EB 05.70

ESTATES STRATEGY AND IMPLEMENTATION PLAN

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Important Notes

1. **With regard to any need to undertake service change and comply with various statutory duties: -**

   The options set out in this document are for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions over estate strategies which impact on the provision of care to patients and the public. The options set out do not represent a commitment to any particular course of action on the part of the organisations involved.

2. **In respect of any request for disclosure under the FoIA: -**

   This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FoIA the parties should discuss the potential impact of releasing such information as is requested.

EXECUTIVE SUMMARY

This strategy addresses the question: has the CCG got access to sufficient infrastructure to allow its future commissioning plans to be delivered. As such it is an enabling strategy of the overall CCG commissioning intentions.

In making this assessment we have considered the CCG vision and strategic goals, the population, health need and regeneration drivers for change. Service drivers such as the five year forward view, the GP forward view, vision for local care and local primary care ambitions have been studied, along with technological drivers and estate drivers, such as condition, compliance with minimum standards and current use patterns.The population growth has been aligned with individual GP practices. This has allowed an assessment of sufficient capacity for primary and other services in out of hospital settings, whilst looking to improve access to effective care.

We found:

- **Two buildings that did not meet minimum standards**
- **Four buildings that were at capacity**
- **Six buildings that were close to capacity**

There is very limited capacity to allow for future primary care provision and local care shift to be delivered. Investment is required, primarily in the Urban cluster practices which need extensions and in one instance reallocation of space. Two practices in North Cluster need extension and two rural practices. The estimated capital costs of these projects are circa £6 million.

There is no capacity in the primary care estate to deliver hubs to allow service transformation. The rural cluster could use East Cross clinic for this purpose and the North cluster should explore using the William Harvey Hospital site to provide the required estate. However, the Urban cluster, which is where the majority of the population growth is, requires either land identified for a new build or the reuse of existing public sector assets in line with One Public Estate principles. There will be a significant cost (both revenue and capital) to deliver these projects and the funds must follow the service.

There are various sources of funds to explore. NHS England Estates and Technology Transformation fund will fund the Ivy Court development. Section 106 contributions will help with other extensions. NHS England capital can be bid for subject to PID and business case processes. Private Finance can be accessed to design, build and finance new schemes. Local authority funding could be explored, and Landlords would be approached to extend their buildings in return for rent.

The key challenges for the CCG are: the changing growth scenario,; stakeholder management; Improving access to services; pressures on primary care and delivery of out of hospital / local care strategy.

Key risks are the capacity to manage the agenda, national economy which may affect development plans, section 106 funds, failure to get engagement with stakeholders and managing expectations – the premises cost directions limit what funds can be given to General Practices for premises developments.

Other key enabling risks are GP providers closing lists, GP aspiring to take on local care but not open to increasing primary care provision and workforce strategy.

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1. INTRODUCTION AND LOCAL OVERVIEW

1.1. Purpose

The *Estates Strategy and Implementation Plan* (SIP) presents the Ashford strategy for the provision of its future healthcare estate in support of national and regional policies and an increasing demand and evolving requirement for healthcare services in the borough.

The SIP is a live document, which will be reviewed in light of potential changes to the service provision or population figures. This document, therefore, points out the direction of travel concerning estates and will be the foundation for any responses to new models of care.

The SIP is also supportive to the wider 'Sustainable Transformation programme within which *estates* is one of the enabler work streams.

The purpose of the Estates Strategy and Implementation Plan is to ensure there is the required community based healthcare infrastructure in place to meet the needs of the Ashford population over the next decade. It will need to be reviewed and refreshed annually to ensure that it is still relevant and reflects the current and future infrastructure needs of the borough.

1.2. Ashford Clinical Commissioning Group

NHS Ashford Clinical Commissioning Group (CCG) is a clinically-led organisation that was established in April 2013. Made up of all 13 general practices in Ashford, it is committed to bringing about better health for the local population, constantly improving services and ensuring that best use is made of the NHS resources allocated to the CCG.

1.3. Vision and Strategic Goals

Ashford CCGs prospectus outlines the CCG's approach to delivering transformational change in health and social care, to improve health and social outcomes over the course of the next five years. The strategic goals are:

- **Priority 1:** Maintain Health Status - Promote health and wellbeing, enabling Ashford's population to be as healthy as they can be and make informed choices about their health and lifestyle;
- **Priority 2:** Reduce Health Inequalities - Utilise the knowledge and skills of our GP membership, ensuring patient centred, consistent primary care for the people of Ashford;
- **Priority 3:** Maintain clinical effectiveness - Ensure Right Care First Time. Working with patients, the public, GPs, the Local Authority, service providers and other stakeholders, and develop local and joined up care- we will work with primary care, the Council and other health and social care partners, to streamline and join up complex care and support for the frail and elderly and those with complex long term conditions, with care provided at home or as close to home as possible.

Ashford CCG has the following vision for its healthcare estate:

> *To create an efficient and sustainable estate which is fit for purpose and flexibly, effectively and efficiently supports new and emerging models of care and positive patient experiences. Investment in the estate will ensure services keep up with population growth whilst adjusting to the changes introduced by new, integrated, care models to improving health and well-being in Ashford.*

A high quality Estates Strategy and Implementation Plan is vital to the delivery of this vision and the following allied estates strategic aims; regarding the future management and development of the Ashford healthcare estate, underpin this SIP document:

- Estates development will have a recognised role in supporting the improvement of patient experiences and positive patient outcomes
- The estate will be of high quality – achieving performance targets asset assessment methodology, benchmarking favourably against equivalent facilities elsewhere and progressively delivering improved value for money

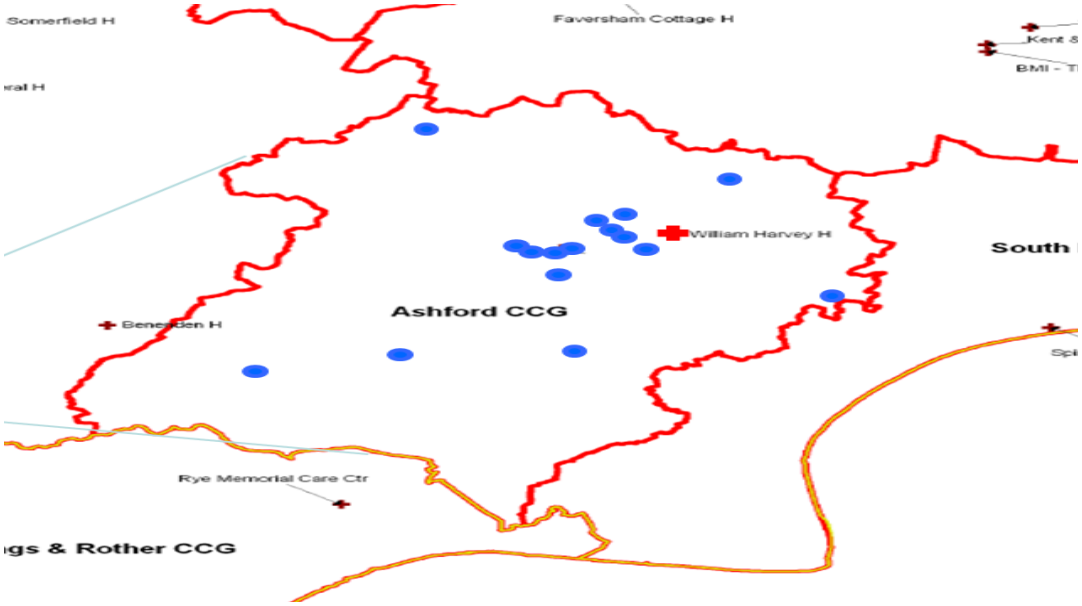
1.4. Scope

The scope of this estates strategy includes:

- All 13 GP practices currently operating out of 15 sites
- All community sites where healthcare services are provided
- Non-clinical NHS estate, such as office/administrative bases.
- Pharmacies, Dentists, Ophthalmology premises will be considered where relevant to this strategy.
- Whilst this estates strategy does not seek to address every organisation's estates plans, the aim of the engagement process has sought to identify where there are clear synergies, opportunities and needs that partners can help each other to address in an efficient and cost-effective way.

As more defined plans are formed around occupation of specific sites, engagement with secondary care, community and third sector organisations will be undertaken where necessary.

1.5. Ashford CCG Area



A series of buildings and land make up Ashford health estate. Whilst the CCG does not directly own any land or buildings, it funds them all via rent payments, contractual payments or void payment and is thus the defacto head tenant. It is thus essential that the CCG ensures the assets are used optimally and deliver its service and commissioning strategy. The CCG is responsible for strategic estate planning to ensure the buildings are fit for purpose, compliant, well maintained and well utilised. The over-riding

purpose of the estate is to provide sustainable, cost effective, flexible and adaptable facilities to deliver health services and achieve positive health impacts.

1.6. Programme Oversight Group

The SIP will be managed through a Local Estates Group. The forum is to be chaired by Ashford CCG. Participants in the forum will include NHS England, Ashford CCG, GP Federation, East Kent Hospitals NHS Trust, Kent Community Health NHS Trust, Kent County Council (social care, public health) and Ashford Borough Council (planning).

1.7. Stakeholder Engagement

A wide group of relevant stakeholders have been positively and constructively engaged in development of the Estates Strategy and Implementation Plan - through team workshops and individual meetings.

Providers

General Practice (GPs) – General Practitioners look after the health of people in their local community and deal with a range of health problems. A Kent Local Medical Committee representative and Practice representatives sit on the Estates Working Group.

Kent Community Health Services NHS Foundation Trust (KCHFT) – provide wide-ranging NHS care for people in the community, in a range of settings including people's own homes; nursing homes; health clinics; community hospitals; minor injury units and in mobile units.

They are one of the largest NHS community health providers in England, serving a population of about 1.4 million across Kent and 600,000 in East Sussex and London and employ more than 5,000 staff, including doctors, community nurses, physiotherapists, dietitians and many other healthcare professionals.

Ashford Clinical Providers (ACP) – There is a single GP federation operating in Ashford, known as Ashford Clinical Providers. This consists of all member practices and provides the entity for practices to work together at scale. This is both a strategic response to the commissioning framework for primary care but is also necessary to mitigate the workload and financial pressures which practices report that they are experiencing.

East Kent Hospitals University foundation Trust (EKHUFT) – East Kent Hospitals is one of the largest Acute Trusts in the country, serving a population of around 720,500. It has three major hospital sites in Ashford (William Harvey Hospital), Canterbury (Kent and Canterbury) and Margate (Queen Elizabeth the Queen Mother).

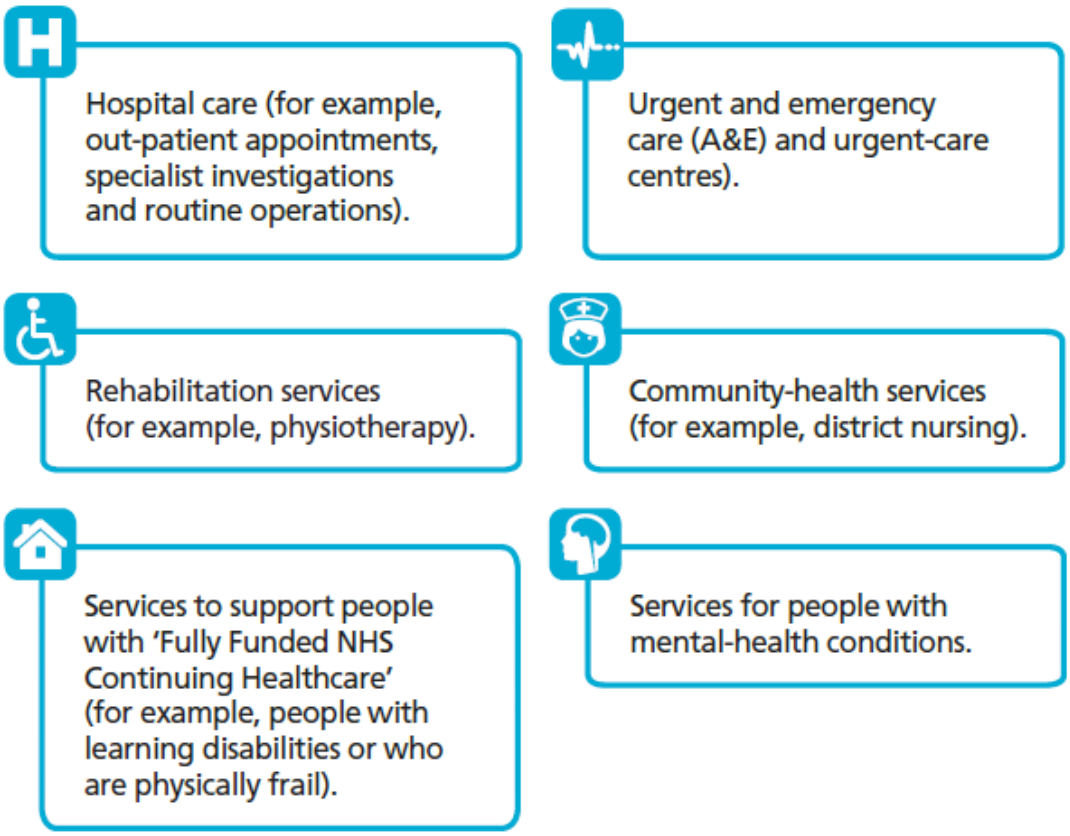
Mental Health - Kent and Medway NHS and Social Care Partnership Trust provides mental health and social care services for Kent in partnership with Kent County Council

Other primary care providers – include pharmacies, opticians, dentists.

Following the introduction of the Health and Social Care Act in 2012, CCGs are now responsible for commissioning most hospital, community-based and mental health services, and as from 2015 primary care services.

2. DRIVERS FOR CHANGE

NHS Ashford CCG is responsible for planning, monitoring and commissioning the majority of health services used by Ashford residents. This includes



Kent County Council is responsible for commissioning social care and local public health services including:

- Social care services
- The Healthy Child programme for school age children, including school nursing
- Sexual health services
- Mental health promotion, mental illness prevention and suicide prevention
- Local programmes around nutrition, physical inactivity and obesity
- Substance misuse services
- Early diagnosis of dementia and delivery of dementia services

Ashford Borough Council formulates the wider regeneration and development plans for the borough enabling infrastructure and population growth to be adequately taken into account in planning for future population pressures, service impacts and hence estate needs.

There are a number of factors leading to the need for a clear strategy for changing the way that services are delivered in Ashford and hence the estate infrastructure. These drivers for change are described in this section under the following themes:

- Population, health need and regeneration drivers
- Service drivers
- Technological drivers
- Estates drivers

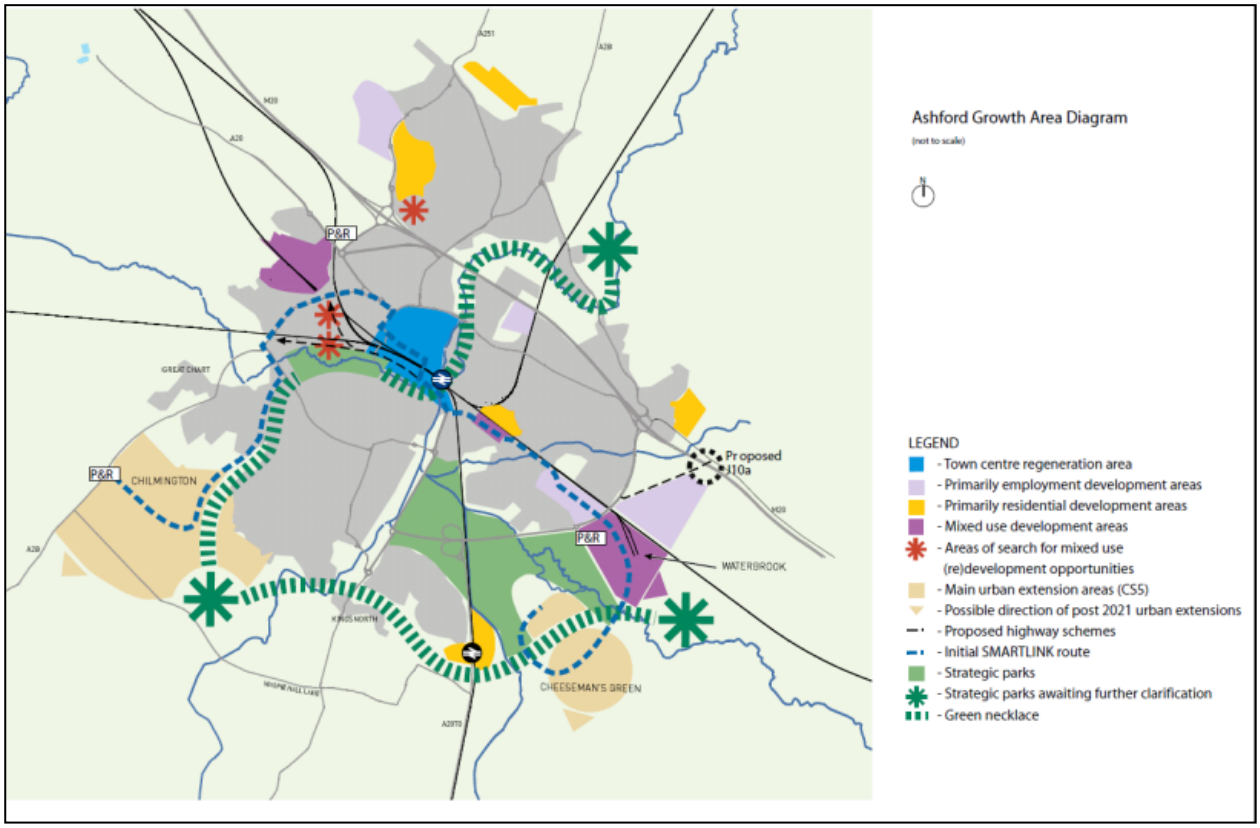
2.1 Population, Health Need and Regeneration Drivers

2.1.1 Demand Modelling

The Office for National Statistics (ONS) projections in 2010 estimated the Ashford population to be 115,500 people. By 2030, depending on the scenario, the population could reach 158,800, a 38% increase. The projected growth is thus very significant. ONS estimates show there will be an increase in population across all age groups.

Population density is sparse across Ashford CCG, only those wards near to the town centre have a higher population density, with the highest being in Stanhope (71-120 people per hectare).

The wards in Ashford that show the highest population change are Tenterden South, Weald East, Godington, North Willesborough, Aylesford Green and Victoria with an increase of 10%. Apart from the Tenterden South ward, all other wards are situated near the town of Ashford. More rural areas show a decline in population change.



2.1.2 HOUSING GROWTH

There is expected to be an increase of 17294 houses by 2030.

- 5750 will be at Chilmington .
- 2082 units are in the rural cluster, the greater proportion of which is Ivy Court
- 2067 are rural, mainly at New Hayesbank which has already been extended
- 6616 is Urban impacting on Sydenham, Willesborough, Kingsnorth and South Ashford Medics. For the latter a review of room usage is required to create more primary care rooms.

2.1.3 DEMOGRAPHIC GROWTH IN ASHFORD

The Premises Assessment shows that there are currently 7133 metres square of net internal space available across Ashford CCG area to provide primary medical services to 132,812 patients. This equates to a CCG average of 18.61 patients per square metre. This is a high level benchmark and does not differentiate clinical and admin space. It also does not look at how well the space is utilised, hence productivity of the estate is a key issue.

When considered at a cluster level, the Ashford Urban cluster as a whole exceeds the CCG average of net internal area patients per sq metre by 1.78 metres square, whilst Ashford North and Ashford Rural are below the CCG average patient per sq m.

The Ashford Urban cluster is approximately twice the size of the other clusters and consideration could be given to splitting the cluster into two grouping to fit with local care model of around 30,000 patients

Ashford Cluster	Net Internal Area m^2 (current)	Patients (01/07/17)	Patient per metre sq (current)
Ashford Urban	2994	63230	21.11
Ashford Rural	2072	35065	16.92
Ashford North	2067	34517	16.70
CCG	7133	132812	19.61

As a result of planned residential development of key strategic sites across Ashford, this growth will not be distributed equally but focused mainly in a small number of areas; the data only includes projected increase in patient list sizes for primary care and not the impact estimated from the shift in local care.

When considered at a practice level Musgrove and Ivy Court Surgery are showing as the practice with the greatest space pressure at 39.41 and 32.32 patients per metres square respectively, followed by Willesborough Health Centre (27.34), Sydenham House Medical Practice (21.70) and Hollington Surgery (20.80). All other practices are showing as around or below the CCG average metres square per patient.

Otterpool Park

Otterpool Park is a proposed new garden town near Folkestone. It will be 12000 homes and a potential population of 29,000. Whilst not in Ashford, the nearest GP practices are in the Ashford border. The population increase would require a new building and a potential closure of an Ashford practice and relocation would be an option to consider. The development has not yet received Government approval but the development needs to be monitored.

.1.4 HEALTH CONSIDERATIONS

Key statistics from the Joint Strategic Needs Assessment (JSNA) as outlined in the Ashford CCG Group Prospectus:

- Life expectancy is years lower for men and 5 years lower in the most deprived areas of Ashford. Ashford has the highest life expectancy in Kent at 82.5 years, however inequalities exist between affluent and deprived wards. In the most deprived wards people die 9 years earlier then people living in the affluent wards. There appears to be a link between deprivation and health outcomes. Adult obesity and smoking prevalence is higher (30% and 20%) in the wards south of Ashford town (Beaver, Stanhope, Norman and Aylesford Green).
- The elderly population is projected to increase by 21% over the next 15 years.

'Healthy life expectancy' is the number of years from birth that a person can expect to remain in 'good' or 'very good' health. The services have to be designed around these particular needs of some of the population if inequalities are to be reduced.

2.1.5 ASHFORD HEALTH & WELLBEING STRATEGY PRIORITIES

All local authorities and linked CCGs are responsible for developing a joint Health and Wellbeing Strategy that sets out the local priorities on which commissioning plans will be based. Ashford has such a strategy which sets the following four priorities:

- Preparation for a healthy life: Improving outcomes for babies, young children and their families by focusing on early years settings and supporting parents' especially older and first time mothers.
- Wellbeing in the Community: Creating circumstances that enable people to have greater life opportunities. We will focus on improving mental health and wellbeing for all and supporting people to gain and retain employment and promote healthy workplaces.
- How we live: Encouraging healthier lifestyles with a key focusing on reducing obesity and preventing ill health through promotion of physical activity..
- Integrated Care: Providing care and support to facilitate good outcomes and improve user experience. We will focus on continuing to work to integrate health and social care services.

2.2 Service Drivers

The NHS is facing challenging times, with a growing demand due to population growth, people living longer and an increase in people with long term illnesses. STP groups are looking at system wide changes to the provision of health and social care.

To address these underlying issues, the way services are delivered, and where, is changing. This strategy sets out how the NHS estate in Ashford will adapt to the changing circumstances and support the delivery of a changing health economy that is promoting collaborations across a wide partnership of organisations and that requires access to services closer to patient's homes.

2.2.1 SERVICE TRANSFORMATION

The 'Five Year Forward View' sets out the future vision for NHS, the challenges it is facing together with what the future may look like.

In line with the Department of Health strategic directions, set out in "Five Year Forward View, ACCG has been contributing to the Kent and Medway Sustainability and Transformation Plan (STP) which describes how health services will need to be transformed to meet future needs of our growing and ageing population. The

STP model for Kent and Medway is working towards delivering local care models scaling up primary care into clusters and hub based multi community specialty providers

The STP describes practices working closer together in alliances along with social care, community NHS and acute NHS clinical staff and services. To this end, Ashford CCG practices have grouped themselves into three connected hubs for shared working arrangements – North Ashford, Urban Ashford and Rural Ashford.

The STP system planning includes more development of new care models , care for people closer to home, delivered by local teams of health and social care professionals, working in GP surgeries, health centres and local communities so for day to day care and treatment, some people won't have to go to hospital as they currently do. The local care shift is an important factor in estate planning.

2.2.2 VISION FOR LOCAL CARE

Our aim is to develop healthy communities across Kent and Medway, where local people are informed and involved regarding their own health. Care provided to local communities will ensure that people are supported to be well and healthy in their own homes and communities. This will be delivered through new models of care that facilitate a connected system, where local people are at the centre of its design and delivery.

People will make fewer trips to hospital, instead accessing services at specialist clinics provided in local GP surgeries, hubs or making different use of the William Harvey Hospital estate. Furthermore integrated health and social services will ensure holistic, patient centred community and home based care.

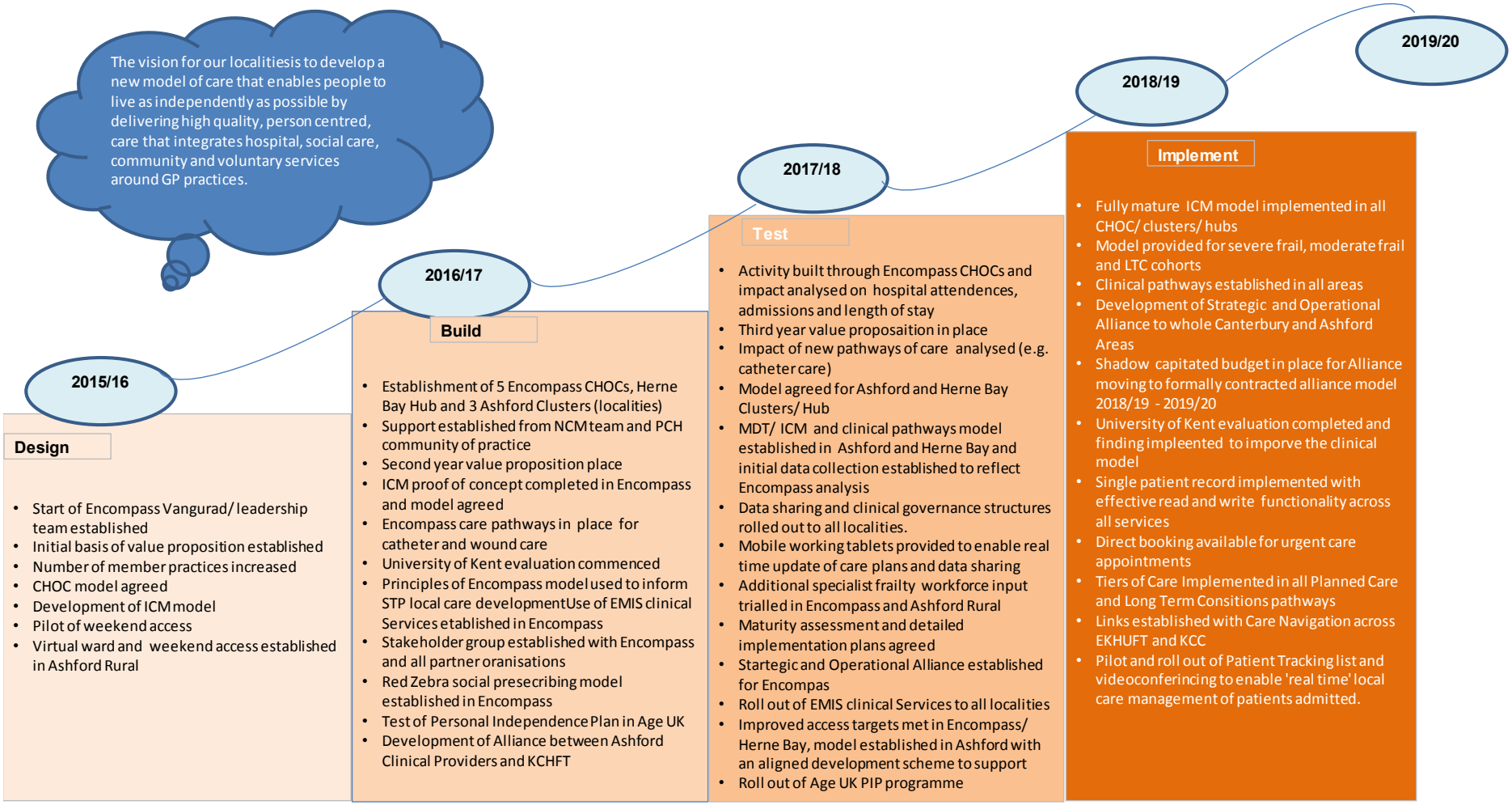
Implementation of new local care models will be via delivery of integrated health and social care teams planned and delivered primarily to clusters of surgeries totalling a 30-60,000 list size. We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

A possible example of future GP practices (note not applicable to every practice and models will need to be adapted)

Within each practice	Aligned to each practice but working across a wider geography / at-scale primary care organisations
GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates.	Prescribing advisors, GPs with a special interest (GPWSIs), care coordinators, wellbeing teams, and 'super practice managers/directors' with sufficient skills to lead the development and operational management of at-scale primary care organisations As part of, for example, a wider Multi-speciality Community Provider (MCP): secondary care specialists, social care, mental health and community services teams, and community pharmacy.

For this type of GP practices to work, the Ashford expectation is for the list sizes to be a minimum of 8,000 patients. This may not be practical in some locations. However, where Hubs are operational they should

support 30,000 – 60,000 patients. For the purpose of this document, a hub can be a building or a series of buildings working together.


The vision for our localitiesis to develop a new model of care that enables people to live as independently as possible by delivering high quality, person centred, care that integrates hospital, social care, community and voluntary services around GP practices.
2015/16
Design
Start of Encompass Vangurad/ leadership team established
Initial basis of value proposition established
Number of member practices increased
CHOC model agreed
Development of ICM model
Pilot of weekend access
Virtual ward and weekend access established in Ashford Rural
2016/17
Build
Establishment of 5 Encompass CHOCs, Herne Bay Hub and 3 Ashford Clusters (localities)
Support established from NCM team and PCH community of practice
Second year value proposition place
ICM proof of concept completed in Encompass and model agreed
Encompass care pathways in place for catheter and wound care
University of Kent evaluation commenced
Principles of Encompass model used to inform STP local care developmentUse of EMIS clinical Services established in Encompass
Stakeholder group established with Encompass and all partner oranisations
Red Zebra social presecribing model established in Encompass
Test of Personal Independence Plan in Age UK
Development of Alliance between Ashford Clinical Providers and KCHFT
2017/18
Test
Activity built through Encompass CHOCs and impact analysed on hospital attendences, admissions and length of stay
Third year value proposaition in place
Impact of new pathways of care analysed (e.g. catheter care)
Model agreed for Ashford and Herne Bay Clusters/ Hub
MDT/ ICM and clinical pathways model established in Ashford and Herne Bay and initial data collection established to reflect Encompass analysis
Data sharing and clinical governance structures rolled out to all localities.
Mobile working tablets provided to enable real time update of care plans and data sharing
Additional specialist frailty workforce input trialled in Encompass and Ashford Rural
Maturity assessment and detailed implementation plans agreed
Startegic and Operational Alliance established for Encompas
Roll out of EMIS clinical Services to all localities
Improved access targets met in Encompass/ Herne Bay, model established in Ashford with an aligned development scheme to support
Roll out of Age UK PIP programme
2018/19
Implement
Fully mature ICM model implemented in all CHOC/ clusters/ hubs
Model provided for severe frail, moderate frail and LTC cohorts
Clinical pathways established in all areas
Development of Strategic and Operational Alliance to whole Canterbury and Ashford Areas
Shadow capitated budget in place for Alliance moving to formally contracted alliance model 2018/19 - 2019/20
University of Kent evaluation completed and finding impleented to imporve the clinical model
Single patient record implemented with effective read and write functionality across all services
Direct booking available for urgent care appointments
Tiers of Care Implemented in all Planned Care and Long Term Consitions pathways
Links established with Care Navigation across EKHUFT and KCC
Pilot and roll out of Patient Tracking list and videoconferincing to enable 'real time' local care management of patients admitted.
2019/20

2.2.3 General Practice

The General Practice Forward View gives a clear steer to how services should be delivered in the future and has a commitment to continue to provide a list based GP system. It states that primary care estate will be developed and there will be investment in better technology.

- Investment in general practice estates and infrastructure, supported by continued public sector capital investment, estimated to reach over £900 million in the next 5 years.

- A greater use of technologies to enhance patient care, drive productivity of assets and positively affect on footfall at practice premises. The impact of record sharing, health apps, self-care management / reporting etc. must be considered against estates investment and the impact of technological advancement in health on patient demand / access must be recognised.

To be able to cope with the increase in demand, the patient offer may look different depending on what type of service user it is. An emphasis will be on preventative and self-care, to avoid drainage on the health system.

Who is providing the service will also change depending on the need. There will be a mix of care and support available from different professionals. This will require a mix of professionals and services available closer to patients' homes (diagnostics, pharmacy, social workers, community charities, advice services, support groups).

The majority of GP practices will not be able to offer all services directly from their practice as there is no scope or capacity within the infrastructure to do so. However, the estate structure across the area will require hubs to be created in NHS owned / leased assets so that all patients will be able to access services, albeit some may be at an alternative site to their GP/Core services. There is no capacity in the current estate to achieve this.

Partnerships with all health providers will be essential for success, but also closer working with the Council and their services through links with community centres and children centres.

In 2016/17 the CCG has signalled a clear commitment to explore new models to help it meet the challenges it faces in Ashford. In summary it agreed it needed sustainable system(s) of health and social care which deliver the best outcomes for our respective residents and is affordable. There are many new models of care being discussed nationally and internationally including multispecialty community providers (MCPs), primary and acute systems (PACs) and Accountable Care Organisations (ACO) (or variants of these).

2.2.4 Local Primary Care Ambitions

Ashford CCG has full delegation for the commissioning and performance management of primary care. Following discussion with the GP membership of the CCG seven primary care ambitions have been identified which will improve local services for our patients:

- **Ambition 1 – Patient Access, Quality and Outcomes:** Every patient will have access to a core offer of high quality primary care which is continuously improving and delivering excellent health outcomes

- **Ambition 2 – Patient Participation:** We will have effective engagement with our patients, and their carers, to ensure that our services and information meet their needs and lifestyles
- **Ambition 3 – Workforce:** We will have an attractive training environment which develops our doctors, nurses and allied staff to be the best healthcare workforce
- **Ambition 4 – Premises:** The premises used to deliver services will be fit for purpose meeting the current, and future, needs of our growing population
- **Ambition 5 – Integration:** Improved patient care will be delivered by removing boundaries between primary, community, hospital and social care
- **Ambition 6 – Technology:** We will use technology to deliver the highest quality care in the most appropriate manner
- **Ambition 7 – Payment and Investment:** We will ensure that there is a payment and incentive system to support improved outcomes, ensure value for money and reflect the workload.

2.3 Technological Drivers

- Primary and community care services are already making considerable advances in the use of information technology and this will continue to grow over the years benefiting patients, providers and practices whilst facilitating more cost effective services. The emphasis will continue to be on reducing paper processes and putting in place systems and procedures that will speed up services whilst at the same time improving data quality and data capture. The aim is also to enable more holistic patient care through the sharing of patient data with local Ashford providers for the purposes of direct patient care.
- Information and IT is a key enabler for service transformation locally and can support staff in new ways of working and empower patients to be active participants in their care.
- Each CCG has its own IM&T strategy and implementation plans. In Ashford, technological investment priorities will focus on a number of key programmes as follow 9will need investment before being progressed):
- Digitalisation of patient records – exploring whether hard copies of the GP patient record (Lloyd George notes) can either be stored off site or scanned and destroyed. This will help free up capacity within practices allowing space to be used for clinical purposes.
- Electronic Discharge Notifications (EDN) – aimed to eliminate the need for sending discharge summaries by post and include automated capture into GP system work flows.
- Electronic Prescription Service Release (EPSR2)
- Business grade secure WIFI devices for all practice sites
- Web conferencing; the aim being to reduce time spent travelling and to maximise effective use of time and resource.
- Providing GP patient data access to the local providers in the acute and community setting
- Mobile devices such as iPads and laptops are increasingly being used by practices and providers.
- Patients Online Services is supporting GP practices to offer and promote online services to patients, including access to records, online appointment booking and online repeat prescriptions. The CCG is exploring alternative methods and opportunities to enhance the utilisation and uptake of patient online services through the wider health and care network.
- iPlato is a SMS replacement service for NHS Mail SMS which allows practices to send appointment reminders to patients and enables patients to respond to the text alert to confirm or cancel the appointment. It also allows health promotion messaging to be sent to patients.

- Electronic Referrals (eReferrals) integrated into the GP IT system with longer term development including the ability for GPs and patients to track where the patient is in the system following the initial referral.
- Use of health Apps need to be explored and scoped to identify which might be of benefit to our population.
- Ensuring that GP systems of choice are fit for purpose and the future and capable of delivering the technological change agenda.
- The CCG would want to explore out of hospital care and the continuity of care provision using tele-healthcare service developments.
- To facilitate improved access, the CCG will need to initiate a central bookings facility in order to manage this enhanced service, ensuring fair access to appointments and ease for patients.
- The provision of extended hours (8-8) in new hubs or existing GP practice sites. This may include a Federated level central telephone hub or central telephone hubs per LCN. This will improve patient experience and facilitate both working at scale and extended opening hours. It is the most cost effective way of providing more clinical space.
- As the CCG becomes aware of practice mergers and / or practice developments, or practice system migrations take place, the CCG would need to support this and funding would be required. Core GP IT infrastructure & software investment will need to be available to meet the needs of practice organic/incremental growth, practice developments e.g. mergers and possibly significant primary care developments such as new builds or the development of a local care network.

2.4 Estates Drivers

There are a number of estates issues that are driving the need for the public sector to review its estates strategy. These are summarised below

- As a mixed rural and urban borough, Ashford has more space relative to the more densely populated boroughs. Ashford is already able to respond to the pressing need for more housing. The regeneration plans shows how the Urban part of the borough will be regenerated to develop
- The quality and efficiency of usage of the national NHS estate is highly variable and much does not meet evolving needs. There is significant scope to transform the way that estate is used across. In Ashford there is small variability in the quality of the primary care estate. There are a number of practices that operate out of converted residential premises that do not necessarily provide the functional and flexible space required. Opportunities for site reconfiguration, practice mergers and branch rationalisation will be considered to improve the efficiency of practices' operations and services to their patients
- Poor utilisation and unsuitable types of estate has been a result of:- perverse incentives, insufficient investment and fragmented decision-making on primary and out-of-hospital estate,; A lack of incentives for GPs to rationalise the use of estate, and Inflexibility of lease arrangements. Productivity reviews of key sites will be required to support business cases for investment.
- There is a need to unlock value: The NHS does not have any new money and therefore must look at how to unlock value from the current estate and capital regime to address the issues within the system. Partnership working one a One Public Estate principle is essential as almost all oractices are at full capacity.
- There are opportunities across the public sector for organisations to co-locate and share sites to meet the growing pressures of more housing and school places.

- Ensuring that all GP practices are fit for purpose in line with Care Quality Commission requirements and are Disability Discrimination Act 1995 compliant, energy efficient and comply with infection control standards.

3. FUTURE ESTATES INFRASTRUCTURE

3.1 Future Model of Care and Service Priorities

As part of the CCG's aim of bringing care closer to home primary, community and social care services need to be more accessible and better integrated, supporting a preventative and holistic approach to patient care over time.

Primary care plays an integral role in delivering our strategic priorities, whether as a provider within the care pathway, or by ensuring that there are good processes in place for referral and management of patients following their interaction with more specialist acute or community services.

The services available will be proactive, accessible, coordinated and provide continuity; with a flexible, holistic approach to ensure every contact counts. This will be primary care delivered to geographically coherent populations, at scale, whilst still encouraging self-reliance. This will be a universal service covering the whole population 'cradle to grave'.

This care network approach will involve primary, community and social care colleagues working together and drawing on others from across the health, social care and voluntary sector to provide proactive patient centred care. Services within will be delivered in ways that respond to the varied needs and characteristics of the community it serves.

In Ashford there are three clusters that align with the proposed model:

Ashford Cluster	**Net Internal Area m^2 (current)**	**Patients (01/07/17)**	**Patients per metre square (current)**
Ashford Urban	3241.92	62666	19.33
Ashford Rural	2071.81	34807	16.80
Ashford North	2202.80	34428	15.63
CCG	7516.53	131,901	17.55

3.2 Our vision

It is critical that public sector organisations locally make the most efficient and effective use of their estate so that over the long-term, there is the required infrastructure in place to support the delivery of services in the locations that best respond to the need. In terms of primary care, it is vital that the technological and estate infrastructure reflects new models of service delivery which form part of the primary care transformation agenda and the development of care networks. In order to do this, there needs to be fit-for-purpose, well utilised, sustainable, affordable estate located to best meet the health needs of the population.

The development of primary and community care infrastructure in Ashford needs to help facilitate delivery of the following priorities:

- Aligns with the Ashford Growth Strategy and addresses any service and infrastructure needs that result, including ensuring sufficient GP provision across Ashford

- Ensures there is sufficient capacity for primary and community care services to be provided in out of hospital settings.
- Advance technological solutions that reduce the need for face-to-face consultations, better equip patients to self-manage, enable more preventative care and strengthen communication and collaboration between organisations. This will include utilising web conferencing facilities, and other web based solutions, between practices, practices / branches and practices / patients. This will enable practice education to be undertaken virtually to reduce staff travel time, increasing time available for patients and reduce patient travel time as patients can be seen remotely. In addition, the GP systems of choice need to be fit for purpose both now and in the future.
- Reduces reliance on clinical and office space through use of remote and mobile working.
- Improve access to effective care.
- Seeks to rationalise branch sites where this enables more efficient ways of working, without hindering patient access, ensuring remaining practices, across the borough, are fit for purpose and have the required capacity to meet the needs of Ashford's population.
- Ensures that all practices in the borough are CQC compliant, meet minimum standards, DDA regulations and that premises are fit for purpose and meet the CQC requirements.
- Ensures that there is sufficient training and workforce development capacity and improved accessibility across practices,; improving the learning culture across Ashford. This will also facilitate an increase in the number of practices able to offer placements for all student healthcare professionals.
- Greater partnership working across providers through co-location of services.
- Delivers the emerging strategy including the consideration of hub sites.
- Maximises the use of purpose built, high quality estate for clinical purposes through exploring the potential for the relocation of administrative and storage functions off site at a lower cost, or through digitalisation.
- Identifies where buildings are surplus to requirement for all partners and investigating there potential for use across the borough before disposing of assets.
- Ensure any changes are beneficial to patient access and do not exacerbate health inequalities. This will include reviewing recommendations within CQC reports and instigating improvements to ensure that premises are fit for purpose.
- Maximise the use of space through exploring with partner organisations how space can be reconfigured to deliver maximum value to the public sector and improved facilities for patients.
- Ensures the maximisation of digital technology to facilitate patient care.

4.4 GP list sizes

Ashford current spread of list sizes by building (not practice) ranges from 1,000 for the smallest to 21,000 for the largest. The CCG ambition is to move to list sizes of 8,000 plus per practice. 7 GPs currently have a list size smaller than 8,000. It is noted that it is part of the primary care strategy to determine the optimal list size range and the primary care patient offer. When this has been decided an estate assessment may be needed if the plan is to follow the ambition, as current GP estate will not be able to accommodate such list sizes. Rural practices might not be sustainable at the targeted level so the CCG need to consider how the policy is applied in rural areas.

Current GP building list size	No.

GPs > 5,000	3
GPs - 5,001 - 8,000	4
GPs - 8,001 - 15,000	6
GPs - 15,001 <	2

3.4 The Current Estate

The current estate within Ashford CCG area comprises the following;

Ashford Borough Asset Overview	
1	Acute Hospital
0	Community Hospitals
3	Health Centres
14	GP Practices

Borough of Ashford Asset Overview

The configuration of estate will form a significant part in understanding where we are now and where we want to be in the future, and this section provides a more substantial breakdown in understanding the location, quantity of estate and its dispersion throughout Ashford. This will help inform decisions about key estate, which will be addressed later on in the document. Note, NHS services are also provided from pharmacies, dentists and opticians but the are not considered in this document.

The GP estate in Ashford is privately owned, leased or leased from NHSPS. Building surveys were carried out by an independent surveyor and the results of these surveys identifies that in the main the primary care estate is in a good condition but the age profile suggests an investment programme be developed to address issues driven by age.

The surveys which have been rated on a High, Significant and Low risk rating have been translated into a Red, Amber and Green scale respectively. Figure 4 identifies Red and Amber sites i.e. properties which should be regarded as High or Significant risks which fail to meet statutory compliance.

The GP, under their contract, is required to provide suitable and compliant premises from which to deliver services. Where they fail to do so the properties fall into disrepair and are no longer fit for purpose. The CCG needs to ensure it does not take on additional liability than it needs to and must drive best value out of investment being, made through rental payments and improvement grants. The CCG must drive this by ensuring its contractors are doing what they have committed under their contract. Breach notices can and should be issued where the facilities are poor and sub-standard. It is also important that the leases are managed effectively.

All premises investments must be subject to the achievement and maintenance of minimum premises standards in line with Premises Cost Directions.

GP Estate							
Cluster	**Address**	**Tenure**	**Age Profile**	**RAG Rating**	**NIA m2**	**List size 01/07/17**	**Remarks**
Urban	Sydenham House Medical Practice	Leased			614	13324	Post 1998 purpose built new generation primary healthcare premises. Clinical rooms on the ground floor; administration on the first floor. The building is DDA compliant. The surgery specification is 20 years old and some fixtures and fittings no longer meet the more demanding current infection control standards. On-site parking for staff, visitors and patients.
Urban	Musgrove Park (Branch of Sydenham)	Leased			186	7322	Pre 1998 purpose built surgery premises. Principally single storey accommodation with loft storage area. Well maintained and improved premises but further planned upgrading of the clinical rooms and reception is required. DDA compliant except in respect of a disabled car parking space in the surgery car park. Local amenities are a short distance from the surgery including additional car parking adjacent to commercial premises.
Urban	Kingsnorth Medical Practice	Leased			751	11797	Post 1998 purpose built surgery premises. New generation primary healthcare centre. Generally DDA compliant. Barn style one and one half storey accommodation. Continuous planned programme of improvements have kept the premises and facilities up to date. Close to public transport links. Developed by G.P Premises Ltd. Premises are in flood plain which may limit expansion potential.
Urban	Singleton Health Centre	Leased			174	7838	Pre 1998 purpose built surgery premises. Single storey accommodation which is intensively used. Some clinical rooms have been partly refurbished but the remainder of the surgery is in need of a general upgrade and improvements. Adjacent to the local centre car park which is available for users of the medical centre. The surgery received an increase in the patient list following the closure of Singleton Surgery opposite.
Urban	Stanhope Surgery (Branch of Singleton Surgery)	Owned			102		Non purpose built converted and extended (1990) small surgery premises. Clinical accommodation on ground floor; administration or vacant rooms on first floor. Limited improvements have been undertaken over a prolonged period and the accommodation is poor and now requires upgrading or disposal. Low list size. Limited on-street parking only. Garage excluded. Public transport links are close by.
Urban	South Ashford Medics	Leased			653	8842	Post 1998 purpose built new generation primary healthcare centre. Full range of primary care, community and dental services. Fully DDA compliant. Local transport links to Ashford town centre are close-by. On-site car parking for staff, visitors and patients. Development by Assura PLC, leased and managed by NHSPS
Urban	Willesborough Health Centre	Owned			514	14107	Pre 1998 purpose built surgery premises (1993). Clinical accommodation on ground floor; administration on first floor. No lift. Older style surgery premises with some recent upgrading to nurses clinical rooms. Further upgrading to floor coverings are proposed. More significant plans to extend the first floor accommodation and reconfigure the ground floor area. Limited on-site car parking with additional car parking on an adjacent site. Local transport links are close by.
North	Hollington Surgery	Leased			166	3503	Non purpose built converted surgery premises. Two storey building not fully DDA compliant. Twenty year old conversion with only minor improvements undertaken in the intervening period. Now in need of a major upgrade to the facilities and the fixtures and fittings. No Lift. Transport links are within short walking distance from the surgery. Town centre is approximately 200 metres. Limited on-site car parking.

GP Estate							
Cluster	**Address**	**Tenure**	**Age Profile**	**RAG Rating**	**NIA m2**	**List size 01/07/17**	**Remarks**
North	New Hayesbank Surgery	Owned			912	17439	Pre 1998 purpose built surgery premises (1988). Multiple extensions have been undertaken including a recently completed two storey extension part funded with a MIG. The building is DDA compliant and generally modernised and maintained to a good standard. Some older clinical rooms remain to be upgraded. Ample car parking available.
North	Sellindge Surgery	Leased			413	4883	Post 1998 purpose built surgery premises. New generation primary healthcare centre. Modern facilities throughout. DDA compliant. Public transport links are a short walk.
North	Wye Surgery	Owned			576	8692	Pre 1998 purpose built surgery premises. Two storey building not fully DDA compliant. Well maintained surgery with evidence of a planned maintenance programme. However, the older design and specification is of its time and some areas of the surgery require an upgrade to the layout, fixtures and fittings to meet current standards. No lift. Car parking for staff visitors and patients.
Rural	Charing Surgery	Owned			613	9812	Pre 1998 purpose built surgery premises.Clinical rooms on ground floor; administration first floor. One and one half storey accommodation. Largely DDA compliant. Modern surgery premises with integral pharmacy. Busy practice with growing list. Large car park.
Rural	Hamstreet Surgery	Owned			491	7186	Pre 1998 purpose built surgery premises. Extended 1994 and 2011. Modern two storey extension with clinical rooms and meeting room. Older part is principally used for administration, dispensary and staff facilities. Further proposals to extend and alter the accommodation to facilitate training places. The surgery car park is shared with the village hall. Additional staff car park located close by.
Rural	Ivy Court Surgery	Owned			439	14194	Pre 1998 purpose built and extended surgery premises. One and one half storey accommodation. Some limited upgrading of the accommodation. Various extension have resulted in a difficult layout with four stairs to first floor but no lift. Substantial proposals to extend the accommodation at first and second floor together with additional upgrading to clinical rooms and DDA compliance. Transport links, shops and services are a short walk.
Rural	Woodchurch Surgery	Owned			317	3950	Pre 1998 purpose built surgery premises. Single storey accommodation extended from the original. Older style layout and fixtures in the reception, waiting area and common parts. More modern extension with clinical rooms to the side. Well maintained throughout. OFCH. Large car park is full at busy periods as public transport services are limited. Serves large rural area.
					7133	132812	

Group 1	Non purpose built converted surgery premises
Group 2	Pre 1998 purpose built surgery premises
Group 3	Post 1998 purpose built surgery premises

3.5 Individual GP premises assessment

In consultation with the GP federation, the impact of population growth on individual practices has been considered and its impact on space and cost of new space assessed. No assessment of asset productivity has been included or other suggested methods of increasing clinical space such as by moving out administration functions and ensuring optimum opening hours. As such the comments below are observation: they may require agreement from third parties and will need to develop a feasible and financially affordable / viable project for the CCG to support. By their inclusion in this paper, no suggestion as to the underwriting of rent by the CCG is intended without a full review of the project and its finances in line with CCG governance processes.

Premises assessment

Sydenham House Medical Practice. The population growth between the two practices is estimated at 3489. This equates to 291m2 and an estimated cost of £640,200 plus project costs. The premises have development potential. The current ration of patients to arae is high so additional space is necessary.
Musgrove Park (Branch of Sydenham). Heavy current space pressure suggests extension be scoped and implemented.. Need to determine how much extension can be built.
Stanhope Surgery (Branch of Singleton Surgery) No changes required but the list size is small and premises poor so closure should be considered.
Kingsnorth Medical Practice This practice expects a population growth of 3323.). Potentially, and without other productivity assessments this could generate a space need of 277 m2 (estimated cost £609,000 plus project fees). Any extension would necessitate addressing the current flood plain issues, the current ownership arrangements and extending the current lease.
Singleton Health Centre The population increase assigned to this practice is 213 which would require 1 additional clinical room, although it may well be able to be absorbed as is.productivity study to assess.
South Ashford Medics A significant population growth of 4327 equates to 361m2. The building has limited expansion potential but is a large building and rooms could be converted to primary care. A productivity review of the centre is urgently required.
Willesborough Health Centre The population growth impact is significant (4528). Potentially, and without other productivity assessments, a space increase of 377m2 may be required, estimates cost £830,000 plus project costs. However, there is only limited scope for extension so a review of existing space use is essential. Patient per sq m ratio is high.
Hollington Surgery The allocation of growth suggests that an additional1968patients could register at this practice, 164m2 additional space. However the premises are RED rated and not capable of extension. The population growth will have to be absorbed by other practices in the boundary area. .
New Hayesbank Surgery The population impact is expected to be 4062 people. The site has recently been estended and so should be able to address this growth.
Sellindge Surgery The population increase assigned to this practice is 204 which would require 1 additional clinical room, although it should be able to be absorbed as is. However the Otterpool park development may drive a new approach.
Wye Surgery A small extension (37m2) would allow the increased population forecast of 449 to be treated, estimated cost £81,400 plus project costs.
Charing Surgery The population impact on Charing Surgery is expected to be 2232 people. The premises have been extended to cater for 10,000 patients and current list size is 9812, The site has the potential for extension and growth and to deliver r other services. An extension of circa 200m (est cost £410,000 plus fees) is needed just for primary care growth.
Hamstreet Surgery Although there are no firm plans at the moment, do have the potential to expand above on part of the premises. There has been a recent expansion and the population increase for the practice is assessed as 732 which should be absorbed in the existing footprint..
Ivy Court Surgery This surgery has a very high patient to area ratio and needs expansion to cope now but with the population growth (2422 people) and additional 202m2 is needed. A project to extend above the existing surgery will add approximately 600m2 to the building and is being funded though NHS England capital funds. The scheme will take the existing occupants of East Cross Clinic leaving that building vacant. This could be used as a Hub for the Rural cluster (subject to refurbishment and internal redesign) or if not needed, sold. This is the priority scheme for the CCG
Woodchurch Surgery The premises are pretty much at capacity now, so with the historical patient growth pattern of the past ten years and projected growth they will be needing support to extend the premises to meet the anticipated future demand of current service provision and the additional demands of services being passed down from secondary care and the district nursing service. However the forecast population growth is only 59 people so no action is recommended.
New development at Chilmington This will be built under s106 funding and is 1000m2 in size, serving 5750 patients. The CCG must consider how it manages the patients prior to development being ready.

There will be additional rental implications for the suggested extensions which will affect CCG revenue. Increases in rateable values are also likely and potentially clinical waste costs.

Double running costs whilst projects are being developed are likely.

3.6 Local Care Shift estate strategy: transforming service change

Hubs are a stated priority and this paper estimates at least three hubs will be required to serve populations of circa 50,000, but there is no data available to be able to scope the impact of local care shift on the estate. There is no capacity in the local primary care estate.

Potential ways to achieve the hub development are:

- use of East Cross Clinic for rural cluster
- review of use of Vicarage Lane Clinic
- Extending additional premises and operating as a virtual hub
- Opportunities to co-locate healthcare services with other public sector bodies and services, such as the LA, as per One Public Estate principles
- Opportunities to convert existing public assets to hubs
- Use of hospital estate as local hub
- Identification with local authority of potential land to build new hub
- Explore with local authority potential for funds to build centres and lease back
- Build new super surgery

It must be noted that this will have significant capital, revenue and project management implications for the CCG, which has not undertaken a project of this size previously. Revenue form services currently provided in a hospital setting will need to be freed to help fund the premises. A new hub build would be around 2500 m2 and cost £3,500 per m2 to construct. Running costs are around £700 m2.

This is a key work stream that must be managed as strategies firm up. Decisions on locations, service make up, number are crucial to facilitating service change.

3.7 Clusters

The Kent & Medway Sustainability Transformation Plan describes practices working closer together in alliances along with social care, community NHS and acute NHS clinical staff and services. To this end practices have grouped themselves into three connected hubs for shared working arrangements – Ashford North, Ashford Urban and Ashford Rural.

- Ashford North includes: Hollington Surgery, New Hayesbank Surgery, Sellindge Surgery and Wye Surgery.
- Ashford Rural includes: Woodchurch Surgery, Ivy Court Surgery, Charing Surgery and Hamstreet Surgery.
- Ashford Urban includes: Sydenham House Surgery, Willesborough Health Centre, Singleton Health Centre, Kingsnorth Medical Centre and South Ashford Medics.

The following premises have development potential in terms of land available for development:

3.7.1 Urban Cluster

- Sydenham House Surgery
- Musgrove Park (Branch of Sydenham House)
- Kingsnorth Medical Practice (subject to environmental advice)
- Willesborough Health Centre
- St Stephens Health Centre (South Ashford Medics)

3.7.2 Rural Cluster

- Charing Surgery

- Ivy Court Surgery
- Woodchurch Surgery

3.7.3 NORTH CLUSTER

- Wye Surgery
- Sellindge Surgery

Further potential for increased clinical activity include:

- Ensuring extended opening hours
- Productivity review of rooms and how they are used
- Movement of admin staff to leased office space and conversion of freed to clinical space

3.8 Community Premises

East Cross Clinic, Tenterden	Health Centre	Purpose built health centre; occupies site adjacent to Ivy Court GP surgery. Long term hold. Very underused and void costs apply. Potential hub
Vicarage Lane Clinic, Ashford	Health Centre	1980s purpose-built health centre. Long term hold. Review of use and potential use as hub.
St Stephens	Health Centre	Purpose built health centre. Primary Care and other services. Review of use and internal service plan to generate more clinical activity.

3.9 CCG Headquarters

The CCG HQ building is located at Inca House. The building is leased by NHS PS, The CCG has undertaken an options appraisal to review its HQ base and the most cost effective solution. As a result notice has been given to vacate the premise in September 2018 and relocate to Canterbury and Ashford Council premises.

4. Challenges and Opportunities

The NHS and in turn the CCGs are under financial pressure to ensure that the health estate is rationalised and that assets are maximised to their full potential. This will present a number of challenges as well as opportunities to improve the functionality of the estate in line with the service strategy.

Engagement with the key stakeholders in the borough has led to identification of the challenges and opportunities that Ashford faces. Identification of these will enable the chance to address these issues and act on the opportunities that arise.

Challenges	Mitigation
Growth scenarios still being developed for the Ashford growth strategy but will cover the next 30 years	Maintaining a constant dialogue about long term housing development and population growth through the Local Estates Forum with relevant stakeholders
Monitoring the proposed housing developments over the next 30 years and ensuring S106 and CIL opportunities are captured	Maintaining dialogue with Ashford Council's planning and development department.
Not knowing what accommodation (particularly clinical) is available.	Development of shared estates database that can be accessed by all stakeholders.
How to create an effective system that allows different organisations to share flexible space and facilities effectively.	Develop / invest inroom booking system, which potentially can be rolled out across Ashford.
Lack of capital investment for development/reconfiguration	Local Estate Strategy will set out improvement that can be applied for though NHS England capital funding or private finance
Large number of stakeholders	Maintain the Local Estates Forum and ensure all stakeholders, remain fully engaged.
Constraints of leases and budgets	Working with the NHSE, creating a flexible lease framework for service providers.
Population distribution and health inequalities	Ensuring Health hubs are accessible for all
Lack of transparency within each agency	Creating local estates meeting with key stakeholders on a regular basis to encourage engagement.
No facilities capable of housing out of hospital services	Option appraisal and working with LA
Under investment in core primary care could act as disincentive to grow list sizes	Revise investment strategy for primary care
National NHS workforce crisis removes ability to staff services	Work with NHSE on recruitment initiatives

4.1 Estates and technology opportunities

- Maximising the use, and realising the benefits, of digital technology which will include data sharing across and within the health economy, digitalising records and enabling practices to work in different ways to maximise the available estate, allowing absorption of growth, and improving

patients' experience and outcomes. The Local estate strategy will set out to create meaningful forums to discuss needs and match with capacity.
- Improve the use of clinical rooms in all key estate.
- Engage in cross boundary discussions to ensure that the need for health services is met in the borough.
- Create a hierarchy of services – decide what we want, how we provide it and where.
- Creating one voice for the estate.
- Look at other boroughs where success is evident, in terms of technology, estate strategy and patient care.
- Co-locate services where possible and sensible.
- Create a system for all health estate and wider public estate so that organisations have the opportunities to share, swap and borrow buildings
- Dispose of single service sites over time and where sensible.
- Identify any existing leases where there is poor value for money.
- Rationalise branch sites where possible and it is in the best interests of the population and value for money.
- Maximise the use of Ashford's health facilities and ensuring all sites are fit for purpose, DDA and CQC compliant.
- Map, collect and maintain real estate information across the estate.

4.2 The Estate Challenges

This section focuses on regeneration and population growth and change. The future estate will need to accommodate an increasing demand for services resulting from population growth and demographic change. The development and regeneration of areas provides site opportunities to modernise and rationalise the estate. The planning system can help identify future health infrastructure requirements and secure financial contributions from developers in the form of section 106 and Community Infrastructure Levy (CIL) to mitigate the impact of development.

The STP estates group have stated that the role of estates is to identify way of achieving best value and to consider the accommodation required to support new ways of working in health and social care. In Ashford this is driven by two factors: increased capacity in primary care due to population growth and capacity for shift of services from acute to community.

The initial assessment confirms that the current GP estate is in relatively good condition. What is also clear is that Ashford will be part of a major population growth over the next 10 years at the same time as the way health is provided will change to cope with increased financial pressures and patient needs. Ashford is a mix of town and rural locations and this will affect the estate solutions proposed.

The care models are becoming more integrated across health and social care with the GP still in the centre providing access to care for their patients. With the evolving health landscape the estate has to be flexible to be able to adapt to changing needs and future partnerships. How the estates supports new service models will therefore be reviewed on an on-going basis.

The primary care estate is a vital part of the health estate infrastructure in the area and the CCG is committed to ensuring that, under the GP contract, contractors deliver premises which are fit for purpose, compliant, provide sufficient capacity to respond to population growth and align with national and local commissioning priorities.

This will identify where investment in the primary care estate infrastructure is needed in the future. This assessment will take into account planned investment via the creation of Out of Hospital Hubs, the NHS England capital and Section 106/Community Infrastructure Levy opportunities.

The key criteria identified nationally, and supported locally, for investment in primary care premises are:

- Improved access to effective care
- increase capacity of Primary Care
- enable access to wider range of services to reduce unplanned admissions to hospital
- increase training capacity in general practice
- support the delivery of the Out of Hospital Strategy and delivery of community based services as part of the CCG commissioning intentions

In addition to increasing demand and changes to service models, the estate also has to meet quality requirements and be viable over the medium to long term for care delivery.

The aim is to have a fit-for-purpose and efficient estate, which provides value for money with increased sustainability and facilitates flexible working. A dual approach to maximising the estate is needed, simultaneously improving the quality of current estate where needed and taking forward a capital programme to future proof the estate.

The required estate is thus defined by the implications of service moves to community, the population growth over the next decade and the significant increase in elderly population.

The population growth is primarily in the Ashford Urban cluster and it is this area that requires the significant increase in estate.

A rolling capital programme for upgrade should be considered to support GPs in their contractual liabilities.

Work has gone into understanding the future demand over the coming 15 years. This identifies areas of focus that need to be assessed further as a priority.

Decisions about new models of care or the introduction of new technologies will impact on the estate needed, and the Estates Strategy and Implementation Plan will have to be revised and go through a re-iterative process to establish the final programme of interventions.

Options for hub development to facilitate shift of local care are urgently required. This is of fundamental importance if service delivery is going to be transformed.

4.3 Future footprint needed vs void

The additional footprint needed based on the projected figures has here been mapped to known void space.

5. SOURCES OF INVESTMENT

The Local Estates Strategy seeks to coordinate and make best use of all available funding for premises development. This includes the Estates and Technology Transformation Fund (ETTF) (previously Primary Care Infrastructure Fund (PCIF) and Primary Care Transformation Fund (PCTF)), NHSPS customer and landlord capital, NHS Trust capital investment, and developer contributions in the form of Section 106 contributions or CIL and private finance.

To some extent additional demand can be accommodated within the existing estate by using the estate more effectively, but are demand hotspots where new investment is needed, particularly in the Opportunity Areas.

5.1 Section 106 contributions / Community Infrastructure Levy (CIL)

Prior to the introduction of the borough Community Infrastructure Levy (CIL), s106 health contributions were routinely secured from planning applications.. Future contributions may be received as developments commence and are completed. The process for securing funds has changed and investment proposals are now required. NHS England receive the funds and then the case for draw down has to be made. It is important to demonstrate that the proposed project can be fully funded.

To facilitate developments management of section 106 and CIL funding is essential.

S106 is agreed for the Chilmington development.

Note: a temporary solution is required at Chilmington as the project is not triggered until 1800 homes is reached.

5.2 The Estates and Technology Transformation Fund

The Estates and Technology Fund (ETTF) is a multi-year £1billion investment programme to help general practice make improvements, including in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS Five Year Forward View.

Stronger GP services are the cornerstone of delivering a new deal for primary care and this fund is designed to accelerate investment in infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients. Alongside programmes like the GP access Fund, it will support new ways of working that are needed to deliver a wider range of services and a new deal for primary care.

Ashford has one scheme funded, Ivy Court Practice.

5.3 NHS England Capital

This can be bid for and is subject to business case review and approval.

5.4 Private Finance

Third party developers are available to design, build, finance and in some cases operate new premises subject to agreement on rental payments.

Where investment is going to be required, feasibility studies need to be commissioned and subsequently project teams need to be formed. Project Initiation Documents (PIDs) need to be approved and the

business case process should be commenced with a view to providing facilities on time to meet the increased population's needs..

The business case process is set out in the NHS England, Business Case Approval Process – capital, investment, property & ICT guidance. It will require early engagement with NHSE, Projects Appraisal Unit PAU), who assure property and ICT investment business cases for the NHS England Board, prior to approval.

All cases at each key stage (e.g. strategic outline case (SOC), outline business case (OBC), full business case (FBC), as appropriate are required to adhere to the principles of best practice set out in the HM Treasury Green Book, the Capital Investment Manual and the (DH 1994) and NHS Estates Code (DH 2007).

As this process can be lengthy, the CCG and its partners need to plan ahead and engage with key stakeholders. Essential to this process is early knowledge of development proposals and an assessment of their likely impact on health services in that ward. Horizon scanning and placing of markers with the Local Authority that additional facilities may need to be provided is essential. Also, markers should be placed in estates strategies and with NHSE PAU to highlight future funding requirements.

The financial resources currently known to be available to the CCG will include:

- S106/CIL monies: The CCG is able to apply for health contributions for all new housing developments through a section 106 agreement by way of an application to the local planning authority in order to meet the primary medical services needs arising from new populations. This is done by evidencing the impact arising from the development on primary care provision. This requires consistent engagement with the Local Authority.
- For Chilmington Green (5750 homes), a section 106 agreement is close to being finalised with a value of approximately £4.8 million that will provide 1000 metres square of space to provide 6 GP consulting rooms.
- For Finberry (1100 – 4300 homes) the section 106 agreement was approved back in 2002 with an approximate value of £3.6 million that will provide land of 600 m2 and building for the provision of primary health care.
- For Court Lodge Farm (1370 homes) no formal discussion on health contributions have taken place and will commence as planning applications start to come forward. The CCG needs to manage engagement and include local stakeholders
- Where a section 106 investment has been secured to provide a healthcare facility for new populations, alternative sources of NHS funding will not be released to meet the same population need.
- For new populations such as those highlighted, the CCG will need to engage local practices whose boundaries cover these locations to commission primary medical services for these new communities
- NHS England capital funds subject to viable and affordable scheme development
- Redistribution of current rent and rates payments from premises relocating/closing
- Ensure tariff funding shifts with services and monies secured from the commissioning of out of hospital services i.e. moving PBR funds from acute to community. This is essential to fund estate required by local care shifts
- Increase capitation payments following increased population must happen but the time lag needs urgent discussion as up front funding is needed
- The work in this document is theoretical unless agreement is reached with practices to actually increase list sizes.

6 ESTATE DEVELOPMENT

The realisation of the full vision (and specifically a high quality estate) is a continuing process, requiring on-going and progressive estates improvements over a number of years and benefitting from some or all of the following principles:

- Opportunities to maximise use of current estate in the networks and/or localities.
- Opportunities to co-locate healthcare services with other public sector bodies and services; notably Local Authorities, to achieve more efficient use of the public sector estate as per the One Public Estate Programme
- Opportunities to rationalise the healthcare estate through co-location and/or consolidation of healthcare services.
- Out of hospital estate is funded by the in hospital tariff.
- Disposal of inefficient or functionally unsuitable buildings in conjunction with estates rationalisation. Capital is likely to be taken nationally but revenue savings will stay locally
- More efficient use of buildings through improved space utilisation.
- Innovative approaches to the delivery of healthcare services reducing demands on the healthcare estate, e.g. use of technology.
- Only invest in substantial capital development works where these are supportive of strategy delivery.
- Only undertaking new build where opportunities to rationalise and/or maximise use and efficiency of the existing estate have been realised or where such developments deliver a whole life cost saving versus continuing use of the current estate.

All sites should be initially assessed for investment on the basis of the emerging NHS England criteria as follows:

- Increased capacity for primary care services out of hospital,
- Commitment to a wider range of services as set out in commissioning intentions to reduce unplanned admissions to hospital,
- Improving access to effective care,
- Increased training capacity.

Other investment criteria to include are:

- Evidence of patient involvement,
- Consistency with the local estates strategy,
- Clear identified need,
- Sustainable in the long term,
- Flexible design.

Additionally consideration could be given to the following complementary criteria for analysing premises for investment.

- Good geographic location to support growth areas,
- Good public transport accessibility,
- Statutory compliance – including access to and around buildings,
- Fit for purpose and capable of being ICT enabled,
- Capacity to co-locate integrated services into multi-use accommodation,
- Functionally suitable, good quality, flexible accommodation,
- Sustainable premises capable of working at scale,

- A minimum patient list size.

Consideration could then be given to exit those sites that do not meet the above criteria if and when alternative facilities are available. However, Hospitals are considered fixed points and must be secured for the population. Therefore, if any review shows under-utilisation, on these sites, the services will be expanded to maximise use.

6.1 Outline Estates Strategy – what we will do

Model	Secondary	Local care shift	Primary	Admin
ESTATE TO REDUCE/ EXIT				Inca House to be vacated mid 2018
ESTATE TO INCREASE		Provision of new hub(s) to provide out of hospital services Fill existing voids	New primary care provision; possible extension to existing practices Chilmington Green development Potential Tenderden reconfiguration/extension Subject to viable scheme being achieved in timeframe	CCG to explore options to relocate HQ
ESTATE TO OPTIMISE			Utilisation reviews of GP practices to explore potential underused capacity Use of void space by local care shift	

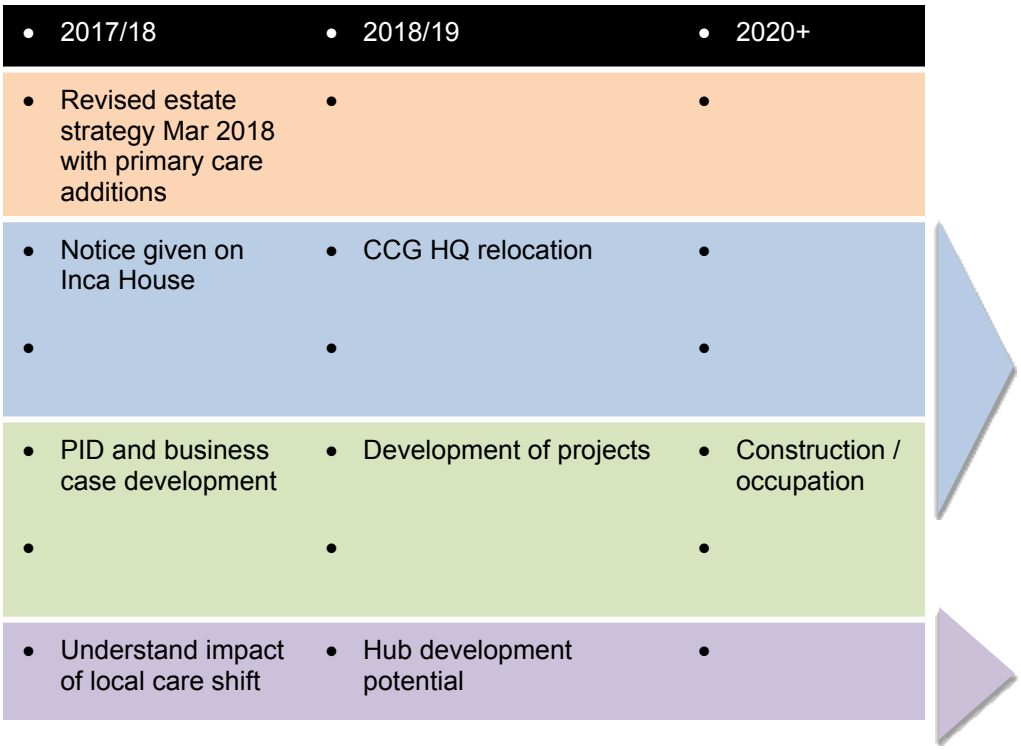
6.1 IMPLEMENTATION PLANNING

Delivering the strategy will require ACCG to share its vision and undertake further work practices and other stakeholders to secure change, ensuring full patient and public engagement at the same time.

The strategy assures alignment to the geographical and demographic need of the population. The improved facilities will enable services out of hospital to be commissioned, increasing the range of diagnostic and community services to be available more locally.

ACCG will need to identify resources to take forward the change agenda and secure the estate that will enable delivery of care well into the 2020's

The implementation plan has been developed to ensure the health economy in Ashford is supported by a fit for purpose estate over the next 10 years. The Estates Strategy and Implementation Plan is a constant work in progress and will need to be considered when major changes happen to care models and introductions of new technologies take place.



6.2 Short Term Work Plan

1. Development and implementation of primary care estates strategy; identify all future hubs and service reconfiguration required to enable new models of care.
2. Support for all other new models of care planned for the system using infrastructure as an enabler.
3. Ensure all fixed points in the system are fully occupied and utilised
4. Productivity and utilisation assessments of key sites
5. Every NHS PS building to be statutory compliant with agreed programme of landlord works if needed; Vicarage Lane, East Cross, St Stephens
6. Buildings identified for disposal or lease surrender to be disposed of in a timely manner and void charges to cease such as Inca House
7. Liaise with the council to overlay health and other public sector estate to identify further opportunities for integrated care and estates optimisation.
8. Feasibility study across Ashford to firm up accommodation projections made in this paper for GMS
9. Demonstrated that the scheme meets the strategic plans of the local commissioners, in particular , addressing the provision for new and extended growth plans for the area
10. The availability of section 106 contributions need to be explored and the use of any available funding verified and built into the plan, identifying how each investment pot will be used to the benefit of primary care across Ashford
11. Undertake a detailed piece of work to ascertain the S106/community infrastructure levy health contributions that have been secured, are still being negotiated and where discussions are yet to commence.
12. Confirm the section 106/community infrastructure resources available,
13. Identify development areas within local plan where s106/CIL resources still need to be negotiated (such as Court Lodge Farm).
14. Review the terms of each section 106/CIL Agreements their attached conditions and ascertain commercial flexibility to reconcile with options
15. Proposals then need to come forward as to where the S106 investment should be directed across Ashford CCG area to mitigate planned growth and the impact on primary medical services.
16. Engage with the developers and Ashford Borough Council to propose alternative development options, timing and preferred procurement route to enable best value recurring revenue costs.
17. It is also anticipated that there will be a clear link with the STP estates stream, a link with NHS Property Services estate and an indicative premises disposals list.
18. Identify where further feasibility work is needed on key growth areas if not covered by section 106/CIL agreements.
19. Assist Ivy Court practice in development of scheme for NHS England capital funds by end March
20. Individual practices/groups of practices will then make proposals on contracting routes that will be explored and provide proposals for testing and confirming the right solution. This will include occupancy arrangements, tenures/lease length and management, break clauses, NHS design and specification
21. Need to secure new HQ, negotiate lease and manage move from Inca House.

6.3 Ongoing medium and long term work plan

Ongoing medium and long term priorities:

1. Impact of acute reconfiguration on local care shift and community estate
2. Regeneration/housing growth
3. Use of technology and agile working to further optimise estate
4. Work with the local councils to reduce public sector estate across each borough and identify any potential for co-location which may lead to rationalisation

6.4 Workforce

- Similar to the finance point made above, a workforce strategy is required to ensure sufficient staffing resources as available to manage the additional care required. This will need close liaison by CCG and GP Federation.

  ACCG will need to consider resourcing an estates lead who will:

- Lead the implementation of the strategy with stakeholders, support PID and business case development and the procurement of schemes – possible access to finance. PIDS and business cases will be to implement CCG strategy
- Manage STP estate engagement and ensure Ashford strategy is reflected in this work
- Receive and review applications for estate and technology transition funding against the strategic direction set out in this strategy
- engage with stakeholders
- engage with residents and practices' communities,
- review practice delivery against the quality framework to ensure practices are meeting their contractual targets
- offer guidance to practices for developing PIDs and business cases for schemes with ACCG agreement

6.5 Enablers of change and managing constraints

- Analysis of data from the 6-facet and utilization surveys
- Undertaking the surveys of the condition of GP premises, whether there is underutilised accommodation and whether there is a potential to extend/develop will provide clarity for investment priorities. It will also provide information on where additional out of hospital services may be offered.
- NHS Ashford Clinical Commissioning Group must remain responsive to evolving Government policy and initiatives and to patient need when commissioning future health services. It would be the intention of the NHS to secure development monies via Section 106 agreements where provision relates to a localised need or as identified through the site allocations in the Local Plan. Alternatively the NHS would seek to secure Community Infrastructure Levy receipts to deliver strategic health provision across the borough..
- NHS Ashford CCG would like to enable planning permission and s106 investment (or CIL where appropriate) to be granted for
- The provision of new purpose built primary health care facilities (hubs) on suitable sites where this would not conflict with other policies in this Plan. This may also include the provision of back office functions that support the provision of primary medical services at scale.
- The refurbishment, extension or mergers of general practice.
- NHS England capital funding (subject to viable scheme submission)
- Development of GP locality hubs

- Fundamental to the strategy is the development of larger premises that can support the delivery of a wider range of services to a population.. The CCG will need to work through the constraints and concerns of smaller practices not wishing to connect or relocate to larger locations, through available commissioning routes and funding opportunities. This may be using:
- Identifying levers to 'encourage' relocation
- Encouraging occupiers of one premises share limited resources across a wider patient base
- Providing the patients with information on how and where to access services, which may encourage change
- Workforce development and enlargement in context of National workforce situtaion
- Management of disincentives to grow list sizes

6.6 Risks and Mitigations

Risk	Mitigation
Lack of capacity and estates expertise to further the agenda	Procurement of estates and project management expertise
National economy and housing market	No mitigation identified
NHS funding – changes in priorities	No mitigation identified
Inadequate and poor data	Work with partners to make data as up to date and reliable as possible
S106/CIL contributions	Ensure good, consistent engagement with Ashford LA to ensure health requirements are fed into local development plan. Map existing contributions status, develop process maps for management of same.
Failure to obtain engagement for the long term CCG ambition for the borough with GPs	Stakeholder management, financial strategy, workforce strategy
Failure to obtain engagement for the long term CCG ambition for the borough with local authority	Ensuring effective shared vision and building on the work of the Health and Wellbeing Board/ public health links
Failure to obtain engagement for the long term CCG ambition for the borough with acute Trust	Need to link with acute Estates strategy Agreement through commissioning on the timescale of relocation and recommissioning of hospital services that will impact on estates requirements
Predicted population growth does not materialise	Ensure that plans include a timeframe that is realistically ahead of the population growth curve and includes options for alternative temporary use of facilities by other stakeholders
Poor engagement from providers	Ensure strong leadership and buy in from all parties to the value of working together
Lack of capital funding	Explore all routes, support GPs in business case development
Lack of project development funds	Seek project support from NHSE
Unable to attract a sufficient and effective primary care workforce as nationally there are predicted shortages of GPs and practice nurses	Ensure training opportunities within practices are maximised, recognising GPs often practice from where they have trained

	Work with universities to encourage nurses to undertake APN roles and support the backfill Subsidise training programmes
Building not operated to maximum effect and no incentives to drive utilisation though building management	Implement processes so that estate is managed and maintained through a shared overarching asset management system using an agreed programme methodology; created in collaboration with healthcare service providers and estate asset owners and operators; governed by the Ashford CCG.

7 GOVERNANCE

An Estates Strategy and Implementation Plan is always a work in progress and will have to be considered as and when new service models are introduced or delivery improvements such as technology introductions are made. It is the role of the governance framework to oversee and manage delivery effectively; as well as on-going strategic asset management.

A strong governance structure will ensure all estate needs are assessed holistically and prioritisations are made with the system as a whole taken into account. It is envisaged that all new estate needs are presented to the Local Estate Group in accordance with the Treasury five case model and prioritised in line with the development approaches outlined in section 4.2 of this strategy.

Strong links to be developed to the council's Infrastructure Development Forum to ensure health needs are part of the future Community Infrastructure Levy (CIL) plan.

Figure 7.1 – Outlined Governance

Master Assumptions List

A number of assumptions have been made to draft this SIP. The main assumptions have been listed below:

- Population growth data from LA
- The estates baseline is based on the NHSPS data

8 Glossary

ACCG	Ashford Clinical Commissioning Group
ACO	Accountable Care Organisation
CCG	Clinical Commissioning Group
CIL	Community Infrastructure Levy
ETTF	Estates Technology Transformation Fund
FM	Facilities Management
GP	General Practitioner
GPWSIs	GPs With Special Interest
HQ	Headquarters

JSNA	Joint Strategic Needs Assessment
LA	Local Authority
MCP	Multi-speciality Community Provider
NHS	National Health Service
ONS	Office for National Statistics
PACS	Primary and Acute Systems
S106	Section 106 of the Town and County Planning Act 1990
SIP	Estates Strategy and Implementation Plan
STP	Sustainability Transformation Plan