

## North East Essex Primary Care Trust **Estates Strategy** **2008-11**

### **Executive Summary**

An estates strategy does not have any status as an objective in its own right. It is an implementation strategy, setting out ways to identify and close gaps in the infrastructure which may affect the capacity and/or capability of the organisation to deliver the objectives set out in the Five Year Strategic Plan. For this reason, the assessment tools and contextual principles set out within the strategy are as important as the various actions described within it, most of which will invariably be achieved and superseded by new priorities over the duration of the strategy.

The management of existing estate to its full potential may mean divesting the PCT of uneconomic assets or liabilities which no longer fulfil the desired role. Opportunities may be sought, or be presented, for new developments or acquisitions. There is also a need to consider the separation of PCT commissioning and provider functions and what this will mean in terms of retained estate. The strategy seeks to establish the key principles underpinning these decisions and outline some of the tools which provide the decision-making framework for the next tranche of actions..

A full survey of all PCT properties is being undertaken early in 2008 to enable a review of the PCT's current estate capacity and suitability. A survey of primary care estate is also being undertaken to contribute to the commissioning prioritisation process. This will be combined with a public health needs assessment to ensure that new investments are targeted as closely as possible to patients with the greatest needs, including the development of new services and premises where indicated.. The Estates Strategy will be reviewed throughout 2008 to incorporate the next set of actions required on the basis of the estates survey and needs assessment.

Seeking out new developments rather than responding to provider need is a key departure from some processes in the past, where funding regimes (such as those in primary care) meant that PCOs were often passive participants.

It is a significant factor in the strategy that all PCT investment decisions are commissioner, rather than provider, led. Any investment proposals presented to the PCT by a provider of services must be balanced against all other commissioning priorities as well as judged on its own merits in terms of how well it may serve the patients who may use it. New developments will also be considered where there is currently no provision, for new provider procurement.

As a LIFT partner, the PCT aims to work in partnership with other local stakeholders to maximise the potential for joint working and pre-empt growth and demographic change. A number of schemes are already underway within the LIFT programme, and these will continue to be developed. Schemes which have not yet achieved Stage 1 LIFT status will be subject to re-assessment along with other potential developments.

All LIFT schemes must be approved by the Strategic Partnering Board (SPB) and signed off within its annual Strategic Service Development Plan (SSDP). The SSDP will include the developments which have been identified as priorities by the PCT in its Estate Strategy as well as any other partnership developments which fall within the remit of the wider LIFT programme (hence the need for two separate documents).

The document is ordered into three main sections:

- Where are we now – current context, service strategy and enabling mechanisms
- Where do we want to be – aims and objectives, how managing estate will contribute to achieving them
- How will we get there – required actions and plans.

All the actions for immediate implementation in 2008 are set out in the final section.

This version of the Strategy was ratified by NEE PCT Board on 25<sup>th</sup> March 2008.

**Tonia Parsons**  
**LIFT Project Director**

# NE Essex PCT Estates Strategy 2008-11

## 1. Introduction

NE Essex PCT's vision is to:

*Improve the health and well being of the local population and to make sure that the services we buy are: high quality and effective, as close to home as possible, available when needed and are good value for money.*

This overarching philosophy underpins all commissioning decisions and implementation, including procurement of estates and other assets.

NE Essex Five Year Strategy sets out the actions required for achieving the PCT's health improvement objectives, strongly focussing on reducing inequalities, developing primary care commissioning competency and improving access to primary care for local people. It also includes the East of England wide pledges targeted at specific service improvements and the national objectives such as those in the Lord Darzi Next Stages Review published in October 2007 to help achieve a vision for the NHS which is fair, personalised, effective and safe.

These aims will be achieved in NE Essex through a number of implementation documents, including this Estates Strategy. This document should be interpreted in the context of the main strategy and in conjunction with other complementary implementation plans. Where relevant, there is also specific reference to national directions or guidance which may support or influence the proposals.

This document is prepared in recognition of the transitional status of PCTs from commissioning and providing organisations into two separate entities. From April 2008 the provider arm of the PCT will become an "arms length" organisation. The process for agreeing the division of PCT owned and leased premises is drafted within the strategy, with a view to the final decision being made as part of the overall process of agreeing organisational and financial separation. The timing of the separation will in part be determined by the pace of options such as community foundation trusts and other provider structures.

NEEPCT is a third wave LIFT (Local Improvement Finance Trust) development partner. The NE Essex LIFTCo, Realise Health Ltd (RHL), has already delivered two major schemes to the area - a comprehensive primary care centre sited next to the Essex Rivers District General Hospital (DGH) in Colchester, and a community hospital in Harwich providing community beds for the elderly, as well as dental, maternity and primary care facilities to the wider population. Four further schemes are currently in development, which will provide new primary care facilities to 7 primary care practices.

The PCT has set up, with Board approval, the Capital and Estates Sub Group. They met monthly and their remit to monitor capital expenditure and developments within the organisation and any estates issues. Their terms of reference are attached as appendix xx. The group has a direct reporting line into the Finance and Performance Committee and then to Board. It envisages that once the estates

strategy has been approved and there is an operational plan to support the strategy it is this group which will monitor its achievement.

The Strategic Partnering Board (SPB) oversees delivery of the LIFT scheme, with a key role to encourage wider collaboration with other agencies and to help facilitate co-location of services. LIFT can be a way of engendering improved partnership arrangements across health and social care organisations, and this strategy is also presented in that context. Full details of the national LIFT programme are available on the DH Community Health Partnership website [www.communityhealthpartnerships.co.uk](http://www.communityhealthpartnerships.co.uk).

The PCT LIFT SSDP will include the priority actions and developments identified by the PCT in its Estate Strategy as well as any other partnership developments which fall within the remit of the LIFT programme.

The document is ordered into three key sections:

- Where are we now – current context, service strategy and enabling Mechanisms
- Where do we want to be – aims and objectives, how managing estate will contribute to achieving them
- How will we get there – required actions and plans.

## **2. Where are We Now?**

### **2.1. NE Essex PCT Profile**

NEEPCT has a population of 311,000 across the Colchester & Tendring district and employs more than 1,460 staff. The population consists of patients registered with GP practices commissioned by NEE PCT.

Part of the PCT provided services are through the community hospitals in Clacton and Harwich. In addition to a range of community nursing and other allied paramedic provision, the PCT is also a provider of learning disability services.

The PCT will achieve financial balance in 2007/8 and has an annual budget of £442 million.

Population growth is predicted at 16% and 18% respectively for Colchester and Tendring over the next 10 years. To accommodate this there are a number of regeneration programmes and housing developments currently in progress and others planned for NE Essex. (view document 'A Sustainable Community Strategy for Tendring' and appendices at:

[www.northeastessexpct.nhs.uk/content.asp?page\\_id=345](http://www.northeastessexpct.nhs.uk/content.asp?page_id=345)

The population is served by 44 GP practices, 23 in the Colchester area, and 21 in the Tendring area made up of 22 GMS practices, 4 PCTMS practice and 18 PMS practices. All NEE PCT practice lists are open and patient allocations are few.

The main secondary care provider is Essex Rivers NHS Healthcare Trust (ERHT). The Trust has applied to become a Foundation Trust from October 2008.

Statutory mental health services are provided by North East Partnership Foundation Trust (NEPFT). To ensure system wide planning, mental health and learning disability services are commissioned on behalf of NEE PCT by West Essex PCT and Essex County Council respectively.

### **2.2. Strategic Context and Service Strategy**

An estates strategy does not have any status as an objective in its own right. It is an implementation process for the commissioner or provider, to help close gaps which are identified in the infrastructure which may reduce the capacity and/or capability of providers to deliver the required service specification. There will also be a need to divest the organisation of uneconomic assets or liabilities which no longer fulfil the desired role. This strategy seeks to establish the key principles underpinning these investment decisions.

The commissioning PCT aims to introduce choice and contestability to service delivery, putting patient need and convenience first. In primary care, this will be used as an inducement to maximise efficiency and responsiveness of the primary care provision as a whole, and to address the issues outlined in this strategy.

The service aims common to the commission of all services in NEE are to:

- To improve continuity of care
- To address the specific health needs of the population
- To extend the range of services for patients
- To improve access and choice
- To improve capacity
- To reduce health inequalities

These key influencing factors are the foundation for most national guidance and policies, including the extension of primary care surgery hours and the development of a new health centre following the Darzi review. In NEE, they underpin the process of determining estates developments for the future. Priorities will be derived through the use of a balanced scorecard, with numeric assessment of the key factors in order to achieve a ranked list of priority developments.

Through the management of estate, the following can be achieved to help deliver the above aims:

- Enable and encourage innovative ways of delivering services.
- Provide modern facilities where teams of professionals can deliver services to the community, directly aimed at meeting local needs and reducing inequalities.
- Create opportunities for developing partnerships with other organisations to enhance the range of services on offer.
- Enable the transfer of services from centralised hospital settings into the community, closer to where patients live.
- Maintain estate to the highest possible level, improving the service environment through a proactive year on year programme of improvement and maintenance.

The estates strategy will be delivered through a mixture of actions to address areas of greatest shortfall and identified gaps.

In preparation for publishing the estate strategy, a survey of PCT owned buildings and GP primary care premises was undertaken between January and March 2008 to map existing facilities and assess their general condition (the survey for PCT owned premises included a more detailed survey in this respect, on the basis that the PCT is responsible for upkeep and repairs). The results of the survey will form one aspect of the balanced scorecard to be used to determine primary care development priorities. The assessment tool includes public health needs assessment data, suitability of the existing facilities and strategic fit of any proposed development, all expressed (where possible) in numeric or other comparative form. This is used to determine which developments are included into the PCT's capital programme, and subsequently the LIFT scheme (where appropriate). The assessment tool for existing premises is shown in Appendix (mapping facility for new/greenfield developments currently in procurement).

Whilst recognising the importance to patients of all primary care facilities, this strategy does not include those premises for which the PCT currently has no direct financial responsibility for providing or improving. The provision of estate and facilities through other commissioned providers of services, including dentists and pharmacists, will continue to be influenced and performance managed within the contracts through which they work. It is acknowledged, however, that some contractual frameworks are not yet sufficiently mature to ensure that premises are

always of the optimum standard. It is not yet possible to provide an analysis of all primary care premises.

## 2.3 Funding

Funding for all estates developments by the PCT must be found from the single allocation and proposals will be judged against all other investments within the annual Local Development Plan (LDP). In this way all priorities will be determined by patient need balanced against other priorities, rather than by the inclination of providers (which was often the driving force in previous funding regimes).

The LDP priorities are aimed at achieving the strategic objectives of the PCT. Some of these may have estates implications, particularly in the following areas:

- Urgent care strategy
- Impact of patient choice and more services provided in community settings.
- Primary care strategy – growth, where services are to be commissioned, increase/reduction/consolidation of practices
- Improving primary care access, in relation to additional facilities required
- Darzi recommendations, including proposals for development of polyclinics or modification of existing facilities to meet the requirement
- Relevant elements of Local Strategic Partnership or Local Area Agreements
- Options on community sites
- Environmental strategy and travel policies

The development of new funding regimes in the NHS is also reflected in the scope of business investments coming through the PCT for estate developments. For example, implementation of the national tariff for acute services means that most secondary care investments are sourced and managed directly by hospital trusts, and there is no longer an unlimited source of central funding for GP premises.

As part of the business planning process for the LDP, all options will be explored to identify the most appropriate course of action to meet the identified need. This may include expansion, refurbishment or replacement or new premises. Equally where facilities fall short of being able to deliver the required level of service because of their location or condition, the proposal may include divestment where this enables resources to be recycled in a more productive setting. Some developments will be in greenfield sites, where no or few facilities current exist.

Developments may include sharing or co-location of services, and as a LIFT partner, these opportunities can be explored through the SPB. The commissioning arm of the PCT may also wish to have available some facilities to enable some services to be provided on rotating short term basis as part of its management and development of the provider market (explored in section 3 below).

The range of services provided will vary according to local need, location and other factors such as workforce issues and transport links. The development of any new facility will need to demonstrate that all relevant factors are taken into account as part of the LDP business planning process, with robust implementation plans supporting any proposed investment in new services. For example, the shift of services from

one location to another must be supported with evidence that resources for any duplication or double running costs have been identified and that moving the workforce to a new location will not have a detrimental effect on residual services.

## 2.4 LIFT Developments

A LIFT scheme is a partnership between the NHS and private investors (40/60 share respectively) through the establishment of a limited company. The partnership spans 20 years to enable long term benefits to be gained from the partnership arrangement, both in terms of the transfer of skills and knowledge, and maintenance of the premises. The 20 year NEE PCT LIFT agreement began in 2004.

Under the LIFT scheme the NEE LIFTCo, RHL, builds and owns premises for the duration of the lease agreement (typically 25 years). The leasing arrangements are contained within a Lease Plus Agreement (LPA), which in addition to normal lease conditions, sets out the lifecycle maintenance obligations of both RHL as landlord and the PCT as tenant (the premises may have other health care tenants who have a lease directly with RHL). It is the long term maintenance of the premise to a high standard by both parties that offers one of the greatest benefits under LIFT schemes. The full 20 year lifecycle costs of fulfilling the landlord's obligations are built into the LPA costs which can sometimes make LIFT premises appear to be more costly than simple lease comparisons, and this will be taken into account when comparing such costs.

Under the LIFT partnering arrangement all capital developments funded by the PCT in excess of £20,000 must be first offered to RHL as a development opportunity (they may choose to decline).

Through the SPB, the LIFT scheme provides the opportunity for long term partnerships with other commissioners and providers, as well as harnessing the estates expertise and innovation provided through the LIFTCo at an early stage of development.

Whilst the LIFT scheme can help improve collaborations across key stakeholders, it is recognised that it is still essentially a procurement route for health care premises and that the driving factor behind all procurement decisions must be that of patient need. All investments by the commissioning PCT will require a robust business case demonstrating how the investment will support these initiatives or other service needs.

There are a number of important lesson learned, both nationally and locally, regarding the way new estates investments are planned and delivered. In recognition of this, the PCT has agreed the following operating principles for management of the LIFT Scheme<sup>1</sup>:

- LIFT is an enabling function of commissioning, responding to population needs identified in the Commissioning Strategy and service specifications (i.e. commissioner, rather than provider, led).
- Schemes must contribute to national initiatives, such as the requirement to operate within a contestable market and improve patient choice.



- All future LIFT schemes will be procured and financed in line with other PCT funding policies, notably those relating to GP premises reimbursements<sup>2</sup>.
- Tenants are to made fully aware of the cost implications for them, and will be required to formally sign up to the terms and conditions of the sub lease and other responsibilities (including occupancy timetable) prior to securing land and commencing the build.
- Expected service outcomes are based on realistic assumptions, supported by appropriate evidence where relevant.
- Planned service changes and shifts from existing sites must be supported by compelling implementation plans and prior commitment from those involved.

*“..making the shift from hospital to community care involves much more than merely changing the place at which services are provided. Instead, there needs to a change in entire way that care is conceptualised and organised” Institute for Innovation and Improvement<sup>1</sup>*

## 2.5 Developments Already Underway

The PCT has a number of estate developments in hand, including those from the previous years' estates strategies of the former Colchester and Tendring PCTs. Some of the LIFT schemes contained within them were reassessed by the Board of new NE Essex PCT early in 2007 and were subsequently given Stage 1 status in the SSDP approved by the Strategic Partnering Board.

LIFT projects are delivered in tranches:

### *Tranche 1 LIFT schemes::*

Fryatt Hospital, Harwich – now open and operational

Colchester Primary Care Centre – open and operational, includes offices of the commissioning PCT HQ

Great Clacton and Holland on Sea – under review, full option appraisal taking place in 2008.

### *Tranche 2 LIFT schemes:*

All are single primary care schemes in the planning stages:

Wivenhoe

West Mersea

Parsons Heath, Colchester

### *Other developments outside LIFT::*

Divestment of PCT provider services Learning Disability facilities

## 2.6 Partnership Working

The PCT has a number of strategic and operational alliances with other key local stakeholders both through the SPB and other formal and informal arrangements. These are important alliances and it is intended that these continue and are strengthened where possible.

Strategic partnerships are provided through the formal LSP arrangements, with membership from the PCT Chief Executive and Director of Public Health. In addition, there are a number of other operational partnership arrangements which help facilitate joint estates developments:

Colchester Borough Council (CBC): The PCT Assistant Director of Public Health spends one day each week at CBC HQ and attends their monthly strategic planning group which explores potential developments in the town. This enables early joint understanding and involvement in developing solutions to improving the infrastructure in growth areas, as well as helping identify development opportunities.

The PCT and CBC have an agreed formula for calculating the contribution towards the infrastructure costs of health services to new populations, normally transacted through Section 106 arrangements with developers (Appendix 8).

The LIFT team works in partnership with CBC to explore site options for the tranche 2 schemes currently being planned.

Multi-agency or other schemes with PCT involvement include a public health multi agency centre in Clacton, opportunities for shared service facilities in Manningtree and a proposed Health village in Colchester

Tendring District Council (TDC): The PCT CEO or Director of Public Health sit on the LSP Board, and a PH Assistant Director sits on the lead partners group as well as leading on the health theme group (one of six sub groups). There is also a PCT representative on the Neighbourhood Interaction Board, which is supported by the Safeguarding Communities Fund to focus on key priorities and target resources in most deprived wards.

Collaborations with TDC have resulted in two key site options being made available to the PCT under restricted planning conditions, which keep the sites affordable for health developments. These are plots of land in development sites in the growth areas of Bockings Elm (W Clacton) and Jaywick. TDC is working closely with the public health team to develop the Multi-Agency Centre in Clacton.

The PCT also has regular representation on local groups such as the Infrastructure theme group of the Local Delivery Framework, the Older People's Forum and the LIFT team is working closely with residents in Clacton and Holland on Sea to explore developments there.

Essex County Council (ECC): The PCT Director of Nursing and ECC Director of Adult Services collaborate on a number of projects, including the delivery of community residential care. Plans are underway to deliver a Community Well-being Centre in Manningtree, with the PCT invited to participate. Members of the public health team are also members of the Life Expectancy Alliance (feeding into the LAA), the Community and Wellbeing Board, and lead the adult and children's Obesity Alliances.

### 3. Where Do We Want To Be?

This section is broken down into the two areas of consideration for the PCT as it prepares for divergence into two organisations:

- Requirements of the provider arm of the PCT and estate requirements to enable delivery of services.
- Procurement intentions of the commissioning arm.

Separation of the two PCT functions will include a division of the existing estate across the new organisations, and realignment of their respective strategic focus. In broad terms the focus of the commissioning PCT will be to develop overarching health improvement strategies and procure appropriate providers to deliver the national and local objectives within them. It will not provide any of those services itself and hence will question the ownership or acquisition of assets directly associated with delivery, including estate. Conversely the provider arm of the PCT will only wish to manage those assets which add value to its service delivery.

The final decision regarding the split of estate will be assessed against the financial and other implications for both organisations at the time of the separation. This approach is supported by current DH advice, with further guidance regarding the division of assets to be issued in due course.<sup>3</sup> In preparation for this, a full understanding of the current and future costs of each site is being prepared. Factors for consideration will include the following:

- status of ownership, length of lease, break clauses, etc
- overhead and other costs per sqm
- room by room utilisation, including rental or income from other providers
- anticipated site disposals and sale proceeds
- outstanding backlog maintenance
- approved capital developments
- fit with service strategies
- anticipated commissioned activity changes
- length of any sub-leasing or other arrangements with visiting providers

Where neither organisation considers it prudent to maintain a long term interest in managing or maintaining a premise, it may wish to consider the possibility of using an external agency or shared service organisation for these functions.

#### 3.1 Provider Services

The PCT provider arm delivers a comprehensive range of services including community nursing, health visiting, palliative care, learning disability services, community hospital/in patient services, etc. 1,300 of the 1,466 PCT employed staff work within the provider arm.

Services are delivered from a range of premises as set out in Appendix 1.

## Division of Estate

Upon separation of the two parts of the PCT, the provider arm portfolio will be constructed on the basis of the following:

1. The information listed above will be collected on estate already owned or leased by the PCT and analysed in the CAD database. This will provide the basis for mapping potential sites for division.
2. The structure for the new provider organisations will be material to any decisions about estate transfer. For example, in the case of a Community Foundation Trust, this may be the result of mergers between a number of provider organisations and a wider strategic perspective will be required. Service provision will remain localised, but decisions about the acquisition and maintenance of estate will be influenced by the objectives of the newly formed organisation.
3. Where it is agreed that the provider arm will assume responsibility for a property, as the property owner the PCT will need to decide under that arrangements this is progressed (i.e. a full lease or an SLA).
4. The decision about what responsibilities provider services will take in respect of property management will also effect how our current estate support services function. Considerable further work is still required on this.

### **3.2 Commissioned Services**

The commissioning arm of the PCT employs 166 of the 1,466 PCT employees. Most of these staff are based at the PCT HQ in the Colchester Primary Care Centre and it is not anticipated that any additional office provision will be required off site.

As a commissioner of services, the PCT will no longer retain any provider functions nor any of the incumbent assets required for service delivery.

Commissioners must retain flexibility to procure services from the wider market to meet the requirements of free choice for patients from December 2008. Acquiring and retaining estate or other facility for service provision can limit this flexibility and potentially challenges the ability of the commissioner to be suitably responsive, particularly when working in partnership with practice based commissioning groups who may wish to expand the provision of services to a far greater extent.

However, there are circumstances where the ability of the commissioner to develop and manage new markets is enhanced by the ability to offer cost effective and high quality clinical accommodation to new providers. Without this facility, many prospective providers may be deterred from entering the market by prohibitive costs and poor availability of suitable accommodation. This criteria would only apply to premises which accommodates a range of services which may change over a relatively short period of time, depending on commissioning need. For example, the use of minor surgery or out patient rooms for visiting clinicians or GPs, or health education or consulting rooms for voluntary sector providers.

Where providers are the sole occupants of a premise and likely to be the incumbent provider for the foreseeable future, there would be no case for the commissioning PCT to wish to retain control or responsibility for the provision of the premises.

On the basis of the above, the commissioning arm of the PCT would seek to retain the premises within its direct control to assist with provider market management. The decision as to which premises would remain in direct commissioning PCT control will be based upon this as well as the process outlined in section 6.1 above in respect of divestment of assets to the provider arm.

The current guidance from the DH indicates that commissioning PCTs will be free to commission LIFT buildings in the same way as before.

### **3.3 Primary Care**

The NE Essex Primary Care Commissioning Plan states that world class standard of primary care services will be essential to improve the health of North East Essex's population and to reduce health inequalities. This can be achieved through primary care playing a key role in anticipatory care and more proactive identification and management of chronic disease and illness and working with other local agencies such as social care and welfare services (housing and employment support). Supporting patients to take responsibility and active interest in their own health through the Expert Patient Programme is also an essential part of our local Health Strategy.

The focus for primary care commissioning, and hence key influencing factors in the delivery and management of estates, are:

- Increasing the number of health professionals particularly GPs in areas which are under doctored. Maximising use of capacity and ensuring flexibility of new or refurbished estate is essential, particularly where this improves access.
- The survey of existing primary care estate will be used to determine where current facilities can offer additional capacity or where new sites are required. As well as helping to prioritise existing primary care estate developments, the public health Needs Assessment will be used to identify new sites ("greenfield" developments). Where a high need is identified which cannot be met through existing facilities, a new development will be considered (including the procurement of new providers where appropriate). Existing facilities can be assessed using the data set out in Appendix 5, and the new mapping software currently in procurement will be used to help to map where greenfield developments may be required.
- Encouraging the merger of practices where feasible. The major implication for estates is that primary care facilities should not be designed to accommodate a number of small practices in the long term – the buildings must be easily adaptable to accommodate a single larger provider. Practices could merge and still work from existing sites where this is practical and convenient to patients, but it is unlikely that the cost of building small premises as branch surgeries would emerge as a cost effective option for new developments.

- Encouraging the development of larger or co-location of practices rather than separate single handed or small practices. New premises should be designed to co-locate practices without permanent structural isolation of different practice areas, so that the premise can easily adapt to accommodate a large single provider when required.
- Reviewing options for co-location and integration across a number of GP practices, pharmacists, dentists and optometrists. Where it is agreed that co-location is desirable, contractors will be free to design their own accommodation and hold the lease directly with RHL.
- Commissioning more services through willing provider or local enhanced services procurement routes to bring care closer to home. Premises must have generic and flexible application to allow providers to develop and change their clinical service portfolio. Standardised and multi-purpose clinical rooms have been shown to facilitate this<sup>4</sup>
- Commissioning new or additional primary care services through APMS contracts, to enable contestability and greater choice for patients. Primary care premises should also allow practices to aspire to the standards achieved by training practice as part of their development.<sup>5</sup>
- Promoting self care, providing self-help support and information to groups of patients requires the space to accommodate them and appropriately deliver the information.

*“Merely providing information is not enough to make people feel...able to manage their own conditions. Information must be presented in a way that is easily accessible (and) inviting” DH review of evidence 2003<sup>6</sup>*

- Where possible, new and refurbished facilities should be designed with this in mind, incorporating space for health promotion activities where this is not otherwise locally available. This is particularly an aspect of design where shared use of space should be fully explored with other agencies.
- Facilitating improved use of IT and information systems for patients. This includes facilities to help provide choice of provider for patients through the Choose and Book system and on-screen booking in systems for appointments whilst retaining sufficient flexibility to allow for the way that electronic systems will inevitably change over time.
- Improving patient experience and developing extended services outside normal “core” 8.00 – 6.30pm Monday to Friday working hours in general practice. This means that premises will sometimes be open out of normal hours, with fewer staff – lone worker policies and security will be paramount. The ability to close off and secure areas of the premise not being used will be incorporated into new designs.
- A recent review of minor surgery in primary care shows that there is an 8 fold difference in the number of minor surgery referrals by GPs to secondary care. The reasons for this and other such variations are to be further explored to

determine why some practices prefer to refer patients to secondary care. Again, the PCT will employ as much flexibility as possible in facilities to ensure that premises can be adapted to accommodate varying levels of in-house service.

The design brief for all new primary care premises being delivered through the LIFT scheme incorporates all of the above features, with a particular focus on improved access. A local Access Action Plan is in place to help ensure that practices are able to improve access during core hours as a priority and identify how they will meet specific needs of their population outside core hours.

### **3.4 Performance**

From the survey results, the PCT is preparing a performance structure within which to manage its estate. This will be populated from the results of the premises surveys, draft shown in Appendix 2.

The performance management of estate is essential in order to continue the theme of ensuring good value for NHS investment. This is in recognition of the increasing emphasis of ensuring all commissioned resources (i.e. not just new investments) are targeted at achieving the best results for patients.

*“Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources”. Vision for World Class Commissioning, DH Feb 08*

Where estate fails to achieve a minimum level of performance and/or cannot meet current and future need, the PCT will wish to consider all options to ensure a more appropriate investment is in place. There are number of feasible options including better use of existing sites, modifications or extensions which may improve utilisation, further exploration for co-location of services, etc. The options will also include exploring divestment or externalising management of the facilit

## 4. How Do We Get There?

Within the context of the above, the actions now required in respect of estates are highlighted in grey throughout this section.

### 4.1 Primary care and LIFT Schemes

The results of the estate survey will contribute to the prioritisation process for the next tranche of primary care developments. Existing facilities will be mapped to areas of prioritised patient need and help identify the requirement for any new greenfield developments. Any new development proposals requiring investment will be submitted as part of the next batch of LDP proposals for the 2009/10 financial year and beyond.

GPs are able to commission new premises outside the LIFT scheme where they choose to lead and finance the project themselves. They are advised, however, that increased rental payments for the new premise cannot be guaranteed unless they have sought prior approval from the development from the PCT. Any request for increased resources, capital or revenue, will be prioritised in the same way as all other PCT investments. Currently there are no new development schemes outside LIFT with approval to proceed (the one below being brought forward from 2007).

Practices are also able to apply for development grants to fund a percentage (normally 66%) of premises improvements. These grants are assessed and approved by the PCT Premises Panel, reporting to the Capital and Estates Sub Group. Where practices are in receipt of notional rent then increased rental payments are abated where a capital sum has been awarded as a contribution towards the extension or improvement (in line with the process outlined in the DH Primary Care Premises Funding Directions<sup>7</sup>).

#### 1. Non LIFT schemes approved for 2008:

Bluebell Centre – Purpose built Centre for Dr Kuriakose's practice, childrens services community staff and Highwoods/St Johns Community Association ptrns, Total rental charge £93,000 pa (subject to DV confirmation).

A summary of the agreed action for all current or proposed LIFT schemes is shown below. All schemes to be delivered through the LIFT programme require formal sign off by the SPB for inclusion in to the annual SSDP. Some schemes which have featured in previous years' SSDPs were sponsored by the former Colchester and Tendring PCTs and have now been reviewed to assess their suitability against current need. Some, such as the Garrison and review of Kennedy Way scheme, have been subject to detailed re-appraisal, details of which are available separately where relevant.

The NEE LIFT schemes which already have Stage 1 status have done so under the original guidance which allows Stage 1 to be achieved at an early stage of planning. This means that none of the schemes yet have business case approval. Any new schemes joining later tranches will need to be approved under the 2008 guidance which requires a greater level of preparation prior to the award of Stage 1 status.



Any schemes which change significantly from the original proposal must seek re-approval for new stage 1 approval (which will almost certainly apply to the remaining Tranche 1 scheme for Great Clacton and Holland on Sea).

## **4.2 Use of Existing LIFT Premises.**

Attention is still required to properly market and utilise the first two LIFT schemes, the Colchester Primary Care Centre and Fryatt Hospital, Harwich. This provides an opportunity for the commissioning PCT to maximise its market development potential and enables the further development and co-location of services. A marketing portfolio of the technical specification and cost of all available rooms will be developed to enable providers to make an informed choice on the accommodation, and a formal licensing process is being established to provide appropriate governance arrangements.

### **2. Future use of PCC and Fryatt Hospital.**

On completion of all remedial works on the floors and the detailed analysis of the available space using CAD software (to enable detailed costing of each area), spare capacity will be actively marketed to prospective tenants.

## **4.3 Tranche 1 LIFT Scheme with Stage 1 approval**

Great Clacton and Holland on Sea (proposed for Kennedy Way, Clacton) The original proposal for this scheme included a diagnostic treatment centre and centralisation of four GP practices. However, the primary care element of the scheme is now to be fully re-appraised following a capacity analysis of the original proposal in July 2007, which showed that surplus diagnostic capacity would have been created if the scheme went ahead as planned.

A group was formed in January 2008 specifically to look at future options, and included representatives of patients, public and all the affected practices. A long-list of alternative options was constructed, with a short-list to be limited to those which are deliverable, i.e. where sites are available, planning consent likely to be obtained, etc. The short listed options will be known in April 2008 following the feasibility analysis and will then require a full 3 month public consultation. Once a preferred option is established, new Stage 1 LIFT approval must be sought (requiring greater preparatory work under the new guidance).

Under the original proposals, the Kennedy Way site was purchased by the PCT with a planning application made to place the new building in the car park opposite the then Tendring PCT HQ.. Tendring District Council (TDC) granted planning consent, but conditional upon the signing of a Section 106 agreement in respect of the PCT funding a shuttle bus to provide patient transport between the new development and its satellite sites. This agreement was not signed at the time of the planning application, and TDC issued notice to NEE PCT that unless it were signed by 31st March 2008, the option for obtaining planning consent on the car park site would be withdrawn. RHL advised that the value of the site would be affected by failure to sign the agreement.

The PCT was required to consider the issue against the two key factors - service need and financial risk.

In terms of service need, the new long list of options does not include constructing a new facility on the car park site nor a provision for satellite facilities. There was also little support for a shuttle bus from the group convened to lead on the options for the future.

With regard to financial risk, the PCT sought professional advice (including that of the District Valuer) on the matter. The professional advisors to the PCT advised against signing the S106 agreement.

The PCT has decided not to sign the S106 agreement for three key reasons:

1. The proposals for new options at Kennedy Way do not include the need for a shuttle bus - this is not considered to be a viable solution to any of the potential access issues.
2. Professional advice that the terms of the S106 agreement as currently proposed are not acceptable to the PCT.
3. That the potentially reduced value of the site without planning consent is judged to be of less risk than the potential financial obligations of the S106 agreement.

### 3. Section 106 Agreement for Kennedy Way site.

Notice will be issued to Tendring District Council in March 2008 that the PCT will not be signing the agreement.

## **4.4 Tranche 2 LIFT Schemes, with Stage 1 approval**

### Wivenhoe, West Mersea and Parsons Heath, Colchester.

For each of the tranche 2 LIFT schemes, the PCT is working with stakeholders in project groups established to deliver the design brief and endorse the subsequent design solution presented by RHL. The role of the project groups is very focussed, to ensure the following:

- Requirements are as specific as possible without eliminating room for innovation and creativity through LIFT partnership working
- All growth and capacity is supported by an identifiable service need or development, and population growth predictions
- Any service changes or growth are deliverable in terms of any relevant workforce, service redesign or contractual issues
- Prospective tenants to be fully aware of the cost and lease obligations for them.

Each of the projects reports to a LIFT Steering Group, acting in a programme management role, to ensure appropriate governance in terms of signing off proposals and ensuring that adequate support is provided<sup>8</sup>.

The key factors that the Steering Group (with support from external professional advisors as required ) will use to test the suitability of the design solution for the scheme will include:

- How well the proposal meets local need, judged against the specific requirements and criteria contained within the AEDIT assessment tool (functionality, impact and build quality)
- Value for money, using benchmarked costs
- Alignment to relevant PCT policies and strategies
- Sufficient flexibility for service or population changes (in so far as these can be reasonably anticipated at the time).

The project plans for each of the three schemes sets out stages to achieve full business case approval from NEE PCT Board and the SPB by January 2009.

Should for any reason any of the current tenants decide to withdraw from their development, then the scheme will be subject to full re-assessment before proceeding. If that occurred, the options for the PCT would at that time broadly be:

1. Where the scheme is assessed to be of lesser need than others within the PCT (using the prioritisation process) then the scheme could cease to progress any further. There would need to be a formal withdrawal through the SPB and other processes.
2. Where the need was still demonstrably higher than others or deemed to be of sufficient worth to continue, then the new development could proceed without a known tenant/provider. A provider would then be procured through the established process.

#### 4. Tranche 2 LIFT Schemes.

To proceed through the various development stages as planned.

### **4.5 Pre-Stage 1 Schemes, Opportunities and New Developments**

This section includes those schemes which may have already appeared in previous years' SSDPs but have not yet been progressed or where a final decision is still pending.

Bockings Elm, West Clacton. The PCT is likely to offered a piece of land, with limited planning consent and hence favourable cost, by the developers of the planned 400 new houses in West Clacton. At the time of publication (March 08) the developers are still in negotiation with TDC in respect of the purchase of the site and the availability of the land is subject to a favourable acquisition. However, it is agreed that the PCT continue to pursue the option for this site given the anticipated growth in this particular area, the current paucity of primary care in West Clacton and the opportunity to develop a greenfield site in an area of relatively high deprivation and low GP numbers for a favourable cost.

#### 5. West Clacton.

Investigate the possibilities of securing land in the Bockings Elm development. This would be desirable, subject to financial analysis and assessment of growth and need against capacity within existing facilities.

Jaywick. In addition to the West Clacton site, TDC has also set aside a piece of land for potential health use in Jaywick. This opportunity will be explored in the light of the option for West Clacton, above. It is unlikely that both sites would be required, with the preference for West Clacton but until this is secured both will be kept open if possible.

#### 6. Jaywick.

Do not pursue further, unless land in West Clacton is subsequently unavailable.

Garrison Medical Centre. The Garrison site was offered to NEE PCT under a S106 agreement by Colchester Borough Council (CBC) after they had been offered the site as part of the Garrison campus redevelopment by Taylor Wimpey.

#### 7. Garrison.

Full option appraisal to be completed, for final commissioning decision by end April 2008.

Mersea Road, Colchester. This was proposed as a development option in the 2005/6 SSDP, but will not now be pursued before the full assessment of local need is mapped to local available resource in the commissioning prioritisation process. In this context, this scheme is now removed from that of priority option.

Tiptree Surgery. As above, whilst accepting that the premise is not of a high standard this scheme must be re-assessed against all other priorities in the context of the primary care premises survey before it can be considered as a priority development.

#### 8. Tiptree, Mersea Road and other outstanding proposals pre Stage 1 LIFT approval.

All proposed developments will be subject to assessment using the balanced scorecard assessment set out in Appendix 5 (which helps prioritise existing facilities) and new mapping software to identify where there is a need for greenfield developments.

## **4.6 PCT Premises**

### Estates Methodology

A survey of the current estate shall be undertaken in order to determine the condition of the Estate in relation to the following elements.

Physical Condition  
Statutory Compliance  
Functional Suitability  
Space Utilisation  
Quality  
Environmental Management

The survey is updated and managed through the MICAD database.  
A summary is included in appendix 1.

The outcome from the condition survey shall provide a risk based approach to ensuring statutory compliance, and backlog maintenance.

#### Quality Standards

The Estates Service shall be delivered in a manner to achieve Standards for Better Health and to continuously improve Patient Environmental Action Team scores.

Space utilisation and value-added benefit from estate will be an important factor in assessing its worth to the organisation. Where premises are sub-standard, cease to be cost effective or fail to deliver the required benefit to the PCT, they will be considered for divestment.

#### Facilities Management

The PCT will work collaboratively with ERHT and other organisations to ensure best value from facilities management contracts at the time of renewal.

### 9. PCT Estate Portfolio

The PCT estate portfolio will be assessed against a broad range of criteria for a decision to be made on the future benefit of the premise to the PCT. Investments or divestments will be made on the basis of the quantifiable data available.

### 10. Division of Estate Across Provider and Commissioner Functions.

An assessment of estates needs for both commissioning and provider functions will be undertaken prior to the final separation of the PCT into two separate organisations.

### 11. Next Steps

Once this strategy has been approved by the Board, an operational plan will be drawn together which details how the issues raised in this strategy will be delivered. This piece of work will include the outcomes of the conditions survey and may well mean that a further review/revision of the strategy itself is required within a short timescale.

## APPENDICES

1. Property Schedule
2. Property performance analysis
3. Land and property Disposal and Acquisition Programme
4. Estates Targets
5. Prioritisation Process for developing existing primary care premises
6. Capital Programme 2007/8 (2008/9 in draft)
7. Strategic Services Delivery Plan 2007/8 (2008/9 in draft)
8. Formula for S106 Funding

## References

---

- <sup>1</sup> Strategic Commissioning and Development Directorate Report, NE Essex PCT Board October 2007
- <sup>2</sup> NEE PCT Primary Care Premises Funding Policy 2008
- <sup>3</sup> LIFT Business Case Approval Workshops - Follow up Question and Answer Brief, CHP Nov 2007
- <sup>4</sup> Jim Latta, NHS Strategic Health Asset Planning Team presentation 04/12/2007
- <sup>5</sup> "Rebuilding the NHS – A new generation of Healthcare Facilities" DH Jun 2007, p18
- <sup>6</sup> "Supporting Informed Consumer Health Decisions..." Hibbard, Peters. Annual Review of Public Health 2003; 24; 413-33
- <sup>7</sup> The NHS (General Medical Services – Premises Costs) Directions 2004
- <sup>8</sup> LIFT Project and Steering Groups Terms of Reference, NEE PCT 2007