Primary Care Estates Strategy Update

E

Primary Care Commissioning Committee meeting

18 April 2019

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Purpose of Paper

To provide members with an update on the implementation of the Primary Care Estates Strategy and associated estates projects and workstreams aligned to the strategy.

Key Issues

- Considerable work has been undertaken and progress made in achieving the Phase 1 deliverables, although progress has been slower than originally anticipated.
- A Phase 1 completion report is due in May 2019. Progress has also been made towards Phase 2 deliverables.
- A 'sense-check' will be undertaken to ensure alignment and currency against emerging key service strategies. (e.g. Urgent Care, Primary Care Networks)
- Clarity is required on what future services are to be delivered in the primary care setting, and at what scale.
- Models of capital funding / partner equity / premises ownership are key issues going forwards.

Is your report for Approval / Consideration / Noting

Consideration

Recommendations / Action Required by the Primary Care Commissioning Committee

The Primary Care Commissioning Committee is asked to:

- Consider the progress towards the Primary Care Estates Strategy implementation, the proposed forward plan, and any specific issues highlighted.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?
There are no capital or revenue requirements arising from this update
Have you carried out an Equality Impact Assessment and is it attached?
No – EIAs are included in individual change proposals, however the principles of ensuring no groups are disadvantaged are integral to the strategy, which seeks to improve equality and accessibility for all and reduce differences in primary care across the city.
Have you involved patients, carers and the public in the preparation of the report?
No – Update only. The Primary Care Estates Strategy has previously been approved by the PCCC in public session.

NHS
Sheffield
Clinical Commissioning Group

Primary Care Commissioning Committee
Public Meeting

Primary Care Estates Strategy Update

18 April 2019

1. Introduction

The purpose of this paper is to provide members with an update on the implementation of the Primary Care Estates Strategy, and associated estates projects and workstreams aligned to that strategy. It is planned to prepare a Phase 1 completion report during May 2019, ahead of any decision to continue to Phase 2 implementation. This will include gap analysis of tasks due to be completed, those outstanding and our plans to close any such gaps.

2. Context

The Primary Care Estates Strategy is the framework that helps ensure the right property assets are in place to support the delivery of Primary Care across Sheffield. There are 108 existing GP premises currently within scope, supporting a total registered list size of some 758,000 people. The Estates Strategy was prepared in response to the GP Forward View and NHS Sheffield commissioning intentions. The agreed principles for improvement are included at Appendix A. Work on implementing the agreed strategy commenced in March 2018, and is based upon a 3 phase approach. The deliverables for Phases 1 & 2 are included at Appendix B.

Simultaneously, work has also been underway to deliver a number of significant change projects, aligned to the Estates Strategy. This update paper focuses on the work elements to deliver Phase 1, which is now nearing completion and also recognises the changes within the health care system as we commence planning for Phase 2 – a review of strategic objectives will be undertaken to ensure continued alignment to emerging developments such as those set out in the NHS Long Term Plan and the introduction of Primary Care Networks, amongst other drivers of change.

Oversight and monitoring of the Primary Care Estates Strategy is now within the remit of the Capital & Estates Group, chaired by the Director of Delivery – Care Out of Hospital. The group meets on a bi-monthly basis and will provide a valuable forum and channel to ensure progress and alignment of estates matters with other key workstreams within the CCG.

3. Key Issues / Discussion

3.1 Overview

We have completed the majority of elements required for the Phase 1 deliverables, and also a number of those in Phase 2. The original intent was to have concluded Phase 2 objectives by the end of March 2019. Determination of service models, at city, locality and neighbourhood level is key to the development of cohesive estate plans to meet

those needs. These remain the most significant element still to be agreed and will be a priority going forwards. Whilst progress has been slower than envisaged, the quality and volume of data upon which planning is based has been higher than expected, and additional tasks have also been incorporated. In addition, some elements have been progressed and become live estates projects, not just as plans or frameworks. This has enabled greater understanding of the issues and complexities to be faced but also adds to our ability to roll out change processes with increased agility.

Inter-organisational planning has not been fruitful to date and has impacted upon progress of themes such as co-location and agile working. To progress with increased pace and certainty, we need a clear and shared vision of the services we are developing our premises for – not just now, but for the future. Progress on each of the key workstreams is expanded below, and the Phase 1 completion report will include further anaylsis against each of the objectives included at Appendix B.

3.2 Estates Performance Developments

3.2.1 Statutory Compliance

Work continues to achieve higher levels of assurance from practices based upon the requests for information made in September 18. There will now be a renewed effort through Locality Managers to ensure a complete set of returns – the results of which we expect to be available by mid- May. Where returns have been made by practices, improved compliance can now be evidenced across the 11 key areas. Advice and support has been provided to practices requesting help in addressing gaps.

3.2.2 Estates Dashboard

An estates dashboard has been developed to help practices and commissioners understand the performance, challenges and opportunities presented by GP premises – this work is understood to be a national first, linking activity, quality, costs and assets in primary care. An overview of the dashboard contents is included at Appendix C. The Quality and Asset performance elements are well advanced and we are currently seeking ways to populate the database with existing activity data and demographic information, including links to the SHAPE (Strategic Health Asset Planning & Evaluation) tool.

The data within the dashboard is being used to populate a premises based planning intent for each building, to inform neighbourhood / network planning and investment requirements. Each property is designated one of 6 statements (Satisfactory, Improve, Re-design, Re-provide, Co-locate or Transformation) and given a short, medium or longer-term timeframe to inform the locality / neighbourhood plan. It is vital these proposals are joined to the service delivery plans in each area, and do not just exist as a standalone property plan.

We have also had discussions with NHSI who are keen to work with us in developing the dashboard for Primary Care, alongside the NHS Model Hospital work that is driving performance and efficiency improvements in secondary care. It is intended that once a neighbourhood pilot has been completed, the tool is offered

to GP practices on a voluntary and confidential basis, so they can compare information they provide, against anonymised peer practices.

3.2.3 6- Facet Surveys

The analysis of the earlier 6 -facet surveys has been further enhanced and is being used to inform a number of workstreams such as performance, investment, compliance and quality. We have now secured support to offer those 15 premises that did not receive a survey visit in 2017 to be completed. This is expected to be undertaken during April, and the results will enable the final analysis to be completed. Investment decisions such as Case for Change, NHSE business cases and assessment of capital bids all rely upon having 6-facet data and supporting metrics.

3.2.4 Overall Estates Performance

By combining data gathered from a number of sources (including 6-facet surveys) we have been able to undertake analysis to show relative pressures and opportunities on GP premises at city, locality, neighbourhood and practice level. An example of these metrics (linked to the dashboard work) is included at Appendix D. The full processing of this data will take place once the outstanding 6-facet survey (and other data) is uploaded and verified. This data is key to capacity planning and investment decisions across Sheffield.

3.3 LIFT & NHS Property Services Ltd (NHSPS) Assets

3.3.1 LIFT & NHSPS Utilisation

We are actively working with both CHP and Community 1st Sheffield to improve the performance and utilisation of our 7 LIFT and 3 NHSPS assets, where low utilisation and high void rates remain unacceptable. We have had significant success in securing CHP customer capital to enable relocation from 3 poor / below average quality GP premises into the Jordanthorpe and Darnall Primary Care Centres. Further planning to increase occupancy for Fairlawns and Beighton Health Centres is underway, although progress has been slower than anticipated. These are now receiving significant focus.

We have now achieved a working model for ‘gain/pain share’ between the CCG and GP Practices that is removing the barriers to occupancy and change within our LIFT buildings. In short, practices can operate from exemplar fully serviced premises, offering a wider range of services but with increased non-reimbursable costs whilst the CCG sees significantly increased return on investment but cash releasing savings are limited to those released from other reimbursable property costs. We should now formalise this approach to enable other services to take up space in LIFT buildings on an equitable basis and maximise the benefit of our patients and communities.

Our LIFT buildings represent perhaps the most significant opportunity and resource to help deliver upon some of the Out of Hospital, Elective, Urgent Care and Primary

Care Network projects and to ensure we can increase access to wrap-around services within the community. In making alterations to the LIFT buildings above, we have worked hard to protect facilities that may best serve these projects, until their future purpose has been determined.

A programme to review each Sheffield LIFT asset in line with the strategy principles - positively creating void where utilisation is lower than expected, enabling relocation and then divesting of poor or under-performing assets - is underway. As part of the Phase 1 completion report, we will include a range of options for each LIFT building, aimed at making significant improvements in both utilisation and void rates. We will require a clear decision from NHS Sheffield on the level of support to wrap-around and third-sector services, to inform future space planning. The LIFT utilisation work is linked to the bookable space and void cost review workstream below.

3.3.2 Bookable & Void Cost review

A report has been now prepared for SMT detailing the costs associated with bookable and void space within LIFT and NHSPS assets, linked to recommendations for improvement. The work undertaken with regards to Jordanthorpe and Darnall LIFT buildings is expected to enable a c£500k cash releasing saving in 2019/20. Increasing utilisation of LIFT buildings still further is expected to generate significant efficiency savings to the system, but cash releasing savings to the Primary Care budget are expected to be limited to reimbursable costs from vacated premises. We are also now able to explore Direct Payments, where the CCG can pay CHP directly for LIFT reimbursable costs – this may have advantages to all parties.

3.3.3 Dynamic Capacity Management (DCM)

The introduction of Active Centre Management ("Fareham Model") to our LIFT buildings was a key enabler to improving their utilisation and to increase patient-facing sessions, as outlined in the Estates Strategy. Since 2017, CHP have been refining this model and it is now being piloted, known as Dynamic Capacity Management. We are pleased to confirm that our request for Sheffield to now pilot and roll-out DCM has been approved, subject to SMT receiving a briefing and supporting its introduction. Whilst this development has been long-awaited, it represents a very significant and timely opportunity as we develop our plans to support the delivery of a number of key service strategies, as outlined elsewhere in this update.

3.4 Capital Developments

3.4.1 Estates & Technology Transformation Fund (ETTF) Bids

We continue to work with stakeholders to refine and confirm the submission of ETTF PIDS to NHS England for 2 Transformational GP Hubs (City and SAPA), incorporating a total of 10 current GP premises. A short series of 'task & finish' workshops are currently taking place with GP stakeholders to refine and update earlier work, and to ensure ownership and accountability arrangements are in place.

Whilst these are currently under the ETTF programme, we need to ensure that through the business case process we focus on delivering the best solution, not just an ETTF compliant solution. As identified below, we should consider a plurality of delivery solutions to best fit stakeholder and affordability requirements. We are expecting details of either an extension or successor to the ETTF programme, given the prominence of Primary Care development in the NHS Long Term plan.

3.4.2 Business as Usual (BAU) Capital Allocations

We have now proactively invited practices to submit initial capital bids for inclusion in the 2019/20 BAU capital programme. At this stage, we do not know the level of funding available, and due in part to slippage on previous years schemes, there are already some pre-commitments against the programme. However, 22 initial bids have been assessed against a range of criteria linked to delivering on the aims of the Primary Care Estates Strategy – the first year that this has been undertaken.

We are currently awaiting details of funding levels for 2019/20 before qualifying practices are asked to complete PID templates and due diligence. We are working hard to ensure slippage on schemes is avoided this year, and we will have additional schemes in a state of readiness should slippage occur in other areas or further capital funding becomes available. Whilst slippage in several schemes has occurred in 2018/19, this has been necessary to ensure quality and compliance standards have been applied where previously external professional advice has been lacking.

3.5 Transitional / Change workstream

A number of GP practices have been supported to bring forward change schemes, including relocation, development of new premises, branch closures and a range of property advice to practices undergoing change programmes. One key issue that emerges frequently is the ability of partners to either join or leave a practice, due to property issues such as ‘sale and lease back’ terms and early release fees on commercial mortgages – this is a significant concern to both Partners and to the sustainability of practices in their current form. It is also a potential barrier to further development of premises, with unreasonable terms and processes being applied

Whilst changes to the NHS Premises Directions are widely anticipated, new models of property ownership for GP premises are needed and the Joint Venture (JV) model set out in the Primary Care Estates Strategy is now being actively discussed with stakeholders to explore its potential. These discussions are at an early stage but could be very significant in delivered both larger scale developments and individual practice transfers of ownership. It is possible this model could help to address differences in property values when decommissioning GP premises to other uses and encourage stakeholder investment in areas with lower property values. Similarly, if new national models of property ownership for primary care are approved, these will of course be explored. (e.g. Regional Health Infrastructure Companies – RHIC).

If we rely solely upon ETTF / BAU / Practice funded capital sources, it is unlikely we will be able to meet the expectations and requirements to develop our GP premises quickly enough, and at scale. The objective remains to put in place a range of

sustainable funding models, including non-lease plus arrangements thought our LIFT company, working with NHSPS, Joint Venture, Public Private Partnership Developments (3PD) and other funding routes.

3.6 Strategic Context

As the end of Phase 1 nears, we are mindful that there have been a number of key developments within the health economy that have both delayed progress to date but are also an important check point for the future shape of estates delivery. We (and GP stakeholders) need to be clear and aligned on what services are to be delivered within the Primary Care setting, at what scale, where they can be delivered from and what facilities are needed to deliver them.

Without incurring cost or delay, we will sense-check the Primary Care Estates Strategy to ensure the anticipated outcomes from programmes such as Urgent Care, Elective Care, Out of Hospital Care and Primary Care Networks are identified and incorporated. The Sheffield Strategic Estates Group (SSEG) has also been requested to produce a refreshed Strategic Estates Plan (SEP) that draws together the key elements, opportunities and constraints of all health estate across Sheffield to better inform planning by the Directors of Strategy on estates matters, and in turn help ensure better estates planning to support the delivery of strategy.

Alignment of property plans with other key groups across the Sheffield City Region has not proved possible, despite the One Public Estate / STP programmes. There has been little progress in finding synergy between the needs of such a diverse range of stakeholders, however we remain optimistic that a renewed approach may deliver some benefits.

We are also in discussion with Sheffield City council regarding population growth and planning assumptions to help ensure our capacity planning projections remain accurate. We have recently ensured that suitable primary care estates needs are included in a major growth bid for the city and will continue to do so.

3.7 Forward Plan and Timescales.

Work will continue on all workstreams towards the Phase 1 completion report, but key tasks and due dates are included below for information.

Task	**Due Date**
CHP DCM Pilot & Direct Payments review	25/4/19
Completion of additional 6-facet surveys	30/4/19
Outstanding statutory compliance follow-ups	30/4/19
LIFT & NHSPS Premises Plan	30/4/19
SSEG Overview report	30/4//19
Stakeholder discussions on future funding models	w/c 6/5/19
Estates Dashboard processing and validation	3/5/19
Phase 1 completion report to Capital & Estates Group	24/5/19
Phase 2 review & sense check	27/5 – 29/5/19
Phase 2 workplan submission	30/5/19
Phase 2 Target completion	23/8/19

4. Recommendations:

The Primary Care Commissioning Committee is asked to:

- Consider the progress towards the Primary Care Estates Strategy implementation, the proposed forward plan, and any specific issues highlighted.

Paper prepared by: Mike Speakman, Willowbeck Ltd, Management & Technical Consultants
On behalf of: Nicki Doherty, Director of Delivery, Care Outside of Hospital

Date: 11 April 2019

Appendix A – Principles for Improvement

- 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, co-located 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

Appendix B – Implementation Deliverables

Phase 1

- Agree services to be delivered on city and sub-citywide 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.

Phase 2

- 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.

Activity

- Number of GP appointments
- Number of Nurse Appointments
- Number of Telephone Consultations
- Number of Home Visits
- List Size (by Surgery / total practice)

Costs

- Premises Costs (reimbursable)
- Business rates
- Energy & Utiliities (individual supplies – total)
- Maintenance

Base Data – already held
Base Data – input required
Next steps data

Quality

- 6-Facet rating (Condition, Functional Suitability, Space Utilisation, Quality, Statutory H,S & Fire Compliance, Environmental Performance)
- Age of premises
- Backlog Costs (High, Significant, Moderate, Low) – Total
- Statutory Compliance (10 items)
- Purpose built or converted

Assets

- Number of Consulting Rooms
- Number of Treatment Rooms
- Gross Internal Area (M^2)
- Patient facing area / non patient facing area (M^2)
- Asset value
- Equity / loan value

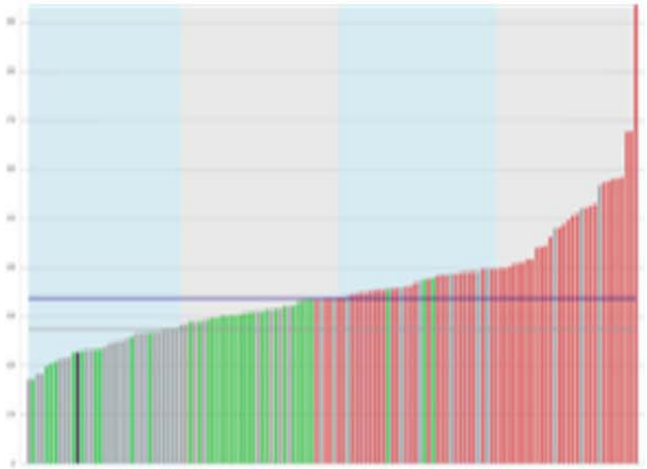
Suggested Dashboard Indicators

CORE:

- M^2 per 100 registered patients
- Consulting Rooms per 100 registered patients
- Treatment Rooms per 100 registered patients
- Cons / Treat Rooms per M^2 Gross
- Premises cost per M^2
- Backlog Cost per M^2
- Relative 6 Facet performance
- Relative statutory performance
- Relative backlog costs
- Relative age

Filterable by group / facet (E.g. – converted or purpose built properties)

Presented as a variation chart



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MANAGEMENT & TECHNICAL CONSULTANTS

Appendix D – Estates Performance Examples by Locality

Locality	List Size	Average Building Age (Yr)	Total Gross Internal Area (M2)	Total Consulting / Treatment / Exam Rooms	M2 per 100 patients	Overall Clinical Rooms per 100 Patients	Clinical Rooms /100 m2	Maintenance Backlog £ Per M2
West	233493	51.4	12838	144	5.5	0.062	1.122	50.49
Central	201162	43.8	25900	185	12.9	0.092	0.714	18.47
North	173773	48.7	18873	182	10.9	0.105	0.964	35.63
Hallam & South	149672	65.5	12201	149	8.2	0.100	1.221	44.19
City - All	**758100**	**51.5**	**69812**	**660**	**9.2**	**0.087**	**0.945**	**33.49**