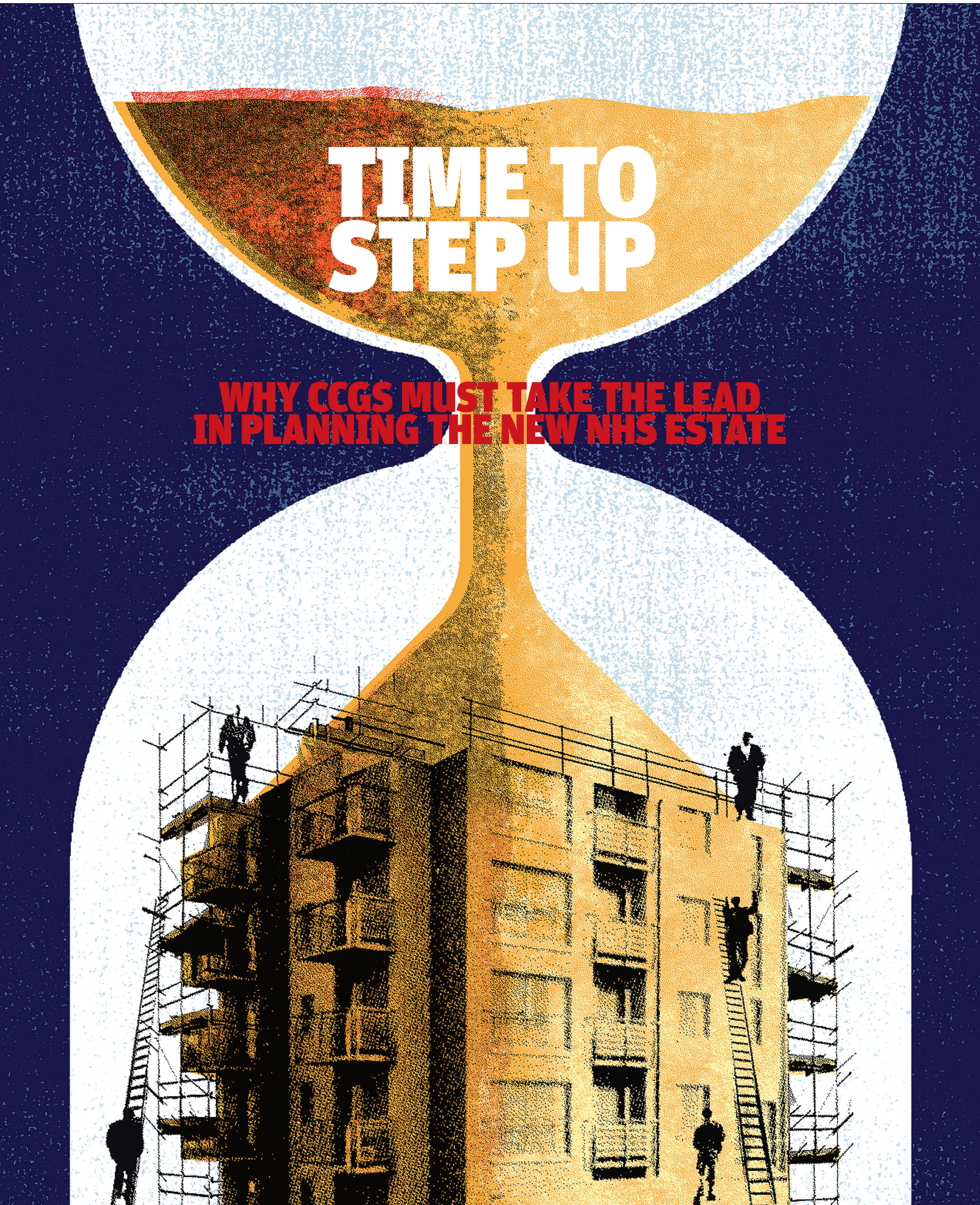
FOR HEALTHCARE LEADERS
HSJ COMMISSIONING
AN HSJ SUPPLEMENT/20 JUNE 2014

TIME TO STEP UP

WHY CCGS MUST TAKE THE LEAD IN PLANNING THE NEW NHS ESTATE



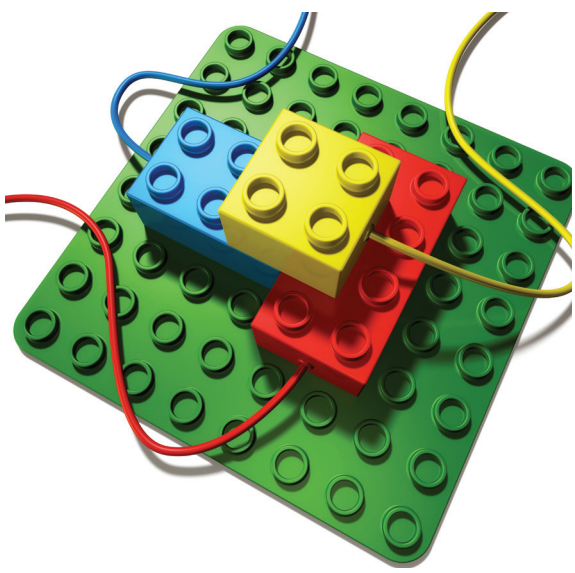
CONTENTS

INSIDE

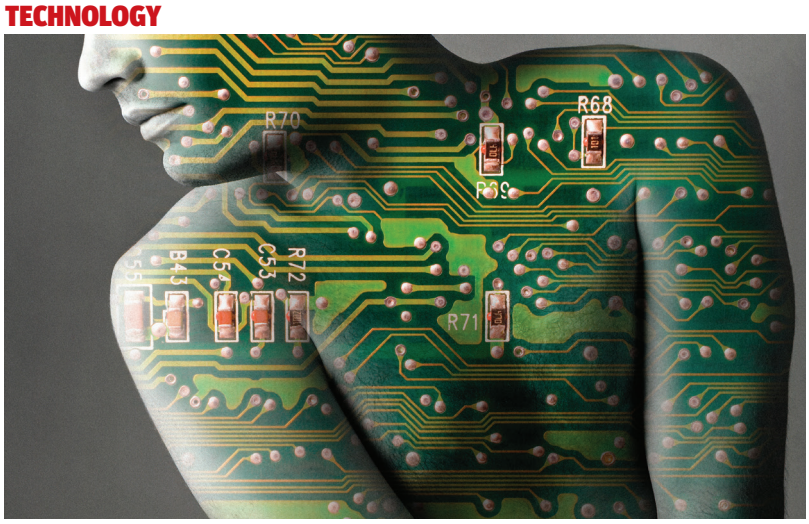
Supplement editor
Emma Maier

ESTATES MANAGEMENT

What does 'strategic' estate and infrastructure planning mean in practice? In primary care, this will involve 'sweating' as much as disposing of physical assets by, for example, developing more flexible spaces and sharing facilities with other organisations. Old-fashioned PFI deals also look set to give way to joint venture capital investment schemes. Page 6



TECHNOLOGY



'Interoperability' technology could transform the way primary care works. It lets the networks most used by GPs share and use each other's information, enabling things such as online appointments, e-prescriptions, and decision making support. It also allows clinical commissioning groups to disseminate local policies and complex guidelines to all their GP practices at the press of a button. Page 10

ESTATES MANAGEMENT

Reshaping the NHS will mean reshaping its huge estate – constructing new buildings, finding new uses for existing ones and disposing of unwanted space. As most clinical commissioning groups own little property, it is vital that they influence what providers do with the estate through their plans for commissioning. Page 2

HILARY BLACKWELL ON THE NHS ESTATE

The Health and Social Care Act 2012 made provision for a number of changes to the NHS which affected many areas, none more so than the NHS estate.

On 1 April 2013, some of the NHS primary care trust estate was transferred to the NHS providers, namely trusts and foundation trusts. NHS Property Services Limited was set up by the Department of Health to manage the remaining PCT estate, apart from Lift (local improvement finance trust) buildings which were transferred to Community Health Partnerships, another DH-owned company.

As part of the drive towards achieving sustainable efficiency savings, NHS provider organisations have come under increasing pressure to maximise returns on their estate. This may include effectively managing and disposing of properties which are no longer required by the NHS for the delivery of services, capital redevelopment, or a combination of both, ie funding redevelopments through property disposals.

NHS Property Services is under similar pressure to reconfigure the estate, although any decision as to whether a property is surplus to requirements and should be released for disposal should be led by commissioners.

'NHS estates strategy should align with clinical services strategy'

In his address at the Cambridge University Land Society Lecture at the Royal Institution in March, chair of NHS England Professor Sir Malcolm Grant challenged NHS estates professionals to develop a comprehensive asset register and consider more flexible working practices for clinical staff.

NHS bodies should take stock of their current estate, carry out a space utilisation review and align their estates strategy with the local clinical services strategy.

Community Health Partnerships has been leading the way with their work on strategic estate reviews.

There is a process set up for identification of pipeline projects and prioritisation within the local area. NHS England has taken a lead on this; and used proactively this should help with effective use of scarce NHS resources. It is important that a system-wide overview is taken, led by the CCGs who are closest to their population and their particular needs, with an eye to more effective care pathways. Without proper planning the required savings, maintenance and improvement of service quality will not take place. Fortunately the arrangements have been put in place to facilitate this and we look forward to continuing to support NHS transformation.

Hilary Blackwell is a partner in the real estate department at Capsticks solicitors
www.capsticks.com

ESTATES MANAGEMENT

GET YOUR FOOT IN THE DOOR

Why CCGs must shed any reluctance to get involved in the crucial task of estates planning. By Alison Moore

It's a cliché to say that the NHS is not about the buildings – but while it may be true that NHS services are the important thing for patients, they are often determined in part by where they are delivered.

The NHS has an enormous estate, much of which is not suited to the way it wants to deliver services. Buildings may no longer be fit for purpose; they may be in the wrong place as care moves closer to home; and they may be surplus to requirements.

As NHS organisations look to drive efficiencies and improve services for patients, it is natural that they should be looking at what role their existing buildings will play in this. But this should not just be an issue for providers – commissioners, as drivers of change in their local health economy, should be addressing this as well.

However, the separation of the commissioning function from providing services means most clinical commissioning groups own very little property and won't take the decisions on how it is used. Instead they will need to influence what providers do through their plans for commissioning.

"Commissioners have to think about their needs for facilities and how they interact with NHS Property Services, Community Health Partnerships and trusts around this and the delivery of services," says Jessica Kohler, a partner in Capsticks commercial division. "We have to invest in setting up new services and new ways of doing things before we can disinvest in the old bricks and mortar."

Sheila Childerhouse – until recently interim chair of Bedford CCG – says: "I think the key thing is to be clear about what we want to commission. Too often it is the providers who are providing the running. If you have that clarity about services you want for your population then you can start to look creatively at how you can achieve this."

Sometimes being creative can bring greater health and wellbeing benefits for an area, for instance, the redevelopment of a community hospital in Norfolk (see case studies, overleaf). But she says there is an opportunity for CCGs at the moment because projects like this fit into the integrated care agenda and there is political will behind it.

But are CCGs yet grasping this opportunity? Perhaps in some areas, but so far they have been reluctant to get involved in estate planning, possibly not seeing it as their role, adds Ms Kohler. But this is very much what system leaders should be doing.

She says a lot of the working on the ground has been driven by providers wanting to use their estate better. CCGs generally own little property themselves, so don't have the immediate link into estate use, and need to get involved in driving that agenda forward.

Capsticks partner Hilary Blackwell points out that NHS Property Services and Community Health Partnerships are set up to do what commissioners want them to do. "CCGs need to consider estates early on as they develop clinical strategies – that will give them the time needed to move their area's estate into line with the services they want delivered and to help deliver QIPP savings."

While CCGs have faced issues such as competing priorities and a lack of estate expertise, how much progress is made can sometimes depend on personalities and their willingness to engage with these issues, she says.

For well thought through investments, money can be found. "Things under £1m don't have a very onerous process and even up to £3m there is a delegated system to push it through the appropriate system. It's a very iterative process," she says. "There is

CASE STUDIES OVERLEAF ▶

Well disposed: the former Royal Earlswood Hospital in Redhill, Surrey, now luxury apartments

money but you need to be in the pipeline."

However, there is help at hand for some CCGs. Community Health Partnerships took on 301 leases of Lift (local improvement finance trust) properties when the Health and Social Care Act came into force last year. Since then it has been looking at each Lift area to do a desktop examination of likely needs for facilities – drawing on a variety of plans across health and local authorities – and to match this against what is available.

What is coming out of this is a mixed picture: some areas will be well served for facilities and may want to dispose of some, others will need more. The important thing is that commissioners need to sit down with other parties and talk.

CHP commercial director Graham Spence says that the next year will see more detailed work. "The commissioners have been working very hard with their clinical strategy so we have been saying we can help with the estates side."

While the new CHP system has taken some time to bed in, he points out that a Lift plan has already been brought to fruition in south east London.

This has seen contracts signed on a community hospital for Eltham, which will also house two GP surgeries. Its facilities will include diagnostic services, 40 intermediate care beds, outpatient consulting rooms and a minor surgery suite. Community services will also be relocated to the site. The design has been used to create maximum flexibility in the use of space.

Greenwich CCG chair Hany Wahba said: "This will benefit patients by bringing health and social care together in one place for easy access. This will be especially beneficial for

'For well thought through investments, money can be found. "Things under £1m don't have a very onerous process"'

those with complex needs and long term conditions."

The hospital should be in use next year and is a public private partnership between CHP and four companies forming Lift Healthcare Investments. To proceed, it has required the support of many stakeholders – particularly the CCG – and to meet tests laid down by the health secretary in 2010 around siting and appropriateness of the care it will provide.

For NHS trusts, spare capacity can be a headache. Even if wards or whole buildings are closed, there can still be costs associated with them such as security and maintaining the fabric in a safe condition.

"You can stop using a ward but you can't take it out of the hospital," says Mr Spence. Sometimes this space can be used to increase throughput of other patients, especially in the elective area.

But disposing of sites or parts of sites can be a challenge – especially for acute trusts which are likely to have a small numbers of sites, and potential public hostility to closing one.

Space freed up within an operational hospital can be difficult to use for other purposes – although other health-related services can be a possibility.

Ms Kohler points out there can be a number of options for trusts that want to sell or redevelop part of their estate. It can be sold on the open market, trusts can enter into partnerships with other NHS bodies, or they can form a joint venture with a private partner. What is the best solution will depend on the individual circumstances and the aims of the organisations involved.

Many trusts, feeling the economic chill, will try to sell vacant land and buildings for the highest price.

But the National Housing Federation is trying to persuade the NHS that there could be alternative uses for the land which can deliver improved health outcomes and potentially reduce the burden on the health service in the future.

This could include developing facilities for mental health patients who need supported accommodation or housing suitable for the elderly with long term conditions which allows them to be supported to live independently rather than moving into care.

Patrick Vernon, health partnership co-ordinator at the NHF, said the organisation was trying to understand the barriers – both real and perceived – which stop NHS organisations pursuing developments like this, and to engage with NHS organisations around the issue. The organisation has already met with the chief executives of some mental health trusts in London to start a dialogue.

One structural issue is that the impetus for service development which might be aligned with this sort of approach comes from CCGs – but it is cash-strapped trusts which generally have the land. ●

ALAMY

ESTATES MANAGEMENT: CASE STUDIES

VOYAGE INTO SPACE

As some parts of the NHS vacate space, other parts of the NHS can reuse it to provide new services or it can be opened up to the wider community

ESSEX

Essex is an example of a complex NHS landscape with seven clinical commissioning groups and five acute trusts. Working out the future requirements for buildings – and how current investment can map into the planned shape of service provision – is no easy task.

But the Essex area team of NHS England has been helping other health organisations in the area with this.

One of the challenges is the changing demands of general practice and the desire of many practices to have more space, often because they want to provide more services on site. The Essex area team has developed a set of criteria, against which these proposals can be measured against to allow for prioritisation of investment.

It's important that any investment fits into the emerging primary care strategy. There are sometimes cases where GPs feel they need additional space but there may be space available in other NHS buildings – and then there is a need to work with NHS Property Services and CCG colleagues to see if there is a solution.

Basildon University Hospital, Essex

In Clacton, for example, facilities commissioned for use by the acute sector have been left vacant after plans changed. They are now likely to be used for primary care.

But often making use of spare space on a main hospital site is a challenge. Using it for primary care can sometimes work but it can also give the wrong message to the public – that you go to hospitals for all your health needs. Longer term, of course, many patients won't need to access hospital for the same reasons they do now and the demand for the NHS estate may be very different.

And what estate there is may need to be worked more intensively – the idea of facilities which are only used Monday to Friday is at odds with the advent of seven day a week working.

The team is trying to be proactive rather than reactive – something which will become easier as CCGs finalise strategies for the next few years and the shape of their requirements becomes clearer. "From an area team perspective we need to think how these reflect priorities across Essex and beyond," says Dawn Scrafield, deputy area director and director of finance.

Currently the team has 80 active projects on its books. Some applicants need help and support to develop their schemes so they are more in line with priorities, says Mat Thorne, assistant head of finance. Values range from £10,000 up to over £3m. "One of the challenges in the new environment is that there is not really one organisation responsible for capital development," says Ms Scrafield.

But she sees CCGs as crucial. "They are the gatekeepers and the visionaries around future service models... increasingly we are working in a partnership with local authorities." In Wickford, for example, the council has invested in a health centre in an area which it wants to see regenerated.

'One of the new challenges is there is not really one organisation responsible for capital development'

"It is not a straightforward process. There are a variety of different stakeholders that we have to involve at certain times, there is a lot of communication and managing the decisions that people are unhappy about."

And it is not just the GPs who are can be unhappy about change. Ms Scrafield says: "The public are very committed to buildings. There have been a number of times where we have tried to move or where it is not appropriate to continue a practice but people get hung up on their buildings. We are mindful never to underestimate the power of the public voice."

New lease of life: the old St Michael's building now provides a community centre as well as complex nursing care

ALAMY

NORFOLK

When NHS Norfolk decided St Michael's Hospital in Aylsham should close back in 2007 it might have been the death knell for a much loved but outdated institution.

But an innovative solution, which involved the NHS working with a local charity and private developers, has led to health services remaining on the site.

Today the site, along with some neighbouring land, has been developed into a care home with nursing, residential and dementia care with some NHS-commissioned beds, and housing for care for those independent enough to remain in their own home.

The hospital building itself has been turned into apartments and houses and there is also a health centre, which is a base for community health staff, and a community centre offering a wide range of services and activities and manned by volunteers.

It's a stunning transformation which has provided a lot of facilities for the town – much more than what existed before – while also allowing services to be provided at lower cost for the health service in a way that should be sustainable for the future.

Edward Hare, a trustee of the Aylsham Care Trust which came up with the plan, says ACT had been given a piece of land by its chaplain. This was next to the community hospital site but access was difficult.

The charity put forward the idea of combining the two sites and redeveloping services, releasing some land and buildings for development by commercial partners, and giving the charity funding for a community centre. This was accepted by NHS Norfolk – which then operated the hospital.

"The driving force was to keep the services in Aylsham," says Mr Hare. "We feel passionate about keeping community hospitals."

He thinks key elements were the gift of land which enabled the project to get off the ground, the willingness of partners to consider an innovative solution, partners who could bring capital to the table, and getting support from the local council planning department which could see the benefits for the community. ACT is also a well organised charity, whose trustees had useful skills and expertise to contribute to the project.

There have also been benefits for patients elsewhere in Norfolk, as the cash from the sale of a plot of NHS land has been used to redevelop a community hospital in North Walsham.

The scheme has had the enthusiastic support of health minister Norman Lamb, and is generating interest as a model for other community hospital developments.

The scheme was delivered before CCGs but Mr Hare believes there are lessons for them. "If CCGs take the lead and threw out this challenge I think it would create solutions for community hospitals."

And Sheila Childerhouse, who was chair of Norfolk PCT during this time, says: "It's brilliant to have everything from a community centre right through to high end complex nursing care on one site. It is planning well with partners and working with them very carefully and strategically so you are aligning a lot of very disparate interests." ●

DR SUE O'CONNELL ON BEING STRATEGIC

The NHS has witnessed the biggest reorganisation for decades and commissioners, managers and clinicians alike are facing a future of growing demands, which must be met from static or reducing budgets.

'Estate' or infrastructure is being increasingly viewed as a strategic commodity, which, like other technology assets and human capital, can be managed to achieve better access for patients and better efficiencies for commissioners and providers.

There is also recognition that there needs to be a more fundamental redesign of services and that estate, buildings and infrastructure all play a key role in making this redesign a reality, as a non-clinical intervention in care pathways.

There is growing realisation that a strategic approach to the planning, use and disposal of the primary healthcare and community estate can help tackle these challenges and drive significant savings for the NHS.

A head start has been made in the areas of England covered by the Lift (local improvement finance trust) programme, where Community Health Partnerships, NHS Property Services and the 49 local public private partnership Lift companies are well underway in supporting commissioners to develop and implement local estate plans that support CCGs' two-year operational plans and five-year strategies.

In these areas, locally led strategic estate partnership boards are being re-established to facilitate discussion, planning and decision making by bringing together the key partners in their locality.

This structured and targeted programme to support the strategic planning of the estate will deliver huge benefits – both in the short and longer term – including:

- **increased efficiencies, through the better use of high quality primary and community care estate;**
- **better service integration, delivering improvements in service efficiency and better health outcomes for patients; and**
- **new service models, replacing outmoded and inadequate premises, and releasing capital through a structured programme of disposals.**

The strategic estate planning and implementation programme is evolving and the intention is that there will be robust strategic estates plans in all areas by the end of March 2015. These will support real change in the local estate and generate practical solutions that drive system-wide savings, service integration and new models of delivery.

The NHS simply cannot build more and spend money on short term fixes, without being sure they are the right solutions in the medium and long term. Hard work and a united commitment to the long term cause will ultimately create huge benefits for patients and communities alike – and that has to be worth it.

Dr Sue O'Connell is chief executive of Community Health Partnerships

www.communityhealthpartnerships.co.uk/

ESTATES MANAGEMENT

BUILDING BLOCKS OF THE NEW ERA

The 2012 reforms did not focus on estates but will have a huge impact on what goes where. By Nic Paton

Last year a policy paper by the King's Fund calculated that the floor area of the NHS estate in England would cover the City of London ten times over. The NHS owned land totalling seven million hectares, or the equivalent of two London boroughs while total trust and primary care trust floor space was estimated at 28.5 million square acres, it added.

With the NHS in profound flux and under severe financial pressure, how this estate – a massive resource but also a massive cost – is best used is a key question for the future of the service.

Equally importantly, the big changes to England's healthcare system in the transition from primary care trusts and strategic health authorities to clinical commissioning groups and the greater integration of health and social care have put the spotlight firmly on estate and infrastructure planning, says John Bacon, chair of Community Health Partnerships, which provides estate services to the NHS.

"To develop community-based services and to integrate services across the different health and social care agencies, you need a fit-for-purpose, properly located estate," he says.

To that end, estate or infrastructure is increasingly being viewed by commissioners as a strategic commodity, one that, much like assets such as technology or even staff, can be managed to achieve better access for patients and better efficiencies, he argues.

"There is, I think, an awareness the NHS estate is not as well utilised as it might be and it is often not in good condition. So it is about making sure you are concentrating services and using your existing estate in the best possible way as well as developing new estate," says Mr Bacon.

But what does strategic estate and infrastructure planning actually mean in practice, and what's the best model for the NHS to pursue?

According to Richard Darch, leader at change consultancy HealthCare Partnering, strategic estate planning "is a bit like flared trousers; it is coming back in fashion".

What he means by this is that, while the 2012 reforms did not in themselves focus on estate or infrastructure, the knock-on effect has been that commissioners are having to ensure their commissioning strategies factor in issues such as the connection between quality of estate and patterns of service provision.

"What is being increasingly recognised is that you need to have some level of strategic planning in terms of location, the quality of your infrastructure and how that supports the quality of your healthcare," he explains.

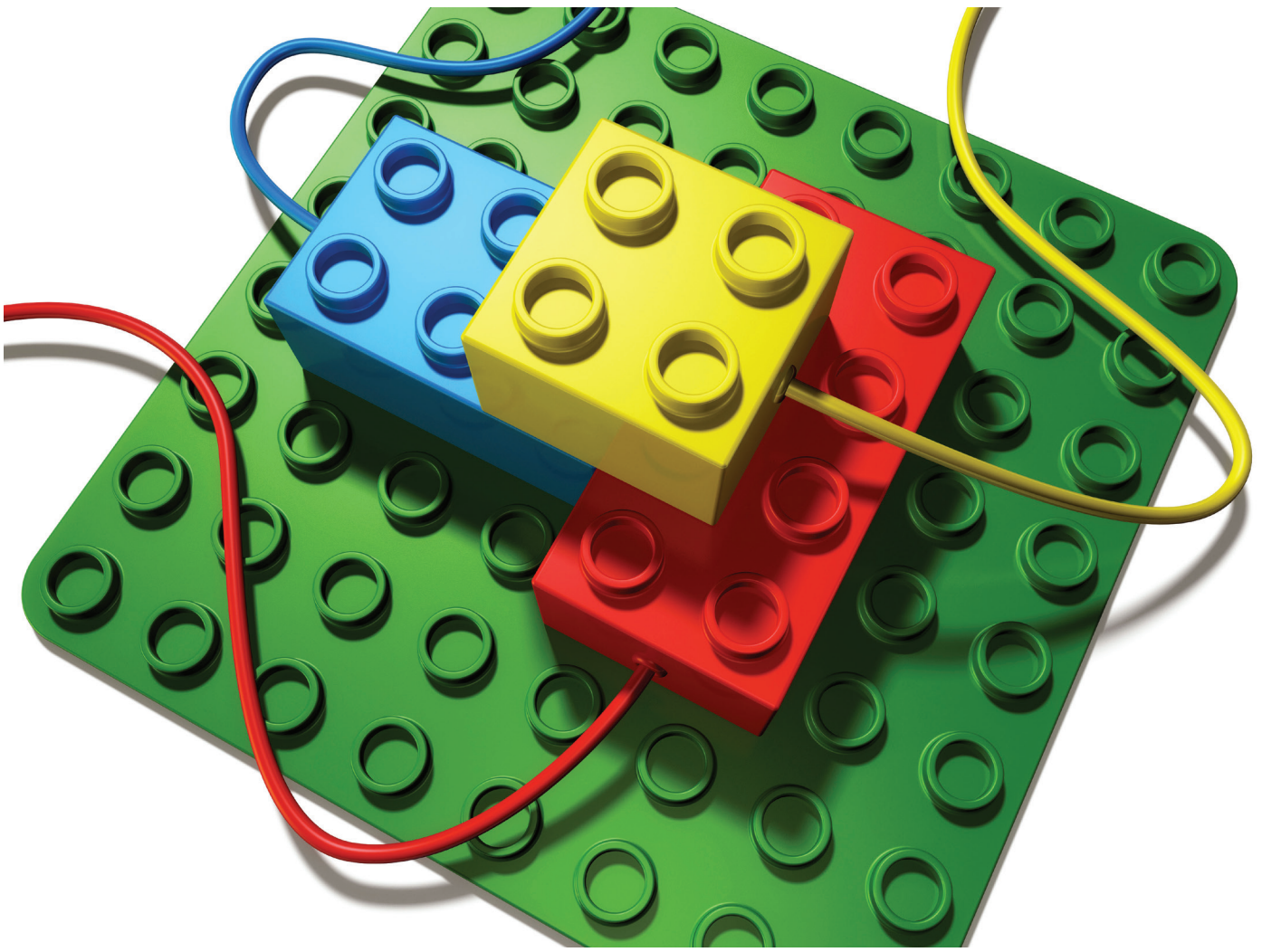
"It is about looking at what you have got, what do we want to buy in terms of services, and what have we got in terms of our estate to help us achieve this? It is about recognising that infrastructure is a major enabler for change," he adds.

In practice this can mean a multitude of things. Yes, certainly, one element can be straightforward disposal of buildings or land – and the King's Fund report highlighted the fact that disposals have already reduced unoccupied floor area to 1.5 million square metres, though there are still improvements that could be achieved. Sale and leaseback deals are another transactional option.

But at a more micro level it's also simply about using existing space better or smarter. Independent research earlier this year commissioned by CHP – of senior commissioners and practitioners – suggests the emphasis, at least in primary care, will be on "sweating" as much as disposing of physical assets.

The size of consulting rooms would decrease so as to increase capacity

CASE STUDIES OVERLEAF ▶



ALAMY

elsewhere, respondents predicted. Buildings would need to become more adaptable (for example with the space able to be used more flexibly or go up or down in size as required); and there would be an imperative to share space more with other service providers (both public health and more generally within the public services).

Within this it is important commissioners retain an element of control, meaning a joint venture capital investment model is the better way to go rather than, say, an old-fashioned PFI approach, advises Mr Darch.

"In the days of PFI there was clarity about the procurement route. Within the NHS now it is unclear how new infrastructure is going to get funded and delivered. But the joint venture route allows commissioners to have influence but also to make sure something is not completely controlled by the provider," he points out.

"Commissioners need to be more aware of the importance of infrastructure as a catalyst for change; they need to be embracing it and being more involved with it, not seeing it as someone else's problem to deal with. It is a travesty that the NHS's estate is so poor," Mr Darch adds.

'The emphasis, at least within primary care, will be on "sweating" as much as disposing of physical assets'

And that is where an organisation such as CHP can play a role, argues Mr Bacon. Following the 2012 reforms, CHP is now one of the two principal, public sector-owned organisations offering primary and community healthcare estate services to local commissioners and the wider NHS, the other being NHS Property Services. As such it can support CCGs to plan and use their estates more efficiently.

"The commissioner must be the key player in this, along with the relevant providers. It is about freeing resource through much better use of the estate. The CCGs that are thinking about this, we find, are the ones that are making significant progress," he says.

However, while CCGs do have an important role to play, it also has to be recognised that, for a strategic estate plan (SEP) to be truly effective, there has to be a genuinely collaborative, partnership approach, emphasises Juliet Hancox, chief operating officer at Coventry and Rugby CCG.

"You do have to arrive at agreement with your partners. Everyone is looking at getting rid of redundant estate right now so it can happen in a piecemeal fashion and there is a danger you end up throwing the baby out with the bathwater," she says.

This means not just bringing on board and consulting with those that own estate and 'brokers' such as CHP, but also functions such as IT, she contends, given the importance of technology and wifi in the modern-day estate.

"We have really benefited from having all our partners signed up to the SEP. You do have to think wider than the provider boundaries.

"If you are not careful you can just end up with a situation where each organisation has its own estate strategy rather than something that is properly joined up," she argues. ●

ESTATES MANAGEMENT: CASE STUDIES

'IT'S NOT ALL ABOUT SHINY NEW BUILDINGS'

Do you really need to book that hotel room? How the NHS is learning to get the most out of what it has...

CITYCARE HULL

Since last autumn Citycare, the Lift (local improvement finance trust) public private partnership company for Hull, has been working with Hull clinical commissioning group to audit beds in the community. It aims to get a much clearer sense of what provision there is, what condition that provision is in and how that resource can be better applied to service needs.

"Buildings are vessels for services to be delivered from; you need to know what the building is going to be used for and consider how you are going to make the most back from it," explains chief executive Jo Barnes.

"In the current climate every penny, and every bit of space, has to be maximised," she says. "You do not want to spend money on something if there is no service need for it. There needs to be a link between service planning and estate planning. Often people do it just from either end," she adds.

The audit is looking in detail at how space is used and booked, how well resource is allocated on paper versus what happens in reality and how to bring things more together. The second phase of activity will be to look at spending activity and, from there, draw up a new service plan.

"The estate is a dynamic thing. We have buildings that have been open seven or eight years and have been through two or three iterations of tenants. Things have changed, you cannot do things as you did them, say, 40 years ago," says Ms Barnes.

"It's not just a case of 'is a space let or full?' it's a question of 'are you using it for the greatest service benefit?'. Long term strategic planning has not always been knitted as closely together with estates as it should be. Often you find estates strategies will pay lip service to service strategies. Your head of service and head of estates should sit in the same office but often they do not," she adds.

Another initiative will be the launch in the next few weeks of a new portal to encourage all public sector organisations within Hull to collaborate more when it comes to booking rooms or space. The aim is ensure organisations are using each other's space rather than splashing out on a room in a local hotel.

"It should be a priority for the public sector to be booking rooms with other public sector organisations, perhaps with a common rate and a common website or phone number. It is so obvious, and everyone wins," says Ms Barnes.

"Within the NHS we have a lot of properties that are treasures and a lot that are liabilities. We need to get rid of the liabilities and invest capital into improving the rest of the service space. We need to be much cleverer about integrating service delivery. It may be trite to say it, but it is a journey. One that will probably never end.

"We need to recognise there is no money, and there is unlikely to be, so we need to be working in more connected, realistic ways. It's not all about shiny new buildings, it is also about making the best of the estate we already have," Ms Barnes adds.

The work Citycare is doing feeds into a wider landscape of integration, collaboration and transformation, argues Emma Latimer, chief officer at NHS Hull CCG.

The CCG is leading an ambitious transformation programme, Hull 2020, focused on developing a new landscape of integrated local health services by 2020. It will be one where the NHS, local authority, police, fire and ambulance services are all working more closely – and using their estate more strategically. Hull is also one of the pilot sites for the government's One Public Estate initiative, which is aimed at encouraging public sector organisations to share or release unused buildings and land.

"We are looking to develop more community hubs, to 'sweat' assets, such as existing Lift buildings," says Ms Latimer. "Overall, there is far too much public sector estate in this city and we need a system whereby we are better able to align strategies across the public sector."

For example, the CCG is currently working on the business case for developing a new integrated care centre that can be used by other 'blue light' public services.

"If you are going to ensure that buildings are genuinely community assets it stands to reason they need to be available across the community," says Ms Latimer.

"You need to make sure service transformation drives the estate rather than, as too often in the past, developing a building and then putting something in it," she adds.

HALTON CCG

The Health Care Resource Centre (HCRC) in Widnes, Cheshire has been a busy, popular health resource for the local community in Merseyside for the past eight years. But this

Check out the alternative: why meet in a hotel when there may be space in a local NHS building?

autumn will see it relaunched as an Urgent Care Centre designed to reduce the pressure on the acute sector and help the local Halton CCG meet government demands for 15 per cent cuts in A&E admissions over the next five years.

The £800,000 initiative is a partnership between Halton CCG, Halton Borough Council, Renova Developments (the Lift company covering St Helens, Knowsley and Warrington), NHS Property Services and Community Health Partnerships.

From a commissioning perspective, it is also a prime example of how a CCG is taking the lead in terms of driving and promoting a more strategic approach to estate management and planning.

Dave Sweeney, director of transformation at both the CCG and the council, has spent much of the past year working with Renova to put in place a collaborative, overarching estate plan for Halton – that overlays the NHS and Halton Borough Council plans. It feeds into and complements the CCG's priorities around improving health and wellbeing in the area and has also meant working closely with a wide number of local providers, including Warrington and Halton Hospitals Foundation Trust, St Helens and Knowsley Trust, Bridgewater Community Healthcare Trust and out of hours primary care service Urgent Care 24.

'Your head of service and head of estates should sit in the same office but often they do not'

As Mr Sweeney explains: "We had the opportunity to reduce unwanted NHS estate, reconfigure the remaining space and improve patient care, and that just made perfect sense to me. We came together very quickly, set our stall out and established our joint vision."

With the closest A&E departments several miles away and in an area that has one of the lowest levels of car ownership in the country, more strategic use of estate has meant providing a primary care-based alternative to A&E as well as better integration of services such as mental health and wellbeing.

"We needed something on both sides of the water. In many ways we are as united as a borough as we are split by the Mersey. So it has been a question of looking proactively at creating a health 'hub' where people can go to access their GP as well as medical care; a building we can use to reduce the demand for non-elective activity and A&E admissions," says Mr Sweeney.

The revamped centre will have a single new reception and waiting room (consolidating the six that used to be spread throughout the building); new X-ray, imaging, ultrasound and diagnostics facilities; an on-site pharmacy; wider doors and corridors (to accommodate trolleys); and a new children's play area that will include state-of-the-art interactive media. This will ease the stress for parents and children awaiting treatment.

It is also expected to lead to the required 15 per cent reduction in A&E admissions over the next five years, as well as a 15 per cent reduction in non-elective admissions through A&E. In the longer run, it hopes to deliver a 20 per cent reduction in A&E attendances. Financially, the centre is expected to save the wider health local system £150,000 a year.

This is an important point, argues Mr Sweeney. The new centre has, clearly, required a significant investment upfront. While over time the savings will be significant, strategic estate management is often something that requires a longer term, system-wide perspective rather than assuming you will be able to achieve quick financial wins.

"The savings may be elsewhere. But, especially given the significant integration with our local authority, we potentially now have so many different pieces of land or buildings that can be used in better ways," says Mr Sweeney. "If you are providing a local service where people do not have to travel, say, 20 miles to get to their A&E, the spin-offs are going to be really important. It is about investing for the long term.

"This is not about privatising the NHS, it is just about using its estate better. Estate management is, of course, not a panacea but, to me, it is absolutely essential, a key component towards creating a truly integrated approach," Mr Sweeney adds.

The role of CHP in all this has been to, effectively, be the estate planning link between the NHS and other public services, says area director Mike Chambers.

"Rather than implementing plans from above, our partners rely on us to lead from alongside them," he says.

"In Halton, success has been down to the energy and enthusiasm of the CCG. We have a local authority that is naturally collaborative and a Lift company with a great track record. Trust and cooperation are earned.

"Those are the ingredients that give real cause for optimism, because the resulting projects are 'owned' by local organisations and local people." he adds. ●

MAX BRIGHTON ON INTEROPERABILITY

IN ASSOCIATION WITH INPS

VISION

INPS is an advocate of interoperability – making existing IT systems across the NHS work together to facilitate integrated care. Interoperability is really about attitude – letting go of short term territorial sensitivities and seeing the long term potential for the health system. Our competitors offer it in varying degrees, but with reluctance. Their strategies are based on dominating an entire area with their systems so it is not really in their interest to facilitate interoperability.

We believe our approach is better for patients, clinicians and the NHS. The alternative of a single monolithic system across a whole CCG stifles competition and innovation, and removes system choice. It lets only those clinicians using the system work together – in the NHS there will always be clinicians and providers on the outside who become isolated.

Vision Outcomes Manager is a common-sense approach to interoperability. It works with all major GP IT systems, allowing CCGs and health boards to involve every single practice and clinician in targeted health improvement initiatives without having to change those systems. This means it can be deployed quickly without incurring the cost, disruption and inevitable data loss of unnecessary wholesale

'A monolithic system across a whole CCG stifles innovation'

system changes.

The solution is the same for all GP practices regardless of the IT system. This makes it easy to deploy with consistent training for all staff. Data recorded using Vision Outcomes Manager is stored as normal clinical data, using native coding, within the existing GP clinical systems.

Uploading statistics about the number of patients meeting the criteria of each node and decision point on a pathway gives commissioners invaluable insight into the care being provided, but does not involve any patient data moving around. This means that information governance requirements are minimal. Patient permission does not need to be obtained and it is not necessary to undertake a costly and time consuming public awareness campaign – which often costs much more than the IT systems themselves.

We were one of the first suppliers to sign up to the new GP Systems of Choice funding framework, which extends the notion of choice. We believe that GP practices should be able to exercise their right to choose the GP IT system they want, and which works best for their particular circumstances. Vision Outcomes Manager allows CCGs and health boards to realise all of the benefits of a single system, without compromising the choice agenda.

Max Brighton is managing director of INPS
www.inps4.co.uk

TECHNOLOGY

DOING EVERYTHING IS AWESOME

Varya Shaw on the advantages of linking all primary care systems together to offer 'interoperability'

Interoperability is not the most exciting word in the English language but it represents a quiet revolution. It allows different clinical systems to collaborate, creating endless new possibilities.

INPS is a market leader in the field of primary care interoperability. Its product, Vision, allows the networks most frequently used by GPs – EMIS Web, TPP Systm1 and Vision AEROS – to share and use each other's information.

Headline tools and benefits include a task manager, online appointments, e-prescriptions, a customisable screen, QOF prompts, decision making support for prescriptions using the online medical dictionary Gemscript, a recall facility which tracks patient response, and simple data entry.

These are obviously useful, but as a list they do not capture Vision's potential to transform the way primary care works.

So what can Vision do? It allows CCGs to disseminate local policies, simple templates and even very complicated guidelines to all their practices at a press of a button, regardless of clinical system.

For GPs sitting at their desks, Vision provides prompts that pull together and analyse symptoms and test results, and suggest the next step in the pathway. When a referral is needed, a form is generated at a click of the mouse. There are two benefits to clarifying what pathway stage a patient is at: it helps GPs act sooner when it is appropriate, and stops them referring patients unnecessarily.

Vision supports GPs to help patients they might miss, and help them sooner. It allows CCGs to do the same for practices. A central dashboard aggregates GP data so that CCGs can see which practices are struggling to comply and provide support.

The analytics provided by the dashboard inform commissioning by showing where secondary care is under pressure. They also provide proof of outcomes which allows CCGs to evaluate changes to pathways and start again if they are not working.

There are currently 60 Vision pathways including the NHS healthcheck, chronic kidney disease (CKD), diabetes, colorectal cancer, wound care, and the Unplanned Admissions DES. Eight of these are being piloted this year.

One of the earliest pathways to be developed was the CKD module, which was authored by GP Dr Jon Behr.

Dr Behr explains why it was an ideal testing ground for Vision: "There is cynicism about CKD from GPs and dealing with the results is very onerous if you want to do it properly in accordance with the NICE guidelines, which are very lengthy. The key thing is those guidelines are objective, dealing with hard numbers, and there are rules you can write based on those numbers.

"With a designer, I developed a plug in manager with clinical decisions report for CKD. We want to make sure that practice CKD registers are more accurate, and that all patients that should be on ACE inhibitors are, unless there's a good reason not to. But we came to a dead end because we weren't a company.

"We heard about the huge potential of Vision Outcomes Manager and got in touch and saw that for CKD it was perfect. It seemed to me Vision was an opportunity to improve diagnosis and management of a condition that is not particularly well managed at the moment.

"For a particular patient you might want to know whether they should be on an ACE inhibitor or should they have been referred because of the pace of decline. Vision will tell you."

The module, which will be piloted in Hull

CCG, will keep CKD registers up to date so QOF payments will be maximised, but it ultimately aims to reduce the numbers of patients reaching end stage kidney failure. This will have a knock-on effect on strokes and heart failure, in which CKD plays a role. But for now the pilot will measure adherence to the guideline, increases in ACE inhibitor and A2A prescribing where appropriate, and improvements in blood pressure.

CCGs do not need much persuading to see the benefits, but what about GPs? Phil Kozcan, a GP and chief clinical information officer for UCL Partners, says: "The question for GPs is how well does a programme integrate with their existing system. If you have a tool like this that is very closely integrated, they will use it."

Dr Behr adds: "The nature of the alerts is they don't feel tickboxy – they are useful clinical summaries for CKD. If you can give GPs an easy solution – just click this thing in front of you and you can improve the patient's outcome – they will go for it."

He adds that the Unplanned Admissions DES module will provide an even stronger incentive to those GPs who have it to make full use of Vision.

'If you give GPs an easy solution – just click this thing in front of you and you can improve the patient's outcome – they will go for it'

Vision provides immediate efficiency gains. The CKD software module costs around £300 per practice, far less than, say, payroll software. Asking each practice to install pathways, guidelines and templates themselves is much more expensive than deploying these centrally through Vision. It also saves clinical time. Medicine is hugely complex with thousands of pathways. By supporting clinical decision making with prompts which make quick work of the algorithms and flowcharts GPs normally must wade through, they have more time to communicate with the patient.

Vision has the potential to do a lot more. It could transform remote care once it is optimised for use on mobile devices. It could also transform patient involvement, for example, it might be possible for someone having a test to access a patient-friendly summary of their results, which could encourage safe and effective use of medication. Dr Behr is working on an app for patients with CKD which will allow them to be more proactive in self management.

But the programme is already changing the landscape. Like any disruptive technology – the internet for example – interoperability creates opportunities that were not there before. Challenges such as efficiency, managing long term conditions, and integrated care are suddenly much simpler.

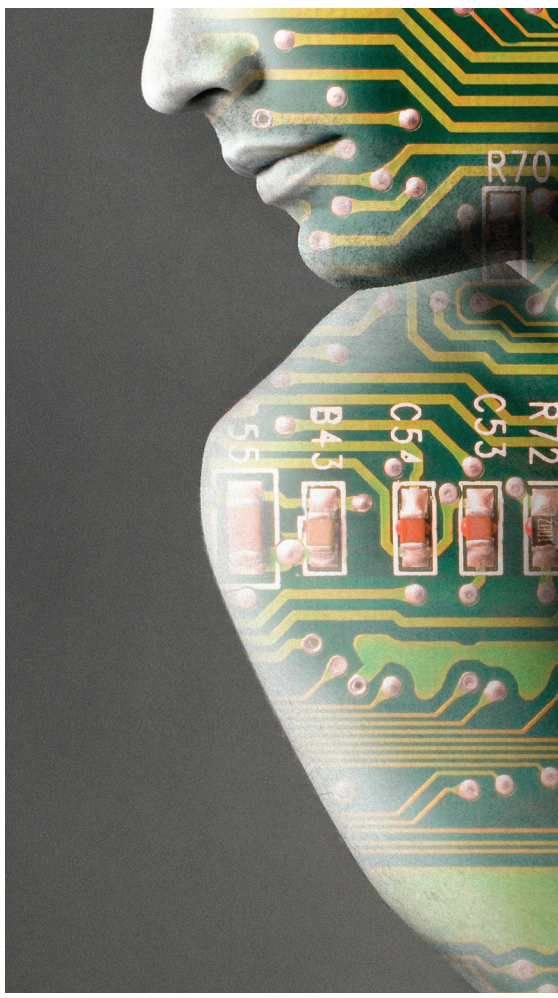
As Ciaron Hoye, who is piloting three Vision pathways as manager for intelligence at Birmingham CrossCity CCG, says: "It's a massively different way of thinking. This is a radical change in concept and approach." ●

ALAMY

TECHNOLOGY: CASE STUDIES

PRESCRIBING MADE EASIER

Using interoperability at the sharp end to improve care, spread new practice swiftly and inform commissioners



BIRMINGHAM CROSSCITY CCG

Birmingham CrossCity CCG was developing its own in-house interoperability solution when it heard about INPS's work on Vision Outcomes Manager. It decided not to reinvent the wheel.

Ciaron Hoye, the group's manager for information, says Vision is unique: "It is the only decision support tool that will let the CCG directly design new rules, publish templates into clinical systems to get the practice to capture clinical data, publish documents like patient leaflets into the clinical system, and then monitor progress centrally."

He adds: "INPS has grasped what interoperability should be and made it a reality. They've jumped in with both feet whereas others are just playing round the edges."

Birmingham is now piloting modules for diabetes and colorectal cancer among others. The city has one of the country's highest rates of prescribing for diabetes. The diabetes module targets nurse practitioners and GPs, supporting them to prescribe correctly according to NICE guidance CG87 on type 2 diabetes. Mr Hoye explains: "CG87 has got a giant, really complex flowchart of how you should prescribe diabetic medication, and 95 per cent of people don't understand flow charts. We've reduced that to a rule set that runs in the background."

The rule looks at patients' blood tests and medications and flags up any need to change their prescription.

Mr Hoye stresses that the programme supports clinical decision making rather than replacing it.

"The clinician still has to make a clinical decision but we try to prompt them down that path. It's about noticing the patient earlier on. The background creepers of blood tests often get missed, but if you do it through a computer it draws your attention to it. People spend ages trying to figure it out – you could spend that time much better with the patient."

Similarly, the colorectal cancer module waves a flag when the NICE scoring methodology has been triggered. This is powerful because one trigger for an investigation is repeated spells of diarrhoea, which are often reported to different clinicians. Vision puts those symptoms together, then prompts the GP to question the patient. If a referral is indicated it will take the clinician straight to a form.

The pilots started in April and will be evaluated in October. Metrics include comparing the behaviour of practices that are using Vision to a control group which is not. In the case of diabetes, Birmingham will measure compliance with the NICE prescribing guidelines, and appropriate fast track referrals.

So far the pilots are performing well, with clinicians capturing data during consultations as hoped. The next step is to make the prompts specific, for example a mental health flag which only a GP or specialist nurse would see.

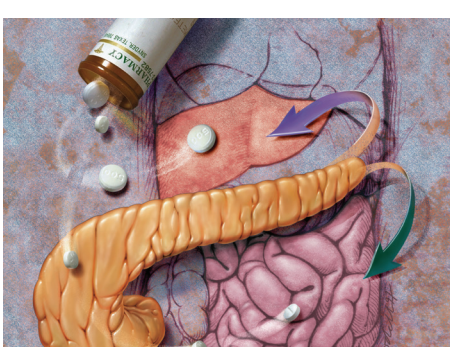
At CCG level, Outcomes Manager provides a significant efficiency gain, by allowing Birmingham to distribute material such as a redefined pathway or a new model of healthcare to all its practices.

Mr Hoye says: "We have 118 practices with different clinical systems and we are getting new approaches out to all of them, rather than asking them to go through the job themselves 118 times or sending someone physically out to install it for them. Now I do a piece of work once, and all the practices have to do is say 'yes, give that to me'."

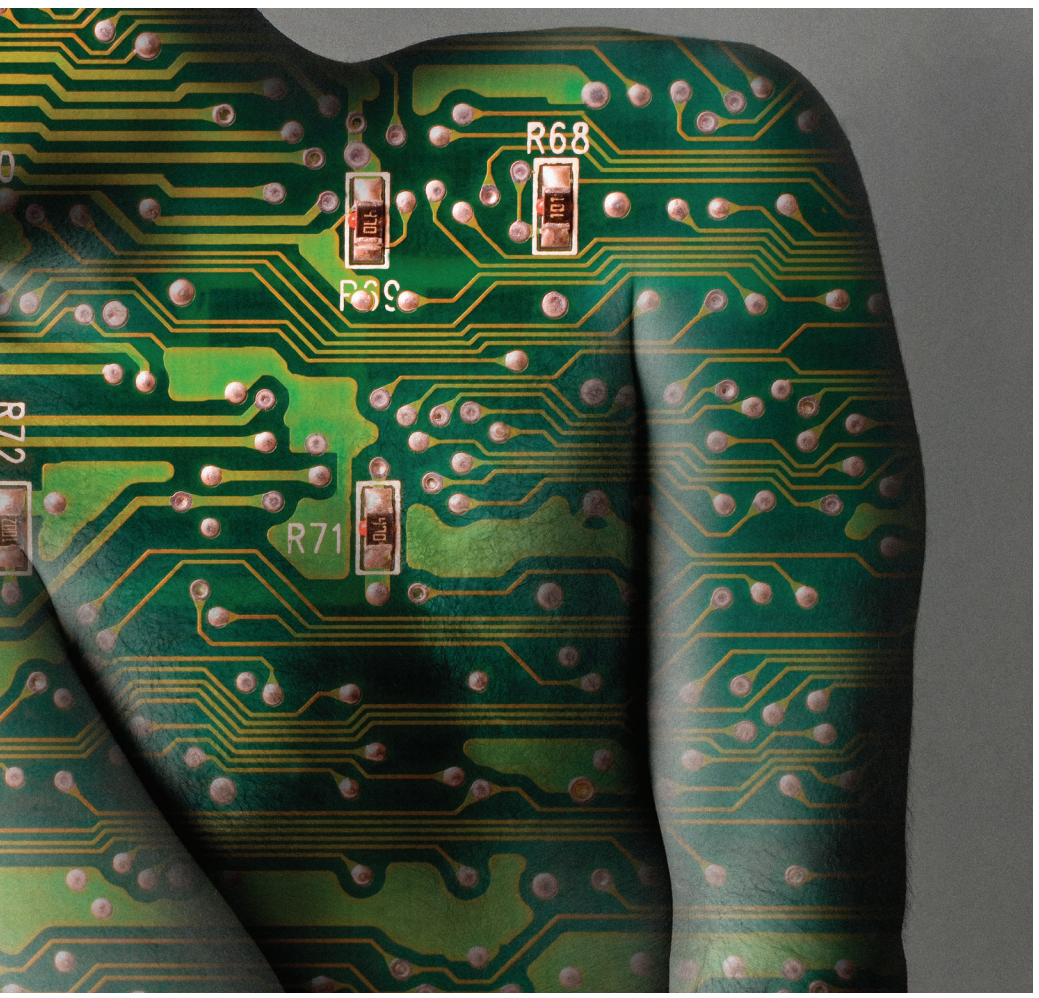
The programme permits finer tuning of commissioning. Mr Hoye explains: "We can only have informed commissioning if we start from a position which has data with which to inform our position. Outcomes Manager allows us to start from that informed position and formulate a change in process or pathway that we wish to implement.

"Once done, we can ask for a change in behaviour from our members. You can look at any given rule and the number of patients that have been actioned. This allows them to review their own compliance and the CCG to proactively contact them before there is an issue. We can support them through a change rather than retrospectively penalise them for failure to deliver.

"Finally, it allows us to look at the



Downer: prescribing flowcharts can be hard to use



All the numbers: computer systems can ensure GPs note all the relevant test data

outcomes. We can then validate the commissioning pathway if appropriate, or return to the start of the audit cycle if not."

GREENWICH CCG

"If you think about asthma or hypertension, there is uniformity across the settings in how you manage them," says Rena Amin, joint associate director of medicines management at Greenwich CCG.

"Whereas in wound management there is variability. The district nurse says 'we have a beautifully healed leg', they transfer it back to primary care, and because of variability of skills it does sometimes deteriorate."

This is why she asked INPS to use Vision Outcomes Manager to develop an electronic wound management template. She explains: "We wanted something to guide nurses through the process systematically. We were looking for a cost-effective, evidence-based approach which was user friendly to the clinician."

The interoperability of Vision was a plus point. It is compatible with both INPS and EMIS clinical systems, making it an attractive proposition for Greenwich commissioners.

Wound management is shared by GP nursing teams and community nursing teams. The template helps primary care teams treat wounds consistently and to a high standard, and spot when they are complex. First, it analyses the nature of the wound and suggests treatment. Then, if this first line of treatment is not working after six weeks, it advises the practice that the wound might be more difficult to treat and may require input from a tissue viability nurse.

It also encourages proactive management – for example requesting a pressure-relieving mattress for prevention of pressure ulcers in high risk patients –and a holistic approach which takes into account the patient's quality of life, nutrition, mood and levels of pain.

This helps prevent chronic wounds, which have a huge impact on a patient's quality of life and on their family, and are very costly.

"The template allows us to set up a comprehensive care plan and treatment strategy. It is a whole systems approach with the patient at the middle," says Ms Amin.

Large quantities of inappropriate dressings are often given to patients which they may never use, and the template tackles this via an electronic formulary which is integrated into GP clinical systems. The formulary is embedded into the template, and set up in such a way that it defaults to minimum quantity of dressings. This lowers pharmaceutical wastage and boosts appropriate use of dressings.

The full template is currently confined to practice nurses, as evidence of variability is greatest in primary care, so they need the most support to make consistent, timely interventions. However, district nurses in Greenwich use the same formulary. Because of this, prescribing is consistent across primary and community care.

'We are getting new approaches out to all 118 GP practices, rather than asking them to do the job themselves 118 times'

In time, Greenwich hopes to roll the full template out to district nurses, tissue viability nurses and care homes. "The technology is already there, but needs wider stakeholder engagement," says Ms Amin.

She adds: "We are exploring the idea of GPs visiting care homes with the template integrated into an iPad. That's the direction of travel. If we can make wound care seamless at the point of assessing and prescribing, whether in primary care, community care or a care home, it should reduce variability in the care clinicians provide."

The pilots, being set up in six GP practices, are due to go live this month and will be evaluated in August.

Greenwich is also piloting a referral pathway for lower urinary tract symptoms to reduce inappropriate referrals, and increase appropriate ones. Service design and procurement manager Jan Matthews says: "The result will be a really good referral which will ensure the patient is seen in secondary care having had all the appropriate tests and treatments..., allowing secondary care to do what it does best."

Once the LUTS pilot is evaluated, it will be rolled out to all 42 practices and expanded to all pathways, with a goal of raising the quality of referrals across the board.

Both Ms Amin and Ms Matthews value the degree to which they have been able to collaborate with INPS. Ms Amin says: "They have been supportive – I went to them and said 'I have this problem and I think this is the solution'. From then on they have been very useful, they have come up with the goods."

She adds: "If we want to improve efficiency and productivity, we have to be innovative, which means doing things differently with the resources we have. That means technology and interoperability." ●

ALAMY