Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Primary Care Estates Strategy

Governing Body meeting

D

2 November 2017

Author(s)	Mrs Katrina Cleary, Programme Director Primary Care Mr Mike Speakman, Director Willowbeck Management, MS and Technical Solutions
Sponsor Director	Mrs Nicki Doherty, Interim Director of Delivery – Care Outside of Hospital

Purpose of Paper

To approve the Primary Care Estates Strategy, as supported by the Primary Care Commissioning Committee (PCCC).

Key Issues

Modern Primary Care Estate is a key enabler of resilient and sustainable primary care. There is a need to develop clarity around which estate is fit for purpose, how current void space can be best utilised and how the primary care 'at-scale' model can be supported by fit for purpose estate

Is your report for Approval / Consideration / Noting

Approval

Recommendations / Action Required by Governing Body

The Governing Body is asked to approve the Primary Care Estates Strategy as supported by the Primary Care Commissioning Committee

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
To improve the quality and equality of healthcare in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?

Not at this point

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not
Individual initiatives/proposals falling out of the strategy will need to be subject to an EIA

Have you involved patients, carers and the public in the preparation of the report?
The PCCC recognised that individual service strategies which need to be supported by modern estate should ensure wide patient and public engagement

NHS
Sheffield
Clinical Commissioning Group

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1. Introduction / Background

The CCG's Primary Care Strategy recognised the need to develop an estates strategy specific to general practices. This need was further asserted with the local GP Forward View (GPFV) plan.

In late 2016 the CCG and Community Health Partnerships (CHP) commissioned Willowbeck Management and Technical Consultants to work with key organisations and general practices to produce a Primary Care Estates Strategy.

The strategy (attached) was presented and discussed at the September meeting of the Primary Care Commissioning Committee and was accepted as a positive step forward and should be recommended to Governing Body for approval.

2. Action for Governing Body / Recommendations

The Governing Body is asked to approve the Primary Care Estates Strategy as supported by the Primary Care Commissioning Committee.

Paper prepared by: Mrs Katrina Cleary, Programme Director Primary Care
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On behalf of: Mrs Nicki Doherty, Interim Director of Delivery – Care Outside of Hospital

24 October 2017

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

SHEFFIELD

Primary Care Estates Strategy 2017 to 2022

Building capability and capacity for Primary Healthcare in Sheffield

Important Notes:

The options set out in this document are for discussion purposes. The involved NHS and Local Authority bodies understand and will comply with their statutory obligations when seeking to make decisions over estate strategies which impact on the provision of care to patients and services to the public. The options set out do not represent a commitment to any particular course of action on the part of the organisations involved.

This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FoIA the parties should discuss the potential impact of releasing such information as is requested.

"Our aim is to support the providers of Primary Care in Sheffield and other stakeholders to improve and develop their services by delivering the most cost effective and best value space from which high quality services will be provided, supporting the wider communities that we serve."

The intention of the Strategic Estate Planning process is to support real change in the local Primary Care estate and to generate strategic estate solutions that drive system wide savings, integration and new patient centred service models, closest to the point of need wherever possible.

Significant efficiencies and quality gains are achievable through a structured and targeted programme to support the strategic planning of the Primary Care estate, which will deliver:

- **Better service integration**, driving improvements in service efficiency and better outcomes for residents of Sheffield.
- Improved **capability and capacity** for Primary Care provision.
- **Reduced risk** and **improved service resilience** at local and system levels.
- **Increased efficiencies**, through the better use of high-quality community and central estate.
- Support for **New service models**, supporting the drive to move services into the community, replacing outmoded and inadequate premises and releasing capital through a structured programme of disposals.

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FOREWORD

We have set out an ambitious and forward looking plan across all parts of our healthcare system across Sheffield, that will require innovation and new models of care to be delivered. We have put Primary Care at the heart of our plans, and are supporting our provider organisations to work together to deliver the best outcomes possible for the people of Sheffield, and to support our dedicated healthcare teams.

Our Primary Care estate must support those ambitions, to provide the highest possible care, closer to our patients home. We need our estate to enable great care, not hold it back, and we need our estate to be fit for the future - the right property, in the right place, available at the right time.

I welcome the publication of the Sheffield Primary Care Estates Strategy, and call upon all stakeholders to come together, to show how much can be achieved in collaboration and to help us deliver the premises that underpin our ambitions to transform Primary Care services for Sheffield.

Maddy Ruff

Accountable Officer

NHS Sheffield Clinical Commissioning Group

July 2017

OBJECTIVES

The objectives of the Primary Care Estates Strategy are;

- To develop a strategic estates framework that supports the delivery of Primary Care across Sheffield, taking into account Health and Local Authority assets, using a holistic view of service needs, capacity & demand and whole-system economics.
- To engage stakeholders in developing a high-level route map for each locality, to support the development of achievable and relevant solutions at neighbourhood and locality levels.
- Identify short to medium term development needs and opportunities of the local Primary Care property portfolio.
- Set the trajectory for medium to long term development planning and investment to deliver upon the vision and commissioning intentions of NHS Sheffield.
- To agree a set of strategic aims that provides the longer-term framework for Primary Care estates development and utilisation, upon which stakeholders agree, as the basis for delivering change.
- Identify under-performing Primary Care assets to enable re-use or release, creating improved efficiency and re-investment opportunity.
- Promote collaborative working between stakeholders, including 3rd sector partners.
- Ensure both commissioners and providers understand their responsibilities in helping shape and deliver the future estate for transforming Primary Care in line with the GP Five Year Forward View response.

*In summary, **to create a better quality Primary Care estate that better supports frontline service delivery** for patients and stakeholders, taking into account both current and future requirements.*

The Sheffield Strategic Estates Group (SEG) meets regularly and has representation from health and local authority stakeholders, including NHS Sheffield and NHS England. The SEG receives regular updates on the Primary Care Estates Strategy development, providing the opportunity for discussion and feedback.

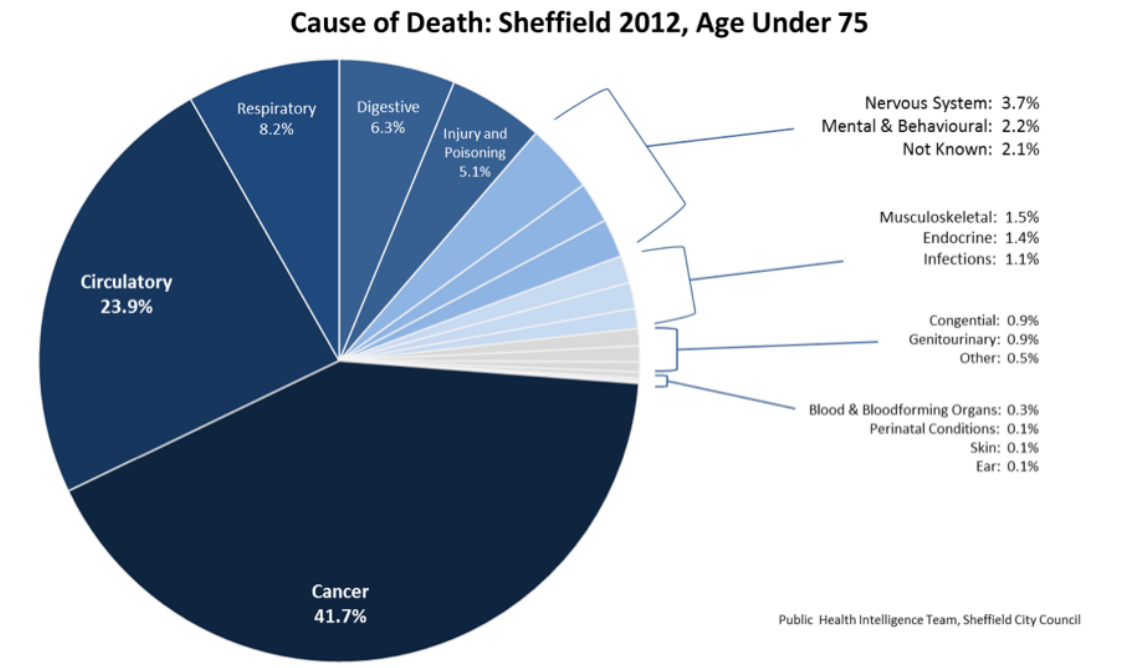
NATIONAL & LOCAL CONTEXT

Over the past 10 years, the health sector has seen unprecedented requirements to improve both quality and efficiency; improving patient outcomes whilst facing increasing demand; an ageing demographic with increasingly complex service needs. Nationally, if the health service continues to deliver services in the current manner, by 2030 we will need an additional 40 acute hospitals at a cost of £20bn just to meet demand. We have a population expanding by 8 million people by 2032; almost 3 million people living with 3 or more long-term conditions by 2018; the number of people living with dementia will double over the next 30 years; the rate of diabetes will increase by 30% by 2025, affecting some 4 million people.[1]

The early years of health sector reform created some unpredictability, but the Five Year Forward view (2014) gave greater clarity on the direction and requirements to meet the quality, demand and efficiency challenges. In 2010, the productivity gain required was £20 billion by 2015. Now, in 2017, the current estimates put the funding gap at £32 billon by 2022. New models of care are essential in meeting the challenges, and ensuring that investment is made to much greater effect than many traditional models. There is no 'one size fits all' and local determination of the best clinical models, delivered by the right people in the right location is key.

Sheffield faces perhaps even greater challenges in addressing demand for health services locally. Whilst improvements have been achieved, overall life expectancy is still below the national average, with significant variation across the borough. Men have a life expectancy of 78.4 years and women 82.1 years, compared to the national average of 78.9 & 82.9 years respectively. There are large inequalities in life expectancy across the city, in the region of 8.69 years for men and 7.35 years for women. The under-75 death rate has also been reduced over recent years but still remains higher than the national average. This equality gap has remained fairly consistent when compared to the 2001-03 data. (8.69 men, 7.10 women) The most common causes of death in the under-75 group are cardiovascular disease and cancer, which account for over 60% or premature deaths as shown below.[2]

1. Kings Fund - Delivering Sustainability & Transformation Plans Jan 2017 / NHS England Five Year Forward View October 2014
2. NHS Sheffield Commissioning Intentions 2014-19



Sheffield Clinical Commissioning Group is responsible for commissioning the majority of healthcare for the population of Sheffield City (approximately half a million people). In April 2016, the CCG took on the commissioning role from NHS England for GP services and now directly contract primary care services (GP, pharmacy, dental and optometry services) from local providers; Pharmacy, dental and optometry services continue to be commissioned by NHS England.

Primary Care services are an integral part of the wider health and social care system with no part of the system working in isolation. The interdependencies are myriad and complex. Planning the provision of Primary Care services must, therefore, be considered within the context of community, mental health, hospital, social care, voluntary services and specialist services.

There are many drivers for change within health and social care. The most significant of these is the ever-increasing rise in the volume of demand for services. This is being experienced within all parts of the system, and in most aspects; the resultant pressure from this will impact on the quality of services if it is not addressed.

National drivers for change

These drivers are well documented[1] and can be summarised as:

- The number and proportion of older people in the population is increasing; the health and social care needs of older people are often more complex.
- There are more people being diagnosed with long term conditions and a greater proportion of people living with co-morbidity; this increases the demand for services and demands a different type of service provision.
- Greater prevalence of mental health needs and co-morbidity of physical and mental health illness.
- A shift in culture towards patient centred care, for all parts of the healthcare system.
- The healthcare expectations of the population are changing in line with greater consumer choice, 24/7 access, fast response times and better informed consumers.
- The approach to healthcare provision is shifting away from a paternalistic model with a greater onus on patients taking a more active role in the care of their own health; the Collaborative Care and Support Planning (CCSP) or person-centred care approach[2].
- Significant differences in health outcomes for different population groups; a persistence of health inequalities.
- Funding levels have decreased in real terms; the same resources are being spread more thinly requiring more efficient use of funds available.
- Greater integration between health and social care commissioners as a result of the Care Act and introduction of the Better Care Fund (BCF).
- Changes in technology are enabling improved survival rates, more complex conditions to be managed in a community or home setting and alternative ways of seeing and assessing patients.
- There are significant workforce issues in many parts of healthcare and this is keenly felt in primary care where fewer GPs are entering the profession and more are leaving it early[3]; there are too few practice nurses and a lack of dedicated training and career structure; physician's assistants courses are in their infancy.
- A combination of workload and workforce pressures and, in some cases, reductions in funding, are pushing some general practices to consider closure[4].

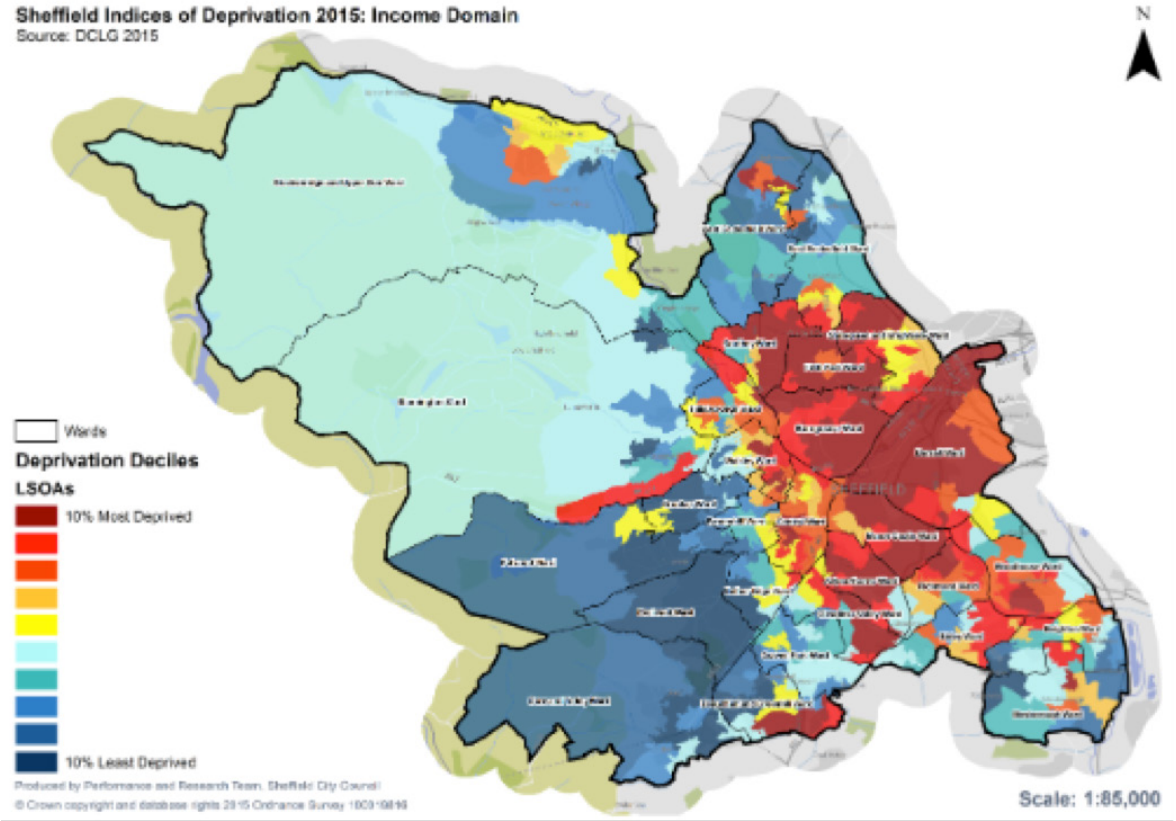
[1] Five Year Forward View, NHS England, October 2014 and General Practice Forward View, NHS England, April 2016
[2] Stepping Forward. Commissioning Principles for Collaborative Care and Support Planning. Professor Nigel Mathers, RCGP Clinical Innovation and Research Centre, 2015.

[3] Responsive, safe and sustainable. Towards a new future for general practice, British Medical Association, 2015.
[4] General Practice Forward View, NHS England, April 2016.

Local Drivers for change

The population of Sheffield is stated at 563,749 (mid-2014) and is expected to rise to 633,000 by 2032, but could rise still further if proposed housing developments go ahead. The greatest rise in population will be in the over 65's, followed by the under-16's.

Sheffield is ranked as the 60th most deprived Local Authority in England, and 6th of the 8 Core Cities in England. 68.3% of the adult population is in work, which is well below the national average of 72.9%. Approximately half of this group claim employment support or incapacity benefits. 25% of children are said to be living in a household reliant upon out of work benefits. Almost 46% of private sector rented dwellings did not meet the Decent Homes standard, with 25% of them having hazards considered to pose a significant risk to health and safety. Some 17% of households in the private rented sector are said to be in fuel poverty. Figure 1 below shows the Index of Multiple Deprivation 2015 relative to the rest of England.



Mental Health issues affect some 11.4% of the population, and premature mortality for this population is significantly worse than the general population of Sheffield. Levels of smoking are high at 21.5% of the adult population and is the largest reversible cause of ill health in Sheffield. Alcohol consumption, obesity, diabetes and depression are all higher or considerably higher than the national average, whilst health eating and exercise levels are considerably lower. There are some 51,000 'high-risk' drinkers in the city and 23.7 of adults are either overweight or obese. In 10-11 year olds, the obesity rate is 34.7%.

The financial pressures on Local Authorities in England have been even greater than those faced by the health sector, requiring a radical shift in the prioritisation of services and the way in which they are delivered. Sheffield City Council has made such changes, faced with similar pressures of demand, and has rationalized the way it provides services. As in many localities, some of these changes have exacerbated pressures on health services in the city.

SHEFFIELD HEALTH & WELLBEING VISION

A shared vision for the health and wellbeing of the city of Sheffield is set out in the Sheffield Joint Health and Wellbeing Strategy 2013-18. The strategy draws on the data supporting the Joint Strategic Needs Assessment and sets out 10 principles. These reflect a commitment to address the wider social economic and environmental determinants of ill health and to base plans on a respect for people, evidence and faith in delivery through partnerships. Quality and innovation is presented as the tenth principle.

The strategy realistically recognises the constraints under which public services are currently required to operate and the impact of economic stress on the city's communities. The CCG recognises this challenge within its Commissioning Intentions for the period 2014-19 in which the increasing demands placed on the NHS by an ageing society and rising expectations are set against the well known financial constraints and the increased costs of providing care. The CCG's aims are:

- To improve patient experience and access to care.
- To improve the quality and equality of healthcare in Sheffield.
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield.
- To ensure there is a sustainable, affordable healthcare system in Sheffield.

The CCG's ambition for the next five years is:

- All those who are identified to have emerging risk of admission through risk stratification are offered a care plan, agreed between them and their clinicians (possibly circa 15,000 people).
- By establishing integrated Primary Care and community based health and social care services, care planning, and holistic long term conditions management to support people living independently at home, to significantly reduce emergency admissions and Emergency Department attendances. (By up to 20%)
- Care requiring a specialist clinician will be brought closer to home.
- To reduce the number of excess early deaths in adults with serious mental health problems and achieve similar improvements for people with earning disabilities.
- To put in place support and services that will help all children have the best possible start in life.
- To minimise repeated trips to the GP and hospital for specialist diagnosis and monitoring of health problems, replacing them with community and home based services that make best use of technology, and keep people at the centre of their care.

Alongside this existing strategic direction the CCG and local partners have undertaken work in response to the Five Year Forward View, which sets out a clear vision for the future of the Health & Social Care. Local community engagement events (Shaping Sheffield) took place last year, which has confirmed the direction of travel and agreed the key priorities. This local vision will help shape the future estates requirements across the city and it is anticipated that the Sheffield Strategic Estates Plan will be further revised to reflect these emerging priorities, and aligned to the agreed outcomes for this Sheffield Primary Care Estates Strategy.

NHS Sheffield Clinical Commissioning Group

As commissioners of Primary Care services for Sheffield, the CCG has responsibility for ensuring the right capacity and accessibility is in place to meet the needs of the population, that Primary Care is developed in a sustainable manner and appropriate support and co-ordination is given to practices within the city. NHS Sheffield, having previously contributed to the wider Sheffield Strategic Estates Plan (SEP) in 2016, identified the need to improve the quality, utilisation and efficiency of the Primary Care Estate to support the implementation of the Transformation Plan - Delivering the GP Forward View, which sets out how Primary Care Services will be developed across Sheffield.

The estate from which Primary Care is delivered plays in important role in shaping the future configuration of healthcare across the city, as part of the overall South Yorkshire and Bassetlaw Accountable Care System to reduce admissions to secondary care, support wellness and prevention agendas and move to new models of care. The pressures of demographic change and long-term conditions are understood and reflected in these plans.

The CCG also has a strong financial and quality incentive to improve the utilisation of LIFT assets. It is known that utilisation of the 7 Lift buildings across Sheffield is in need of significant improvement, and that fundamental changes to the way in which they are operated will be required. The LIFT buildings represent a £3million per annum opportunity for the health community through improved utilisation, with a clear and firm commitment to change being required from our 'PropCo' partners.

Further, NHS Sheffield helps shape the assets deployed by all providers when commissioning services, and will co-ordinate bids against the national Primary Care Transformation Fund (PCTF) as just one part of the implementation of the Primary Care Estates Strategy. The main focus of PCTF bids will be to improve the quality and sustainability of the Primary Care Estate, and improve the utilisation of key assets. It is essential that the revenue consequences of any PCTF bids are understood and contained within current provision. There is a strong intent to support sustainability of practices, either through merger or federation to help improve quality

and viability at a neighbourhood and Locality level, and enable the delivery of more care closer to home.

Whilst the role of NHS Sheffield is to support practices and help facilitate wider-scale change, the responsibility for taking proposals to develop their assets forward does rest with GP providers. The ownership of plans and having the skills and capacity to take them forward must rest with Primary Care providers, working collaboratively, with strategic support and facilitation by NHS Sheffield. The development of joined-up working within localities and neighbourhoods is a key enabler to the delivery of sustainable local plans, which NHS Sheffield has strongly signalled it is keen to support.

The model of Active Support and Recovery (AS&R) set out by NHS Sheffield and endorsed by stakeholders, will form the basis of shifting activity away from acute settings, to provide care closer to home. The ambition is for providers to work collaboratively to provide a greater range of preventative care, an urgent response and escalation capability and revise the admission thresholds to prevent inappropriate admissions and enable reduced length of stay for relevant episodes. NHS Sheffield has indicated its strong support for Primary Care providers to develop such proposals on the ground, within neighbourhoods.

In setting its vision and commissioning intentions for the future delivery of care, NHS Sheffield is committed to overseeing transformation of local services, and the implementation of new models of care, with Primary Care at the centre. Whilst many services are able to meet the challenges ahead, it is recognised that some may not achieve the expected standards of quality, accessibility and efficiency required to play an effective role or meet the full needs of patients in line with the GP Forward view. In these cases, alternative solutions will need to come forward through local plans rather than accept a lower standard.

Primary Care Sheffield

Primary Care Sheffield (PCS) are a GP led organisation, with membership of all GP surgeries in Sheffield. The vision of PCS is to encourage stakeholders to work together in more flexible and innovative ways, to deliver improved access for patients and improve the working lives of Primary Care Teams.

PCS seek to provide a range of services both for patients and general practices in Sheffield, including

- Providing a unified voice for primary care and its future development within the health and social care system

- Providing education, support and referral guidance to GP practices for 7 outpatient department specialities.
- Providing evening and weekend appointments, 52 weeks of the year, with GPs and practice nurses at four sites around the city.
- Directly running 6 GP practices, through 5 APMS and 1 GMS contract, in partnership with Sheffield Health and Social Care NHS Foundation Trust
- Supporting and engaging the general practices in the city to work together in local groups

PCS work in partnership with statutory and voluntary organisations across the city and as such, as a Primary Care led organisation with GP membership across the city, are very well placed to influence and promote innovation in the way services are configured and the development of our Primary Care estate. Their values are strongly aligned to the vision of Primary Care being the cornerstone of patient care, and ensuring practices have the resources and infrastructure they need.

Delivering the GP Forward View - Transformation Plan

The NHS Sheffield response to the GP Forward View (GPFV) is closely aligned to the Primary Care Strategy and commissioning intentions, and sets out three main aims:

Aim 1– to ensure that all practices have a clear plan to remain sustainable to deliver the future primary care agenda.

Aim 2 – To develop our existing primary care workforce to increase capacity as necessary to deliver high quality, capable service offer in out of hospital community and Primary Care settings.

Aim 3 - To ensure that our estate and technology strategies support the sustainability and transformation of Primary Care.

Transforming and strengthening Primary Care is core to the delivery and ambitions of the CCG, and embedded in the place based plan and those of the ACS. The GPFV response recognises and embraces the challenge for care to be innovative, affordable and improves access. Its expected outcomes are also aligned, and provide key references for the Primary Care Estates Strategy;

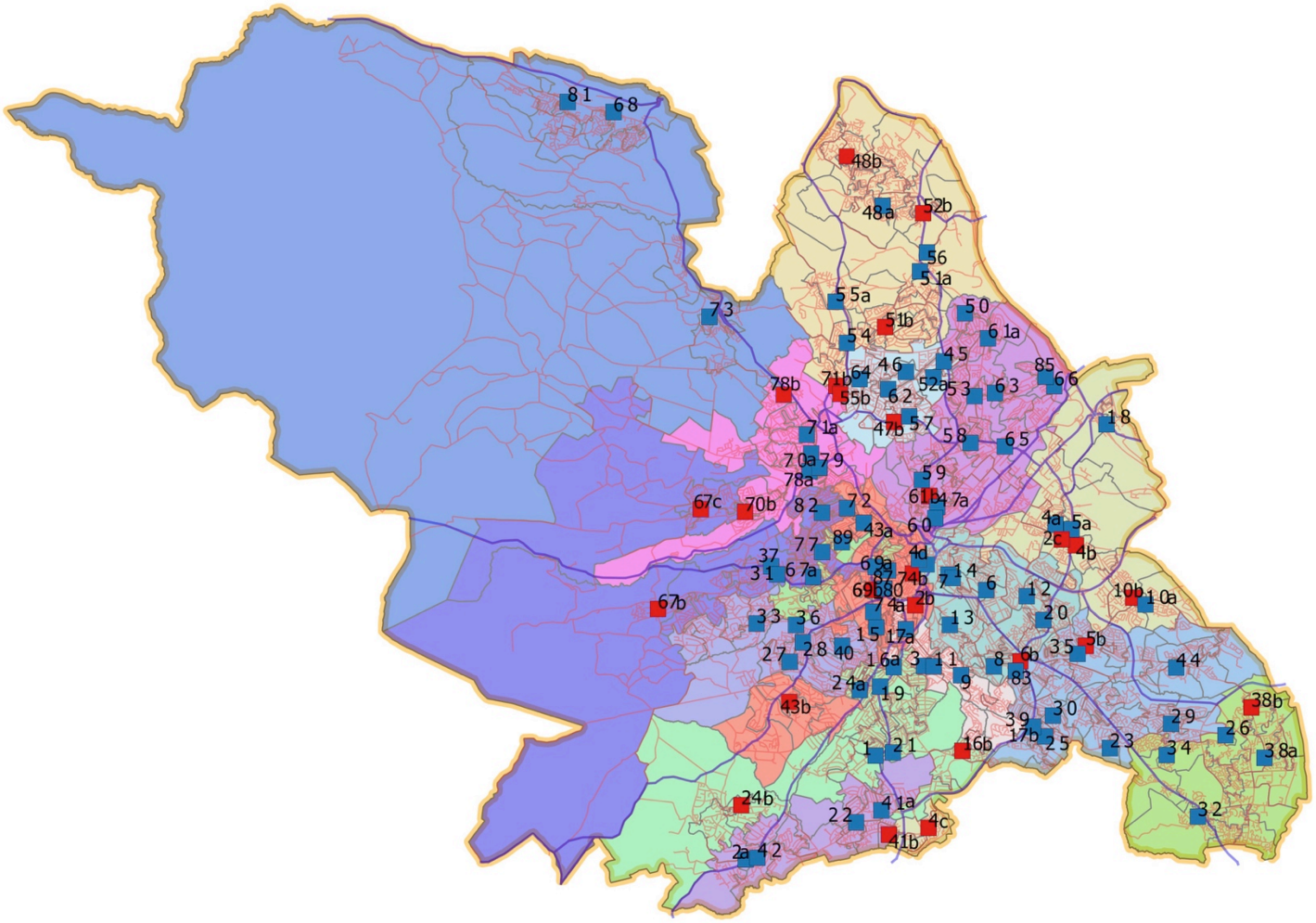
- Better equality in health outcomes for people living in Sheffield; this means improving how people manage their own health and ill health and making sure they have access based on need to the support they need, regardless of their social circumstances;

- Stable primary care services with sufficient numbers and skill mix of staff to manage the demand plus IT and buildings that support and enhance service provision;

- People receiving the right interventions at the right time from the right professional - mostly in their local neighbourhood.

The GPFV response also sets out expectations for the public, providers and commissioners to respond differently to help meet the challenges for healthcare already outlined; for the public, seeking alternatives to their GP for common problems, and taking responsibility for their own health; For providers, to work differently with patients and more collaboratively with other providers; And for commissioners, to support the shift of resources and lead on changes needed to grow the Primary Care workforce, develop IT and estates infrastructure.

At the heart of the plans for Sheffield is the delivery of strong, localised care delivered in neighbourhoods, with effective collaboration between services covering 30-50,000 people. This collaboration requires the CCG, GPs, Sheffield City Council, secondary care, social care and our third sector partners to come together to meet the specific challenges in each neighbourhood and support those in greatest need of care. A map of the 16 neighbourhoods showing current Primary Care estate is shown overleaf.



Legend

- Practices (main sites)
- Practices (branch sites)
- Main Roads
- Minor roads
- Sheffield LA Boundary

- N01 - GP Association 1
- N02 - North 2
- N03 - Townships (I)
- N04 - W4GPA
- N05 - Darnall
- N06 - Carrfield
- N07 - Jordanthorpe
- N08 - City Centre Practices
- N09 - SWAC
- N10 - SAPA
- N11 - High Green
- N12 - Tramways
- N13 - Oughtibridge
- N14 - Universities
- N15 - Porter Valley
- N16 - Townships (II)

Key	PRACTICE NAME
26	Crystal Peaks Medical Centre
32	Mosborough Health Centre
34	Owlthorpe Medical Centre
38	Sothall and Beighton Health Centres
67	Broomhill Surgery
31	Manchester Road Surgery
37	Selborne Road Medical Centre
76	Stannington Medical Centre (Shurmer)
77	The Crookes Practice
82	Walkley House Medical Centre
4	Clover Group Practice
5	Darnall Health Centre (Mehrotra)
10	Handsworth Medical Practice
18	The Medical Centre
6	Dovercourt Surgery
7	Duke Medical Centre
8	East Bank Medical Centre
12	Manor Park Medical Cetre
13	Norfolk Park Medical Practice
14	Park Health Centre
20	White House Surgery
47	Burngreave Surgery
50	Dunninc Road Surgery
53	Firth Park Surgery
58	Page Hall Medical Centre
59	Pitsmoor Surgery
60	Sheffield Medical Centre
61	Shiregreen Medical Centre
63	The Flowers Health Centre

3	Carrfield Medical Centre
9	Gleadless Medical Centre
11	Heeley Green Surgery
15	Sharrow Lane Medical Centre
17	The Mathews Practice
22	Avenue Medical Practice
2	Baslow Road And Shoreham Street Surgeries
41	The Meadowhead Group Practice
42	Totley Rise Medical Centre
49	Crookes Valley Medical Centre
69	Devonshire Green Medical Centre
72	Harold Street Medical Centre
74	Porter Brook Medical Centre
43	Upperthorpe Medical Centre
1	Abbey Lane Surgery
24	Carterknowle And Dore Medical Practice
16	Sloan Medical Centre
19	Veritas Health Centre
21	Woodseats Medical Centre
45	Barnsley Road Surgery
46	Buchanan Road Surgery
52	Elm Lane Surgery
57	Norwood Medical Centre
62	Southey Green Medical Centre
64	The Health Care Surgery
48	Chapelgreen Practice
51	Ecclesfield Group Practice
54	Foxhill Medical Centre
55	Grenoside Surgery
56	Mill Road Surgery

70	Dykes Hall Medical Centre
71	Far Lane Medical Centre
78	Tramways Medical Centre (Milner)
79	Tramways Medical Centre (O'Connell)
68	Deepcar Medical Centre
73	Oughtibridge Surgery
81	Valley Medical Centre
80	University Health Service Health Centre
27	Falkland House
28	Greystones Medical Centre
33	Nethergreen Surgery
36	Rustlings Road Medical Centre
40	The Hollies Medical Centre
23	Birley Health Centre
25	Charnock Health Primary Care Centre
29	Hackenthorpe Medical Centre
30	Jaunty Springs Health Centre
35	Richmond Medical Centre
39	Stonecroft Medical Centre
44	Woodhouse Health Centre
75	Clover City practice

Combined Public Estate

It is widely recognised that property and the built environment is an important part of delivering high quality public services into the communities we serve. It also represents a significant cost and therefore it is more important than ever that as much as possible of the public services budgets is spent on front line service delivery. Put quite simply £1 saved from property is an additional £1 available to spend directly on frontline services.

There are continually growing demands and expectations placed on the public sector and current models are considered to be no longer sustainable in the long term. As such there is a real need and opportunity for public services to work more collaboratively to reduce duplicated overhead costs and to deliver more joined up services at a local level.

Sheffield City Council has made considerable progress in rationalising the property base it owns and from which it operates services. Our health organisations are actively working now to the same, to release outdated and surplus assets, and prepare to support and enable the transformation of services, which both creates opportunities for Primary Care and creates challenges. The principles of the Government's One Public Estate Programme (Promote greater integration and customer focused services, Reduce running costs, Generate capital receipts and Create economic growth) provide a useful framework for the Primary Care Estates Strategy to achieve mutually beneficial outcomes for all stakeholders.

To support this direction of travel and to ensure that property decisions are public service led, meet the needs of individual communities and are sustainable for the long term, a more strategic approach to property management and ownership is now being taken. The Sheffield Strategic Estates Plan (2016) was a positive continuation of this journey and will continue to be developed and updated in full consultation with local stakeholders. We must ensure alignment and synergy of the Primary Care Estates Strategy with the wider plans for health and care estate across the city.

Other Estate Opportunities

The features that are desirable in achieving high quality healthcare environments - locality, accessibility, footfall, extended opening, adjacencies for example - are often present in other sectors such are leisure, retail, education or transport. Consideration should be given to how Primary Care may work in partnership with such sectors, not least given changing trends in shopping, the needs of older people and the expectations of younger people. Floor space may be made available in settings not traditionally used for healthcare (e.g. supermarkets, shopping areas), or where a synergistic relationship can give mutual benefit, or support a wider wellness agenda (e.g. leisure centres, schools).

WHERE ARE WE NOW?

Introduction.

This section examines the current state of the premises we provide Primary Care from currently. As is common in most cities, Sheffield has a mixed economy of estate, but with the majority of premises in the ownership of individual practices or consortia. By its very nature, the Primary Care estate has evolved over many years in to its current form, without the development control planning used for secondary care sites. Aside from LIFT, there have been few wider scale initiatives to transform the Primary Care Estate. Our estate has many challenges - capacity and economies of scale for example - but it also has many strengths - it is embedded within our communities and has strong local relevance. Understanding the estate from which we currently operate at city, locality and neighbourhood level is essential in planning for the future.

Our Current Primary Care Estate

The Primary Care Estate comprises of 111 properties in and around Sheffield, with a combined gross internal floor area of approximately 63,569m^2, with an estimated operating cost of £5,409,468*. The age range for the properties is from 1850 to 2011, with an average age of 51 years (1966) for the original building construction. Many practices have had extensions or refurbishments since construction.

* Based on average GP practice size & reimbursable costs

It is assessed that there are 729 consulting / treatment rooms, and a further 219 treatment / examination rooms within our current Primary Care facilities (an average of 8.5 per practice).

Sheffield has a high proportion of smaller practices, operating from converted premises, as shown in the table below.

Property Type	Main Surgery	Branch Surgery	Total
Purpose Built	53	16	69
Converted Premises	34	8	42

The average practice floor area is 577m2 (Gross Internal Area). 18 practices (including 11 Main Surgeries) are under 300m2. 19 surgeries have a floor area in excess of 800m2.

The 6- Facet Appraisal

Following on from the Sheffield SEP, a 6-facet appraisal process has now been completed to gather improved data on the Primary Care estate to inform the development of this strategy, help assess Primary Care Transformation Fund bids and ensure the facilities are able to support emerging new models of care. The 6-facet survey includes;

- **Physical Condition** – an assessment of the state of repair of each element of the building.
- **Functional Suitability** – the suitability of the premises for the purpose it is used for.
- **Space Utilisation** – how effectively the physical space is being used.
- **Building Quality** – assesses the overall quality of the building amenity, comfort engineering and design for purpose.
- **Statutory Compliance** – assessment against a range of building related statutory requirements.
- **Environmental Standards** – from an energy efficiency / carbon reduction perspective.

Backlog Maintenance Costs are also calculated, to improve to "Condition B" (only minor defects or improvement required) for Physical Condition and Statutory Compliance.

Key findings of the 6-facet appraisals are summarised below;

Condition

The condition of the majority of the buildings was assessed as being "Condition B/C" which means they are considered operationally safe but will require some significant work soon to maintain that position. However, there are a number of practices (7) that are graded C which indicates major repair or replacement will be required within the next 2-3 years. 46 properties are identified as having one or more high or significant risk items that require rectification.

Functional Suitability

The majority of the properties were assessed as being satisfactory for current use and activity or satisfactory, with only minor changes needed.

However, there were a small number (6) deemed not to be satisfactory and some major changes will be required. The practicalities and feasibility for any changes within these practices will need to be reviewed further.

Space Utilisation

The vast majority of practices were reported as being fully used during surgery times, with only 7 practices reporting the buildings being under used. 7 practices were assessed as being overcrowded overall. This of course is highly variable depending upon activity levels during certain times of the day or week. This position is not unusual in Primary Care, but should not be seen to be an acceptable position.

However, this general statement should be caveated that this is the view fed back by staff working within the practices and is only in relation to when the buildings are actually currently open – it does not take into account opportunities to increase utilisation though extended sessions, or use by other health professionals outside of GP surgery hours. A technical utilisation survey using motion sensors may be a useful aid, where changes are being planned.

Quality

The majority of the buildings are assessed as being of average quality where they require some form of general maintenance and/or some minor capital investment to continue to be considered as suitable facilities.

There are a few exceptions where the properties are deemed to be of excellent quality but, as would be expected, these are the most recent constructions.

At the lower end of the spectrum there are two practices that are regarded as being very poor facilities and in need of significant capital investment or indeed replacement. We will be discussing with these practices their plans in relation to these issues in the near future.

Statutory Compliance

A significant number of practices (38) have been assessed as having a known contravention of one or more standards, with 12 practices being significantly below the required standard, and unable to demonstrate compliance with 7 or more standards.

In the majority of cases this was simply because there was no documentary evidence to support that the appropriate standards were being recognised, being in place or being adhered to.

Although the need for this information will have been shared with the practices at the time of the survey it is recommended that the requirement for, and availability of, such documentation be reinforced with all practices. Aside from the Estates Strategy, consideration will be given to how practices are supported and monitored with regards to understanding and fulfilling their statutory obligations.

Environmental Management

In the majority of the buildings there were no Display Energy Certificates (DEC) available and so an assessment was made by the surveyor on site based on the age and condition of the building, and the installed systems.

As would be expected from an estate with such a wide age profile, the majority of older buildings lay in the lower of efficiency (D-E) within the overall range of A-G, with newer buildings achieving band C.

Backlog Maintenance Cost

The results of the surveys showed that there was a considerable backlog maintenance issue in a significant number of practices, with an estimated value of £2.89 million excluding fees, enabling cost and VAT. Of this, £484,000 relates to significant or high-risk items.

The average backlog maintenance figure per practice is £26,521. The range is from £nil to £64,400. 20 Practices have a backlog cost in excess of £100 per m2, against an average of £54 per M2.

It should be noted maintenance costs to keep buildings in a safe, sound and functionally suitable condition to deliver care should be met from the cost/notional rent payments received by practices. It is not acceptable for practices to ignore such items, and quality standards should include plans by practices to survey premises periodically and rectify maintenance issues in a timely manner, to prevent breaches of regulatory standards or risks to service availability.

The DH Primary Care Transformation Fund (PCTF) is intended to enable improvements in the Primary Care estate and capacity, and often backlog maintenance issues are a key driver for change where major renovation or replacement is required (Condition Cx /Dx) and the Sheffield Primary Care Estates Strategy will provide a reference framework against which future bids can be assessed for strategic fit.

Our LIFT Building Utilisation

The 7 Sheffield LIFT buildings offer very high quality, exemplary community assets. However, overall, utilisation is quite poor - estimated at circa 33 to 50% of potential capacity, varying by site and by use / user. Whilst the cost of occupancy to new entrants appears high, the health and local authority community is paying for the asset as a whole already and improved utilisation is a shared objective between commissioners and providers. Utilisation by current occupants has not been reviewed robustly since occupation, by either the landlord or tenants.

As an example, detailed utilisation study has been completed at Darnall LIFT Centre, using motion sensing devices in all key rooms over a 2 week period. Key finding include;

- Average Occupation of circa 34%.
- Peak total utilisation of clinical areas 66% (Wednesdays).
- 79% of clinical accommodation had an average utilisation less than 40%.
- 67% of non-clinical accommodation had an average utilisation less than 40%.
- Bookable space average utilisation was circa 16%.
- NHS FT average utilisation of designated space was circa 25%.

The detailed utilisation study is valuable in providing occupancy details over an extended period, to help inform service planning and identify opportunities, and is recommended to confirm the planning assumptions and assist accommodation planning for new multi-specialty provider

services. It is planned to roll out the detailed utilisation studies to the remaining LIFT assets across Sheffield.

There are currently few incentives for most tenants to utilise space efficiently. Rent increases combined with cost improvement plan retractions are creating unsustainable cost pressures for some providers. Working practices do not lead to efficient use of space, and hence funded resources are not deployed effectively.

There may be surplus capacity in some locations, above stakeholder demand in the locality. Some GP practices appear to be occupying excess space for their practice size (based upon patient list), but premises costs are reclaimable from NHS Sheffield in most cases, thus giving little incentive to use space more effectively, or give up excess space to other uses.

A schedule of the potential capacity assessed as being releasable within each LIFT building is shown below. This is based on practical utilisation to an effective level, but does not include further utilisation or voids through current reconfiguration by secondary care providers. It is based upon current operating hours for each service - further capacity gains are readily achievable though extended operating hours and 7-day services, where such demand can be demonstrated.

Lift Centre	Gross Internal Area	Recorded CHP Void Capacity m^2	Potential efficiency space gain M^2
Darnall Primary Care Centre	2379m^2	Nil	840 m^2
Deepcar Medical Centre	858m^2	239m^2	369 m^2
The Flowers Health Centre	1114m^2	81m^2	276 m^2
Foxhill Medical Centre	1776m^2	349m^2	605 m^2
Jordanthorpe Health Centre	2250m^2	Nil	767 m^2
Norfolk Park Health Centre	1904m^2	288m^2	690 m^2

Wincobank Medical Centre	1679m^2	100m^2	475 m^2
Totals	**11960m^2**	**1057 m^2**	**4024 m^2**

Based on 2016 survey of all assets and costs

Whilst patient experience and satisfaction of using LIFT buildings remains high, the experience of tenants and commissioners with regards to cost, flexibility and operational support indicates that significant changes are required, if the health economy is to achieve maximum benefit from such high quality buildings, and the investment made in them. As already stated, there is a £3m opportunity to the health community in achieving full and efficient utilisation of LIFT assets, and significant cost avoidance in the future. The commitment of all parties to work constructively in implementing new, more agile and more tenant-focused solutions is essential in achieving this goal.

Community Health Partnerships have recognised the need to find new operating models that better meet the needs of tenants, and present LIFT buildings as a highly positive and responsive option when shaping health services locally. In Fareham, a pilot scheme known as Agile Property Management (APM) has proved successful in removing common barriers to effective use by simplifying terms, is supporting the Community Hub approach, has increased utilisation to a target of 85% and ensures best value to commissioners. The model, which included a concept known as Centre Management, promotes integration of services and partnership working between commissioners, healthcare providers and CHP.

Current Estate Summary Position

A summary of the Primary Care stakeholder assets, including our LIFT centres, is included below.

- **Utilisation** – Whilst there are significant elements of under-utilised estate in LIFT assets giving significant opportunity for reconfiguration, many GP practices are either full during surgery times or do not have sufficient space to operate at optimum levels. The ability for such practices to increase capacity, offer new services or ensure accessibility are very constrained without such spacial flexibility.

- **Quality & Condition** – The Primary Care estate is of variable quality, with some unacceptable assets that require more urgent attention. Overall, condition is below average (Condition B/C), with the majority of buildings requiring investment within 2-3 years to prevent them falling into unacceptable standards. The backlog maintenance requirements (as known) are typical for Primary Care assets, which rarely benefit from system wide improvement initiatives due to the ownership models used. Our LIFT

assets represent the best quality buildings deployed for Primary Care which, being recent builds and fully maintained, are in 'Condition A'.

- Overall Capacity – Between our GP premises (c63,569m2) and the GP practices within LIFT centres (4,317m2) Sheffield currently has a Primary Care capacity of 67,886m2 within existing buildings. LIFT buildings have a potential capacity gain of 2,841m^2 with a realisable spacial efficiency gain of 37%. Overall this indicates that as a health economy the city has some 120.5m2 of estate (Gross Internal Area) deployed per 1000 capita. This is 2.3% above comparable city based health economies.

- Cost – Whilst there is potential to reduce actual premises spend through localized efficiencies, the greatest single cash releasing opportunity is presented through improved LIFT asset utilisation (c£1.24m), taking into account differences between reimbursable premises costs and the current LIFT costs. The overall opportunity for NHS Sheffield through improved LIFT utilisation is £3m, but it is recognized that while this may not be fully cash releasing, there could be significant quality, accessibility, service improvement and risk reduction benefits, and some future cost avoidance.

- Data – The recent 6-facet appraisal survey has significantly enhanced the visibility and awareness of backlog maintenance requirements, statutory compliance and environmental performance. Data regarding utilisation and occupancy costs, specifically related to quality standards, needs to be improved.

- Investment Needs- to be confirmed once locality plans are developed and agreed, but current high and significant risk backlog maintenance costs at practice level is calculated at £484,000, and should be addressed within the current financial year by individual practices.

The issue of overall Primary Care capacity is fundamental to the future delivery of high quality, place based care, and needs to be addressed through the Estates Strategy. We know that we face increasing demands, and that we need to support the delivery of care out of hospital. Having the right assets, in the right place and of the right quality is essential to meet these challenges.

Based upon the standards set out in Health Building Note 11-01 (Facilities for Primary & Community Services), it can be extrapolated that for its current population, Sheffield has a gross requirement of 62,247m2 for GP practice accommodation (excluding non-Primary

Care LIFT space). This (theoretically) would indicate an excess floor area of some 5,639m2 (9%) if all practices were optimally sized and located and had the prescribed facilities to HBN standards, or that there is overall capacity within the current system for an additional population of 51,000 people.

The blue print for a model Primary Care facility as detailed in Health Building Note 11-01, has 14 consulting rooms, and a total Gross Internal Area of 1,928m2. By contrast, just 13 of the current surgeries in Sheffield are over 1,000m2. The average surgery Gross Internal Area is approximately 570m2, with some 45 facilities being smaller than this figure. This data is presented to help illustrate the problems with the current configuration of Primary Care in Sheffield, having a high number of small practices, and to reinforce the need to reconfigure service delivery rather than present a case that we have too much spacial capacity.

WHERE DO WE WANT TO BE?

Introduction.

Our patients and their carers expect to have high quality healthcare, delivered in high quality environments and with good accessibility. We have heard that many of our residents still expect the delivery of healthcare in traditional ways, whilst our younger population have very different expectations about location and access times - our demographic is changing and we must try to meet a diverse set of requirements. People want a greater range of services to be delivered in the community, rather than in a hospital setting. They want their GP to be the co-ordinator of their care, to be involved in planning and decisions about them. Overall, they have an expectation of a modern, effective and responsive healthcare system. As a health community, we also want these outcomes, with Primary Care at the heart of our transformation, delivered within an economically sustainable and joined-up system. Delivering Primary Care at scale across Sheffield, with new models of care, requires the estate and supporting infrastructure to be in the right place, to the right quality.

Principles for Improvement:

In order to help shape the future Primary Care estate for Sheffield, and address the key issues identified as requirements for a more efficient and higher quality estate to support new models of care, a number of key principles have been developed and tested with stakeholders. These are;

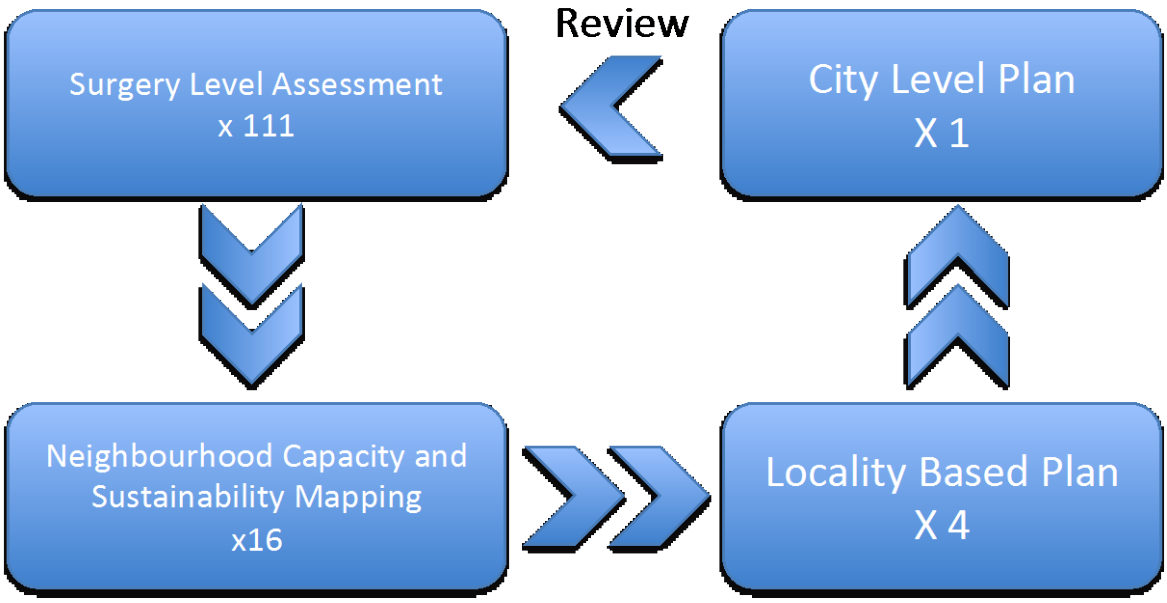
- Divest of poor quality, poorly performing and surplus assets.
- Public and patient facing services prioritised for use of high quality assets.
- Develop assets for the delivery of new models of care and service delivery.
- Prioritise and positively enable greater use of high quality assets, such as LIFT.
- Co-locate services where possible, with shared and/or sessional use between providers.
- Increase utilisation of health and local authority assets, where appropriate.
- Develop agile working across each organisation – in practice.
- Co-locate support functions where possible, if not integration yet .
- Support the continued rationalisation of Sheffield City Council asset base, seeking opportunities for the development of Primary Care services where appropriate.
- Develop agreement on cost gain / pain share across organisations to promote shared use and productive estate.
- Plan for replacement of aging, poor quality and ineffective assets collaboratively.

To help deliver upon these principles, a number of tactical measures may be applied;

- Seek to enhance integration of services across different organisations, recognising people are at the heart of service delivery. We should seek to offer a wide range of services from single points of delivery – pharmacy, dental, optical, chiropody etc as well as opportunity for secondary care outreach services, colocated within Primary Care settings.
- Focused Investment - Reduce the number of buildings of poor performance or quality standards, to reduce the overall investment need, and improve the operational cost efficiency of remaining assets through better utilisation and service provision.
- Quality – Ensuring that we are delivering (commissioning) Primary Care services from high quality estate that is safe and fit for purpose, regardless of ownership models.
- Accessibility – Ensuring that Primary Care services operate from a planned network of accessible buildings that are strategically placed to ensure maximum potential to serve communities, in each neighbourhood – high accessibility to all.
- Collaboration – Practices working together to achieve more in partnership than on their own. Working through opportunities at a strategic level to avoid unintended consequences and cost shifting. No Practice should be unfairly disadvantaged by another's gain.
- Sustainability – Looking for long-term solutions to ensure the holistic care needs of communities are met. Recognising the potential within, and the expectations of communities, and meeting these more effectively through innovative property solutions.

Within Sheffield, a more strategic service led approach is now being taken to ensure the Primary Care estate is fit for purpose, efficient and flexible to be able to meet the needs of frontline services. This strategic approach is based on the supply and demand model below, which is helpful in ensuring a consistent approach across the city, with relevance at both locality and neighbourhood levels.

Key to this model is determining the future demand for property & service requirements. Whilst a number of reconfiguration and development models have been explored, it is considered vital that stakeholders are fully engaged in the process and support the development of plans that must be service led, and support the GPFV response. This staged approach is intended to best prepare and inform the development of locally owned plans, in a consistent manner, using the demand-led review process outline below.



This estates strategy is service led and aims to directly support the successful achievement of core Primary Care priorities and the wider modernisation programme. All property investment

or divestment decisions must be able to demonstrate clear linkage to patient outcomes and/or quality gains, aligned to the commissioning priorities of NHS Sheffield.

Our plans must be forward looking, to ensure we meet the aims of the GPFV response to ensure all practices remain sustainable to deliver the future primary care agenda and support the sustainability and transformation of primary care. We must highlight those premises where the provision of an acceptable standard of service (both currently and in the future) might be compromised through the type, scale, location or condition of the buildings in use, recognising the sensitivity and complexity this brings and ensure our plans include resolution of those matters in an appropriate timescale.

Although the focus of this Primary Care estates strategy is the provision of a community based infrastructure that will, over the term of this strategy, support the new integrated pathways and models of service delivery that will be managed or commissioned through partner organisations, there are matters of compliance and quality requiring short-term intervention to ensure service continuity. Where such matters do not require significant investment or are deemed unlikely to be impacted by developing plans, it is essential that these are taken forward at practice level as a priority, rather than looking to other routes for resolution.

It is also proposed that improvements in frontline services delivery, access to services and space utilisation can be achieved by increased collaborative working with partners within the city. The City Council and CCG boundaries are identical and the council is undertaking pioneering work in planning the local delivery of integrated services in neighbourhoods from intensively used local "hubs", around which Primary Care may be modelled in some localities. In addition to enhancing the quality of the services delivered they and other public service providers are also seeking to identify and implement significant efficiencies from property and see colocation as an opportunity to save money and improve services at a local level.

Extended Primary Care

Our vision for Primary Care across Sheffield requires us to transition our service models where required, so practices can deliver an extended range of services to support out of hospital care and provide care closer to home. From the current assessment of our Primary Care estate, it is apparent that whilst some reconfiguration (right place - right time) can improve utilisation of existing practices, the capacity to deliver extended Primary Care Services is largely limited to the deployment of LIFT centres. The ability for increased working with partner organisations, the third sector and the provision of outreach centres is essential, and to provide this at scale requires the capacity and critical mass achieved through larger Primary Care centres. As a basic planning assumption, we should ensure all neighbourhoods have good access to an Extended Primary Care facility - this does not necessarily mean within each neighbourhood, but with good adjacency and access appropriate to needs.

Future Capacity Planning

Whilst further detailed work is required to confirm the projections, using the demographic projections, the increased prevalence in Long-Term Conditions and the drive for more care to be delivered out of hospital, indicators for the additional space requirement for Primary Care have been derived, based on increased numbers of consultations (and hence consulting rooms, and support facilities). As an indicator, using our current average practice GIA of 577m2, by 2022 Sheffield will require the equivalent additional floor area of 3.6 more GP practices by 2022, and 12.6 more by 2032 purely for demographic changes, if delivered in the current model. When combined with additional consultations with a practice based professional for care out of hospital, and the projected increase in the prevalence of Long-term Conditions, the estimated overall additional requirements may be summarised as shown below;

Driver	2017 to 2022	2017 to 2032
Demographic Changes	2,058m2 (3.6)	7,292 m2 (12.6)
Care out of Hospital	2,512 m2 (4.4)	3,471m2 (6.0)
LTC Prevalence	2,021m2 (3.5)	4,547m2 (7.88)
Total	**6,591m2 (11.5)**	**15,310m2 (26.5)**

Total indicated increase in GIA (Practices based on current average of 577m2)

Practice numbers in brackets are provided purely as an indicator, using current model and configuration

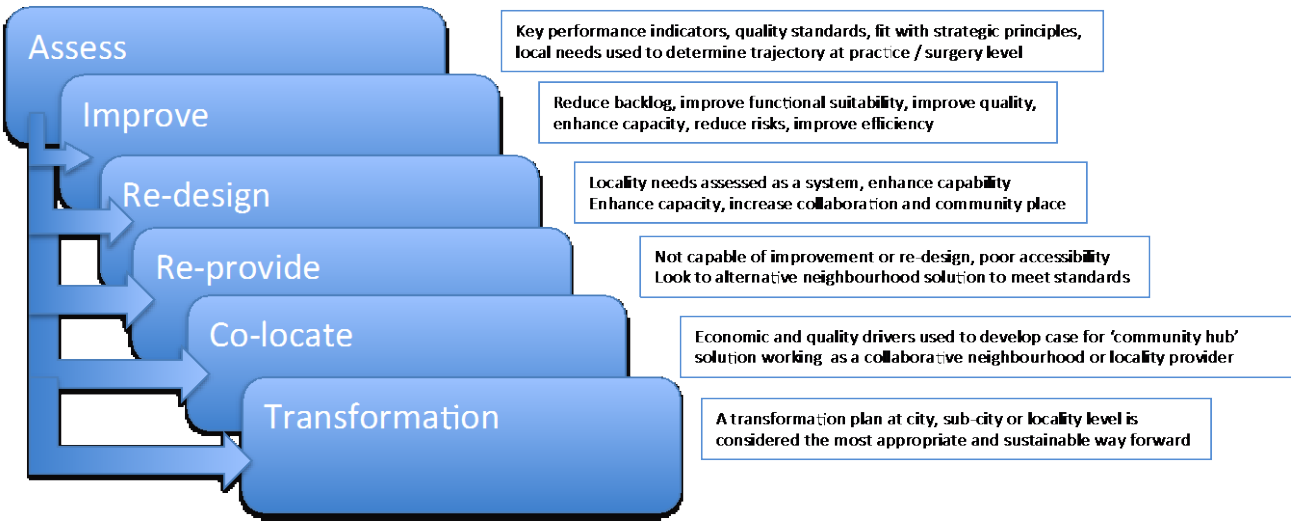
Assumes LTC growth in-line with current trajectories, no mitigation by prevention / wellness strategy

From the above figures, to continue to deliver Primary Care for Sheffield in the current model of practices sizes, configuration and distribution, but for new developments to meet HBN standards, we would need a further 12 practices by 2022. The capacity model indicates that there is currently an excess of 5,639m2 in the system, which, if 50% could be released or utilised, reduces the requirement by 2022 to 3,194m2 (5.5) and by 2032 to 11,913m2 (20.6).

Locality Development Plans

Following a review of strategic options to support delivery of the Primary Care Estates Strategy aims, subject to organisational consultation, a strategy of "Stepped Change" is recommended to provide a consistent basis of an Estates Development Plan for each locality. The plan must take in to account the interdependencies and emerging needs within each locality, be aligned with other strategies - whilst the estate is a key enabler, it should not be the determining factor in shaping the models of care delivered in each locality.

The model below illustrates the escalating series of interventions to help the transition from current form, to the estate required to deliver the aspiration of all stakeholders, and the aims of the GPFV response.



All Primary Care assets are considered, at individual practice / surgery level against a common set of criteria (present state) and the locality needs, taking into account the overall provision, demographics and projected health needs of the locality or neighbourhood, (future state) and then the next appropriate action is determined to populate the capacity and sustainability plan for the neighbourhood, which in turn are used to build the overall Estates Development Plan for that locality. The process is iterative, and may require several process loops to ensure a cohesive and optimum plan is achieved, with full stakeholder engagement. Using a bottom up approach to ensure needs are met at practice, neighbourhood and locality level can only be successful by developing proposals against the agreed principles and city-wide requirements.

HOW DO WE GET THERE?

Introduction

As outlined previously, the outcomes of the Estates Strategy must be service led and have the engagement of stakeholders in following the process that will lead to detailed plans for each neighbourhood and locality. There are a number of high-level proposals that inform those local plans, upon which agreement on the direction of travel is sought.

City Level Planning Assumptions

Whilst a key focus of Primary Care is to achieve care closer to home and the transition of care to out of hospital settings, some elements and themes are best considered at a city or sub-city level, where the demand, degree of specialism or resources required cannot be met at locality level. The emphasis in these cases is in ensuring care and treatment is delivered by Primary Care providers, rather than the setting of delivery. The Primary Care strategy has identified Out-of-hours GP and emergency dental services, and GP led urgent care as examples of this. Early agreement on the models and estate options for city-level provision is essential to inform capacity and sustainability mapping at a local level.

The performance indicators for Sheffield Teaching Hospitals NHS Foundation Trust already indicate a significant excess estate for their income and activity, and the increasing level of care delivered out of hospital may well lead to 'stranded' estate that cannot be redeployed economically. It is therefore recognised that dialogue with STH focuses on potential estate that could be made available for Primary Care (Extended Primary Care) purposes. Consideration should also be given to the development of local urgent care provision, using existing estate either through combined service routes, or the redesign of services provided in LIFT assets. Further scope for Primary Care services delivered on a citywide basis is thought possible with Sheffield Children's Hospital NHS Foundation Trust. Co-location with City Council and third sector services operating 24 hour or extended hour services at a city or sub-city level is also encouraged. Within the Central Locality, for example, sufficient space may also be made available within LIFT assets to support an expansion of citywide services.

Developing Locality Level Plans

Locality level plans will be at the heart of providing Primary Care at scale. The locality plan will be built around the summation of neighbourhood capacity and sustainability mapping. Those localities with larger LIFT buildings should ensure the effective deployment of space to deliver of an Extended Primary Care centre where required, with detailed clinical engagement in determining the scope, capacity and operating model to maximise the impact from such

centres. Where there is a mismatch between the provision of the LIFT assets currently and the needs of patients, we should develop plans for the creation of new facilities along the Extended Primary Care model. Such facilities are likely to be of significant scale, and be able to accommodate a number of GP practices and community based services, as well as third sector providers. At each Locality level, the overview of Neighbourhood capacity and sustainability mapping must indicate a viable and deliverable model, taking into account those services to be delivered on a city-wide basis.

Mapping Neighbourhood Capacity and Sustainability

Practices within each Neighbourhood are encouraged to consider ways in which collaborative working and shared resources can help deliver new service models or improve outcomes. For example, agreement on the provision of same day, extended day or weekend appointments in one or two locations; the hosting of specialist clinics and services closer to home on a sessional basis between practices. Agreement on such proposals can have a significant impact on the utilisation and hence sustainability of individual practices, and also enables investment to be prioritised. These must now be brought into our firm plans within each neighbourhood to support the delivery of our Assertive Outreach and Recovery model, and deliver Primary Care at scale.

Where agreed quality indicators show a higher proportion of surgeries not able to offer a broader range of services, thus limiting local choice or effective collaboration between practices and other providers, a sustainability plan will be required for the locality to show how these issues are to be addressed.

Bringing the issues discussed together, a number of tangible actions are required for all stakeholders;

Short Term Deliverables (3-6 months)

- Agree services to be delivered on city and sub-city wide models where appropriate.
- Agree key quality, accessibility, sustainability and cost indicators to be used consistently for the city as a whole.
- Assess premises used for Primary Care against the indicators.
- Practices with known significant or high risk backlog maintenance or statutory compliance issues to have appropriate plans in place to resolve these matters, to ensure safety and sustainability of care.

- For Community Health Partnerships and NHS Sheffield to develop plans to 'unlock' LIFT assets for more flexible and productive use (e.g. 'Centre Management - aka The Fareham Model') and put in place a new framework to deliver improved operational models across the LIFT estate in Sheffield.
- Agree a Gain / Pain Share approach between Primary Care Providers and NHS Sheffield to remove barriers to occupancy and change within LIFT assets, in line with the above.
- Identify short, medium and long term commissioning intent for all Primary Care assets, including options for improvement, re-design, re-provision, co-location or transformation.
- Identify Primary Care assets to be supported through the PCTF process, using the KPIs and assessment criteria, to ensure alignment with the commissioning intent and quality standards of NHS Sheffield.
- NHS Sheffield to put in place the support framework for practices - working at a neighbourhood level - to implement their short-term needs and develop their medium - long term business planning processes.
- Develop proposals for integration and co-location of Primary Care services within the Neighbourhood where possible, including secondary care outreach, community services and third sector providers working in close proximity.
- As part of the Sheffield SEP, agree and progress a strategy to accelerate and promote Agile Working across the Sheffield First strategic partnership members, with enabling infrastructure to enhance the delivery or Primary Care, and support collaborative working between health and care partners, including the third sector.
- Firm up delivery models and locations from which city wide and sub-city services are to be provided, to better inform locality plans.

Medium Term Deliverables (6-12 months)

- Complete the Neighbourhood Capacity and Sustainability Mapping process, with agreement on the service model to be delivered locally.
- Consider how access to capital could be provided to deliver both minor (<£250k) and major (>£250k) investment a practice level, and the criteria against which support should be determined.
- Develop a framework with funding options for investment in Neighbourhoods or Localities, which are likely to be in excess of £500k and involve two or more stakeholders working in collaboration, which ensures consistency and agility.
- Develop and agree a forward plan for each Locality, based on the Estates Strategy principles to deliver Primary Care at scale, utilising key local assets within each

neighbourhood, and utilising the skills and capacity of all stakeholders, including the third sector.

- Populate the overall Sheffield City Primary Care investment needs and timeline, to demonstrate critical path investment decisions, and inform providers own planning processes.
- Enhance existing local 'spokes' and coalesce relevant services to release assets, producing efficiencies and service gains across a range of providers.
- Purposefully create voids and drive spacial efficiency in LIFT assets, and create opportunities to re-provide or co-locate Primary Care providers and extended sessional secondary care provision to them ('Extended Primary Care Centres').
- Identify future asset needs for the delivery new models of care, and to meet the future capacity needs given population growth and increasing levels of long-term conditions that will need to be managed in the community.
- Use KPI's to drive the performance of the asset base and utilisation, and target improvements for each locality to encourage collaborative approaches (e.g. same day appointment centres, city wide or locality based services).
- Develop business case for changes within each locality, considering funding routes and service planning implications.

Longer Term Deliverables (12-24 months)

- Use capacity within the Extended Primary Care Centres to enable new service delivery models for care closer to home, including accommodation for multi-speciality providers in a model of Community Health Hubs.
- Practices to have plans in place, with support where appropriate, to ensure they are adapt to better meet the needs of their patients in line with the GP FYFV, and working within the collaborative approach taken in their respective neighbourhood.
- Practices, having knowledge of the locality and neighbourhood plans, must have taken action to address remaining maintenance, compliance and sustainability issues, to ensure they meet the expected quality indicators for Sheffield.
- Ensure the delivery of a pipeline of estate transformation projects, locally led with appropriate support centrally.

Funding Routes

To deliver the aims of the GPFV and the estate that is required to underpin such a shift in how and where care is delivered, to meet the rising challenges and to deliver a high quality, sustainable Primary Care service for Sheffield, it is recognised that significant investment will be

required. The South Yorkshire & Bassetlaw Sustainability & Transformation Plan has identified that capital investment of some £200m is required to help deliver the five place based plans - considerably lower than bids in many comparable areas - but it is still highly unlikely that all of the capital requirements can be met from the public purse - we therefore need to consider alternative routes of funding. Some options are considered below.

Primary Care Transformation Fund

The Primary Care Transformation (formerly Infrastructure) Fund is a four-year investment programme to help general practice make improvements, including in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS Five Year Forward View. It is particularly relevant and ring-fenced for Primary Care development.

The PCTF will support new ways of working that are needed to deliver a wider range of services and a new deal for Primary Care. Nationally, the majority of bids have focused on helping GP practices make much needed improvements in access to clinical services by extending existing GP premises, or developing replacements for life-expired properties.

From within the Primary Care Transformation Fund, an Estates and Technology Transformation Fund (ETTF) has been created to enable providers to make improvements and better use of their facilities and infrastructure .

NHS Sheffield has a three ETTF bids currently being developed currently, and the PCTF has been used to support the development costs of a further new build practice It is expected that further rounds of PCTF bidding will include proposals to redevelop premises that do not meet the standards expected or are required to further support the new out-of-hospital care pathways. Further refinement of the Primary Care 6-facet information may also be required to support the bidding process. It is vital that the revenue consequences of any PCTF bids are containable within allocations.

Social Investment Fund

Social investment is a relatively new type of investment activity that involves an expectation of both a social outcome and a financial return, aimed at organisations that deliver significant social or community benefits. The investment would usually be below market rate, and provides a highly affordable option compared to commercial borrowing for such investments.

Social investment is (in most cases) the use of repayable finance to achieve social impact. Community based organisations can use it for capital investment, revenue funding development, capacity building, or other ways of improving their sustainability. The most likely form of organisation to successfully attract Social Investment directed at Primary Care provision would be a Community Interest Company (CIC).

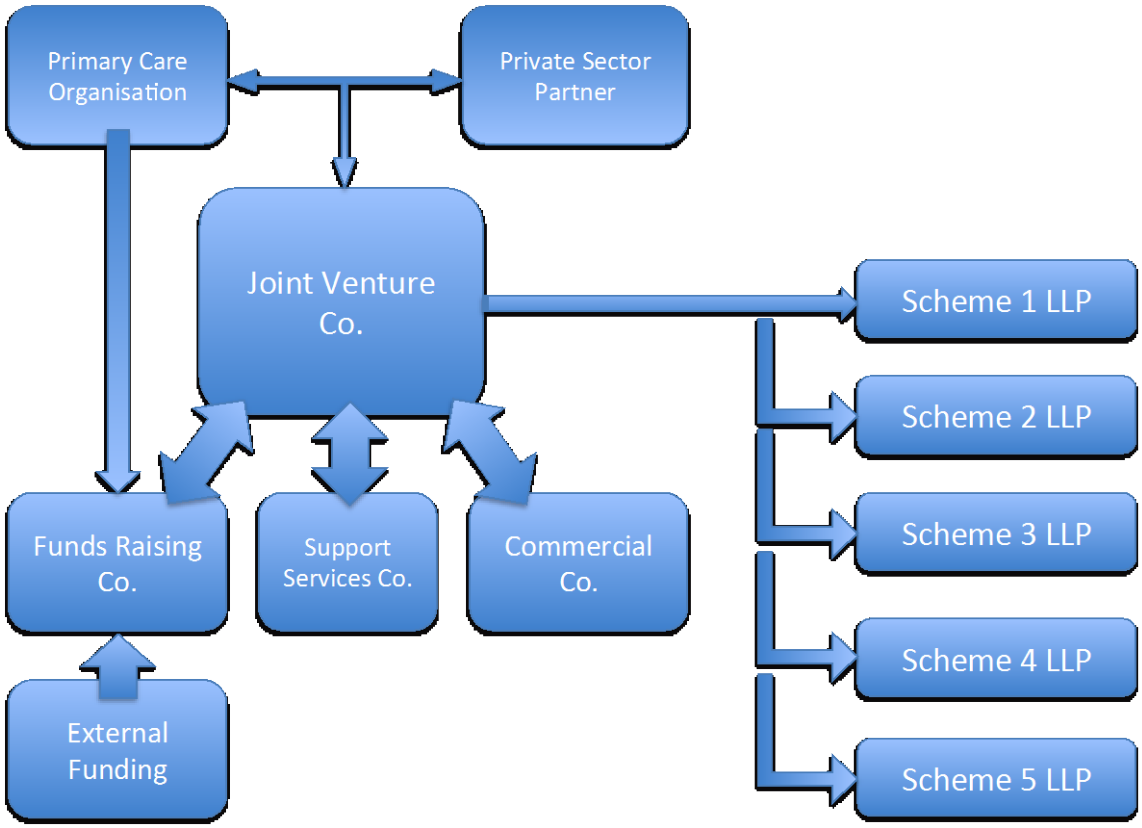
There are now a number of large Social Investment Funds (SIF) who are actively looking to invest in community based healthcare, which is seen as having strong SIF credentials and good covenant - i.e. they offer long term stability with effectively government backed income, provided the governance standards and regulatory requirements are met.

Joint Venture Partnerships

A Joint Venture Partnership is where two or more organisations bring together their skills, resources, expertise, experience, reputation, market share or business objectives to achieve a greater outcome that could be achieved individually. A new legal entity (LLP) is formed between the organisations, fort he overall purpose of delivering a set of broad objectives over an extended period of time - often 15 to 20 years.

The JVP does not deliver schemes its self – it is the overarching framework that enables the delivery of schemes (with funding) in a responsive and timely manner, using innovative methods and levering optimum outcomes. In addition to delivering capital solutions, the JVP can bring added value in delivering support services to meet the operational needs - such as Facilities Management services, IT or Shared Business support - at a scale, efficiency and competency level that may not be achieved in isolation.

A typical arrangement for a JVP is shown in the diagram below for illustrative purposes;



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Typical benefits to the Primary Care organisation and providers would include;

- Access to greater resources and funding routes.
- Surpluses can be recycled - dividend form the JV is split, usually 50/50.
- Dividends / additional profit can be drawn down as income or reinvested.
- Increased and more flexible technical and financial capacity to develop business cases.
- Reduced capital costs (and therefore costs of capital) through earlier delivery of schemes.
- Access to new markets (funds, construction, supply chains).
- Innovative solutions to financial and operational challenges.
- Opportunity to create an off balance sheet accounting position.
- No fixed supply chains.
- Non-exclusive contractual arrangements give greater flexibility.
- Shared risks and rewards, with scope for further risk transfer.
- Shared objectives between partners.
- Ability to develop and deliver new facilities more quickly.
- Lower cost of capital through alternative routes.

Sale & Lease Back Arrangements

Where a practice seeks to release capital, to make further investments for example, there are a number of providers who specialise in 'Sale & Lease Back' arrangements to Primary Care providers. The practice would receive the market value for the property (not the business) and enter into a long-term lease, typically in excess of 20 years. This route does not usually transfer the risks and costs associated with a property and it's professional upkeep to the investing party, as repairing obligations and premises management remain with the tenant in most cases. Rent is then paid by the practice, to the landlord investor, having been assessed by the District Valuer. Rents are typically reviewed every 3 years.

Sale & Lease Back can provide an exit route for retiring partners with equity in practice premises. Additional capital can be secured for the redevelopment, extension or refurbishment of premises. Such investors may also offer to fund new build premises, again linked to long-term leases and may include capital off-set for any residual value of the premises to be vacated. Such arrangements should be approached very carefully, and with full professional advice. Any new lease arrangement would need the approval of NHS Sheffield, in terms of reimbursable rent.

GOVERNANCE & OVERSIGHT

It is essential that the Sheffield Primary Care Estates strategy becomes embedded in the processes to oversee the transformation of Primary Care, as part of the place-based approach set out in the South Yorkshire & Bassetlaw STP. Estates planning must not be carried out in isolation, it is very much at the heart of transformation processes but must be service and demand led. We will put in place appropriate governance arrangements linked to our stakeholder groups, to oversee the implementation of the Primary Care Estates Strategy.

CONCLUSION

Sheffield has set out an ambitious and forward thinking strategy to transform care, linking the high level aims of the South Yorkshire & Bassetlaw STP plans, through into a vision for putting Primary Care at the very heart of patient care and well-being in our city. The challenges we face in Sheffield are significant, but we have many strengths upon which to build. A growing population, an increase in long-term conditions and an aging demographic combined with the delivery of out-of-hospital care will drive demand for community based services over the coming years.

The GP Five Year Forward View sets a clear trajectory and commitment to ensure Primary Care has the resources, infrastructure and partnerships in place to build on the foundations we already have, and supports providers to work collaboratively to achieve mutual aims. The estate is a key enabler of new models of care, and we have shown the need for us to invest in and develop our premises to ensure our Primary Care teams have the right facilities, in the right place to truly meet the needs of patients and their families.

Our current estate has evolved over many years, and we have identified significant challenges to be addressed, both in the short term, and as part of our longer term planning. Our GP surgeries will remain at the heart of our community based care, but we must deliver Primary Care at scale, working with other health and care providers and our third sector partners. We will need to use many of existing facilities in new ways, and we will need new facilities in some locations to provide the full range of services and capacity required.

The involvement and engagement of Primary Care providers and stakeholders in ensuring our locality and neighbourhood plans meet the needs of our population is vital. We have set out a clear framework and established principles to build these detailed plans, and NHS Sheffield is committed to supporting providers in the development and delivery of their plans for each neighbourhood. Providers in all sectors must step forward and work in partnership within their locality and take responsibility for taking plans forward with appropriate support. Whilst investment will be required, we must look to a number of funding routes, not just the public purse.

Planning the estate we need for the delivery of Primary Care is a huge responsibility - the investment in our buildings will set the shape of care for the people we serve now, and for the next generation.