The role of system estate management in meeting ICS aims

A paper by the Good Governance Institute and Primary Health Properties

October 2022

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About the Good Governance Institute

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About Primary Health Properties (PHP)

Primary Health Properties (PHP) is a UK real estate investment trust (REIT) and leading investor in modern primary healthcare premises.

PHP has invested over £2.8bn in the primary care estate since its inception 26 years ago, including by refurbishing or reconfiguring existing buildings or via the delivery of new purpose-built buildings to meet the evolving needs of primary care.

PHP's portfolio comprises 512 primary healthcare facilities valued at £2.8 billion. Most are GP surgeries, with other properties let to NHS organisations, pharmacies and dentists. PHP invests in flexible, modern properties. The company's overall objective is to create progressive returns to shareholders through a combination of earnings growth and capital appreciation.

To achieve this, PHP has invested in healthcare real estate let on long-term leases, backed by a secure underlying covenant where the majority of rental income is funded directly or indirectly by a government body.

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The role of system estate management in meeting ICS aims

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Foreward

The introduction of Integrated Care Systems (ICSs) represents a huge reform to the organisation of health and care in this country. As part of this, financing for estates has transferred from Trusts to ICS, creating opportunities to be much more strategic in the management of assets in support of new health and care models. Estates will be a key component of initiatives to move care from hospitals into communities, fulfilling the digital agenda and meeting net-zero targets.

Close engagement and collaboration with system stakeholders, leveraging their respective estate management skills and assets, will be key to realising benefits. System management will require sharing data, aligning approaches and establishing trust. Stakeholders such as local authorities and private sector partners could be instrumental in helping to address issues around funding, ownership models, capacity and skills.

A significant challenge will be the short-term nature of NHS funding, which, although expanded from one to two years, is significantly less than in other sectors. Infrastructure projects can take multiple years to plan, build and develop. In other sectors, estate management planning horizons span 10-15 years.

This paper begins by exploring the context, including how 'fit for purpose' the current health estate is, the effect of the pandemic, and future demands placed by the digital and net zero agendas.

The following section, identifies the estate management levers (such as co-location, new builds and disposals) and demonstrates how these levers help address the ICS aims: improving health and care outcomes, reducing inequalities, increasing productivity and value for money, and contributing socio-economic benefits to the local communities.

The final section suggests recommendations for next steps for ICSs, and their partners, and highlights key success factors from learnings to date.

We think there is a huge opportunity to create value by managing estates strategically at a system level. We look forward to following the progress and helping to share best practice.

The white paper is based on interviews with over 15 interviews, 2 round table events, 3 editorial board reviews and desk research. We would like to thank Primary Healthcare Properties (PHP), who are the largest real estate investment trust (REIT) in the country, for making this white paper possible and for contributing their expertise. We would also like to thank all those who were so generous with their time during the interviews and events and provided highly insightful comments on the opportunities and challenges.

We hope you find this report useful and that it helps to raise system estate management up the ICS agenda.

Andrew Corbett-Nolan, Chief Executive, GGI

It has been a pleasure to partner with GGI in the preparation of this timely white paper. Outside of NHS ownership, PHP has the largest portfolio of premises in which NHS services are delivered. It is therefore really important that we understand the strategic direction for estate from the new ICBs.

The creation of ICBs means a significant development of commissioning requirements, to provide integrated care. Integration, including the movement of outpatient and community services away from secondary care and into the community, has been a commissioning ambition for many years. The creation of ICBs has provided the commissioning framework to realise that ambition.

As set out in this paper, the requirement for integrated healthcare spans across all aspects of existing and new estate Therefore the flexibility and repurposing of existing premises is every bit as important as the commissioning of new premises. We have already seen those commissioning requirements come through in our asset management and development projects. As IBCs mature and gain command of their estates positions those requirements will, we expect, accelerate.

This is an exciting time for primary and community estate. Estate is a catalyst for changing everybody's experience of the NHS and should be recognised as a key driver for change.

Tony Coke, Development Director, PHP

I. Background, objectives and methodology

On the 1st July 2022, the Health and Care Act 2022 established Integrated Care Systems (ICSs) across England to achieve the following aims:

- Improve health and wellbeing
- Reduce health inequalities
- Improve system productivity and value for money (VFM)
- Act as an anchor institution and contribute socio-economic benefits to their local communities

ICSs constitute a fundamental reform of health and care services, with the management of health and care real estate forming part of this radical overhaul.

The Good Governance Institute (GGI) & Primary Health Properties (PHP) have partnered to identify the role of estate management in achieving the ICS aims.

This paper is the third in a series of GGI-PHP papers on estate management. There were two previous papers:

- **Innovative capital solutions to achieving STP goals (2017)**

The first paper provided insight into the various capital financing options available to providers, commissioners and GPs. It also explored how those looking to develop new estates could use the experience of providers in order to design a balanced development strategy.

- **Primary Care Estate: Delivering value and improving care (2021)**

This second paper explored the commissioning of primary care premises by CCGs, Primary Care Networks (PCN) and trusts, and the influence of healthcare integration and digital access to primary care, post-Covid-19.

For this third paper, we conducted over 15 qualitative video interviews with a variety of stakeholders from ICSs, NHS Trusts, primary care and the local government association.

Interviewees were asked a series of questions about the following topics:

- The current landscape of their organisations, including their estate strategy, primary care innovation/ ambition, and culture and behaviour around estates
- The potential opportunities arising under the new ICS arrangements
- The barriers and enablers they encountered to collaboration between partners
- The future forms of estates in ICSs and what they may look like

Findings from interviews were complemented by desk research.

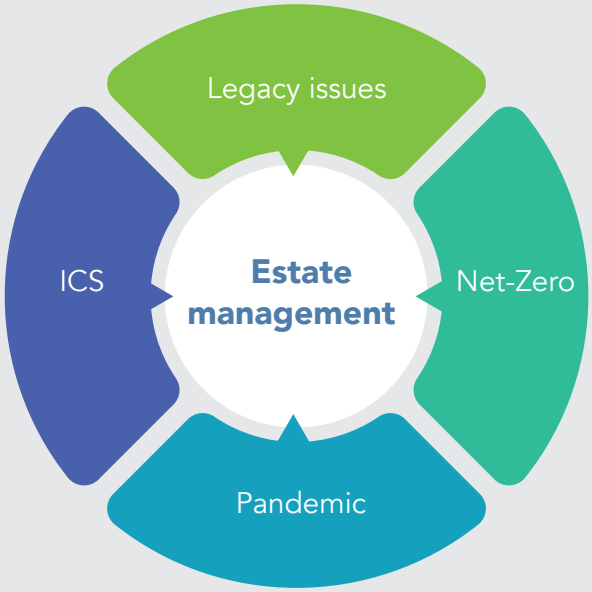
The objectives of this paper are to raise awareness of the importance of estate management in helping to facilitate the integration of health and care and the achievement of the ICS aims. It also seeks to help galvanise system estate management by identifying the key levers and sharing best practice examples.

II. Executive summary

The management of health and care estates is changing fast. There are multiple drivers:

ICS
The introduction of ICSs enable and require system-wide management with greater integration

Pandemic
The pandemic has accelerated the adaption of digital technologies and joined up working between health and care – new models of care and delivery require changes in the location and design of health and care properties



Legacy issues
Legacy issues are unsustainable. There is a huge maintenance backlog and many properties are not fit for purpose in terms of fundamental design or location.

Net-Zero
The Net-Zero agenda means meeting much more demanding sustainability requirements

There are seven high-impact estate management actions: Co-location; Disposals; New builds; Re-fits; Re-location; Shared services; and System estate management.

A mix of these levers can be used to 'right-size' the portfolio, for example disposing of property that is not fit for purpose or not in the right location, refitting and/ or building new properties that are fit for purpose, and gaining synergies by co-locating and sharing services.

These estate management levers are proving to be key enablers for delivering the ICS aims. For example:

- **Co-location** is currently actively explored as a way of delivering integrated care effectively and efficiently and as a way of moving care out of hospitals and into communities.
- **Disposals** are an opportunity to raise capital and contribute to the local economy, for example, by providing land for affordable housing.
- **Refits and new builds** create positive environments for patients and staff, and helps address retention and recruitment issues

To ensure best in class system estate management practices, our research suggests ICSs take the following steps:

1. Understand the health, care and wellbeing needs of the population
2. Map the existing system estate assets against those needs
3. Agree the vision and strategy
4. Monitor the delivery
5. Establish the estate management governance

Key success factors, from experiences to date, include working with local authorities, PCNs, and the private sector. Building strong partnerships involves active communication and education, aligning approaches, being agile and innovative, and modelling behaviours.

Best in class practices include not limiting estate management planning to primary care, or health care and not limiting the thinking to buildings but encompassing all assets which support health, care and wellbeing.

III. Context

This chapter is laid out in the following sections:

- Current state
- The legacy issues in health estates
- The impact of COVID-19
- New ICB estate management duties
- Sustainability targets
- The digital agenda

Current state

A number of ICSs are investing in developed estate management practices:

- "We have an appetite for trying new things in the estate space" (Assistant Director, Health Estates, ICS, South)
- "We see ourselves as innovators… as ahead of the game" (Estates Directors, ICS, London)
- "The estate board are working on re-imagining Estate facilities management, e.g. how we can deliver estate facilities management at system level, and that will look at all of the 'value for money' (VFM) functions from capital spend to sustainability…" (ICS, West)

Those that had developed ICS estate strategies frequently included detailed information on topics such as:

- Estate mapping and linking it to SHAPE data and needs data
- How to change the model of care and what changes are needed in estates management to support this (e.g. what to sell, what to close)
- How to achieve net zero
- How to free up money
- An estates innovation plan

Membership of estate groups varies widely and tends to reflect the priority areas that the ICS has identified for collaboration.

	Health and social care collaboration	Acute pathway collaboration	Mental health pathway collaboration	Health and wellbeing collaboration
Level				
Estates lead	✓	✓	✓	✓
Estates directors		✓		✓
Finance directors			✓	
Digital directors				✓
Range of organisations				
NHSE/I	✓	✓		
ICS	✓			
Local authorities	✓			
Primary care		✓		✓
Acute	✓	✓	✓	✓
Community			✓	✓
Mental health			✓	✓

Estate management **leadership** can be seen to come from local authorities, ICSs, PCNs and the private sector.

ICS partner	Estate management leadership examples
Local authority leadership	• Work collaboratively across the ICS, Councils, not for profit organisations, and the wider NHS – "estate strategy is being developed 'bottom up' all upper tiers LAs involved, District Councils also involved. discussions taking place on using retail space for medical properties"
ICS leadership	• Provide leadership from the ICS to drive the idea of estates forward • Seek to create economies of scale • Shape desired outcomes at places and seeking estate management to support this • Lead the restructuring of primary care
Estate management team leadership	• Reach out to local communities to identify where they can go to receive help and to educate them about care pathways • Drive innovation through a subsidiary (with an appropriate business model)
GP/ PCN leadership	• Merging practices • Primary care innovations, e.g. inviting community staff to practices, moving to zoom/ video consultations (post-COVID)
Private sector provider leadership	• Lead thinking on alternative (multi) ownership models

Legacy issues and other demands

The scale of the current demands facing estates demonstrates the impact of legacy issues that are unsustainable and need to change.[1]

Around 45% of Trust leaders describe their estate as in poor or very poor condition. Many of these properties are old, in a state of disrepair, and frequently not configured to support modern healthcare delivery. Many of the shortfalls in health and care estate design were further exposed by the pandemic.

Poor health and care properties are jeopardising patient safety with clinical service incidents caused by estates and infrastructure failure having risen in each of the past three years.

The situation is getting worse, with the maintenance backlog currently at £9bn (2021), 40% more than 2019 and double the level seen five years ago. Half of the total outstanding capital maintenance has been classified as 'high' or 'significant risk'.

The impact of COVID-19

The COVID pandemic necessitated different solutions for healthcare delivery and has accelerated nascent trends and new ways of thinking about estates.

New practices adopted in relation to estates during the pandemic include:[2]

- **Restructuring current buildings** by converting occupied space into vaccine hubs, or recommissioning vacant or underused space to create additional capacity for beds, testing and vaccination.
- **Using non-traditional locations:** Using accessible, non-traditional estates in the community, for example including pharmacies' back of house, mobile delivery and 'pop-up' spaces. These were used as much to drive awareness as to deliver services.

Among the key enablers that made these changes possible were the following:

- **Digital** technologies
- **New evidence** on safe delivery
- **Flexible approaches** to the leasing and use of community space
- **Improved integration** between local government, the voluntary sector and NHS, which allowed clinical services to be taken to new places
- **PCNs** bridging the gap between local planning and neighbourhoods

Many of these new practices are likely to remain given the strategy for major investments outlined in the Health Infrastructure Plan (HIP), which states that healthcare strategies should:

- Be based on an analysis of the existing estates and future needs for space and function
- Integrate health, care and community services
- Embed technology and energy efficiency so that new buildings are Net Zero
- Include flexible spaces, which can be adapted or converted for ICUs or isolation units

New ICB estate management duties
The establishment of ICSs signals certain major changes for estates management, including:

- **Single system plan:** ICSs are required by NHS England to develop a single estates strategy which supports the ICS in meeting its key aims, as well as the ambitions of the NHS Long Term Plan (LTP).
- **Single system asset map:** System partners, such as Primary Care Networks (PCNs) will be expected to conduct a stock take, map their estate and to add this intelligence to the NHS's SHAPE asset mapping tool, bringing it together with existing NHS estate mapping. Moreover, the mapping will take a wider form " …it should not just be about primary care or even just health care but include all well-being assets… and assets are not just buildings"[3]
- **Single system budget:** ICBs have taken over the commissioning and funding responsibilities previously managed by Clinical Commissioning Groups (now disbanded) and have been given budgetary oversight for overall capital spending.[4]
- **Care in communities:** The increasing delivery of integrated care for patients away from large, acute hospitals and closer to the community in a primary health setting will have significant implications for NHS infrastructure.

ICSs will benefit from a longer planning horizon for estate management, more cohesive control over capital spending and more flexibility. NHSE guidance confirms that ICSs will receive multi-year budgets consisting of 'baseline' envelopes for two years ahead, to allow for longer term planning.[5] From 2022/23 primary care business-as-usual (BAU) and General Practitioner (GP) Information Technology (IT) will be included within ICS capital envelopes to allow them to take a more cohesive approach across the system.[6]

ICSs will also be able as part of their planning process to increase capital investment in primary care subject to considerations of affordability within the system envelope over the period 2022/23 to 2024/25. They will however, not be able to reduce investment in primary care below that included in their allocation.

ICSs will receive a single Capital Departmental Expenditure Limit (CDEL) envelope figure for emergency financing (further details on spending allocations are provided in Appendix).

Sustainability targets

ICSs will also have to meet the key targets set out in NHS England's sustainability strategy which aims to "reach net zero carbon by 2040 and become the world's first 'net zero carbon' national healthcare system."

The first target is for emissions NHS organisations control directly (the NHS Carbon Footprint) to be net zero by 2040, and reduced by 80% 2028 to 2032. The second target is for emissions NHS organisations can influence (our NHS Carbon Footprint Plus) to be net zero by 2045, and reduced by 80% 2036 to 2039.

Meeting these targets has specific implications for ICS estate management. All capital expenditure must take account of the impact on the organisations' carbon emissions, local air pollution, and staff and patient health. For maintenance, repair or construction of NHS estate, purchasers should refer to Delivering a 'Net Zero' National Health Service and the Estates Net Zero Carbon Delivery Plan. Plans are required for heat de-carbonisation to ensure that heating systems, insulation and ventilation are upgraded to reduce carbon emissions where possible as part of backlog maintenance, and that LED lights are used in place of less efficient systems.

The net zero targets are particularly challenging for primary care estates.[7] GP practices tend to have high emissions - the total estimated emissions for the primary care estate consisting of 7,000 GP practices in England last year was 167 ktCO2e (kilotonnes of carbon dioxide equivalent).

Reducing emissions in the primary care estate requires upgrading existing primary care buildings. Emissions can be more than halved through energy efficiency measures such as:

- Improving building insulation, lighting and heating that could save 59 ktCO2e annually
- Improving building instrumentation and energy management that could save 34ktCO_2e annually
- Installing photo-voltaic cells and heat pumps that could save 7ktCO_2e annually

Victoria Medical Centre, Eastbourne

Case study

Description

- PHP created a modern medical facility to house four merged GP practices, enabling their operation as a single PCN,
- The Practices were previously in 'not fit for purpose' buildings, e.g. they had inaccessible consulting rooms and confusing layouts with poor patient flow
- The new facility was completed in August 2021
- The Centre provides services to 30,000 patients, including:
    - Onsite pharmacy, private hire suit for diagnostics,
    - Outsourced call centre
    - Electronic monitoring of patients in care homes
    - Option for remote, digital and face to face consultation
    - Open plan for doctors to hot desk in a shared office space

Activities

The estate management levers involved in the process were co-location and new build – facilitating fudamental service change through enabling primary care at scale via practice merger and the PCN model.

Impact

- Provide access to a wider variety of services
- Increase the wellbeing of staff
- Maintain staff retention and recruitment
- Reduce energy consumption through design features such as roof solar panels, air source heat pumps and LED lights.
- Help the NHS to meet their targets of a net-zero healthcare system
- Support GPs to look after an aging demographic
- Help NHS bring services out of acute hospitals into the community

The Digital Agenda

The NHS Long Term Plan describes a vision where every patient will have the right to be offered digital-first primary care by 2023/24, where they can easily access advice, support and treatment using digital and online tools. Digital capabilities such as increased connectivity, sharing of records, care plans, and virtual care, will have a major role in meeting the broader ICS objective of shaping services around individual needs.

The digital agenda will lead major changes in primary, community and secondary care service provision and feature significantly in ICS estates strategies. The 2017 Naylor Review of NHS estates also stated that it is critical for future estate management to embrace new opportunities that technology brings by:

- improving knowledge
- informing accurate decision making
- optimising asset management
- managing buildings better[8]

To deliver a technology-supported model of care in the new context, it will be important for ICSs to:

- **Develop a vision for technology and the estate:** What will the primary care estate look like in the next five to 10 years?
- **Build capacity:** How well prepared is the organisation for adopting digital technologies? How can the estate accommodate the use of future technologies?
- **Establish strategic skills across the system:** How can ICSs ensure that plans and decisions on estates and technology are effectively integrated with clinical plans?

IV. Estates management impact on ICS aims

From our interviews, seven types of actions that are high-impact enablers or accelerators for estate management were identified. Each has the potential to contribute towards meeting the four ICS aims in a number of ways. Co-location partnerships, in particular, are being explored as a way of delivering integrated services.

The table below describes the estate management actions and provides examples.

Actions	Examples
	**Co-location:** Bring several health, care and/or wellbeing services under one roof, e.g. GP surgery, diagnostic centre, leisure centre, social care offices, citizen's advice bureau, etc. Shared buildings could include shared meeting rooms, shared reception and shared back-office services.
	**Disposal:** Sell properties which are under-utilised, in need of extensive repair, and/or cannot be re-fitted to be fit for purpose. An example buyer might be a local authority or social housing provider.
	**New builds:** Build additional buildings, or a whole new site, which are fit for purpose (e.g. support transformed pathways) and future-proofed (e.g. flexible).
	**Refits:** Re-design, re-fit and refurbish existing properties so that they are fit for purpose: They support transformed pathways, meet net-zero targets, and are financially sustainable with low maintenance costs.
	**Relocation:** Move teams and services to different properties in the existing estate.
	**Shared Services:** Set up shared spaces to support shared functions, e.g. shared back office.
	**Strategic System Estate Management:** Co-ordinate activities across the system, identify areas of under and over-spend, simplify/ streamline activities, and/ or reduce transaction costs.

Each of these estate management actions has major contributions to make towards meeting ICS aims.

	ICS aim 1: Improve health and wellbeing outcomes	ICS aim 2: Reduce health inequalities	ICS aim 3: Increase productivity/ value for money	ICS aim 4: Contribute socio-economic benefits
Co-location	Improve the patient experience by enabling joined up provision and personalised care Help address prevention as well as treatment, e.g. social prescribing	Increase accessibility by providing relevant services in one place	Reduce costs through shared reception, shared meeting rooms, etc. Improve staff recruitment and retention – cross-functional teams could provide more interesting and accessible career paths, enable joint recruiting	Support broader wellbeing initiatives
Disposals		Remove properties whose design or location are inaccessible	Release capital for reinvestment	Support positive re-use to meet local needs, e.g., for housing
New builds and Refits	Add fit for purpose buildings that support new pathways Improve the patient experience by offering better spaces	Add properties whose design and location are fit for purpose	Add properties designed to be financially sustainable, e.g., lower maintenance costs, flexible use spaces Use vacant or redundant estate to create accessible health hubs	Add properties which help meet net zero targets, support staff wellbeing
Relocation	Encourage patients to seek a diagnosis earlier by providing more convenient locations Provide better support for pathway transformation	Improve accessibility and convenience, including for hard-to-reach population groups	Improve utilisation Decrease maintenance costs, by relocating to a building in good repair	Help regenerate under-used properties/ areas
Shared services	Enable better co-ordination of appointments Enable healthcare professionals to have a close understanding of different working arrangements, build relationships ('water cooler' moments), and share information and skills	Remove the barrier of having to deal with multiple organization Enable greater support, e.g. shared translation services	Spread costs across services	Support/ subsidise voluntary sector activities
Strategic system estate management	Identify system priorities and issues Reprioritise allocations to high priority areas	Allow a joint, coordinated response to accessibility issues	Identify areas of under and over-spend across partners Reduce transaction costs and complexity Reduce duplication and simplify/ streamline activities	Include wider system needs in estate management decisions

Of the seven enablers identified above, co-location is currently attracting considerable attention. As one interviewee noted:

> "Using buildings which are familiar to the community means you can integrate services better… and it is reducing cost to the system and helps achieve sustainability" (ICS, South)

Co-location partnerships are diverse. The table below shows the range of partnerships identified in the interviews.

[Add case study or 2 here of co-location? Or at least more info on some examples]

Example of co-location	Health centre	Out-patients	Acute	Primary care	Mental health	Local authority services	Leisure centres	Youth centres/ Schools	Care co-ordinators
Health and wellbeing (ICS, South)	✓						✓		
Mental health and support				✓	✓	✓			
Mental health and access (relevant location, removes stigma)					✓			✓	
Care in community (ICS, South)		✓		✓					✓
Optimised acute pathway			✓	✓					
Primary care hubs (ICS, North)				✓					

More information on spending allocations[9]

The 2021 Spending Review confirmed:

- £4.2bnover the SR21 period to make progress on building 40 new hospitals and to upgrade more than 70 hospitals.
- £2.3bn over the SR21 period to transform diagnostic services with at least 100 community diagnostic centres (CDCs) across England to permanently increase diagnostic capacity.
- £2.1bn over the SR21 period for innovative use of digital technology so hospitals and other care organisations are as connected and efficient as possible.
- £1.5bn over the SR21 period to support elective recovery, through for example new surgical hubs, increased bed capacity and equipment.
- Around £450m over the SR21 period for mental health, to complete the programme to replace mental health dormitories with single en-suite rooms and invest in NHS mental health facilities.
- In line with the Delivering a 'Net Zero' National Health Service strategy, capital investment should contribute to the NHS's over-arching goal to reduce carbon emissions, and improve local air quality, and staff and patient health.
- For 2022/23, the NHS capital allocation will be split into three categories:
- A system-level allocation (£4.1bn) – to cover day-to-day operational investments which have typically been self-financed by organisations in integrated care systems (ICS) or financed by DHSC through normal course of business loans or system capital support PDC (previously known as emergency capital PDC). From 2022/23 onwards this also includes £0.1bn of capital for investment in primary care estates and IT. In 2021/22 this was £3.9bn (excluding primary care).
- Nationally allocated funds (£1.1bn) – to cover nationally strategic projects already announced and in development or construction, such as hospital upgrades ('STP schemes') and new hospitals. In 2021/22 this was £1.2bn.
- Other national capital investment (£2.7bn) – including national programmes such as elective recovery, diagnostics and national technology funding and the mental health dormitory programme. In 2021/22 this was £1.7bn.9

London Estate Delivery Unit (LEDU)

Case study

Description

LEDU was set up to produce a single estate strategy for London and bring together the estate community to work in a collaborative and coordinated way to transform the estate to improve healthcare and outcomes.

Activities

- Secured £3.8 billion in healthcare estates to date, against the £8 billion aspiration for 2028
- Released a surplus of NHS land worth £500m since 2018-19 to support the delivery of 7,500 homes (the aspiration was for 12,5000 homes over a 10-year period)
- Secured places for five of the hospitals in London on the 'new hospital programme' – which were identified as requiring significant redevelopment or replacement

The estate management levers involved in the process are **strategic system estate management and disposals**, including:

- Coordinating activities across the system with GLA's housing and Land team, the NHS, Local, national and central government partners and with national and regional partnership
- Releasing NHS lands to use for housing

Impact

- Collaborating at scale, including owning and identifying any capital issues/ deficiencies
- Establishing one set of priorities between different partners and organisations - As a result cash could be moved around the system easily to meet the needs of the estate

Integrated Medical Centre (Mid and South Essex)

Description

Mid and South Essex ICS have been working towards an Integrated Medical Centres model since 2018 - multipurpose facilities designed to provide better access to services and deliver better outcomes for those in Mid and South Essex.

Activities

The developments were set against the broader work that the ICS had been conducting to improve its community estate and involved all 7 levers of estate management:

- Taking stock of existing estate across the system
- Agreeing what, strategically, could be brought together, what could be reused and repurposed, and what needed refurbishment or upgrading

Impact

- Improved integration
- Improved community estate
- Reduction in backlog
- Support in recruitment and retention
- Achieved sustainability (cost efficiencies)
- Easy access of health and care services to staff and users

V. Recommendations

Estate management is a key enabler for achieving the ICS aims.

To ensure best in class system estate management practices, we recommend that ICS's take the following steps:

1. Understand the health, care and wellbeing needs of the population
2. Map the existing system estate assets, and their profile, against those needs
3. Agree the vision and strategy
4. Monitor the delivery
5. Establish the estate management governance

Each of these steps involves sub-steps:

1. Understanding health, care and wellbeing needs of the population, incudes:

- Population health and service transformation needs, e.g., more diagnostic centres in the community, lifestyle/ prevention initiatives, accessibility and transport links
- Service transformation requirements
- Staff requirements
- Digital opportunities
- Place requirements, e.g. housing, leisure facilities
- Provider requirements, e.g. organisations, such as ambulance trusts, who work across systems may need to move capital resource beyond system boundaries
- Regulatory requirements, e.g. net zero
- National and regional targets

"Really understand what population health needs are… What are the barriers to access for that population, be that travel, be that health literacy, be that digital, be that digital literacy, and what are you doing about it? And then you'll be able to understand, if you addressed those things, how to right size your buildings?" (ICS, South)

2. Mapping the system estates assets, involves:

- Creating a system-wide inventory of existing estates and profile utilisation, running and maintenance costs, access, carbon-footprint, etc.
- Mapping estates against population needs and other requirements

3. Agreeing the vision and strategy, includes:

- Engaging all system stakeholders
- Agreeing the system estates vision and strategy to meet the health, care and wellbeing aspirations – this should be reviewed/ refreshed annually

4. Monitoring delivery of the system estate management strategy, including:

- Agreeing an asset development plan, including an innovation plan
- Developing a prioritisation process and identify capital projects that will go ahead
- Distributing the funding allocations
- Considering taking ownership of estates
- Setting up processes to monitor delivery against plan
- Supporting partnership working and service integration
- Sharing learnings and best practices across the system

5. Establishing the system estate management governance, including:

- Setting up processes for engaging stakeholders and agreeing the strategy – this should be reviewed/ refreshed annually
- Setting up a system estates group and the terms of reference, e.g. purpose, membership, etc.
- Establishing the process for decision-making, including escalation criteria and RACI (Responsible, Accountable, Consulted, Informed) decision examples

Key success factors

Key success factors include:

- Working with local authorities, PCNs, and the private sector
- Building partnerships, including communication, education, aligning approaches and modelling behaviours
- Being agile and innovative
- Being a leader

Working with **local authorities** can help address funding, capacity and skills issues:

- Funding issues:
  - "The ICS is working with council to overcome respective funding issues… we are already using s106 and working with LAs to build capacity"
  - "Local authorities can transfer and sell properties to ICSs if it can be shown that the space 'can pay.'"
- Capacity and skills issues: "An option is for the ICS to ask the local authorities to manage some/all system health and care real estate, alongside other public sector real estate, e.g. we are in discussions about a new build which would combine local authority offices, a swimming pool, GP/PCN space, diagnostic hubs, social care space and police offices." (ICS, North West)

Working with **PCNs** can help transform pathways:

"Places are very clear that that collaboration is necessary in primary care and they have a relationship with a community services provider… (we) can bring that all together and provide new facilities for everyone"

Private sector partners can bring expertise as well as access to longer term investment capital:

- Expertise: "We hope private partners can bring technical expertise to unlock land ownership, maintenance and management of contracts." Investment capital: "I think the private sector has a big role to play because the Treasury fundamentally doesn't deliver long term capital investment"**Building strong partnerships** involves communication and education, facilitating alignment, exploring innovative and agile approaches, and modelling behaviours.

Examples of innovative funding models

PCN hubs which are cost neutral to the system

- The Trust/NHS Property Services (depending on ownership) put capital into a primary care building which is not being utilized and create a clinical rooms for general practice
- The clinical rooms are made avaliable to a PCN at zero cost

Example financial structures involving local authorities

- ICS convinces the local authority to sign the lease on a primary care building by promising a cap on service charges (the ICS would pick up the difference)
- NHS community service or community diagnostic hub (MRA scans, etc) lease space within a local authority building

Building strong partnerships	Examples
Communication and education	• **Educating the community** *"Reach out to local communities to identify where they can go to receive help and to educate them about care pathways"* • **Engaging system stakeholders** *"There's system-wide buy-in, the right people are around the table, it's taken seriously, and estates is seen as a priority"* • **Gaining NHSE support** *"It is important that the NHSE is signed up to this direction of travel (single estate, one finance model)"*
Facilitating alignment	• **Agreeing principles** *"Agree consistent estate management principles and approach across the system"* • **Aligning IT** *"Align the room booking system between ICS and the Council so they can use their corporate estate in a much more streamlined way"* • **Supporting mergers** *"Merge GP practices and combine with other services"*
Exploring innovative and agile approaches	**Adopting agile approaches:** *"Shift to agile working policies to reduce capacity requirements"* **Creating new ownership models:** " *We are looking for alternative thinking around multi-ownership models."*
Modelling behaviours	• **Walking the walk** *"Our role as an anchor partner really needs to embrace some of that as well"* • **Being inclusive** *"Estate strategy is being developed 'bottom up' all upper tiers LAs involved, District Councils also involved.. discussion taking place on using retail space for medical properties"* • **Recognising engaged councils** *"We've got some great partners in the District Councils who really want to embrace this and be able to look at this.(diabetes, inactivity)"*

Cavell Health and Leisure Centre

Case study

Description

- January 2021: Surrey Heartland CCG were successful in a bid to NHS England to receive an investment for a new Cavell centre in Staines
- In collaboration with Well North Enterprise the aim was to make Staines 'truly integrated' with other health and wellbeing initiatives and re-provision the centre
- The Campus approach delivers an opportunity for a 'hub' and 'spokes' model of service delivery with spokes to:
    - Local social and wellbeing services e.g. leisure centre, social care, housing, citizens advice, debt management, food banks
    - Businesses on the high street e.g. ophthalmology services, hearing services, pharmacist, schools and colleges, healthy eating, practical cooking etc.

Activities

The estate management levers involved in the process were **re-fits, new-builds and strategic system estate management** e.g.

- Collaborative partnership - bringing together individuals from the public, private and VCSE sectors to inform an outline business case for the new health centre
- Freeing up space in hospitals by bringing clinical outpatients services out of the hospital and into the Cavell centre
- Thinking about increased population over the next 10 years, and its impact on service design, the model of care, planning and requirements for the health centre

Impact

- Providing opportunities to address the wider social determinants of health
- Connecting to the wider community – wellness and prevention
- Offering opportunities and routes to employment for young people

VI. Conclusion

System estate management is a key enabler for ICS, which is often over-looked.

The introduction of ICSs provides an opportunity to manage assets more effectively and efficiently across system partners.

Key to success will be working closely with partners, such as the local authorities, NHS Trusts and Foundation Trusts, PCNs and the private sector. Also key is an openness to new models and agile approaches.

There is a great deal of optimism about what can be achieved. We look forward to following progress closely and helping to share best practices and ideas.

The following case studies show the ambition of ICBs to deliver integrated care, facilitated through new premises.

Scheme 1, West London

A scheme to provide the integrated delivery of Trust based community and outpatient services including mental health, children's services, dietetics, podiatry, community nursing, sexual health and diabetic retinopathy. The proposed Trust based services will be alongside primary care services from a GP Practice and the local Primary Care Network. The integrated services will serve a wider population of approximately 80,000 people. The development will be at the heart of a large-scale regeneration of brownfield land, close to public transport. The premises are proposed to be let to a Foundation Trust. Scheme size is approximately 2,100m².

Scheme 2: South London

A development that will provide space for the delivery of primary care services to 20,000 patients, replacing inadequate premises at the heart of a community that experiences high levels of economic deprivation. The development will also accommodate a Community Diagnostics Hub and will facilitate services from a mobile scanning suite. The development will add to integrated care through the location of Trust based community and outpatient services, serving a wider population of 43,000. The building will be let to the local NHS Trust. Scheme size is approximately 2,500m².

Scheme 3: South West London

This development will add capacity to delivery of local primary care services through two local PCNs. The premises will also facilitate the delivery of Trust based community and outpatient services under the ICB's model of integrated care. The Trust based services will serve a wider population of 75,000 as part of the ICB's model of care. The premises will be let to an NHS Trust. Scheme size is 1,400m².

Scheme 4: Essex

The commissioning requirement is for premises to serve a list rising to 20,000 along with community and outpatient services relocated from secondary care. The relocated secondary care services will serve a population of approximately 40,000. Services will be offered in a patient centred, integrated manner. Scheme size is approximately 2,000m². The development will form a key part of the wider redevelopment of a town centre, with close proximity to public transport hubs.

Notes

1. Nhsproviders. 2022. The growing maintenance backlog across the NHS estate - NHS Providers. [online] Available at: <https://nhsproviders.org/news-blogs/blogs/the-growing-maintenance-backlog-across-the-nhs-estate>

2. NHS Confederation. 2022. Optimising the health estate: now and beyond the pandemic. [online] Available at: <https://www.nhsconfed.org/articles/optimising-health-estate-now-and-beyond-pandemic>

3. Unlike NHS trusts who provide annual Estates Return Information Collection (ERIC) returns to NHS England, ensuring there is a good understanding of the state of secondary care estate, no such clarity on the condition and state of primary care infrastructure outside NHS provider ownership currently exists.

4. "While providers remain legally responsible for maintaining their estates and for setting and delivering their organisational-level capital investment plans, every ICB will be responsible for ensuring overall capital spending across its system remains within these budgets" NHS England, 2022. [online] "Guidance on NHS system capital envelopes for 2021/22" Available at: <https://www.england.nhs.uk/wp-content/uploads/2021/03/B0449-Capital-regime-planning-guidance.pdf> [Accessed 14 October 2022].

5. "We will confirm full ICS-level operational capital funding envelopes for 2022/23 and 'baseline' operational capital envelopes for 2023/24 and 2024/25 will be based on 2022/23 envelopes and include RAAC allocations for each year, but exclude the element related to prior year surpluses, which will continue to be calculated and allocated on an annual rolling basis. In aggregate this will give systems certainty over more than 90% of their operational capital envelopes, which should allow systems to proactively plan capital investments into the future." NHS England 2022. 'Capital guidance 2022 to 2025', Available at: <https://www.england.nhs.uk/wp-content/uploads/2021/12/B1256-capital-guidance-for-2022-25.pdf>

6. NHS England, 2020 "Delivering a 'Net Zero' National Health Service'. [online] Available at: <https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf>

7. NHS Networks 2022 'Supporting the green agenda with our primary care estate', [Blog] Available at: <https://www.networks.nhs.uk/editors-blog/supporting-the-green-agenda-with-our-primary-care-estate>

8. Sir Robert Naylor, 2017 "NHS Property and Estates: Why the estates matter for patients"
Available at <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607725/Naylor_review.pdf>

9. "NHS England 'Capital guidance 2022 to 2025', https://www.england.nhs.uk/wp-content/uploads/2021/12/B1256-capital-guidance-for-2022-25.pdf

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