCNs will be able to access.



Newport Pagnell Medical Centre

Q *What is the condition of these buildings?*

Q *Are the buildings leased or owned? By whom?*

Q *Do the buildings have unused capacity?*

Q *What information do we have about the use of space for each building?*

Q *What rate of use does each practice aim to achieve (e.g. 85 percent)?*

Q *What information is available regarding the connectivity and information technology at each site (broadband connection, WiFi, telephone line, digital health etc.)?*

Levels 2 and 3 – assets in local health and care system / local public estate

Q *Do we have a picture of the wider community estate – how it is used and any available space?*

Q *How much space is rented to other providers?*

Q *How often is it used?*

Q *Have we checked the Strategic Health Asset Planning and Evaluation (SHAPE) tool¹⁷ to understand what estate information is held on the application?*

SHAPE (shapeatlas.net) is a web-enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy. It has analytical and presentation features that can help commissioners determine the service configuration that provides the best affordable access to care.

Other questions

- Q** *What are the core assets held within the PCN? Clinical, non-clinical (i.e. social prescribing) and administrative?*
- Q** *Considering existing services provided across our PCN estate, are there services that could be delivered more effectively from other locations in either the primary care sector or community sector, or co-located with other services?*
- Q** *What buildings in the locality would we like to find out more about in terms of available space that could be appropriate for future services or might accommodate administrative teams? Who holds the information about these buildings?*
- Q** *Do we have a map of available transport links for the locality?*

Checklist

PCNs should seek to collate all the information that is easily available. A checklist is available in Appendix A (page 65) to work through.

At an early stage it is worth finding out if there are CCG colleagues with expertise in this area who can help explain key information.

Gathering similar information about buildings outside of the PCN will require input from other stakeholders.

Networks can also contact their local NHS England and NHS Improvement strategic estates advisor.

Further data may be important at a later stage to help the PCN to achieve a shared understanding of the cost of running each building alongside the applicable reimbursement income.



While knowing colleagues in the area, I had never set foot in most of their buildings. Taking part in this project has helped me recognise the importance of knowing what facilities we have in the network as part of planning any new services.



Dr David Lawson, Clinical Director, St Helens North PCN



East Mendip Outpatients



6. Step two: Outline future health and care models based on population health approach and assess estate needs

2

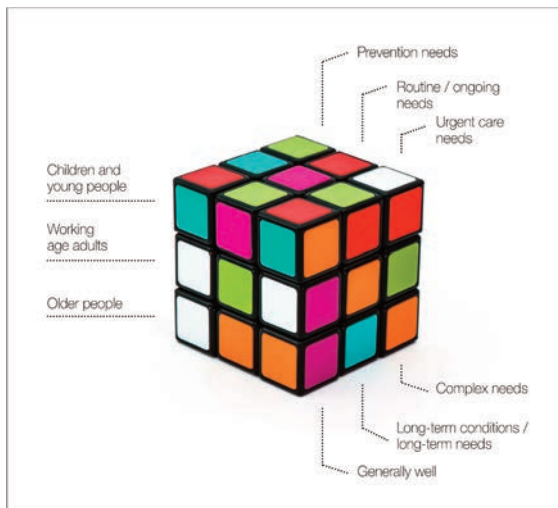
Outline future health and care models (population health approach) and assess estate needs

In this chapter, we outline step two which involves discussion about future health and care models informed by population health priorities and a description of the likely estate needs for the short and longer term.

Understand population health needs first

Population health management (PHM) helps networks to understand current needs and predict future health and care requirements to target support, make better use of resources and reduce health inequalities¹⁸.

Taking a whole PHM approach is integral to the PCH model – it is a proactive approach to managing the health and wellbeing of a population. It aims to incorporate the total care needs, costs and outcomes of the population.



NAPC's population health management cube

NAPC has a comprehensive guide¹⁹ to support PCNs to consider population health priorities using a simple approach which suggests three steps: know your population's health needs, engage with your population and manage your population.

There is a wealth of information available to PCNs including primary care data and comprehensive reports such as the NHS Right Care data packs²⁰. These are available on the NHS England and NHS Improvement

website and can be supplemented with knowledge and insight from local providers and stakeholders.

While there is a requirement for PCNs to tackle health inequalities as part of the DES service specifications from April 2021, considering population health data to identify priority areas is a sound approach to service redesign.

PCNs should start to consider the data easily available to them and then over time build their knowledge by gathering further data and insight from other stakeholders. Once population health priorities are understood the next step is to establish working groups with local providers, patients and the community to progress ideas for redesigning services.

Case study: *Yeovil Primary Care Network*

Yeovil PCN faces a significant increase in demand for primary and urgent care. Other providers including the local hospital are also seeing a marked rise in patients seeking help on the same day. Yeovil has a fast-growing population which is expected to rise by 33 percent by 2028. There is a real need for the PCN to work with others locally, including the local authority, to manage the wider needs of the increasing population.

There is a clear estate requirement – many of the practices are in undersized or unsuitable accommodation. The PCN is joining in a wider discussion about a ‘model for a viable town centre’ and the place for health services within it. The PCN has agreed with its CCG that a joint primary care plan for Yeovil will be developed covering population needs, care model, premises, workforce and funding. It hopes that the Yeovil Primary Care Plan will be an early prototype of a place-based approach to health services planning (see page 56 for full case study).



Ryalls Park Medical Centre

Moving on to redesigning services and estate needs

For the redesign of services to be sustainable, an understanding of the implications for the current estate and actions necessary for the future is essential. As future health and care models emerge, this section suggests further questions for PCNs and wider stakeholders to consider which will inform thinking and development of the PCN estate strategy.

Large scale change and transformation is needed to improve the health and care for patient cohorts (groups of patients with similar health and care needs) and address health inequalities.

Case study: *Granta Primary Care Network*

In 2019 Granta Primary Care Network (a primary care home) was rated outstanding by the Care Quality Commission. Several years earlier, the practices were in sub-standard, prefabricated premises without the space needed to expand and achieve their vision of providing fully integrated healthcare in a community setting. Granta's ambition was to have premises that reflected the practices' values, including respect for patients and staff. In 2005 they finished work on a new, modern building designed to integrate primary, secondary and community services on a single site providing care seven days a week (see page 60 for full case study).



Sawston Medical Centre

Population health-based workforce redesign

Smaller working groups are likely to be set up to work on priority areas, identify the needs of the patient cohort and develop an agreed approach. This will include identifying the skills needed. These groups will need to consider the current and future workforce to support service redesign.



NAPC offers further guidance in its guide: *Primary Care Home: population health-based workforce redesign*²¹. PCNs need to look beyond the traditional organisations to deliver health and care services and consider a phased approach to implementing new models of care.

Understanding current workforce and future workforce requirements will ultimately lead to questions about the space, resources and IT infrastructure needed to accommodate the future workforce.

It is worth looking at the advantages and disadvantages of relocation and allocation of the space for separate clinical hubs and administrative areas. Examples for consideration include hot desk space, remote working and storage.

Case study: *CLICK Primary Care Network*

CLICK PCN in South Somerset came to recognise that its IT infrastructure was a barrier to developing a more effective estate strategy. It had issues around accessing records and recording across sites using the same system. It also didn't have full visibility of the use of rooms across the different parts of the estate which made it difficult to manage. The PCN now recognises that the better use of current estate depends on IT investment and cannot be done in isolation. A full case study on CLICK PCN is on page 54.

The estate needs to match the future service plans which are likely to emerge over time. Below are some key questions to ask about designing future health and care models.

PCN priorities

- Q** *What are our local priorities (based on population health data)?*
- Q** *Are these priorities aligned to those of CCGs, STP, ICS, ICP, trusts, local authority, public health etc?*
- Q** *What are our new service models for the locality and their key elements?*
- Q** *What are the needs of the cohort or patient groups we have identified?*

Workforce

- Q** *What skills and possible roles are needed to provide this service?*
- Q** *What is the staff operating model needed to provide these services (should staff be brought together into one operational base instead of being spread across PCN)?*

Other questions

- Q** *Are any changes expected regarding hours of access for patients to these services?*
- Q** *What impact might this new service have on patient flow (for example a shift of patients from the acute sector into the primary and community sector)?*



welcome

Chadderton
Wellbeing
Centre

Pool, sauna and fitness suite



Implications for the estate in the short and long term

NAPC's experience from the primary care home programme suggests that PCNs may identify service changes that can only be delivered with the reorganisation of existing PCN estate, relocation of services to more accessible premises for patients or new approaches.

Case study: *St Helens Newton and Haydock PCN*

The PCN understood that, to realise its ambition to address mental health problems and chronic disease locally, it needed to work more closely with partners to extend the range of services in primary care and community settings. The vision to deliver new services from one-stop shops had obvious implications for the estate. It also realised that there would be an impact on the workforce as the services it delivered were reorganised. As a network of practices which had once been in competition, it was essential for the PCN to develop new relationships and ease into new, collaborative arrangements. It realised relationships needed to be built and consolidated before difficult conversations about estate could realistically begin. See full case study on page 52.

Service change examples

1 Introduction of group consultations

Group space needed instead of traditional consultation rooms

4 Services for non-medical needs

Community space may be more accessible for wellness hub or social prescribing

2 New multidisciplinary team (MDT)

Space to accommodate integrated team

5 Urgent care hubs

City centre base may be more appropriate

3 Digital health

Location for workforce needs to be considered

6 Shared back office functions

May not need to be located with clinical areas

Aspiration, condition, legal aspects and assets

- Q** *What is the PCN's aspiration of its estate to meet new service models?*
- Q** *What is the duration of contracts for the delivery of these services?*
- Q** *Based on future service provision and population health needs, where do the buildings need to be located to deliver future health and care outcomes and staff operational needs?*
- Q** *What are the core strategic estate assets of the primary care sector?*
- Q** *Have these assets been considered alongside wider community assets?*
- Q** *What is the life cycle of each building (LIFT and NHS Property Services)?*
- Q** *Do we have buildings that are suited to the delivery of our proposed future care models?*
- Q** *What do the condition surveys indicate on the future life of our PCN buildings?*
- Q** *What implications do we face regarding length of leases?*
- Q** *What alternatives have we considered?*
- Q** *Gap analysis: what gaps do we have, how can we overcome them?*



Phased actions, funding and challenges

- Q** *What actions can we take in the short term (1-3 years)?*
- Q** *What will be important in the long term (10-20 years)?*
- Q** *What are the short, medium and long-term investment needs for the estate?*



- Q** *Do section 106 rules apply to any planned local development?*
- Q** *What funding options are available to us?*
- Q** *What are the key infrastructure blockers that must be addressed to achieve the PCN's emerging vision of the estate e.g. negative equity in existing premise, future ownership/ sole trader, IT infrastructure?*

Carbon footprint, environment and transport considerations

- Q** *Have we considered sustainability and environmental impact of any future estate?*
- Q** *Have we explored funding to meet the BREEAM sustainability standards during construction?²²*
- Q** *Are we aware that a net zero requirement may be set in the future which is not just applicable for new buildings?*
- Q** *Are there other factors to consider in relation to how patients may access the future estate and the emissions associated with that?*
- Q** *Are there opportunities to include renewable energy solutions within future buildings?*



Our estate is like a bucket. As we introduce services, we add a rock to the bucket. Just when we think the bucket is full, we find a bit more space by adding pebbles. Again, we think the bucket is full but we manage to find a bit more space by adding sand. We keep finding little bits of space until we add water and then the bucket is really full. Our bucket is now really full – we are starting to wonder how, as a PCN, we will find the extra rooms or space we need for new roles and new services.



Dr Martin Breach, Clinical Director, St Helens Newton and Haydock PCN

*Durham Diagnostic
and Treatment Centre
(courtesy of Assura plc)*



7. Step 3: Produce key elements to begin to form your estate strategy

3

Produce key elements to begin to form your estate strategy

This chapter is aimed at supporting networks to look at the key elements that will be needed to design, develop and deliver the estate changes to deliver future health and care models.

It looks at how PCNs can develop an initial outline framework that describes the current estate position, the changing services and an outline estate plan to deliver them.

This stage is aimed at helping networks to understand the factors involved in estate transformation, make the outline case for change and investment, and get to the table to discuss future funding for transformation. To develop fully costed plans will require further work with expert support.



PCN case for change

The proposed headings for an estate case for change document are suggested below:

Question 1 – *Where are we now?*

This section should summarise:

- Q** *How is care currently delivered in your community?*
- Q** *How does your current estate enable or constrain this delivery?*
- Q** *What are the challenges and opportunities of your current estate regarding the delivery of services and how might you address this, irrespective of any longer-term estate transformation?*

Question 2 – *Where do we want to be?*

This section should summarise:

- Q** *How do you want to change the way care is delivered in your community based on population health needs? What are your desired future health and care models?*
- Q** *Have patients helped you to develop this vision?*
- Q** *What are the short, medium and long-term investment needs for estate, when compared to service redesign priorities?*
- Q** *Using the above outputs what are the core strategic clinical hubs across the PCN?*
- Q** *What are the core admin hubs across the PCN?*

Question 3 – *How do we get there?*

This section should summarise:

- Q** *What are the short term actions and steps necessary to achieve our long-term vision – to help us get started?*
 - Q** *What are the disinvestment opportunities?*
-

Q *What skills, capability and capacity will be required?*

Q *Who are the key stakeholders required to implement this strategy?*

Have we addressed inclusivity?

The Commission for Architecture and the Built Environment (CABE) publication *The principles of inclusive design* sets out five design principles which, if followed, should enable a development that is:

- **Inclusive** – so everyone can use the building safely, easily and with dignity
- **Responsive** – taking account of what people say they need and want
- **Flexible** – so different people can use the building in different ways
- **Convenient** – so everyone can use the building without too much effort or separation
- **Accommodating** – for all people, regardless of their age, gender, mobility, ethnicity or circumstances
- **Welcoming** – with no disabling barriers that might exclude some people
- **Realistic** – offering more than one solution to help balance everyone's needs and recognising that one solution may not work for all.

Inclusive design must be addressed in the earliest stages of the development process, with the PCN brief making clear the desire for inclusivity to be considered in all stages of the design process. Guidance on inclusive design can found in many of the *Health Building Notes*²³ / *Health Technical Memorandum* as well as various parts of the Building Regulations and other specialist publications.

Have we addressed climate change?

The UK is now legally committed to being net zero by 2050. Any estate transformation must take account of this challenge and a PCN's estate strategy will need to include a section on climate change and its strategic sustainability objectives.

More information can be found in the Department of Health's *Environment and Sustainability Health Technical Memorandum 07-07: Sustainable health and social care buildings*²⁴. This looks at the main issues that should be addressed throughout a building's life – highlighting key actions, commitments and responsibilities at every stage. It also explores the reuse of existing

buildings and provides advice on possibilities for sustainable refurbishment. For new builds, the success of a building's performance in terms of greenhouse gas emissions and other sustainability outcomes is dependent largely on the decisions taken at the design, procurement and construction stages of a development.

Have we considered flexible premises and digital considerations?

It will be important to factor in that property and estate requirements are changing rapidly as new digital-first consultation and interventions become embedded in models of care. This trend towards consultations being offered online impacts the way care is delivered and moves some activity away from practices and the local community.

Electronic patient records and cloud technology are reducing the need for physical space to store paper records. This is happening in both general practice and the acute sector, where new premises are being planned and developed without allocated storage rooms. This move towards electronic patient records also has the potential to support more flexible ways of working, for example, by providing staff with remote access to patient information. There will be an even stronger need for this as primary care networks develop, where health professionals from different settings will need to access patient information in real time as they work in different parts of the network.

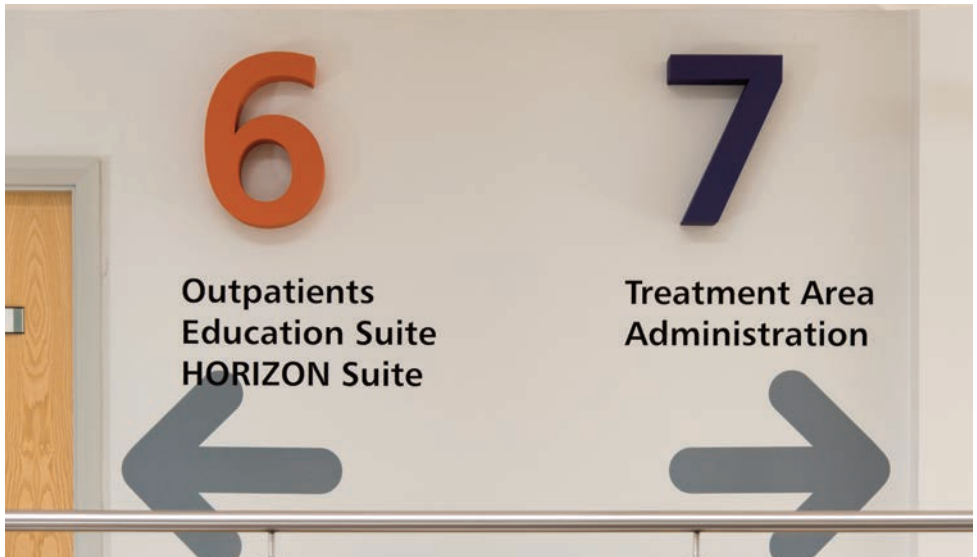


Frome Medical Centre

As noted by research from the King's Fund²⁵, technology is also creating more data about how staff and patients are using the NHS estate. This data can be used to improve services and make them work more efficiently, for example, building sensors allows data to be captured in real time about the use of the estate and equipment on a daily basis. This can lead to a better, more efficient use of space.

In considering the development of estate to support new and future ways of working, it is important to consider building in as much flexibility as possible, especially in new premises. Granta Primary Care Network advises that new projects should consider how a building can be adapted to cope with changing needs. They reflect that their hub (built in 2005) would benefit from more flexibility to accommodate needs in the future. They have a large number of small rooms but now think some larger, more adaptable spaces would have provided more options and flexibility in supporting the changing way services are delivered and healthcare hubs are used.

This is a reflection echoed by Frome Primary Care Network which has benefited from their building (completed in 2012) being flexible enough to respond to changing needs, enabling growth and innovation. Flexible spaces allowed the practice to move some things around to improve services for patients. They have been able to relocate their medicines management team to create a community connections area which provides additional support to patients and is visible when patients walk into the practice.



Frome Medical Centre

Expertise and support needed

Accessing the appropriate skills needed to deliver service and infrastructural change is complicated. This can be magnified with integrated, multidisciplinary team working resulting in multiple partners being involved and the associated governance, approval and finance regimes.

PCNs need to build estate planning skills and capability into their networks. They should understand the wider network of support available, including the local health system, strategic estate planning function at NHS England and NHS Improvement, property companies and the skills and advice from services locally.

Estate strategy development is recognised to be a time-consuming process and some of the details of future estate requirements will take time to understand. The four PCNs who worked with us on this guide identified the support and input that is needed to help. Suggested areas where PCNs will need support are outlined in Appendix B (page 65).

The partners from Frome Primary Care Network put together a team of professionals, including architects, building consultants, planning consultants, ecologists, landscape architects, mechanical and electrical engineers and lawyers to inform discussions and develop the scheme for their new estate (see page 58 for full case study).

Once PCNs have an outline case for change as set out above, they should work with stakeholders that can help them to deliver change. They are likely to include:

- CCG primary care teams
- NHS England and NHS Improvement primary care teams
- NHS property companies and experts
- Local acute trusts
- Local authorities and others who own assets that can be used for care delivery
- Local councils – officers/elected members can help make the case for change
- Patients – as well as being involved at the design stage, wider views from patients should be sought.

Business case approval process

PCNs should build their estate strategy alongside the wider health system, seeking early engagement with commissioners, STPs and all those involved in the process, particularly where it is reliant on NHS England and NHS Improvement approval and revenue or capital funding. They should also seek clarity on gateways and other information that must be delivered to enable the development to achieve business case approval.

8. Considerations and next steps

This guide has highlighted that estate development and management need to be placed at the centre of healthcare reform rather than as an afterthought, as has historically been the case.

If we are to realise the ambition of providing first contact care in a community setting at greater scale, which will have a significant impact in alleviating pressure in acute services, it is vital that primary care is delivered in optimal facilities.

Much of the potential estate available to PCNs may need upgrading and this will require careful planning.

To create a clear estate strategy, an incremental approach should be adopted as part of a framework for maturing PCNs. This staged process will not only address the evolving technical and funding arrangements for primary care estate but also ultimately lead to creating a clear compelling business case.

The first stage is described here, to create some critical thinking and early planning in PCN estate development.

1

Build a picture of current services and estate

2

Outline future health and care models (population health approach) and assess estate needs

3

Produce key elements to begin to form your estate strategy

*Maggie's Barts
(St Bartholomew's
Hospital)*





Case study

St Helens North Primary Care Network (pilot)

The challenge

The primary care network (PCN) consists of five similar sized practices and one larger practice in St Helens, a metropolitan borough of Merseyside, with a registered patient population of around 30,500. The practices are geographically close, but access is a problem as there are fields between them and transport links are limited. There are eight practice buildings including the PCN's largest, Garswood Primary Care Centre, which is a modern, 1,100 square metre building with space available on the first floor, but it is on the outskirts of St Helens and not easily accessible for all.

What the PCN is doing

After analysing population health data, the PCN decided to prioritise improving the care of working age adults with long term conditions and disabilities as well as focusing on a new approach to urgent care. St Helens and Knowsley Teaching Hospitals NHS Trust, the local provider of acute and intermediate healthcare services, has been involved in early conversations about how partners can work together in a more integrated way.

The PCN is working on improved continuity of care, better access to mental health services, trialling remote consultations and meeting the needs of patients struggling with non-medical problems such as housing, poverty and social isolation. Recognising the importance of having an estate that meets the area's future integrated health and care needs, it is looking to make the best use of all available space via more flexible working, hot desking, digital health, a multidisciplinary team approach and group consultations.

Planned impact

The PCN is considering utilising the unused space at Garswood to provide a base for new technology, including video consultation equipment to improve access to hospital consultants and specialist nurses. Options include an initial pilot to target working age adults who are more comfortable with the digital health approach. The same approach may be tested with urgent care





We recognise that GP practices have their own way of working and that using the network's estate in a collaborative manner will involve difficult conversations and likely compromises from everyone.

Dr David Lawson, Clinical Director, St Helens North PCN



patients. Another option is for a base in the town centre which, despite not being central to the PCN, could help overcome transport problems.

Lessons learnt/next steps

The PCN found it needed support to understand the available data and develop options for the best use of their estate now and in the future. The clinical director didn't have detailed knowledge of the PCN's estate so sought help from the clinical commissioning group which had recently commissioned support from Renova Developments, an NHS Local Investment Finance Trust (LIFT company) which is a joint venture public-private partnership. This included a study of the estate's use. The PCN is looking to involve colleagues, patients and carers early in co-designing new ways of using the estate. It is aware that plans to revise how buildings are used in the future could be unsettling for colleagues as their place of work could change. The PCN will be looking to explain why it is important to review the estate and what changes might happen both in the short and longer term.

The team has realised that developing an estate strategy is a slow burn. A considerable amount of time has to be set aside on a regular basis to discuss various options and plan. Finding that time, when workload pressure is already intense, is a difficult but essential part of the process.

Considerations

The PCN should consider whether it really needs eight separate practice buildings. It should ensure it is making the best possible use of current community service facilities and then decide how much of its existing estate needs to be retained.

It might be useful to hold discussions about improving transport routes or providing specific patient transport between PCN sites, taking into account the environmental impact. Estate development should be future proof, and this might involve working with the council to see how social and voluntary care services could be provided in shared premises.





Case study

St Helens Newton and Haydock Primary Care Network (pilot)

The challenge

The primary care network (PCN) – located in the metropolitan borough of St Helens in Merseyside – is made up of seven practices serving around 47,000 patients. Levels of mental health problems and chronic disease, including chronic obstructive pulmonary disease (COPD) and diabetes, are considerably higher in Newton and Haydock than the national average. The PCN's vision is to work more closely with partners to extend the range of services in primary care and community settings to address these challenges.

Some of the practices in the network have already recruited a social prescriber to work in partnership with voluntary and community groups to help patients access non-medical support and manage their own health and wellbeing. The PCN plans to provide other services, normally in the hospital's out-patient department, such as dermatology, gynaecology, COPD and ear, nose and throat clinics. It is embarking on its vision with focused work involving new members of the team including a mental health practitioner and clinical pharmacist. Its first estate challenge has been capacity and it has been facing increasing difficulty locating rooms and space for new team members and services.

What the PCN is doing

The PCN first took stock of its existing buildings to gain a thorough understanding of how well the space was being used. The buildings in the Haydock area, including a purpose-built practice with some spare capacity, were considered enough for the foreseeable future but it was clear the space could be better used. In Newton, the estate is mixed with a new community hospital with some available space, in a fairly hard to reach location, and some older buildings including converted houses which need investment.

The network held a workshop to assess future needs and discussions are underway on the different types of clinical, administrative and multidisciplinary team space that may be needed to accommodate extra staff and new ways of working. The PCN is looking at the possibility of setting up a new COPD community hub with St Helens and Knowsley Teaching Hospitals NHS



“ An estate that is fit for purpose is essential to the delivery of high quality primary care. Primary care has changed and the quality of its estate must now reflect and support the higher standards that practices need to deliver. ”

Dr Martin Breach, Clinical Director, St Helens Newton and Haydock PCN

Trust. Discussions are focusing on the best place for one or more centres, where to house admin staff and the ideal base for district nurses, social prescribers and other healthcare professionals. Consideration is also been given to which services can be provided remotely.

Planned impact

The PCN is developing a plan to maximise the use of all its buildings. In the short term, new team members will be based in existing buildings while options are explored to make their services more accessible in community hubs. The PCN hopes to achieve a 'one-stop shop' approach to improve access to services for patients and give them a better experience.

Lessons learnt/next steps

Practices, which were once in competition, are finding ways to collaborate for the benefit of patients. The PCN has realised that difficult conversations must happen before making changes to the estate and it is important to build new relationships before starting those conversations. External support is invaluable in the early stages of developing an estate strategy, so the clinical director is working with the clinical commissioning group which has commissioned support from Renova Developments, an NHS Local Investment Finance Trust (LIFT company) which is a joint venture public-private partnership. The work includes a study of the estate's use.

Considerations

The PCN needs to consider how a 'one-stop shop' might affect the working arrangements of its primary care professionals and support a team approach to the delivery of its services. It should look at whether members of the team could work across the different PCN sites and the effect that would have on making the best use of its premises.

Thought needs to be given to whether older, converted buildings are fit for modern purpose. It is worth discussing whether it is better to build new premises, consolidate existing buildings and close old, unfit buildings. Estate that is core to service delivery should be used to its full capacity ahead of any new investment for new builds.





Case study

CLICK Primary Care Network (pilot)

The challenge

CLICK Primary Care Network (PCN) based in South Somerset, encompasses seven GP surgeries covering 47,000 patients. Six surgeries are independent businesses, and the seventh is part of Symphony Healthcare Services, a subsidiary of Yeovil District Hospital. The area has a dispersed rural population including three towns, with the remaining 60 percent of patients living outside towns. There is a poor transport infrastructure which is often hampered by seasonal disruption because of flooding. The area has plans for substantial housing growth including in Chard where an extra 700 homes are planned which could lead to a 14 percent increase in the town's population.

As the PCN begins to develop, there is not yet a shared model across the three groups of practices. The IT set up makes it difficult to fully access and share the current estate. It was decided that discussions were needed on how the estate can be developed to meet the PCN's existing and forthcoming challenges. Given the dispersed rural population and its three distinct market towns, the PCN believes that a comprehensive local service offered in each of the three distinct localities is likely to be more effective and acceptable to patients than single centralised services covering the whole PCN. The CCG supports this position as it is committed to a comprehensive local GP service, but it does present estate challenges.

What the PCN is doing

The network has decided that, because of its rural setting and poor transport links, it should retain its three hubs (one in each town). Although this means some duplication, patients in all parts of the community will continue to have good access to services.

There may be greater coordination of use across the wider public estate – especially in Chard, which, because of its size makes a co-located hub with other providers an option.



“ CLICK PCN has strong clinical leadership and has made a great start. The rural geography presents a challenge that PCNs in other rural counties will relate to. Delivering a comprehensive local service in each of its three market towns seems a sensible approach to meeting population health needs. ”

Michael Bainbridge, Associate Director of Primary Care, Somerset CCG

A key priority for the PCN is addressing barriers to the full use of the existing estate. This includes challenges around IT, including being able to access records, and record and find activity across different sites using the same system. The PCN doesn't yet have visibility of the use of rooms across the different parts of the estate. This makes the estate difficult to manage. The lack of understanding about its current use is a barrier to discussing transformation.

Planned impact

CLICK is focused on trying to retain equality of provision and access across the community. The PCN is clear that any new service and estate model must continue to give patients the choice of care setting, if they are prepared to travel.

Lessons learnt/next steps

In a rural setting the pattern of small surgeries in dispersed areas is difficult to change, the geography and the difficulties of transport limit the options available. Aligning incentives for change may be challenging – a co-located hub in Chard may be good for the community, but it may not deliver benefits to the PCN or member practices.

The PCN has also realised that better use of current estate requires IT investment, not estate transformation on its own. Putting estate issues on the PCN leadership agenda is still difficult at this early stage of their development.

Considerations

It is important for the PCN to consider how patient choice will affect the consolidation and use of its current estate as well as any new buildings. The district hospital should be involved in the overall estate plan and there needs to be discussion about providing some of its services in different locations if that's what patients want. Thought also needs to be given to how council services are integrated into estate planning across the three main sites.





Case study

Yeovil Primary Care Network (pilot)

The challenge

All six GP surgeries in Yeovil in South Somerset have come together to form a primary care network serving a population of 58,000. Yeovil PCN faces a significant increase in demand for primary care and urgent care. Other providers including the local hospital are also seeing a marked rise in patients seeking help on the same day.

There has already been a significant population rise in Yeovil and it is expected that by 2028 there will be 15,000 increase in the town's population – a 33 percent growth. Varying building conditions across the PCN partners creates challenges around risk sharing and investment, and negative equity exists for some practices which complicates estate investment needs.

What the PCN is doing

The PCN is keen for estate development to be considered in the context of a wider set of enablers. It is working to understand the local population's health needs, what is driving demand, current capacity and gaps, and to design and deliver a care model that meets and anticipates future health needs. The network is clear that estate development should be considered alongside these and other issues including workforce and digital infrastructure.

Practices have had initial discussions about their views on developing the estate and have conducted a review of existing buildings' capacity, how they are used and their condition.

The network is working with the CCG to develop an overarching Yeovil Primary Care Plan. The plan will consider what is needed to deliver more integrated, community-based care, as set out in the NHS Long Term Plan. It is anticipated that the next stage will be a review of the options around estate development and external support will be needed.

They are also in early talks with the local authority about the town centre's health services.





Yeovil PCN has really taken control of its destiny by developing its own plan for future premises. We're glad to support this with technical expertise and a full options appraisal for the estate needs of the future out-of-hospital care model in Yeovil.

Michael Bainbridge, Associate Director of Primary Care, Somerset CCG



Planned impact

Through its estate development work, the PCN hopes to cope better with caring for Yeovil's increasing population. There is also scope to join a wider discussion about a 'model for a viable town centre' and the place for health services within this, with the benefits of change reaching all parts of the town rather than just the health system.

Lessons learnt/next steps

The PCN believes that benefits of transformation of primary care cannot be fully realised without investment and change in other areas, for example, if transport does not improve across Yeovil, the potential benefits of consolidating delivery of more specialist services may not be achievable. Estate transformation also has the potential to be a driver for wider transformation.

Considerations

With the expected population growth, there may be a need to deliver more than 100,000 primary care consultations annually in the next eight years, so the PCN needs to think about how the current estate or new premises will accommodate that level of service. The PCN's estate plan needs to factor in hospital, social and voluntary services in line with the integrated care agenda and thought needs to be given to how the plan will address health inequalities with a place-based care approach.





Case study

Frome Primary Care Network

The challenge

Frome Medical Practice and Frome Community Hospital began to consider modernising their facilities in 2000. They were located on the same site but both in unsuitable buildings which were in need of repair. The partners of the medical practice had an exciting vision to develop a new co-located health park in modern buildings enabling a more multidisciplinary and collaborative approach. It was important that the building was at the heart of the Frome community – a space where health promotion and self-care were as important as treating ill health.

What they did

The PCT funded two partners from the practice to develop plans for a health park and, after some work, a scheme was chosen. Then the funding rules for the development changed and the only way for the scheme to progress was without the primary care facility. The hospital opened in 2008. Later, the PCH earmarked the practice for development and they were able to start planning again.

The five practice partners formed a company to facilitate the development and maintain control of the project. The bank agreed a £10.4m loan to the company and the PCT strongly supported the scheme. The partners put together a team of professionals, including architects, building consultants, planning consultants, ecologists, landscape architects, mechanical and electrical engineers and lawyers to develop the scheme. Building was finally able to start in 2011 and despite further national policy changes, it was able to open its doors in December 2012 – a vision which had taken 12 years to come to reality.

The impact

The health park offers a modern medical centre and community hospital side-by-side.

The medical centre hosts Frome Medical Practice, a primary care network covering nearly 30,000 patients. It is co-located in the building with the district nursing team, an independent pharmacy, mental health services, and a community eye service. There is a small operating





The building was developed with expansion and innovation in mind. There is space inside to host 50 exercise classes, local support groups and social prescribers, and outside there is a children's play area, community orchard and outdoor gym, placing it right at the centre of the community.



theatre and outpatients' department with consultants from the Royal United Hospital in Bath and Shepton Mallet Hospital regularly using the building, so residents don't have to travel far for key treatment.

The building includes room for expansion and further innovation, for example the medical practice has been able to host social prescribers as part of a Mendip-wide collaboration. The building has more than 50 exercise classes and provides space for local support groups – placing the practice at the centre of the community.

Several multidisciplinary team meetings are held every week, which have helped to build knowledge-sharing between providers. A social care professional offers support every Friday, while drugs and alcohol services work from the building alongside the practice's primary care mental health team. The site's care co-ordination hub also supports vulnerable patients across the practice

The site's green space offers a children's playground and fitness activities with an outdoor gym. It is also home to a community orchard with seats and hosts the Frome Park Run.

The site has had a positive impact environmentally – the practice has worked with Frome Town Council to put in place electric car charging points and solar panels and has won national awards for its sustainability achievements.

Lessons learnt

The building design enabled the site to be flexible and responsive to changing needs, enabling growth and innovation.

Building spaces which encourage integration and collaboration and focus on a holistic vision of health and wellbeing are important to meet the NHS Long Term Plan's objectives. Communication and working at scale have its challenges in a large building.





Case study

Granta Primary Care Network

The challenge

Granta Primary Care Network (a primary care home) serves around 44,000 people and was formed from the merger of four practices in semi-rural South Cambridgeshire. In 2019 it was rated outstanding by the Care Quality Commission. Only a few years earlier, the practices were in sub-standard, prefabricated premises without the space needed to expand and achieve their vision of providing fully integrated healthcare in a community setting. A forward looking and innovative organisation, Granta's ambition was to have premises that reflected the practices' values, including respect for patients and staff.

What they did

They worked with architects to create a new building designed to integrate primary, secondary and community services on a single site providing services seven days a week. Sawston Medical Centre was built in 2005 as a community health hub with a wide range of services including some which had traditionally been provided by the local hospital. Viewing premises as a physical representation of an organisation's values, a lot of thought was put into what the building should feel like for patients and staff as they walked in.

It was financed by Octopus Healthcare with the practices and primary care trust (now the local clinical commissioning group) taking on a 22-year lease. The project was underwritten by the General Medical Services contract so the practices had their rent covered while Octopus received guaranteed income. The Granta estate now consists of five sites – the hub, two buildings owned by the partners, one rented under a standard commercial lease and one owned by NHS Property Services.

The impact

Granta's hub in Sawston feels modern and welcoming. Open spaces, curved walls and a high atrium all help to create a sense of quiet efficiency. Although busy, the building never feels





At the design stage, think about the way light comes into the building and try to ensure it has natural lighting throughout if possible. We now have consulting rooms with natural light but we have to keep the lights on in the main part of the building even in summer.

Gerard Newnham, Strategy Director, Granta Primary Care Home



crowded. Ongoing regular maintenance and attention to detail mean the building feels cared-for and staff and patients respond positively to this.

Patients have access to a broad range of services at the hub including those previously provided in outpatient clinics. It provides 23 GP consulting rooms, nine community consulting rooms, audiology services and minor operations, recovery and emergency rooms, pharmacy and dispensing. There are also two counselling rooms, three rooms for meetings and training and a health education room for up to 40 people.

Lessons learnt

A lack of progress nationally in transforming the traditional funding model into a unified budget for health and social care has meant the building has not been used to its full capacity and is only open five days a week. It is worth using one of the big healthcare investors to plan the overall future working environment. For example, a “hub and spoke” model, such as the Granta one, might involve reducing the size of some sites and focusing joint services at one large site. It is important to consider transport needs of staff and patients at the planning stage of a new-build.

Thought needs to be given to how a building can be adapted to cope with changing needs. The hub has a lot of smaller rooms that can't be altered whereas it would have been better to have a bigger space with adaptable rooms. There is a health education room at the back but it would have been preferable to have a wellbeing room near the front door to accommodate various charities and drop-in services.

Efforts were made to create an eco-friendly building but it is not as “green” as it could have been, for example with the inclusion of solar panels and heat source pumps to recycle rain water for toilets and more thought given to the importance of natural light.



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Appendix A

Current estate checklist

- Map of locations
- Photographs of premises
- State of buildings, maintenance needed
- Grounds including available space for parking
- Building ownership model
- Value of freehold properties
- Terms and remaining time on any lease agreements
- Information about space utilisation
- Information technology available (broadband, telephone etc.)
- Environmental impact assessment

Appendix B

The checklist below includes areas where PCNs may need further help and expert advice. Both NAPC and CHP can offer support in these areas or signpost to other partners.

- Engagement planning and relationship management (involving the local community, workforce and other key stakeholders)
 - Organisational development (supporting teams through a period of change)
 - Liaison with CCG (existing estate and impact of any change)
 - Housing (future housing developments and impact on PCN)
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- Policy (guidance)
- Legal (leasing and ownership options)
- Finance (funding options)
- Digital infrastructure advice
- Project management support
- Estates expertise (training for PCNs, advice and support throughout the process generally or for specific topics such as passive design)
- Estates management (outsourced or through the recruitment of a dedicated PCN role)

Appendix C

Lease definitions

Lease Plus Agreement (LPA) and Land Retained Agreement (LRA) (mainly used in LIFT projects)

The LPA is based in a commercial lease with additional provisions to benefit the public sector. These include a duty to provide premises suitable for specified use(s), building maintenance for the term, guaranteed right to buy at the end of the term and a facility to make deductions for non-availability of specified facilities.

The LRA has similar provision to the LPA but is more akin to a traditional PFI whereby the land is retained by the public sector.

Full Repairing and Insuring Lease (FRI)

In a FRI lease, the tenant takes on all of the costs for repairs and insurance for the property being leased from the landlord. The landlord may choose to insure the building and pass these costs through to the tenant.

Tenant Internal Repair Lease

A TIR lease is where the tenant is responsible only for internal repairs and decorations, with the landlord being responsible for external and structural repairs.



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