NHS

Introduction

1. This guidance has been prepared for PCN Clinical Directors and their constituent practices to identify estates and other opportunities across your network to deliver the additional staffing opportunities set out in the Network Contract DES. It should be read in conjunction with **ADVICE NOTE FOR PCN CLINICAL DIRECTORS: Accommodating additional Multi-Disciplinary Team (MDT) staff appointed under the Network Contract DES**. The guidance note provides steps in the process of identifying, assessing and addressing potential estates requirements driven by the Additional Roles Reimbursement Scheme under the DES.

The PCN contract

2. The Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21 – PCN Entitlements and Requirements ('the Contract') paves the way for around seven additional new full-time clinical support staff for an average PCN in 2020/21. This figure rises to 20 full-time staff by April 2024. The Contract makes no direct provision (financial or otherwise) for estate expansion or redevelopment. Networks are expected to accommodate the additional MDT staff within the PCN estate assets[1]. This note sets out pertinent considerations for Networks facing potential challenges in terms of estate.

PCN Activity – Key Steps in developing a local estates strategy:

Assessing future estate needs with partners crucial to success of PCNs

3. The infrastructure implications of developing PCNs to meet the NHS Long Term Plan ambitions has the potential to be significant. PCNs will be keen to ensure that use of the estate is maximised, costs managed, waste eradicated, and funding released to develop transformational projects. In order to achieve this, networks should always seek to bring stakeholders to the table across the wider system to collectively consider proposal and look to avoid planning in isolation.

4. The NHS Long Term Plan places technology at the centre of several of its commitments. It sets out that every patient will have the right to be offered digital-first primary care by 2023/24, where they can easily access advice, support and treatment using digital and online tools. The digital agenda will lead to major change in service delivery. Response to the COVID-19 Pandemic has already accelerated our use of digital in primary, community and secondary care service provision. Much of this change will remain and form the basis of further development of, and improvement in, services.

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[1] NB: PCN estate assets include GP premises, secondary and tertiary care premises, Local Authority and voluntary sector buildings, etc.

5. To achieve this, the GP contract has laid out a number of digital primary care requirements, including:

    - All practices will ensure at least 25 percent of appointments are available for online booking. Practices are encouraging online consultations and offering non-triage appointments online including those available for direct booking by patients on the phone or in person;
    - All patients will have the right to online consultations by April 2020 and video consultation by April 2021.

6. These principles can easily be applied to the extended workforce under the PCN DES contract, with a move to use technology to develop and enhance the service offering.

Step 1 - Build a picture of current services

7. In order to test need and explore options, there is a need to map the baseline in terms of current service provision. Across the PCN membership, all Practices should list the services provided, and in building a full picture PCNs should capture what else is provided in their locality, from where and by whom. This may require some local research and CCG leads and Provider contacts should help in drawing together relevant information. The SHAPE asset mapping tool would serve as a useful storage solution (see para 23)

8. The recently published NHSE-supported National Association of Primary Care Estate Guide (March 2020), ‘Primary Care Networks – Critical thinking in developing an estates strategy’, provides helpful information and case studies and may help to guide PCN teams through the process.

9. National investment in feasibility studies at such an early stage of PCN maturity is not planned and may not be appropriate but PCNs may consider that this is a key step in the local assessment process and opt to self-fund such work.

Set out your Workforce Strategy

10. Estates requirements will ultimately be driven by recruitment decisions made by PCNs, which will depend on their priorities.

11. To provide some context, a PCN with a population of around 30k patients – to provide an illustrative example – could engage around 3 WTE clinical pharmacists, 1.5 WTE social prescribing link workers, 0.5 WTE physiotherapists and 0.5 WTE physician associates from 2020/21.

12. The employment model of new staff is key to understanding how these staff will operate within the PCN and if they are required to spend at their base if employed by a Trust or another organisation, for which the PCN holds a sub-contract. These

conversations should take place before the new staff member has been taken on by the PCN.

Suggested actions required across the PCN membership organisations:

- Calculate the hours the new workforce will provide to the Network;
- Assess when and where these individual services may be best delivered – clinical or non-clinical setting, GP surgery base (all, or some), for example;
- Identify where these services are typically delivered from other (non- GP surgery) sites, and consider if it is possible that other non-clinical premises could be considered suitable;
- Assess whether more flexible working arrangements across all staffing groups may be attractive and improve recruitment & retention and relieve pressure in crowded premises;
- Determine if flexible working could be established which sees the extended team in particular, providing services outside of core GMS contracted hours, for at least for part of the week;
- Consider if flexible working arrangements be agreed which provide for home or remote working for at least some of the working week.

Step 2 - Outline future health and care models (population health approach) and assess estate needs

13. Once the current provision is mapped, the next step will see the PCN stakeholders considering the responses to key questions:

    i. *In terms of commissioning, which services are specific to local health need and patient demographics?*
    ii. *What does the PCN population require in terms of services?*
    iii. *Does the PCN have data to evidence this?*
    iv. *What services do 'core-'and 'non-core' PCN members already provide?*
    v. *Is that service provision considered sufficient?*
    vi. *Is the service under pressure?*
    vii. *Will the service change as a result of the extended workforce, or for another reason – for example, advancements and improvements in systems and processes made under the digital agenda?*
    viii. *What other extended services outside of the core GMS contract provision are provided across the wider PCN area?*
    ix. *Could the extended workforce be better aligned to those teams – mental health, pharmacy, for example?*
    x. *What opportunities exist for enhanced PCN integration and working?*
    xi. *What is the best way to integrate the new workforce with the existing, and link the Network together with the wider system Providers?*
    xii. *Does this integration require physical co-location, or can it be effected in some other way?*
    xiii. *What time could the services be delivered - 'in core hours' or 'outside of core hours'?*

xiv. *How do we ensure that lone working risks are avoided, and staff are not isolated?*

Stocktake of the PCN estate

14. This next phase will require the PCN members to take stock of all available estate within the PCN boundaries, including everything from community services to third sector estates. Recognition of estate which sits just outside the boundaries of the PCN, but which could serve the PCN population well, should also be considered.

15. Agreement of a service delivery plan and sites to be used should be agreed with your Commissioners.

16. When considering the use of premises, a range of questions should be asked:

- *What do we know about the current use of the building?*
- *Do the buildings have vacant or void space or an element of capacity?*
- *Are the buildings to be leased or owned? By whom?*
- *Is it possible to secure new licence / lease agreements?*
- *Who will take the risk of the licence / lease commitment?*
- *What do we know about the connectivity and information technology systems at each of the sites (broadband connection, WiFi, telephone line, digital health etc.) – how easy would it be to use this space?*
- *What are the opening hours of each site?*
- *Are there restrictions on use of the building – explore the User clause, planning permission, for example*
- *What is the condition of the building?*
- *Does it meet the standards required by the NHS and CQC?*
- *Are capital works required to bring the building to standard?*
- *What are the funding options for capital works?*
- *How long would the works take to deliver suitable premises?*

17. PCN members should consider the advantages of finding a solution collectively. Benefits include:
    - *Helping to improve the quality of one or more patient services*
    - *Sharing of staff can bring about significant cost savings*
    - *Improved patient access*
    - *Provides flexible arrangements between practices and providers*

SHAPE mapping tool

18. A useful resource for PCNs is the SHAPE mapping tool – Strategic Health Asset Planning and Evaluation - a web enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy. The SHAPE Place Atlas is free to NHS professionals and Local Authority

professionals with a role in Public Health or Social Care. Access to the application is by formal registration and licence agreement.

19. The primary aim of the application is to facilitate scenario planning and option appraisal in support of STPs. Specifically, the SHAPE Place Atlas helps organisations consider the evaluation of the impact of service configuration on populations, and to assess the optimum location of services.

    The SHAPE tool provides:

    - an accessible online tool for STP stakeholders;
    - key indicators and data about an area to STP level, with a focus on health inequalities and equity of service;
    - flexible geographies including STP, CCG, LA, ward and Lower Layer Super Output Areas (LSOA);
    - a comprehensive overview of the STP's NHS estate;
    - functionality to enable users to flexibly evaluate and test the impact of plans;
    - support for GP Primary Care Networks.

20. Clinical Directors and other strategic planning staff should consider the use of SHAPE to support the workforce and estates audit across a PCN.

21. NHS England & NHS Improvement is launching a Primary Care Data Collection programme in 2020. As data is collated, it will be added to the SHAPE tool to further inform local service and estate planning.

Step 3 - Produce key elements to begin to form an estate strategy

Gap Analysis

22. Using this information, a basic level overview should now be available to drive local discussions around which options exist to address any demand for additional space.

23. Any consideration for additional space will undoubtedly require Commissioner support where financial assistance is expected under the Premises Costs Directions (2013). No formal agreements should be entered into unless Commissioners have been formally consulted on any proposed changes, have had the ability to consider the application and have formally confirmed approval for any underwriting or commitment to funding new / additional space.

24. The basis of an estate strategy should now be discussed with Commissioners, STP and ICS partners to agree alignment with wider service strategies and to help inform a comprehensive local primary care estates strategy as part of the broader System-wide estates workbook and investment strategy.

Governance considerations

25. Where extra space is required, governance arrangements for approving additional space should be considered and agreed. There is no change to the current arrangements in that the GP Contractor is accessing rights under the GMS (PMS) contract for financial assistance in respect of premises costs in line with the Premises Costs Directions (2013).

26. The GP Contractor is required to make a formal application to the Commissioner. This may be on behalf of a PCN by a 'host' practice and the application should provide necessary detail and evidence of support from all member practices of the PCN and any agreements reached in terms of hosting, running costs, liability, risk etc. The host practice will need to confirm that it is willing to take the risks, liabilities and commitments associated with any financial assistance provided by NHSE.

27. Where leases or licences are to be entered into, the PCN / host Practice should present the draft Terms to the Commissioner for assessment. Standard lease terms can be shared by NHSE to guide negotiations. No lease or licence should be entered into prior to written Commissioner approval – to do so would place the Contractor at risk.

28. Commissioners are required to undertake a formal due diligence process, testing and reviewing any application for financial assistance, seeking professional advice from the District Valuer and other advisers as necessary. Typically, all applications are expected to be considered by the Primary Care Commissioning Committee as a minimum, but larger, complex or contentious applications may require review by more senior committees.

29. The PCN / Practice should not take any steps to formally secure additional accommodation where it is reliant on NHS funding, unless it has been given the express and formal approval by the appropriate Commissioner. To do so without formal approval being in place, will place the Practice / PCN at risk and Commissioners will not be obliged to support such costs.

Practical Implementation

30. The current PCDs allow for the hosting of additional employees as set out in the Network Contract DES; this is because the additional staff should be considered as the extended team delivering services under General Medical Services Contracts. It is assumed NHS England will cover the costs of hosting the additional PCN support staff, typically within the current level of approved GMS space and in new space, only where an application has been made, considered and supported by the Commissioner.

31. Where it can be evidenced that despite the testing of the estate capacity and wider system solutions as described in this Guide, a demand for additional accommodation exists, Commissioners will expect to receive a formal application, as set out in the Governance considerations above.

Holding the Lease or Licence

32. Where new estate is to be occupied, the PCN will need to agree which party will hold the lease or licence for external space. Where the NHS is asked to take on property commitments, we will rely on partners such as NHS Property Services Ltd as Commissioners cannot hold operational property or enter into lease commitments for this type of asset. Where such proposals are being considered, NHSPS will be entitled to undertake its own due diligence and assess the application in accordance with its own commercial judgment. However, NHS commitment to a lease has an impact on NHS national capital budgets and is subject to formal agreement and prior planning.

Agreeing & Regulating the use of ‘new’ or additional space

33. It is important to ‘track changes’ to premises. Where PCN services are being delivered and these are being hosted by a PCN member organisation, or are delivered at an alternative location, the site should be recorded within the formal PCN Network Agreement, including any charges to be levied (see below) and any advice on licence agreements. The GMS/PCN contract needs to be updated to include relevant detail of sites used; CQC registration may also be required.

34. Use of existing primary care floorspace which has already been designated as GMS space, will be covered by the existing GMS contract terms and the Premises Costs Directions. Where charges are to be levied, these will be considered under the PCDs and deductions made to reimbursement payments accordingly. Ultimately, the aim is to ensure occupants should not receive more than 100% of the reimbursable costs.

35. Where a PCN looks to utilise external (perhaps NHSPS, community or hospital accommodation) floorspace which is not currently deemed GMS approved space, an application to the CCG to include this space as GMS approved accommodation is required, as set out in the Governance considerations above.

36. Occupation should be secured by way of negotiation and recorded in a Licence (short term/less than 12 months & no exclusive use) or Lease (longer term / more than 12 months and/or exclusive use of space). Shorter term arrangements may be preferred initially to provide flexibility and change over time should further service changes be anticipated.

Charging for accommodation or utility / running costs

37. A PCN extended roles staff member is deemed to be a GMS service provider and the extended workforce should be considered an expansion of the GMS workforce where significant unseen benefits are available to staff, patients and the system. These teams should not be considered to have a negative impact on the practice costs.

38. A thorough assessment of all accommodation options should be undertaken, as detailed above and consideration given to the impact on Commissioner budgets. A cost-effective solution should be proposed, ensuring appropriate use of public funds and best use of existing accommodation is achieved.

39. In terms of charging a contribution towards costs – where the NHS is already reimbursing costs against that accommodation, these cannot be re-charged to sub-tenants/service providers, to avoid the potential for double-charging.

40. Where hosting arrangements are agreed across a PCN, an agreement may be required between the parties where other members share the burden of any additional costs which the host practice/provider may suffer. Unless the services are delivered out of hours though, where specific additional running costs may be created, it is expected these staff will create little impact on running costs. The creation of bureaucratic recharging deals between parties should be avoided and perhaps, quid pro quo arrangements considered instead, where possible.

41. Where PCN services are delivered in community spaces (typically paid for by local Trusts), conversations will need to be had regarding contributions towards running and rental costs, as a new commitment for a GP practice/PCN.

42. The process for securing reimbursable costs is set out above in Governance considerations; non-reimbursable costs will be subject to negotiation and agreement between the landlord and PCN members on a case by case basis.

NHS England and Improvement
Primary Care Estates Team

For further advice and guidance on estates and PCNs, please access the PCN estates network by following the steps below:

- Go to www.networks.nhs.uk;

- Click ‘register’ (in the top right-hand corner);

- Once you are registered, click onto the link https://www.networks.nhs.uk/nhs-networks/pcn-estates-network/view and select ‘join this network’. You will then receive a confirmation from NHS Networks.