



The innovative use of assets and flexible infrastructure in the world of STPs:

A briefing paper

The Good Governance Institute

September 2017



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The innovative use of assets and flexible infrastructure in the world of STPs

Client: Vanguard Healthcare Solutions Ltd.
Project: The innovative use of assets and flexible infrastructure in the world of STPs: a briefing paper
Version: Final briefing paper
Date: September 2017
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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance both through direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge.

ISBN: 978-1-907610-44-8

This document has been prepared by GGI Research & Development LLP.

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1. Introduction and context

The current policy environment is driving the NHS towards a very different structural picture. Following shifts towards the autonomy of, and competition between NHS organisations, exemplified by the Health and Social Care Act 2012, NHS England's Five Year Forward View (5YFV) of March 2014 favours collaboration. The 5YFV sets out a vision for the future direction of the NHS, the achievement of which will see improvements in public health, the delivery of care that is patient-centred, and the integration of services across health and social care, whilst at the same time ensuring financial savings. The 44 Sustainability and Transformation Partnerships (STPs) across England have been established to deliver on this vision, underpinned by a number of national service strategies in support of areas identified as in need of critical change going forward, namely mental health, urgent and emergency care, general practice, and maternity services.

The Good Governance Institute (GGI) has been exploring many different factors that could enable the successful development and implementation of STPs, and in this paper we focus on the estate. In particular, we consider flexible infrastructure, and the value this could have in accelerating plans, providing flexible and quickly deployed 'lego blocks' as opposed to inflexible permanent structures, following Sir Robert Naylor's recommendation that:

***'STPs should develop affordable estates and infrastructure plans, with an associated capital strategy, to deliver the 5YFV and address backlog maintenance.'*¹**

The NHS estate in England has a considerable floor area, with it being estimated in 2013 that it would cover the area of the City of London ten times over.² Unsurprisingly, estates and facilities have often been managed in the NHS from a 'bricks and mortar' perspective, with there being frequent criticism of estates management for not being sufficiently strategic. A recent King's Fund report noted that while there is no national estates strategy, with NHS Trusts and Foundation Trusts being required to formulate organisational estates strategies, the NHS may lack the skills required to develop an effective estates strategy, with estates management staff often focusing on the operational at the expense of the strategic.³

However, it is clear that this method of managing estates is increasingly unsustainable. Backlog maintenance in NHS trusts is a growing issue, increasing between 2014-15 and 2015-16 by 69.3% from £457m to £776m, and perhaps more concerning, the 'significant risk' backlog increased by 47.6% from £1.06bn to £1.57bn.⁴ Further adding to the pressure on the acute estate is the sheer increase in demand from emergency and elective patients, while patient flow is increasingly difficult, with numbers of Delayed Transfers of Care (DTOC) also rising due to the problems facing the social care sector. Primary care faces similar issues, with premises often being unfit for purpose and historically underfunded.

The NHS has a historic estates stock designed for a fragmented system whereby primary, secondary and acute care providers predominantly worked in silos – it is not designed for the future integrated system. In order to achieve the vision of the 5YFV, it will therefore be necessary for the NHS estate to be reconfigured to accommodate the associated move to out of hospital care and to provide opportunities for greater integration. Whilst the impact on the NHS estate will inevitably vary between the different models of care described within the 5YFV, it is recognised that the ability of the NHS to achieve the vision of the 5YFV will fail unless the estate is improved and changed.

The future NHS estate must be fit for purpose to meet the demands of the current and future population, taking into account:

- the shift in the demand for care, predominantly as a result of the changing age demographic (ageing population)
- the future impact of the transformation of services, with a focus on the expansion and strengthening of primary and out of hospital care
- new advances in technology, which will continue to dictate the way in which care is provided

1) Sir Robert Naylor, NHS Property and Estates: why the estate matters for patients: An independent report by Sir Robert Naylor for the Secretary of State for Health, Department of Health, March 2017

2) Nigel Edwards, NHS buildings: obstacle or opportunity? The King's Fund, July 2013

3) Lillie Wenzel, Helen Gilbert, Richard Murray, NHS estates: review of the evidence, The King's Fund, October 2016

4) National Health Executive, NHS high-risk maintenance backlog increases by 70%, 12 October 2016, <http://www.nationalhealthexecutive.com/Health-Care-News/nhs-high-risk-maintenance-backlog-increases-by-70>

There needs to be more ambition in the way the NHS estate is used. Re-thinking the way in which the NHS uses its estate to deliver the necessary service transformation evidenced through STPs could be a key facilitator of the required change. In particular, STPs will need to consider how services can be reconfigured when they are already 'running hot', taking into account the unforeseen pressures facing all areas of the health and social care system. Furthermore, in an already difficult financial context, with many providers facing deficits, there is a recognised absence of further capital funding being made available to support the reconfiguration of services.

A key solution to this question is for boards to develop a more strategic approach to the estate and think creatively about its use, by using existing assets more innovatively while employing solutions such as flexible infrastructure while the necessary reconfiguration is taking place.

GGI would like to thank Vanguard Healthcare Solutions, who came to us with the idea for this report, and have helped fund this independent research by ourselves. Our report contains valuable insight into an essential issue for NHS boards and policy makers to understand, to support the development of appropriate strategies. We are grateful to Vanguard Healthcare Solutions too for steering us towards the case studies that are provided within this report, and to both the Shrewsbury and Telford Hospital NHS Trust and the Antonius Hospital in the Netherlands.

We also wish to extend our thanks to all those trusts and GP federations who took the time to participate in GGI's research.

2. Methodology and limitations

GGI carried out this independent review between February and July 2017. To inform our findings, we have conducted an in-depth literature review on the current NHS estate, the impact that the developing STPs will have on this and innovative practice in healthcare estate management. This is supported by a set of base research into acute providers looking, for example, at backlog maintenance and capacity issues.

Furthermore, GGI has undertaken a survey of acute trusts in England, conducting short telephone calls with Executive Directors from 28 acute trusts. These interviews covered such topics as the pressures facing the acute sector, the appetite for using assets more innovatively and using flexible infrastructure, and the implications on the estate of the trust's local STP. We also asked trusts if they were aware of the barriers they were facing with regards to their estate, which impacted on their ability to deliver services today as well as transform the estate for tomorrow. This was complemented by a smaller survey of the emerging GP federations, who are likely to become a much bigger player in driving local health as the STPs continue to be developed and implemented. These interviews covered the challenges facing general practice, and how the expansion of primary care might be facilitated.

Although there were variations of opinion from our respondents, particularly those from the acute sector, the survey revealed many similar themes regarding the use of assets in the current healthcare environment. However, these findings may be limited by the number of responses GGI was able to achieve following our invitations to take part in the survey.

3. The case for a flexible estates strategy for STPs

3.1 Fragmentation of estate ownership and development of an STP-wide estates strategy

The current fragmentation of estate ownership within STP footprints – whereby the health and social care estate may be owned by NHS trusts, NHS foundation trusts, NHS Property Services Limited, Community Health Partnerships, local authorities, GPs, private or voluntary sector providers – is acknowledged by a number of STP plans as posing a significant barrier to the effective implementation of the STP. As one Director of Strategy told us, the estate needs to be an enabler of STPs, with organisations ‘unlocking the estate for each other rather than each organisation having the key to their own front door.’ It is therefore recognised that an STP wide estates strategy is needed to support STP footprints in overcoming these challenges, allowing for the estate to be shared and provide a central facet to collaborative working, an expansion of the primary care estate, and the reconfiguration of secondary care services.

3.2 Capital investment in the NHS estate

In the past there has been investment in buildings that are in the wrong place, and others that now appear to be surplus to requirement, or are rapidly becoming out of date as treatments and care change. Many of these buildings are over-specified and inflexible, which make them expensive to operate and to reconfigure. This also means that they often have a low residual or alternative value compared with their initial costs, which makes them relatively expensive to finance and difficult to dispose of.⁵

Furthermore, capital investment in the NHS is being viewed as being insufficient to both fund transformation and enable the current NHS estate to be maintained. In his recent report, Lord Naylor wrote:

‘The general consensus is that the current NHS capital investment is insufficient to fund transformation and maintain the current estate. We estimate that STP capital requirements might total around £10bn, with a conservative estimate of backlog maintenance at £5bn and a similar sum likely to be required to deliver the 5YFV... This report therefore calls for the NHS, through the STP process to rapidly develop robust capital plans which are aligned with clinical strategies, maximise value for money (including land sales) and address backlog maintenance.’⁶

The March 2017 Budget announcement on capital investment referenced that in the Autumn of 2017, a further round of STP proposals would be considered, which would be assessed for value for money. The challenge, therefore, is for local areas to develop high quality plans, with a long-term, strategic view of asset management integral to this.⁷ As part of this, there is a clear need for organisations to be innovative with their existing assets and recycle existing capital and infrastructure in order to facilitate integration.

However, many STPs still seem to be in the early, high level stages of planning how this capital investment will be secured. Focusing on the three aspects of investment that will be required (capital to put in place the appropriate infrastructure and systems, revenue to stabilise the longer term budget, and revenue to ensure that there is sufficient change management capacity), The Chartered Institute of Public Finance and Accountancy (CIPFA) has commented:

‘The STP narratives are patchy both in terms of whether those factors are separately identified and evaluated, and whether the resources said to be needed area are actually in place. It isn’t unusual to come across such statements as “This change will require investment. We are exploring options for identifying transformation funding to support this work.”⁸

Norfolk and Waveney STP, for example, states that ‘due to rapid development of solutions... the implications for capital expenditure are not yet clear... a robust assessment of capital across the system is needed.’ Furthermore, a key risk described in many of the STPs published so far is the lack of capital available to deliver plans.⁹

5) Lillie Wenzel, Helen Gilbert, Richard Murray, NHS estates: review of the evidence, The King’s Fund, October 2016

6) Sir Robert Naylor, NHS Property and Estates: why the estate matters for patients: An independent report by Sir Robert Naylor for the Secretary of State for Health, Department of Health, March 2017

7) *ibid*

8) CIPFA, Reality Check: Next steps in developing sustainability and transformation plans, March 2017

9) *ibid*

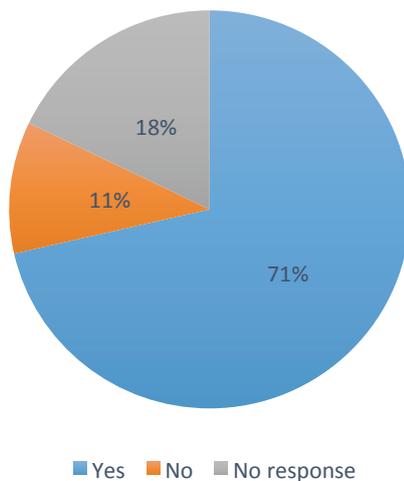
There is, therefore, a clear need for organisations to be innovative with their assets and recycle existing capital infrastructure to develop and sustain estates across the system, in line with the recommendation of the Naylor Review quoted earlier in this paper. Redevelopment of an existing asset can help release capital in site-value back to the NHS, which can subsequently be utilised to redevelop or upgrade other parts of the estate. Committing to a leasing deal on one asset could therefore unlock a further capital programme within the NHS. That said, with the pressure currently facing all parts of the acute system and the need to retain flexibility as the NHS continues to change, redeveloping facilities as concrete, inflexible structures may not be the most effective way forward. Instead, deploying flexible infrastructure, in the form of mobile clinical facilities, will both allow for quicker reconfiguration and ensure that facilities are adaptable to the changing landscape.

3.3 How can NHS Trusts and NHS Foundation Trusts reconfigure services when they are already under pressure?

A particularly significant aspect that the STP estate strategies will need to consider is how to manage the upcoming service reconfiguration, given the pressure that is currently facing the whole system, with unprecedented demand on the acute sector, and primary care and social care sectors that are widely reported to be 'in crisis'.

Each one of the trusts that we spoke with reported having serious issues with the pressure on their services, repeatedly linked to the issues in social care and problems with Delayed Transfers of Care (DTOC) and flow through the hospital.

Are the problems in social care causing issues with patient flow and DTOC in your trust?



This was cited by many trusts as being perhaps the primary factor in causing shortages in beds and longer waiting times in their hospital, and is supported by nationally published figures on DTOC. In February 2017, there were 184,900 total delayed days, of which 124,200 were acute, compared to February 2016 where there were 158,000, of which 104,300 were acute. Of the total delayed days in February 2017, 559, or 15%, were because patients were awaiting placement or availability in a residential and nursing home.¹⁰ The National Audit Office (NAO) has estimated that the gross cost to the NHS of older patients in hospital beds who are no longer in need of acute treatment is some £820 million,¹¹ while the Carter Review argued that hospitals could make savings of £900 million if they were able to tackle issues of DTOC across all age groups.¹²

10) NHS England, Statistical press notice: Monthly delayed transfers of care data, England, February 2017, 13 April 2017, <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/February-17-DTOC-SPN.pdf>

11) National Audit Office, Discharging older patients from hospital, 26 May 2016

12) Lord Carter of Coles, Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, February 2016

Clearly, there are benefits to be gained across the system, both financially and in the interest of patients, by driving improvements in social care and the integration of health and social care organisations as part of STPs to address DTOC. In acute trusts specifically, those hospitals we spoke to were required to dedicate up to 25% of their bed base to those who were ready for discharge, which was in turn impacting on elective care and leading to cancellations of elective procedures, particularly in the winter period when higher numbers of A&E attendances were further increasing pressures.

While some trusts said they had been too busy 'fighting fires' to come up with an effective, longer term strategy for dealing with this matter, others told us of a variety of interesting ways of using their estates to help free up bed space and support patient flow, including the following:

- one trust had been holding 'Capacity Summits', looking at different ways of using existing infrastructure more creatively, for example, through configuring wards differently or moving trolleys. This also gave them more opportunity to think further ahead, for example through beginning to plan bringing in extra flexible infrastructure for next winter far in advance, and ensuring the use of flexible infrastructure was being discussed at board level. This modelling played a key role in helping them to manage the 'crisis' of the winter of 2016/17. In addition, the trust has a Medical Assessment Unit with ten trolleys, with the idea being that this will be cleared by the end of every day, so they are starting every day with at least ten free trolleys. Another trust carried out a review of assets and estates which was clinically led by the Medical Director and Nursing Director, looking at how fixed estates could be used more flexibly. This managed to free up 30 extra beds in the winter periods
- several trusts had expanded upon the range of services traditionally delivered by an acute trust, for example by co-locating a GP at their A&E department, or by entering the care home market themselves. One had been trialling 'virtual clinics' in order to reduce the physical pressure on both emergency and elective services
- others were looking to bring in mobile clinical facilities to host elective activity, which would be ring fenced for elective activity only, with no option to escalate into these areas. This has the benefit of allowing elective activity to be maintained at peak times, and to maintain financial stability, as well as achieving significant benefits for patients
- a trust based in a hospital building pre-dating the creation of the NHS, with some parts of the hospital being over 100 years old and causing significant backlog maintenance, was systematically mapping and measuring every room in the hospital and establishing what space was best suited for clinical and non-clinical use. If necessary, they will then be looking at bringing in extra flexible infrastructure in order to maximise clinical space, a recommendation of Lord Carter's review
- several trusts, especially those with more than one District General Hospital (DGS) were mapping out 'hot' and 'cold' sites and working out how services could be reconfigured in order to maximise the use of existing space and improve patient flow
- to help deal with future winter problems, one trust was planning to bring a community ward and mobile facilities into the hospital, as well as sitting an acute hub at the main entrance

These responses suggest that using estates and assets more innovatively, as well as bringing in extra capacity where appropriate through flexible infrastructure and mobile facilities, is playing a key role in helping to address the issues currently facing the acute sector. It also seems apparent that many trusts are developing clear strategies on using their estates and facilities more flexibly in order to help manage this pressure, including the use of flexible infrastructure and mobile clinical facilities which is providing 'decant space' for elective activity, thus mitigating the risk of cancellations of elective procedures when numbers for A&E attendances and DTOC are rising. The maintenance of elective activity has clear benefits for patients, as well as ensuring that a trust's income from elective activity is preserved.

In a world of system transformation, GGI would encourage this innovation now to be used to give providers further flexibility when services are being reconfigured as part of the STP, and used across the whole system as a key part of estate strategies for the implementation of STPs.

3.4 NHS estate: supporting the delivery of STPs

The implementation of STPs will ultimately bring significant change and challenge to the way health and social care is delivered and should be considered as key for delivering improvements for the NHS estate. In light of this, local STP footprints are being encouraged to identify opportunities for better use of the NHS estate in their STP plans.

Key to this will be the innovative use of assets to ensure the flexibility of estates and infrastructure. This will ensure that the estate is able to meet current and future demand pressures, as well as responding to an evolving service scope. Flexibility would also allow infrastructure to accommodate a mix of services, as well as providing a single point of access to a broader range of services.

Furthermore, following the publication of the Carter report¹³ on achieving efficiencies in the NHS, a core recommendation of which was to reduce the amount of space being used for non-clinical purposes and maximise clinical space, the reconfiguration of the estate as a part of STPS will be a good opportunity to also look at how this could be achieved. In order to maximise clinical space, it will be essential to use existing assets more flexibly and innovatively, which could be complemented by the use of flexible infrastructure. A number of trusts we spoke to were carrying out remodelling of both rooms and beds in order to achieve this, but it seems there is scope to further explore how efficiencies can be brought about.

The Indian concept of *jugaad*: 'frugal innovation and making the best use of limited resources'¹⁴, could well be transferred to the NHS in England in order to deliver such efficiencies and maximise the estate. The use of flexible infrastructure has been shown to ensure the continuation of high-quality care while an individual organisation's services are at full capacity or being reconfigured, making the best use of the estate already available, as the below case study shows. Taking this even further, flexible infrastructure could be a way to continue to do this while services are being reconfigured across the whole system, and help to formulate a system-wide estates strategy.

13) Lord Carter of Coles, Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, Department of Health, February 2016

14) The Good Governance Institute, What is frugal innovation?, 2016

Case study one: Using flexible infrastructure to support service reconfiguration: The Shrewsbury and Telford Hospital NHS Trust (SaTH)'s use of flexible infrastructure

SaTH is the main provider of district general hospital services for nearly half a million people across Shropshire, Telford & Wrekin and mid Wales. Its main sites are the Princess Royal Hospital in Telford and the Royal Shropshire Hospital in Shrewsbury, which together provide 99% of the Trust's activity. Combined, the hospitals have just over 700 beds and assessment and treatment trolleys.

To expand this capacity, SaTH has used flexible infrastructure on three occasions. On each of these occasions, the flexible infrastructure was used to solve capacity issues within a certain timeline, although the focus was different each time. The Trust's experiences using flexible infrastructure are summarised below, following conversations with SaTH's Care Group Medical Director for Scheduled Care.

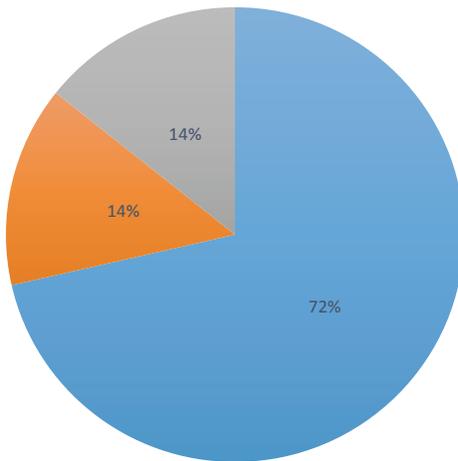
1. SaTH first made use of flexible infrastructure when the endoscopy unit at Princess Royal Hospital was being renovated, and the whole unit needed to be vacated, however, the Trust wished to preserve as much activity as possible. The transfer of activity to a mobile endoscopy unit allowed SaTH to maintain activity during the renovations, with minimal disruption to the delivery of the service or the building work taking place. It also allowed the Trust to separate male and female recovery areas, thus helping it to achieve accreditation from the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
2. In 2014, SaTH was facing a backlog in orthopaedics and dental surgery, and considered outsourcing the procedures to other providers. However, it was a challenge to find other providers that were not facing similar issues and even where that was not the case, patients did not want to go outside of their local area. Therefore, the Trust decided to be flexible with their existing assets and used a mobile theatre and mobile ward unit, which offered capacity to both treat patients and provide room for their recovery. Keeping all treatment at the Princess Royal Hospital site allowed SaTH to make use of their own clinicians, ensuring they could control the quality of surgery and anaesthetics.
3. Despite some scepticism from clinicians at first, they found the transition to flexible infrastructure smooth and the facilities as modern and up-to-date as they were accustomed to in existing facilities. This flexible use of infrastructure had a positive impact on the Trust's activity, with 742 additional treatments taking place in 23 weeks. In Trauma and Orthopaedics, the percentage of patients being treated within the target of 18 weeks after referral increased by nearly a third, while in Oral Surgery, this figure more than doubled.
4. In the winter of 2015/16, the trust faced challenges in delivering its winter plan, for example with no escalation area on the Princess Royal site, and needed to maintain inpatient capacity throughout the winter pressures. The Trust developed the creative solution of moving inpatients into the existing day surgery unit, and placing an extra mobile day surgery unit next to this, in effect creating an extra ward, which they could release for medical patients. The trust was then able to preserve activity in the day unit over the winter, which otherwise may not have been able to take place and would have caused additional waiting list and Referral to Treatment (RTT) problems.

What's next for SaTH?

SaTH intends to embark on a period of major reconfiguration as part of the NHS programme Future Fit, which will be a major component of the Shropshire and Telford & Wrekin STP, with the aim of redesigning care to best meet the changing healthcare needs of the population. Under the proposals, the Trust's A&E services would be reconfigured, which would in turn have an impact on planned care. It is proposed that the Trust will have an emergency centre on one of the two main sites, while the other site would become the centre for planned care. If this large scale reconfiguration takes place, the Trust intends to continue its use of flexible infrastructure, in order to complement and maximise its existing assets and infrastructure while this building work is going on.

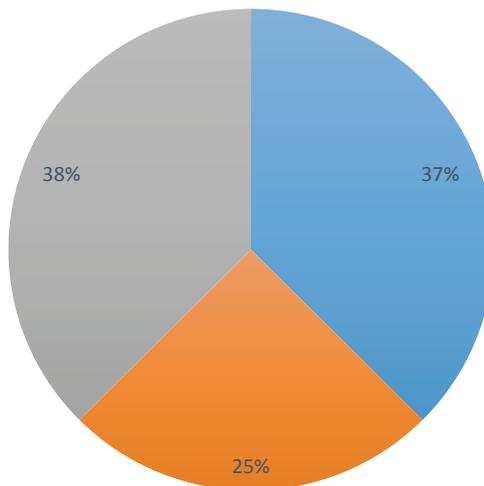
Despite the prospect of major service reconfiguration in STPs, which the majority of trusts we spoke to said featured in their local STP plans, our research has suggested that so far, the development of an estates strategy has not been a key priority, with plans remaining at a very high level. Although it is expected that the estates strategy should follow the clinical strategy, many of the NHS directors we spoke to told us that estates strategy planning remains in its very early stages, and that it was too early to say how assets could be used more innovatively to support the STP process. One director, for example, told us that plans in his area were 'higher than high-level', and he did not foresee reconfiguration taking place for up to three years, while another said that although plans in his area set out 'grand ambitions', he was yet to see much evidence of work taking place to 'get to the tangibles'.

Is it likely that the implementation of the STP in your area will lead to secondary care service reconfiguration?



■ Yes ■ No ■ Not sure / consultation still taking place

Do you assess the requirement for quickly mobilised additional capacity or flexible infrastructure as high or low?



■ High ■ Low ■ Too early to say

This disconnect between those trusts who responded that they did see secondary care service reconfiguration as an integral part of their local STP and those who had a clear vision as to how this would be implemented, reinforces the high level nature of STP estate strategies, perhaps too high a level considering the pace with which local partners are being expected to deliver their plans. One NHS Foundation Trust Chief Executive told us that although she expected there would be a high need to quickly roll out additional capacity in order to support the reconfiguration of services, the feasibility of this was low due to financial and workforce pressures.

Progress on reconfiguring the NHS estate will need to be made quickly, acting as an enabler for clinical strategies and allowing swift delivery of new models of care. The use of flexible infrastructure, which can be quickly rolled out, can assist with this as well as providing rapidly mobilised additional capacity, which a number of trusts said would be necessary in their STP. Meanwhile, care should be taken by leaders of NHS trusts that the reconfiguration and transformation of services does not distract attention from maintaining the day-to-day 'grip' of the running of the hospital, including keeping A&E waiting time targets within expected levels and maintaining elective activity. The use of flexible infrastructure could be a key solution in bridging this gap, by allowing for the faster delivery of reconfiguration and additional capacity, as well as providing 'decant space' for facilities to extend into when existing facilities are being reconfigured.

Those acute trusts which have PFI buildings may face further challenges in reconfiguring services, as, not being the owner of the asset, they will be much more limited in what they can actually do with the fabric of the building. One trust told us that they were exploring the use of mobile facilities as an alternative way of reconfiguring within the constraints of their PFI contract.

Those trusts that did speak of a well-developed estates strategy were in areas where integration was in progress even before STPs were announced as a national policy initiative. For example, an area that is well known for its forward thinking approach to integration is Greater Manchester, and the delivery plan for Greater Manchester Health & Social Care Devolution states the following:

'The health and social care estate in Greater Manchester is a critical enabler for delivery... The significant quantum of estate from which care is delivered needs to be reshaped to respond to the planned transformation. The radical scale up of prevention, the delivery of integrated care in local neighbourhood teams and the standardisation of hospital based care will reduce acute hospital activity and length of stay for those that need to be admitted to hospitals.'

Key features of Greater Manchester's estate plan includes scaling up primary care and the integration of community and social care as well as the creation of multi-purpose community based hubs. The delivery of this will be supported by a standardisation of back office functions, new governance structures to maximise value from the public estate, and the devolution of health and social care, however it is accepted that achieving the vision for estates is made difficult by the complex structure of the health and social care system and the current system for ownership of land assets.¹⁵

Regarding the challenges involved in securing capital for the estate strategy, the document goes on to state:

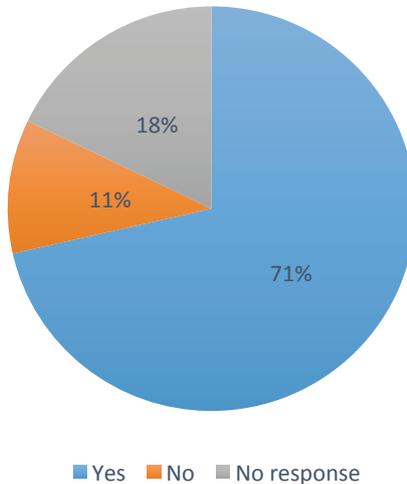
'Given the lack of capital funding available across the public sector, work has commenced on a GM Capital Financing Strategy. This is required to enable the estate to be remodelled to better support new models of care and will include consideration of a Public Private Finance model for Greater Manchester.'

Moving forward, STPs across the country will need to develop this maturity in planning how to finance the reconfiguration work necessary for successful transformation.

15) Greater Manchester Health & Social Care Partnership, Taking Charge: Implementation and Delivery Plan, October 2016

3.5 Financing the investment in estates and facilities

Are the problems in social care causing issues with patient flow and DTOC in your trust?



As already discussed, there is widespread concern about the financing of STPs, specifically the level of investment from the centre, as raised in the Naylor Review of March 2017. Although originally intended as a cost-cutting measure to some extent, STPs will be expensive to implement particularly with regard to the investment that will be required to reconfigure the estate. As Lord Naylor has argued, the cost of delivering STPs 'might total around £10bn, with a conservative estimate of backlog maintenance at £5bn and a similar sum likely to be required to deliver the 5YFV.'¹⁶

Considering the current economic climate of austerity and potentially insufficient capital funding coming from the centre, STP leaders will need to be more innovative in their accessing capital to achieve the goals of their STPs. During our interviews, we found that using assets and estates more innovatively went hand in hand with this, while the use of flexible infrastructure was an effective way of both making the most of existing capital and allowing trusts to take a longer term view. One Chief Executive, whose trust had acquired a modular ward, told us:

'The modular ward is just under £1m a year, if you were to mortgage that you would be able to build and develop further... the modular ward has allowed us to progress our thinking to a longer term view.'

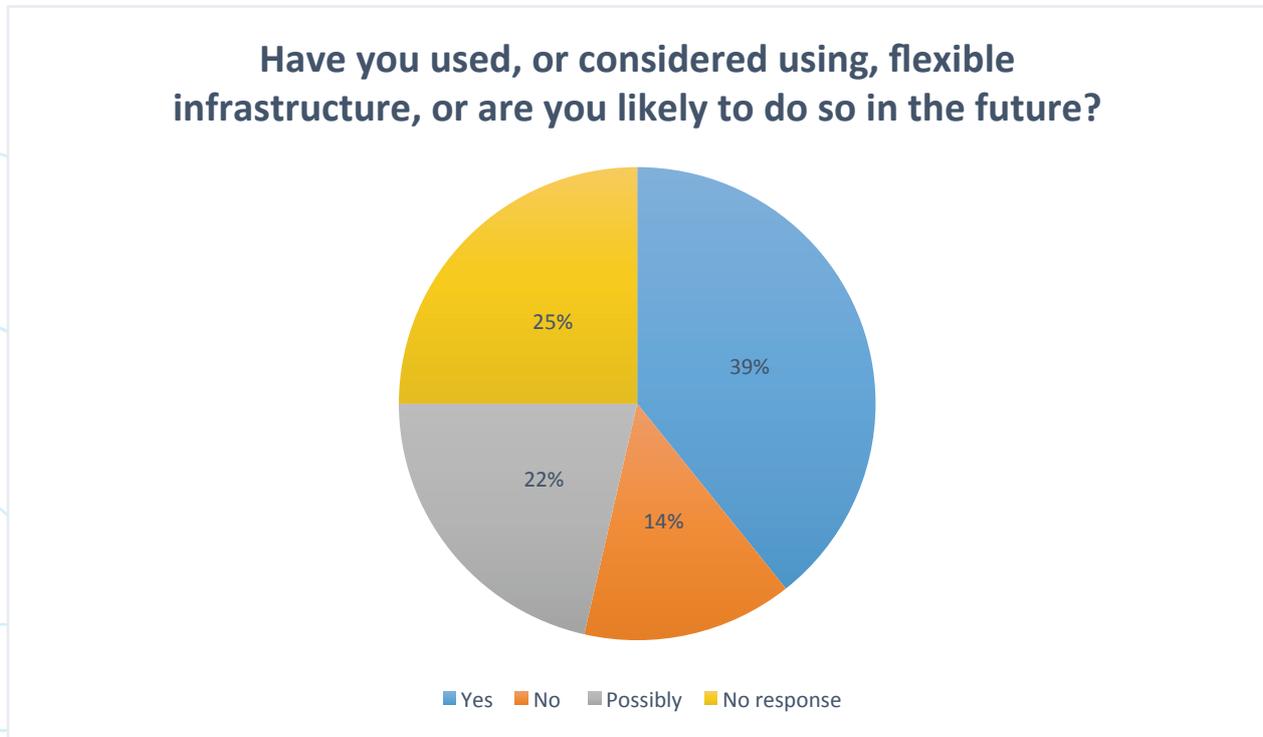
The hospital, which it admitted had been 'caught in a very traditional model of using assets', has now developed a five-year plan for its estate, part of which is using flexible infrastructure to ensure its estate is fit for the future, taking a more strategic, longer term view. Similarly, following the outcome of the General Election in 2017 confirming that STPs now look to be the main policy initiative in the long term, organisations within STPs are entering into a long-term commitment to integrate services and develop new models of care and as such should be creating long-term estate strategies to underpin this, ensuring that the estate is able to support care that is fit for the future.

The initial investment involved in service reconfiguration and bringing in flexible infrastructure will need to be taken into account. As mentioned above, more advanced systems such as the Greater Manchester Health and Social Care Partnership have been developing a strategy for capital financing, including looking at Public Private Financing models. England-wide, there is likely to be a move towards local, risk based financing to complement the limited centrally allocated funding, as recommended in the Naylor Review, and GGI would encourage system leaders to explore the various options available to them in financing the STP estate goals. Furthermore, as was acknowledged by trusts in our research, the costs associated with flexible infrastructure are less than what would be needed for substantive infrastructure, and with the 'Return on Investment' (ROI) they could bring through maintaining performance, this could be a viable solution, which also offers greater value for money, for reconfiguring in times of high capacity and service transformation.

¹⁵ Sir Robert Naylor, NHS Property and Estates: why the estate matters for patients: An independent report by Sir Robert Naylor for the Secretary of State for Health, Department of Health, March 2017

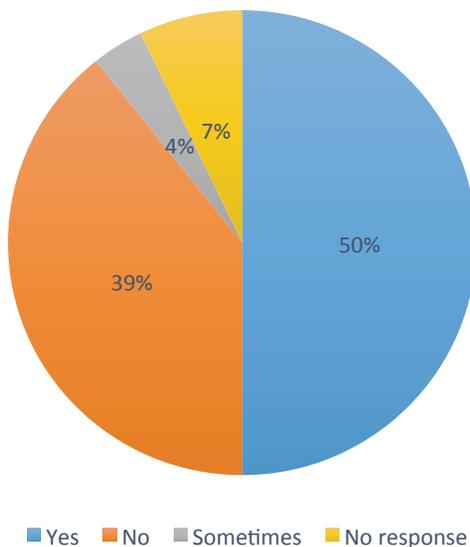
3.6 Backlog maintenance, the use of flexible infrastructure, and the future of hospital based care

In our research, we asked trusts about their experiences using flexible infrastructure, particularly in dealing with periods of high capacity and winter pressures:



Those trusts who said they had not yet considered bringing in extra flexible infrastructure were those who felt they already had too much estate, and were instead looking for ways to release some of this estate. In contrast, many of those who had used it, or considered using it, were those who were extremely constrained by space, which in turn was having a consequence on hospital performance, and they were looking to flexible infrastructure largely as a short term solution, providing much needed 'decant space' to ensure that hospital activity was not impacted by a lack of bed space. This contrast reflects the wide variation in the quality and condition of the estate across the English NHS.

Is limited building space and/or estate a barrier to managing capacity?



However, our research does show that limited space is something which acts as a barrier to managing capacity in the majority of trusts, and in these cases many trusts said that using their existing assets more innovatively, and bringing in flexible infrastructure when this was appropriate, had been a key method in managing this.

Something that was far more consistent across the trusts we spoke to was backlog maintenance, with the vast majority of trusts indicating that this was an ongoing problem in their estate, with one hospital saying that even their 'basic structure' was in need of significant investment in parts, and another (based in a 100-year-old building), had a 'huge amount of backlog maintenance' with some clinical space that was not fit for purpose, acting as a barrier to maintaining clinical capacity. Dealing with this was described as a 'must-do, not a 'nice-to-do', yet the Director we spoke to felt that capital was too constrained even to address immediate, non-transformative, problems.

While backlog maintenance difficulties has been a long acknowledged problem, attempts to manage it often seem to have been unsuccessful, with Nigel Edwards writing in 2013:

*'Some of the newer estate built to deal with historic issues has created new problems of its own. New buildings have often been over-specified, inflexible and too expensive to operate and reconfigure.'*¹⁷

This shows that whatever the estate-related issues are in a specific trust, flexibility is an important aspect of a successful estate strategy. In cases where trusts are struggling with issues of tight capacity and backlog maintenance, the use of additional flexible infrastructure could be a significant help, allowing for 'decant space' while issues of backlog maintenance are dealt with, to ensure that any problems do not escalate to the extent that the condition of buildings and facilities means that procedures cannot go ahead. Furthermore, we would suggest that flexible infrastructure should be seen not only as a short-term solution, but something which can be a vehicle towards a longer term view as system transformation takes place.

As the population and the way care is being delivered is ever changing, and a very different picture to what it was when the NHS was created, it is important that STPs also take a perspective on estates strategies that is long-term, ensuring that facilities are flexible enough to be able to deliver the healthcare needs of the future.

It has been argued that *'while health care needs continually change, as do the service's response and clinical advances, infrastructure investment tends to move from one fixed point to another. This means that, too often, the buildings call the tune when shaping, or more accurately cementing, services in place.'*¹⁸

17) Nigel Edwards: NHS Estate: better together, Public Finance, July 2013

18) Barrie Dowdeswell, Could NHS buildings become tools not temples? The King's Fund, 11 July 2013, <https://www.kingsfund.org.uk/time-to-think-differently/blog/could-nhs-buildings-become-tools-not-temples>

Taking into account the fact that a key aim of the STP approach is to create services that are sustainable for the future, and provide health and social care leaders with an opportunity to refresh the estate in their footprint as they see fit, system leaders should think flexibly whilst this is taking place, and not waste this opportunity by focusing too much on a traditional 'bricks and mortar' view of NHS estate. Instead, mobile clinical facilities can provide much more flexible 'lego blocks', which can continue to adapt to the changing healthcare needs of the population as more and more care is moved out of the traditional generalist hospital setting, as well as ensuring adaptability in the case of any further significant changes in national policy.

3.7 Supporting the delivery of new models of care and the expansion of primary care

*'While there are few explicit references to the estate in the 5YFV, it does propose the development of new models of care. These models will have varying degrees of impact on the NHS estate, but given the emphasis on expanding and strengthening primary and out-of-hospital care, it will not be possible for the NHS to achieve its vision without changes in the estate.'*¹⁹

A key aspect of STPs is the new models of care which will aim to bring a greater amount of care out of acute hospitals and into the community, being delivered closer to home. This will be reliant on a strong and healthy primary care sector, which has facilities sufficient for hosting multi-disciplinary teams and delivering a wider range of services.

Our interviews with GP federations have suggested that in their current state, GP facilities lack this capacity. One GP federation Chief Executive told us that many GP practices in his area were still based in mid-terraced houses which, while facilities may be modern and up-to-date, is not conducive to the expansion of services. Another Chief Executive referred to the 'crisis' of workload in general practice, telling us that in his patch, 'there are some areas struggling to do today's work within existing facilities, never mind tomorrow's.' The general picture was of a primary care sector based in facilities of highly variable quality and capacity.

This is supported by a review of the literature. Deloitte's data analysis of the NHS estate, published alongside the Naylor Review, concluded that 'the extent of single handed and small GP practices is understood to be inconsistent with the developing service strategies to move more care out of hospital into community settings. The five-year forward view is, therefore, predicated on major change in the primary care estate... [there are] practices which, based on high-level indicators, might not meet the future vision of care moving towards delivery through larger primary care hubs.'²⁰

Furthermore, the criticism of secondary care estate for being too inflexible has also been directed towards the primary care estate in England. Nigel Edwards has argued that the issues facing acute care are also existent in primary care, with space often being inadequate, wasted, or inflexible:

*'There is a case for creating multi-purpose, flexible facilities for extended primary care teams, integrated community and social care staff, diagnostics and specialist consultation.'*²¹

Clearly then, significant investment in primary care facilities needs to be a central facet to the estate strategies of STPs. To help achieve this, NHS England has introduced the EETF, a multi-million pound investment (revenue and capital funding) in general practice facilities and technology across England between 2015/16 and 2019/20, which is intended to support improvement in the premises and infrastructure of GPs, in order to facilitate the expansion of out-of-hospital care. However, in our conversations with GP federations it became apparent that, at least in some cases, this funding has been difficult to acquire. A GP federation in one London borough told us, for example, that only one practice in the area was eligible for such funding, and although they had a clear estate strategy for delivering the proposals of the General Practice Forward View, they simply did not have the funding to implement it, and felt it would be very difficult to facilitate the shift of care away from the traditional acute setting using traditional methods of accessing capital. Another GP federation had four out of twenty-two practices eligible but they have not yet obtained absolute commitment to proceed, commenting that 'being eligible for funding and actually getting funding are very different things.'

Therefore, STP leaders and general practice services will need to be looking at more innovative ways of accessing capital and using estates and infrastructure in order to facilitate the expansion of primary care needed to deliver more care in the community, for example services such as diagnostics in an out-of-hospital setting. The GP federations we spoke to were keen to take on a wider range of services in primary care, and were at a range of stages in implementing this.

19) Sir Robert Naylor, NHS Property and Estates: why the estate matters for patients: An independent report by Sir Robert Naylor for the Secretary of State for Health, Department of Health, March 2017

20) Deloitte, Naylor Review: Data Analysis – Key Findings, October 2016

21) Nigel Edwards: NHS Estate: better together, Public Finance, July 2013

These included:

- not yet delivering diagnostic services, but starting to develop a plan with the local CCG for the development of primary care hubs, with a plan of making better use of existing estate to facilitate this
- in conversations with the local acute trusts to work more like an ACS to move services out of hospital, but questioning whether the local GP practices have the ability to host such a move
- already started with two small pathways as a step in that direction, setting up a specialist practice in each locality for other GPs to refer into
- providing services at a newly built central practice, with capacity to deliver such services
- using space at the local acute hospital for community clinics, however this was not seen as ideal or cost effective

Flexible infrastructure could be an effective way to quickly upgrade the facilities that a GP practice can offer, whilst also being more cost effective than immediately building permanently. Furthermore, it would provide flexible 'lego blocks' that could adapt to the changing nature of what will be required from primary care. One GP federation Chief Executive told us that the lack of larger primary care centres was a major barrier and something that needs to be addressed, and said that he saw flexible infrastructure as an opportunity to do this. However, another told us that although he saw the value in such a solution, the system does not yet 'have the maturity to say "this is what we're going to do" and to move wholesale towards care in the community.' Similarly, another GP federation had conducted an informal survey of their practices, mapping out where the clinical, non-clinical, and multi-disciplinary team (MDT) space was, and felt that there was not currently sufficient willingness across the whole system to collaborate in upscaling primary care. This highlights the need for any estate strategies to be backed up with robust governance and behaviours.

A further incentive to use infrastructure flexibly, rather than constructing more inflexible, permanent buildings, lies in the nature of the vision for the future of primary care. The new care models have as a central focus the provision of multi-disciplinary care teams, delivery of services out of hours, and delivery of services traditionally delivered in hospital, and so the estate will need to be reconfigured in such a way so as to allow it to be used flexibly. This has led Dr Nav Chana, Chair of the National Association of Primary Care (NAPC), to write:

*'[Delivering a wider range of services] is possible, but as things stand too few primary care providers have the correct facilities... Building new brick and mortar facilities would take too long, cost too much and – crucially – many new facilities would only be used during peak periods. But by borrowing the acute sector's answer to temporary capacity issues, we can utilise mobile facilities... to flexibly increase capacity and increase service offerings in a primary care setting.'*²²

Dr Chana cites endoscopy as an example of a service that could be delivered in primary care, but this has been prevented by lack of capacity within the estate, and the use of flexible endoscopy facilities could be a key driver in bringing the delivery of such procedures into the community.²³

There have been examples of flexible infrastructure being used in other countries in order to increase the range of facilities that can be offered in primary care, as detailed in the following case study:

12) Dr Nav Chana, Collaboration can make general practice more efficient, GP Online, 31 January 2013, <http://www.gponline.com/dr-nav-chana-collaboration-general-practice-efficient/article/1422349>

23) *ibid*

Case study two: Using flexible infrastructure to deliver primary care at scale and closer to home: Antonius Hospital, Emmeloord, the Netherlands

Established in 2007, the Antonius Hospital in Emmeloord is a branch of the larger Antonius Hospital in nearby Sneek. A primary care hospital, the Antonius Hospital Emmeloord was established to deliver more care closer to home, as well as deliver a wider range of services alongside the traditional general practice services, including radiology, outpatient facilities, renal dialysis, and day surgery. While services at Sneek were being refurbished, it was particularly important that the hospital in Emmeloord had the capacity to deliver services. The hospital, which lacked its own operating theatre, installed a mobile operating unit at the site. While this allowed the hospital to ensure its performance and activity was not impacted by the refurbishment, it also meant that the hospital could further achieve its aim of bringing care to patients closer to their home, as local patients would otherwise need to have travelled 45km to Sneek, as well as delivering primary care at scale.²⁴

In England, there is an opportunity to take this even further by using existing assets innovatively and complementing them with the use of flexible infrastructure. By 'docking on' facilities to existing GP practices, STP leaders can create flexible primary care 'hubs' that are able to deliver a wider range of services and host integrated and multi-disciplinary health and social care teams; while also ensuring that primary care is kept local and personal, one of its key current strengths, and is delivered closer to the homes of the communities it serves. GP federations we spoke to did raise concerns that the expansion of primary care could impact the personal and local nature of primary care and continuity of care, which is vital for the frail and elderly, but also wanted to reap the benefits of economies at scale. The innovative use of existing assets and deployment of additional flexible infrastructure, to complement the space within local practices, could be a key solution to bridging this gap.

Of the new models of care that are focused on primary care, all of the GP federations we spoke to were developing Primary Care Homes (PCHs) in their area, albeit at different stages, and in many cases were leading the development of PCHs. Estates-wise, as was the case when speaking to acute trusts, a common theme was that it was still too early to have certainty regarding the long term estate strategy, and at the moment primary care providers were making best use of existing facilities in order to deliver the PCH model. While one GP Federation Chief Executive told us that they would most likely need to build new facilities but were not sure how this would be facilitated, another said that they did not want to build new facilities as many of the services could be delivered in existing practices due to being out-of-hours, but as more in-hours services were being developed they would need to switch between practices throughout the day, which may not be ideal.

A common theme from our interviews was that flexible infrastructure would be helpful in facilitating the development of models such as PCHs, and supporting them to grow into a place where it would be possible to build new permanent structures, if this was appropriate. Again, primary care providers and STP leaders will need to carefully consider as part of their estate strategy how to best use estate to deliver the primary care-centred new models of care and primary care at scale within the limited capital resources, bearing in mind that the traditional 'bricks and mortar' approach may not necessarily be the most appropriate, instead reflecting on mobile facilities and the flexible, 'lego blocks' benefits they could bring.

24) <http://www.vanguardhs.com/uk/blog/2012/07/04/completion-netherlands-contract-vanguard-proves-value-mobile-surgical-facilities-europe/>

Case study three: Healthportability

The concept of 'Healthportability', the integration of modular facilities, could be an advantageous way to rapidly expand the capacity in primary and community care, whilst ensuring flexibility and long term sustainability. Described as a 'system of community-based healthcare [which] operates by integrating permanent or modular facilities with the flexibility of mobile healthcare units to create a "Healthport"', utilising a modular 'dock unit', a service can then merge a variety of facilities with existing permanent buildings, giving services such as GP surgeries and community providers much more autonomy and the ability to deliver a wider range of services. In addition, it provides capacity to 'sweat' the expensive assets, the permanent buildings, owned by providers. In the case that new services are needed completely, a fully modular purpose built facility can be erected. This would allow providers to deliver a service that is fully flexible to the changing needs of the local community, and could be rolled out much more quickly than a permanent build, as services could be added and removed as necessary, whilst also requiring much less capital investment.²⁵

25) Vanguard Healthcare Solutions Ltd, Community Healthcare Services: What is Healthportability? <http://www.vanguardhs.com/uk/what-is-healthportability/>

4. Conclusions and questions for discussion

In this paper we have explored what the limitations of the estate are in delivering the services needed today as well as transforming the estate and ensuring it is sustainable for the future. We have also considered how the innovative use of estate, and flexible infrastructure, can help the NHS estate to fulfill its role as a key enabler of STPs.

Our research has suggested that individual organisations are using a variety of methods in order to use their assets more innovatively, particularly in the case of NHS trusts who are faced with ever growing pressures on their estates and facilities. We feel that, at least to some extent, organisations are still being encouraged to concentrate on 'fighting fires' and resorting to short-term solutions, rather than ensuring assets are used flexibly and strategically so that they are sustainable for the long-term. As the STPs progress and bring about the need for service reconfiguration, often on a major scale, it will be even more vital that NHS organisations are able to use their assets flexibly and efficiently. It is GGI's opinion that mobile clinical facilities could add considerable value in both allowing the quality of services to be maintained at times of peak capacity, and in the longer term, acting as building blocks while plans are implemented and services reconfigured, and helping to ensure that this takes place at the necessary speed.

Meanwhile, both our interviews and the existing literature show that there is a serious risk of current primary care estates lacking the capacity and capability of fulfilling the vision of new models of care and primary care at scale, as outlined in the 5YFV. While building bricks and mortar facilities from scratch is not realistic within the investment and timeframes available to STP leaders (and perhaps not the most appropriate way of rolling out the models envisioned), there is a real opportunity to use existing assets more innovatively and employ flexible infrastructure in order to quickly upscale the capacity of primary care. This will need to be supported by a culture of collaboration displayed by all system leaders and underpinned by robust governance.

GGI would encourage board members and system leaders to consider the following:

- Does the STP have an effective, sufficiently strategic, estates strategy and, if not, is it going to develop one?
- Is the estates strategy an integral part of the STP? How can we ensure that it plays a central role and is not simply an afterthought?
- Do the boards of organisations understand the potential implications on its estate of the STP and its related clinical strategy?
- Has there been a comprehensive mapping out and modelling of all estate in the footprint? Should this be done?
- Is there scope within the STP to use assets more innovatively? How could this be facilitated?
- Does the STP plan include proposals for major secondary care service reconfiguration? Have the consequences of this on the estate and how this will be delivered been thoroughly considered?
- How can reconfiguration of services that are already 'running hot' be delivered?
- How does the STP propose to deliver new models of care and primary care facilities? How can using assets innovatively help to facilitate this?
- What part could flexible estates solutions play in delivering the ambitions of the STP?

Next steps

GGI will be taking this forward to an expert round table, in order to test these ideas further.

Appendix i: Current condition of the NHS estate

The estate and its related service are pivotal to the delivery of high quality care. However, it is well recognised nationally that the NHS estate is diverse, complex and of variable quality:

- many NHS properties are under-utilised and a significant proportion of the NHS estate is in a poor condition and not fit for purpose
- NHS provider trusts still occupy significant estate that predates the formation of the NHS (18%) or is more than 30 years old (43%). Whilst a proportion of older buildings have been upgraded to meet modern standards of care, it is still too often the case that the NHS is operating out of inadequate facilities. Organisations 'sweat' the core estate in an attempt to use it to best effect, but this can itself be problematic and contribute to backlog maintenance as things come to the end of their economic life and require investment to replace²⁶
- the level of backlog maintenance, which can be defined as '*essential maintenance work that has not been carried out and is deemed necessary to bring the condition of a maintainable asset [the estate] up to a standard or acceptable level of risk that will enable the required service delivery functions of the asset [the estate] to continue*',²⁷ rose significantly between 2014/15 and 2015/16, from £457m to £776m
- anecdotal evidence suggests that the condition of the primary care estate is not markedly better than that owned by NHS provider trusts.²⁸ In our interviews with leaders of GP federations, concerns were expressed about the suitability and capacity of the primary care estate for the STP plans, and the funding schemes intended to reduce this problem
- medicine is changing at a rapid pace, which renders it very challenging to future-proof large-scale investments in estate. Once developed, there are often few mechanisms for such assets to be changed. This means that increasingly, hospitals are designed in a way that is inflexible and prolongs inefficient or out of date practices

26) Sir Robert Naylor, NHS Property and Estates: why the estate matters for patients: An independent report by Sir Robert Naylor for the Secretary of State for Health, Department of Health, March 2017

27) https://www.health.qld.gov.au/__data/assets/pdf_file/0026/365660/qh-gdl-913.pdf

28) Sir Robert Naylor, NHS Property and Estates: why the estate matters for patients: An independent report by Sir Robert Naylor for the Secretary of State for Health, Department of Health, March 2017

Appendix ii: National policy framework

In recent years, there has been a national drive towards the integration of health and social care. Although there has not yet been primary legislation outlining this, policy initiatives show a clear move away from the competition that was central to the Health and Social Care Act 2012. These initiatives, outlined below, will all require reconfiguration of the estate and in many cases, investment in and expansion of the primary care estate. There is widespread concern that this will not be achievable within the current condition of the estate.

National service development framework

a. **NHS Five Year Forward View (NHS England, October 2014)²⁹**

The 5YFV outlines why the NHS needs to change in order to close the triple gap of health and wellbeing, care and quality, and funding and efficiency. It envisages the NHS estates as having a role in supporting the implementation of new models of care and in improving efficiency. This will require commissioners to develop local estates strategies in collaboration with local partners, while local health economies are being encouraged to create local estates forums to support the development of these plans. Support is being provided to local areas (CCGs and STPs) by Community Health Partnerships and NHS Property Services.

b. **Next Steps on the NHS Five Year Forward View (NHS England, March 2017)³⁰**

This goes on to describe what will be achieved over the next two years and how the 5YFV's goals will be implemented. With regards to the NHS estate, the publication describes the need to protect and improve estates and facilities and the opportunities that exist to achieve efficiency savings through, for example, reducing unwarranted variation in energy costs.

c. **General Practice Forward View (GP Forward View) (NHS England et al, April 2016)³¹**

This describes the government's plans for transforming general practice. This includes support for the development of the primary care estate and infrastructure, including through capital investment. The GP Forward View describes how investment through the multi-million pound Estates and Technology Fund will accelerate the development of infrastructure to enable improvement and expansion of joined-up hospital care.³²

d. **Estates and Technology Transformation Fund (primary care) (ETTF) (NHS England, May 2016)³³**

Multi-million pound investment (revenue and capital funding) in general practice facilities and technology across England between 2015/16 and 2019/20. The intention is to support improvement in the premises and infrastructure of GPs to facilitate the expansion and improvement of out-of-hospital care.

Sustainability and Transformation Partnerships (STPs)

STPs build on the collaborative work that began under the NHS Shared Planning Guidance for 2016/17-2020/21, to support the implementation of the 5YFV. They provide a vehicle to support the full integration of health and social care, therefore helping to eliminate silo working and support partnerships to deliver new models of care, some of which are described below:

a. **Accountable Care Systems / Organisations (ACS / ACOs)**

An ACS/ACO can be defined as a group of providers who agree to take responsibility for providing all care for a given population, for a defined period of time, under a contractual agreement with a commissioner, and within a given budget and expenditure target. Providers are held accountable for achieving pre-identified quality outcomes within the given financial circumstances.

29) NHS England, NHS Five Year Forward View, October 2014, <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

30) NHS England, Next Steps on the NHS Five Year Forward View, March 2017, <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

31) NHS England, General Practice Forward View, April 2016, <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpffv.pdf>

32) *ibid*

33) <https://www.england.nhs.uk/gp/gpffv/infrastructure/estates-technology/>

b. **Multispecialty Community Providers (MCPs)**

In this new care model, outlined in the NHS 5YFV and based on the GP registered list, the scope of GP practices expands to include the services of nurses, mental health practitioners, community health services, hospital services, and other relevant specialists where suitable. This shifts certain aspects of hospital care, such as outpatient and ambulatory care, out of hospitals and thus reduces the pressure on the acute system. It requires GP practices to come together to develop networks or federations, and collaborate with other health and social care professionals (nurses, community health services, hospital specialists and mental health and social care practitioners) to provide more integrated services out of hospitals.

c. **Primary and Acute Care Systems (PACS)**

PACS brings together local health and care providers with shared goals and incentives, enabling them to focus on best meeting the needs of their local population. The PACS model allows single organisations to provide joint list-based GP and hospital services, as well as mental and community care services. Joining up services in the PACS model enables better decision-making and for the more sustainable use of resources as well as a greater focus on prevention and on community based care. This lessens the reliance on hospital-based care.

Whilst the PACS and MCP models of care are similar in that they both include the integration of primary, community, mental health and social care, the PACS model also includes most hospital services.

d. **Primary Care Home (PCH)**

Developed by the National Association of Primary Care (NAPC), the PCH is similar to the MCP in that staff come together into multidisciplinary teams, coming from GP surgeries, community, mental health and acute trusts, social care and the third sector in order to deliver care closer to home. Integral to PCHs is a strengthened and expanded primary care sector.

These are emerging models, and it is currently unclear how the estate will be configured to deliver them. However, STPs will need to be complemented by a joined-up, long-term estates strategy. Bearing in mind the fact that estate planning in the NHS has historically often not been sufficiently strategic, and there is a significant amount of estate which is lacking in quality as well as high figures of backlog maintenance, it is likely to be a significant challenge to deliver the reconfiguration of estate within the tight timescales allotted to the STP process. The challenge will be particularly pertinent in the primary care estate, which must be expanded in order to provide the out of hospital care which is integral to the new models of care, but has long been underfunded and inflexible, and is often limited in space. STP leaders will therefore need to find solutions which both quickly, and flexibly, reconfigure the estate whilst expanding the capacity in general practice and overcome the capital challenges associated with doing this.

Supporting a national NHS estate strategy: the Naylor Review³⁴

In March 2017, the Naylor Review, an independent report by Sir Robert Naylor for the Secretary of State for Health exploring how to unlock value from the NHS estate, was published. The report focused on how to deliver STPs through maximising through the estate, both through public funding and alternative means of raising capital, such as disposing of surplus property. One of the key recommendations of the Naylor Review was the creation of an NHS Property Board, to provide strategic estate support at a national level, which would bring together 'functions of NHS Property Services (NHS PS), Community Health Partnerships (CHP) and other fragmented NHS property capabilities into a single organisation.' The report also urges STP leaders to develop estate strategies, supported by capital strategies, in order to deliver the 5YFV as well as addressing backlog maintenance, although recognises the difficulties in accessing the capital that will be necessary for this.

34) *ibid*

Facilities management costs and space utilisation of the NHS: the Carter Review³⁵

Estates were identified in Lord Carter's report for the Department of Health, *Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations*, published in February 2016, as an area that trusts should focus on as part of an overall drive to increase productivity and improve efficiency.

Through analysis of the NHS estate, the review identified significant variation in facilities management costs and utilisation of space, noting that 'the occupied floor area of the NHS is around 25 million square meters... and the cost of running these facilities is over £8bn per annum and these costs are rising [with]... significant variations across trusts.'³⁶ The report concluded that across the NHS, too much land is being used for non-clinical purposes and estate running costs are too high:

- the total estates and facilities running costs per area (£/m²) was significantly variable between trusts, ranging from £105 to £907, with below £320 considered good. Were all trusts nationally to achieve the median, the review suggested that this would result in a reported saving of £11bn annually
- significant unwarranted variation existed when comparing how efficiently acute trusts make use of space, with the review finding that non-clinical space ranged from between 12% to as much as 69%. It was recommended that trusts should develop a plan to operate with a maximum of 35% of non-clinical floor space (space not occupied by patients), and 2.5% of un-occupied or under-used space, to be delivered by 2020³⁷

Since the publication of Lord Carter's review and as part of the 'must do' priorities for ensuring the financial sustainability of the NHS, the drive to achieve efficiencies at provider-level through estates planning has been incorporated into the NHS planning guidance.³⁸

35) Lord Carter of Coles, *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, Department of Health, February 2016

36) *ibid*

37) *ibid*

38) NHS Operational Planning and Contracting Guidance 2017-19, NHS England and NHS Improvement, September 2016

Appendix iii: Board responsibilities with regards to the estate

The trust board has overall accountability for all activities of the trust. This includes the maintenance and management of the trust estate incorporating, for example, land and property matters, planning and strategic investment in the estate, asset management, building maintenance and capital works/upgrades. The board is ultimately responsible for managing in their assets in a way that supports the planning and provision of health services for their local population.

The trust board will delegate responsibility for the management and maintenance of the trust estate to the Chief Executive who has ultimate managerial responsibility for the management and maintenance of the estate. The Chief Executive will delegate the operational day-to-day responsibility and authority to the Director of Facilities and Estates.

There should be an effective governance framework to support the delivery of the organisation's Estates and Facilities strategy and good quality, efficient services.

Board responsibilities:

1. Accountable for the provision of a fit for purpose estate.
2. Responsible for holding their own organisation to account and to report to the public about their performance, providing assurance on estates and facilities matters in the process.
3. Approval of a clearly defined Estates and Facilities strategy that is aligned to the organisation's Clinical Service Strategy, focused on patient care.
4. It is expected that the board should have a sense of the key risks relating to the estate and of mitigating actions. The organisation should have in place a clearly defined risk management strategy and policy, which is agreed and regularly reviewed by the board. Risks relating to the estate that may impact on the delivery of the organisation's corporate objectives should be reflected in the Board Assurance Framework (BAF).
5. The board should have access to professional advice on all matters relating to Estates and Facilities Services.

Therefore, as STP leaders develop estate strategies for their footprints, they will need to consider how these board responsibilities translate to the responsibilities of those leading the system as a whole, and ensure that there are strong governance processes, and a culture open to collaboration, underpinning the reconfiguration of estate that will be necessary.





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