Primary Care – delivering the LTP

The NHSE&I 2019 Long Term Plan, aligned to the 2020 Government manifesto commitments consider a range of factors:

> Value for Money is a key concern and we promised a reduction in bureaucracy and admin costs, improved financial efficiencies and patient flows and ring-fenced faster revenue growth for Primary Care.
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> Workforce continues to be a challenge and we have committed to improve working environments; Increased training, support and professional development and Flexible working through expanded opening / access times.
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> In Secondary Care we have the capital investment commitments by way of the development of 40 new hospitals and have committed to drive 34% modal shift of Outpatient appointments from a hospital to community setting, whilst reducing pressure on A&E through alternative urgent care / same-day access delivered in Primary Care and under the Community Diagnostics programme.
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> Primary Care has seen the formation of Primary Care Networks (PCNs) who will support 26,000 new multi-disciplinary staff and additional 6,000 GPs and deliver 50m additional PC appointments. Co-location of GPs, Community Health and Social Care, alongside an increased role for the voluntary sector and improved use of technology to support service delivery.
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> For Patients we committed to target health inequalities utilising public health management data, Supporting the prevention agenda And Greater Patient empowerment and control;
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> In terms of Sustainability we promised to Improve air quality through a reduction in pollutant emissions and the Adoption of building efficiency standards which supports the carbon net-zero agenda.

The role of primary care has fundamentally evolved since its inception, but many of the mechanisms that support its operation have not (e.g. GP-owned and managed estate, reimbursements, etc.).

We are aware that current systems and arrangements will not deliver large scale change, and rely heavily on Providers to take risk, which is not always welcomed or viable. Reports undertaken by NHSE/I, DHSC & the BMA in 2019 highlighted the challenges faced by primary care, commissioners and GPs.

- Over recent years, successive policy initiatives have understood the need for systemic change and they promote a move towards out-of-hospital service delivery; the development of wider MDT support teams, where the GP is the specialist and an increase of services being delivered in a community setting, and a greater focus on prevention.
- Perhaps the most important change in PC service delivery is the advent of Primary Care Networks where National policy and the PCN agenda set an ambitious target for service delivery, which requires a fit-for-purpose estate in line with the above.

The Primary Care estate ambition:

- ✓ Joined up healthcare services in bright, modern buildings;
- ✓ Patient focused care in the community;
- ✓ “Prevention over cure”;
- ✓ Digital appointments, reduced bureaucracy, self-testing and -referrals;
- ✓ Safe, accessible premises;
- ✓ Effective systems in place to facilitate transformation and improvements;
- ✓ Increased out-of-hospital services.

Sadly, PC estate reality is very different:

- ✓ An aging estate, much of which pre-dates the NHS itself;
- ✓ Limited access and accessibility;
- ✓ Poor sustainability credentials;
- ✓ Complicated ownership models, restricting our ability to invest and deliver transformation;
- ✓ Convoluted business case and other approvals processes;
- ✓ Conflicts between landlord and tenant.

The Covid-19 Pandemic has placed significant burdens on primary care and our estate was not really fit for purpose. What it has done though, is drive the digital agenda at pace so in some ways, pressure on the estate was released. We now need to maintain elements of this digital advancement.

So, Looking Towards tomorrow – we are challenging convention and we have explored international models to ask ourselves what primary care actually is?

Any new models must promote:

PCN concept; multi-disciplinary teams; cooperative working with the community and third sector. Focus on personalised healthcare, social interaction and the promotion of wellbeing.

Fast-track service for ‘low maintenance’ patients. High-tech, with a focus on self-testing and monitoring technology, as well the effective use of data and information.

And it must be PLACE-based, specialist focus on particular age group or condition, achieved through zoning and design. Personable, with community activities and patient education.

Health Hub of tomorrow

The national Primary Care Estates team have been working on the concept of the Health hub of Tomorrow which explores:

1. Self-testing, self-reporting, patient-led diagnosis and personal agency in condition management

2. Targeted, specialised facilities and infrastructure for specific service-user groups.

3. A focus on prevention: Patient education, training, and strong ongoing links with the community

4. A focus on Population Health Management and

A way in which Health can become an Anchor Institution and enable wider regeneration

We have **six pilot sites** identified where we will support Systems to look at new estate which will support the new agenda. These will look to facilitate secondary care shift of services into primary care and significantly broaden the range of services on offer. The estate will support the New for Old model, with standardised design & modern methods of construction used to speed up delivery and deliver improved VFM.

Systems will have the opportunity to release poorer quality and non-efficient estate and create Hubs to co-locate a wide range of services based on local population health needs.

For primary care, property ownership has been flagged as a concern for the Profession – we are working on reviewing current arrangements and testing future models to promote change and underpin new investment through the Reformation Board.

And finally, in terms of **estate strategies**, we need primary care to be formally considered as part of the ICS plan, and the way in which it can be transformed to drive the necessary changes. Investment at this level facilitates change across the wider System. The national Primary Care Data Collection programme will see much more detail on primary care estate being made available to Systems to inform strategies.

Too much of the NHS estate is not fit-for-purpose. Estate such as this cannot be expected to delivery on the ambitions of the Long-Term Plan, and therefore poses risks that perpetuate health inequalities and unequitable access to services for patients. It is therefore critical that Commissioners drive improvements in the quality of primary care estate across a given area, direct investment strategically, and encourage the occupation of better-quality, assets and the disposal of poorer quality estate over time.

Categorising the estate into 'core' 'flex' and 'tail' will help to invest in the right estate, use buildings more effectively and dispose of estate which is no longer suitable.

Core, Flex & Tail

ICS estates strategies will be an NHSE&I requirement moving forward. As part of that process, this programme recommends the allocation of 'core estate' - broadly defined as that which is flexible, fit-for-purpose, and integral for the delivery of the ICS' medium-to-long-term clinical strategy. This accommodation is likely to have level-access to all patient-facing areas,

and room sizes that are in accordance with adopted HBN-11 standards. Recommendation (c) set out that all PFI / LIFT Co estate should be presumed to meet this categorisation, with an alternative categorisation given only by exception. 'Core estate' should be prioritised for investment, and it should represent the best quality estate across a given ICS geography.

A second category is that of 'flex' estate. This is a broad category including, for example, estate that with sufficient investment and improvement has the potential to accord with building and accessibility standards and fully support the delivery of the LTP and represent an asset for long-term retention by the ICS (in time, perhaps being recategorized as 'core'). Another example of 'flex' estate might comprise a medium-quality asset in the vicinity of a high-quality 'core' asset with the potential for expansion or better levels utilisation – the ICS in this example may look to encourage the use of one, better quality asset, rather than two buildings in relatively close proximity but in the interim the 'flex' asset can be considered acceptable for patient-facing services.   A third example of 'flex' estate might be a poorer-quality asset in an isolated, rural location. Whilst this asset may clearly never be 'fit-for-purpose' or align with the ambitions the LTP, it offers access to services for patients (however limited these may be) that its disposal would be unacceptable. Over time commissioners should have ambition for a more sustainable and future-proof solution that will allow this asset to be reassigned as 'tail', but in the interim it is maintained to a minimum standard as 'flex' estate.

Some ICS' estate, however, will be old and simply not fit-for-purpose. There will be little or no opportunity to bring the standard of this accommodation up-to a level that can deliver the service models and the direction of travel heralded by the Long-Term Plan, including the PCN and MDT workforce agendas. Room sizes and circulation spaces are not in accordance with adopted standards, and there is no site-flexibility to achieve this. Most converted residential properties, for example, are likely to fall into this category.