Cheshire & Merseyside Health and Care Partnership Estate Strategy

v1.0

Executive Summary

Our estate strategy will transform the way that care is delivered in our area, increasing operational efficiency and capability for both national priorities as well local needs. We'll work closely with partners to create a place-based healthcare solution that meets patient's desires while also supporting our dedicated health professionals

This will help us make better use of existing assets, create new facilities where they are needed, and dispose of surplus property. It will also enable us to release land for housing and economic growth.

This approach is intended to supplement, rather than duplicate, the current interim report posted on July 20th. The goal is to build on previous progress and refresh priorities and estate workstreams for the system for the next five years. The aim is to assist in establishing an effective estate and be a facilitator for delivering improved services to the local population. This is supported by sound system-wide Estate Planning that aligns with the broader clinical strategy. Targets set in the Carter report have been achieved with further progress made to drive out estate inefficiencies. Estate transformation programmes have seen a reduction in backlog maintenance by % over three years. (Excluding the RAAC issues). However, further work must be put in place to tackle backlog maintenance strategically.

Covid 19 has significantly impacted our estate across the ICS footprint. This has driven the need to have a more responsible and agile approach to the estate where changes can be embedded and adapted to the challenges of social distancing and hybrid working and improve the delivery of better health outcomes to our patients. All parts of the system need to undertake a review to maximise benefits and mitigate the risks both within secondary and primary care. It is more important now that the ICS work together as a system to address the following.

- Support innovative models - Health and WellBeing Hubs / Cavell Centres /Community Diagnostics,
- Consolidation of Community and Corporate HQs where applicable
- Strong Project Management to implement the execution of the Disposal programme
- Consistency and Transparency of what good looks like – i.e. setting and baseline of KPI Estate metrics and a forward view projection of aspirations, i.e. Estates Cost Per M2R
- Strong governance scrutiny over the prioritisation of future capital projects that align to the wider system policies and strategies, i.e. Clinical, Workforce and Digital

Our Commitment

This is a summary of our commitment for the next five years from FY22/23 - FY27/28. We will continue this path by focusing primarily in eight key areas, as indicated below

1 Our Estate will be fit for purpose. It will accommodate the needs of patients and staff alike and provide the best possible care for those who need it the most.

2 We are committed to maximising the utilisation of clinical space – We will be efficient in our design and operation of services.

3 Our Estates will be more environmentally sustainable. We are willing to invest in making our buildings more energy efficient to make this happen. Reduce our carbon footprint and play an active role in tackling climate change.

4 We will strive to ensure maximum value for money and economic benefit for society. We will continuously look for ways to improve the social value and make a positive impact on society.

5 We want to ensure that everyone has access to the care they need when they need it. - Providing care in the right buildings with the right staff and resources.

6 Flexibility is built into Estate - We will adapt our buildings and facilities to meet the changing needs of the service and constantly review /make changes where necessary.

7 We will optimise the use of Technology for our Estate, making sure our buildings are "Digitally Ready"

8 We are committed to working in partnership with Local Authorities to allow for more efficient use of resources and create opportunities for better health outcomes.

Introduction – Cheshire & Merseyside

Cheshire and Merseyside were designated an ICS by NHS England in April 2021.

As one of the largest ICS with a population of 2.6 million people across nine places (and set to increase by 3.8% by 2026 and reach 3 million by the year 2041), the system is supported by

- 19 NHS Provider Trusts
- 51 Primary Care Networks.
- 401 GP Practices
- 9 Local Authorities
- Total Estate cost of £474m

There are many underlying population health challenges in the region; for example, in

- Liverpool City Region 44% of the population live in the top 20% of most deprived areas in England
- 26% of children (0-15 years) live in poverty, and compared to England's average, the region performs significantly worse for premature cancer, Cardiovascular disease (CVD) and respiratory deaths

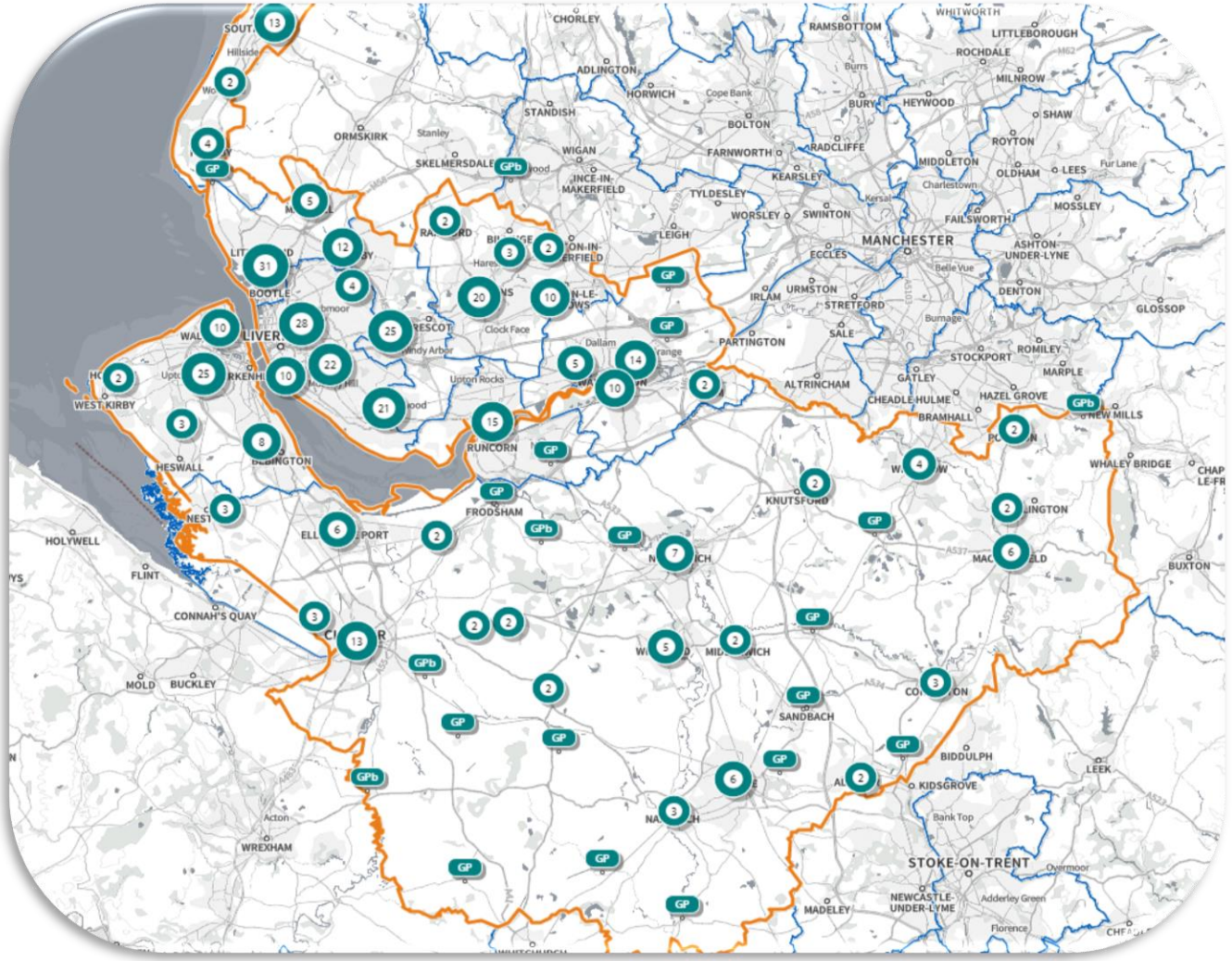
Levels of deprivation are not as high in Cheshire. However, there are stark pockets of poor health outcomes for some long-term conditions, and alcohol and self-harm are worse than the England average.

Demand for health and care services in the region is very high and growing (exacerbated by the impact of the Coronavirus pandemic). Our services are not sustainable without a different approach to working together and a shift in focus from treating illness to prevention and well-being.

Introduction – Cheshire & Merseyside Health and Care Partnerships

Description	
ONS 2020 LA Population	2,941,849
Registered Patients Jun-20	2,585,267
No of GP Practices	406
No of Provider Core Buildings	376
Provider GIA (m2)	1,639,756

Provider Property Type	%
Freehold	63%
Leasehold	13%
TBC	17%
PFI	4%
LIFT CO	3%

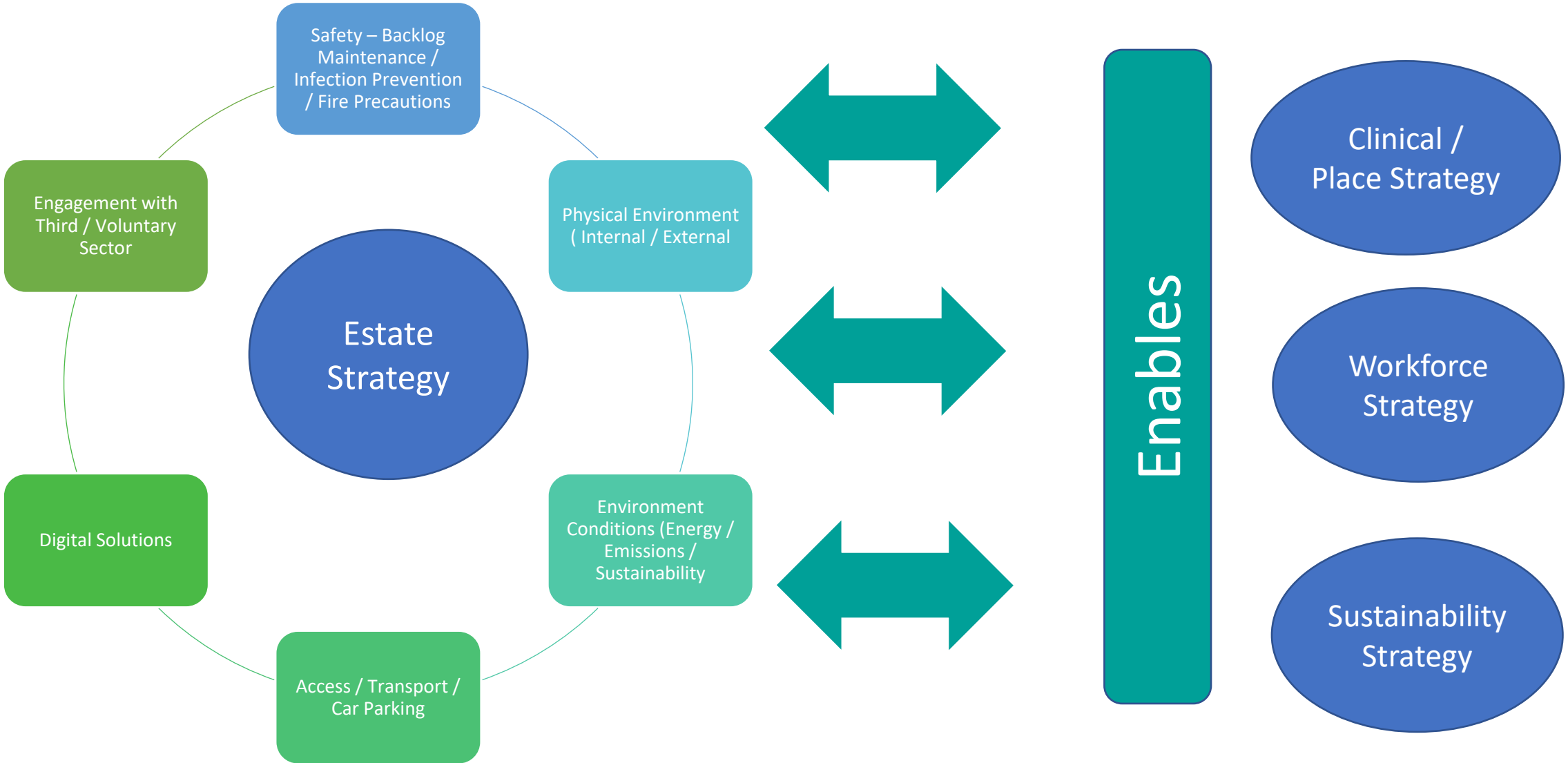


The table above has been sourced from SHAPE highlighting the complexity of Primary Care and NHS Trusts Estate across the Cheshire and Merseyside footprint

Data Source – ERIC 20/21 Submission
**Excludes Mid Cheshire Hospital NHS FT*

Introduction – Cheshire & Merseyside Health and Care Partnership

Our Estate Strategy sets out a clear vision for the future. It is an enabler for the wider ICS strategies incorporating Clinical, Workforce and Finance. It will help us achieve our goal of providing world-class healthcare sustainably. The plan's core elements are supported by several initiatives, as shown in the diagram below. We aspire to create an environment that is fit for purpose and able to meet the needs of our patients, staff and wider population.



Introduction – Cheshire & Merseyside Health and Care Partnership

Strategies within CMHCP that will form and shape the decisions of the organisation will including estate matters are shown below in the diagram with some of the key outputs or areas for focus, i.e. Workforce Development, Digital Inclusion (eHealth), Sustainability. The Clinical strategy is currently a work in progress, but we recognise this will have a material impact in setting the direction, for example:-for independent living, end of life care and addressing the wider determinants of health. All of which must be supported by sustainable finances.

Clinical Strategy	•Pending (work in progress)
Workforce	•Areas of Focus - •Monitor Recruitment & Retention / Improve upon Training Support & Development •Support New Models of Care / Economic Strategy •Become an Employee of Choice for the Region
Digital	•Areas of Focus •Empower patients to utilise digital technologies and manage health & well being • Improve quality, safety and patient experience through digital quality improvements •Connect and support the integration of our local health and care organisations • Create a culture of constant innovation and improvement with the approach to technology
Sustainability	•Areas of Focus •System approach to reducing emissions •Promote the benefits of active travel to patients, staff and visitors •Support the development of more sustainable clinical pathways •Buildings are incorporated with sustainable technology

Introduction – National Context

NHS Long Term Plan

- The plan recognises that the NHS estate is a vital asset that needs to be supported and maintained in order to provide safe, high quality services for patients. The Plan, therefore, includes a number of measures to support NHS Trusts in delivering their estate strategies.

- Specifically, the NHS Long Term Plan will invest £2.7 billion over five years to help NHS Trusts improve and maintain their buildings and grounds. This investment will be used to fund a wide range of works, including new builds, maintenance and repairs, and energy efficiency improvements.

One Public Estate

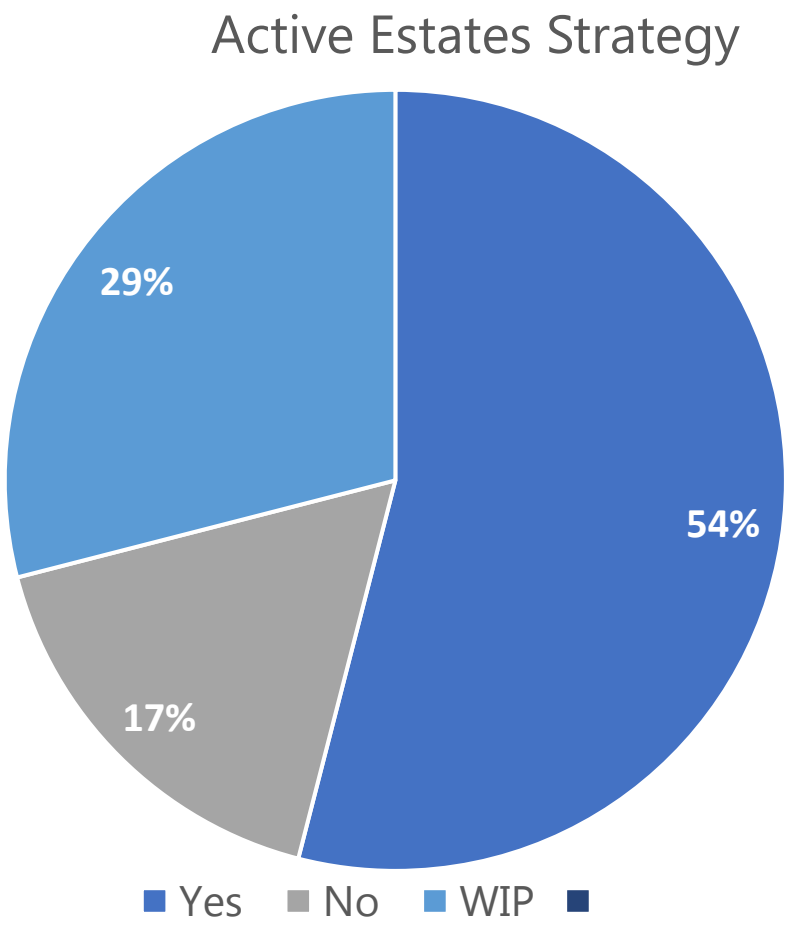
- One Public Estates (OPE) was set up in 2013 to encourage partnerships between NHS organisations and local councils, with one of its key goals being to progressed with the need for housebuilding. Estate strategies provide a long-term vision for the development and use of land and buildings, and are an important part of this work. OPE has helped to support the development and implementation of estate strategies through providing funding, sharing best practice and bringing together partners from across the public sector. As a result of this support, many estate strategies are now being progressed which will help to deliver much-needed housing. In addition, the One Public Estate programme is also helping to delivering other benefits such as improved health outcomes, economic growth and regeneration.

Naylor review

- The Naylor Review recognised the importance of the NHS estate in supporting patient care. The Review made a number of recommendations about how the NHS could make better use of its land and property to generate income and reduce costs. The Estate Strategy sets out the NHS's response to these recommendations. The Strategy includes a number of initiatives that will help the NHS to make better use of its estate, including: renting out surplus space; selling vacant or underused sites; developing "estate hubs" to provide shared services; and reducing the number of hospital beds. These initiatives will help the NHS to generate income, reduce costs, and free up space for patient care.

Where Are We Now – Do we Have a Plan

Our strategy is important because it gives the system a clear focus on the wider objectives such as improving health outcomes and reducing health inequalities. It ensures our resources are used in the most effective way possible and helps everyone has access to high-quality services. Furthermore, by improving the quality and efficiency of our estates, the strategy can help to improve operational resilience and financial control. Therefore, is it essential for all providers and commissioners both at the System and Place level within the CMHCP to have a plan of what the estate's ambitions are for the future.

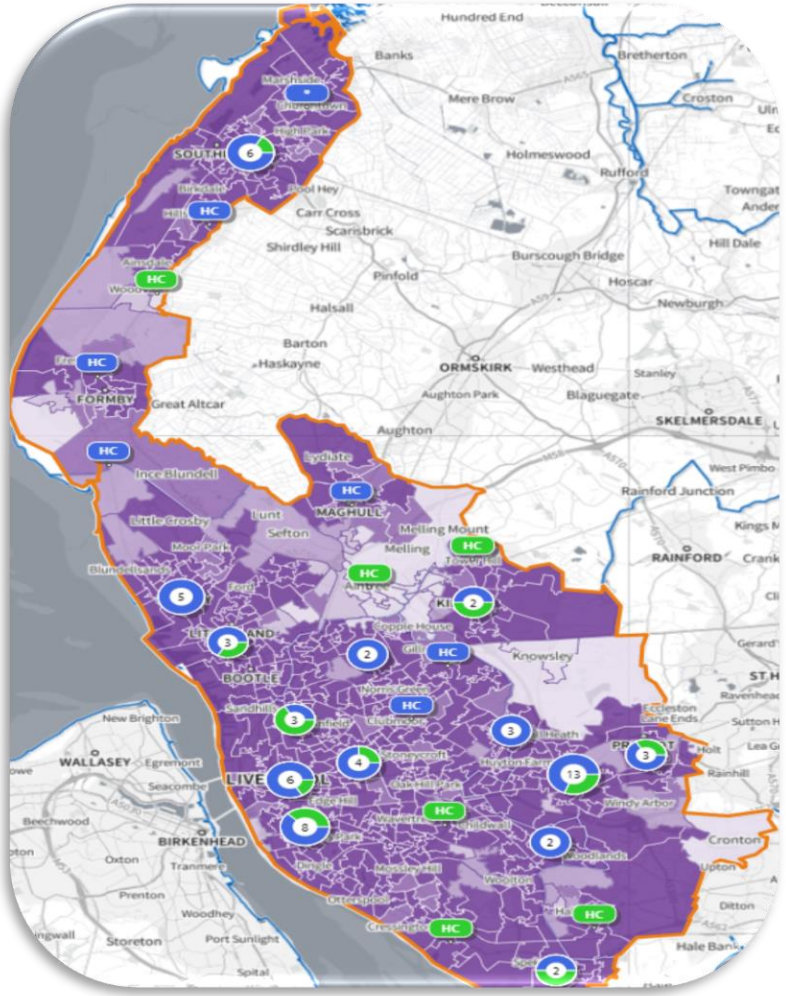


As shown to the left the diagram shows across the CMHCP 54% of the organisations we surveyed said they have a formal estate strategy in place.

One-third are still working on it and another 17%, recognise this is something their organisation needs to address soon.

Where are we Now - North Mersey Primary Care Estate

Improving the utilisation of primary facilities is a key aspiration of CMHCP. However, our estate faces a number of challenges. One of which is to increase access to primary care. The estate has traditionally been focused on secondary care, but with know growth in population, there is an increasing demand for primary care services. This is particularly acute in areas where population growth is outpacing the availability of primary care provision. The following highlights the level of capacity within CMHCP at at sub-region level

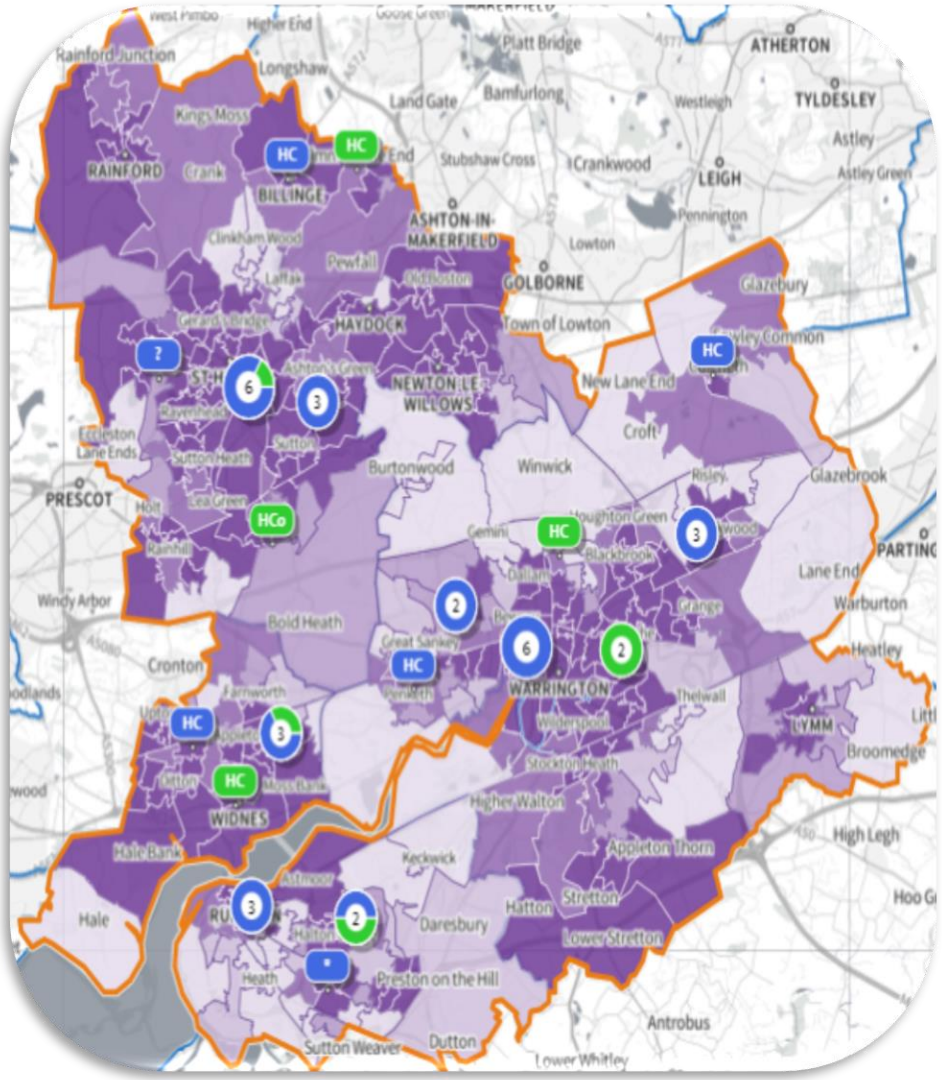


The Map below demonstrates two areas of interest

1. The distribution of sites for NHS Property Services and CHP across the region.
2. Journey time to GP by public transport (as shaded in purple). NHS Knowsley, Liverpool, South Sefton and Southport and Formby CCG's percentage of households with access to GP within 15 mins is 91.45% compared to the average for the System (75.79%) and England (70.7%). Furthermore, data from the National statistics office expects a 4.23% growth in the population by the year 2031.

Description	No of Sites
NHS Property Services	54
Community Health Partnerships	22
Primary Care - GP Practices	171
Secondary Care – Acute / Community	9
Secondary Care – Mental Health	12
Secondary Care – Trust HQ	8

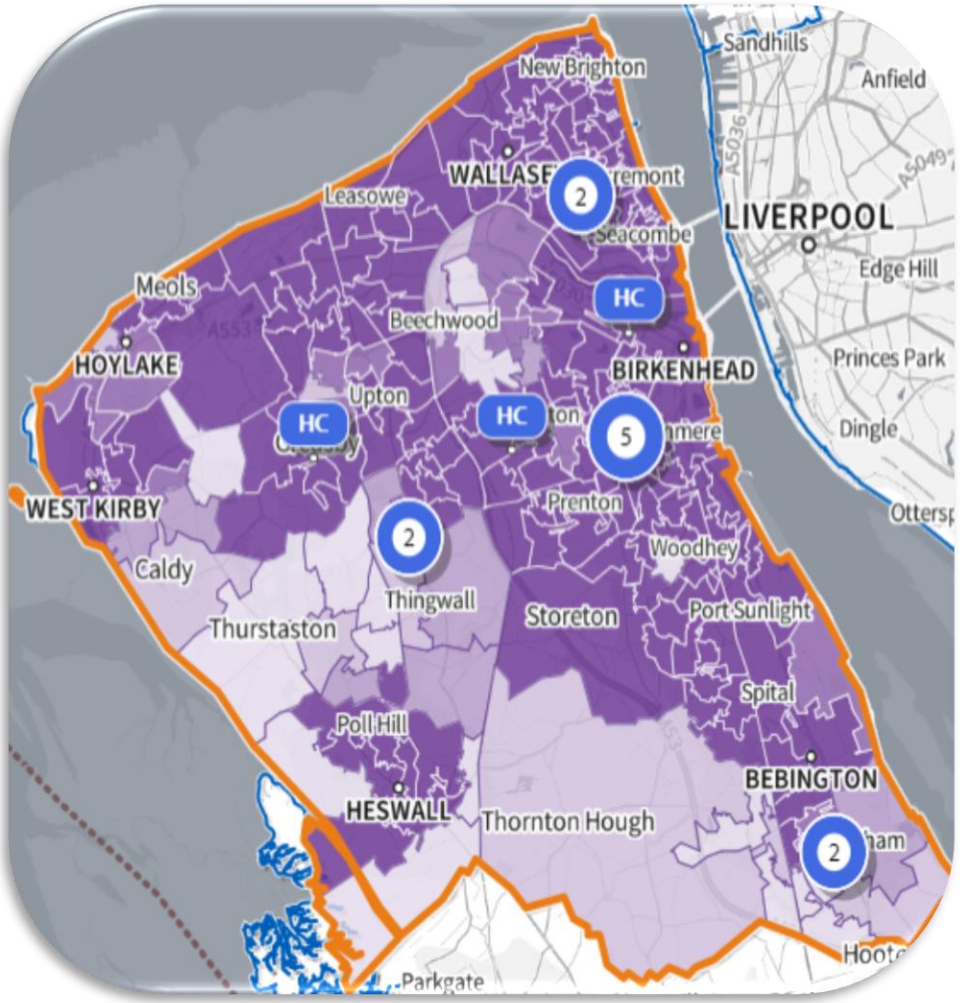
Where are we Now - Mid Mersey Primary Care Estate



The Map below demonstrates two areas of interest. The distribution of sites for NHS Property Services and CHP across the region,
With a particular focus on "Journey time to GP by public transport" (shaded purple). NHS St Helens, Halton, Warrington CCG's percentage of households with access to GP within 15 mins is 72.81% compared to the average for the ICS System (75.79%) and England (70.7%). Furthermore, data from the National statistics office expects a 4.13% growth in the population by 2031.

Description	No of Sites
NHS Property Services	31
Community Health Partnerships	9
Primary Care - GP Practices	86
Secondary Care – Acute / Community	4
Secondary Care – Mental Health	3
Secondary Care – Trust HQ	2

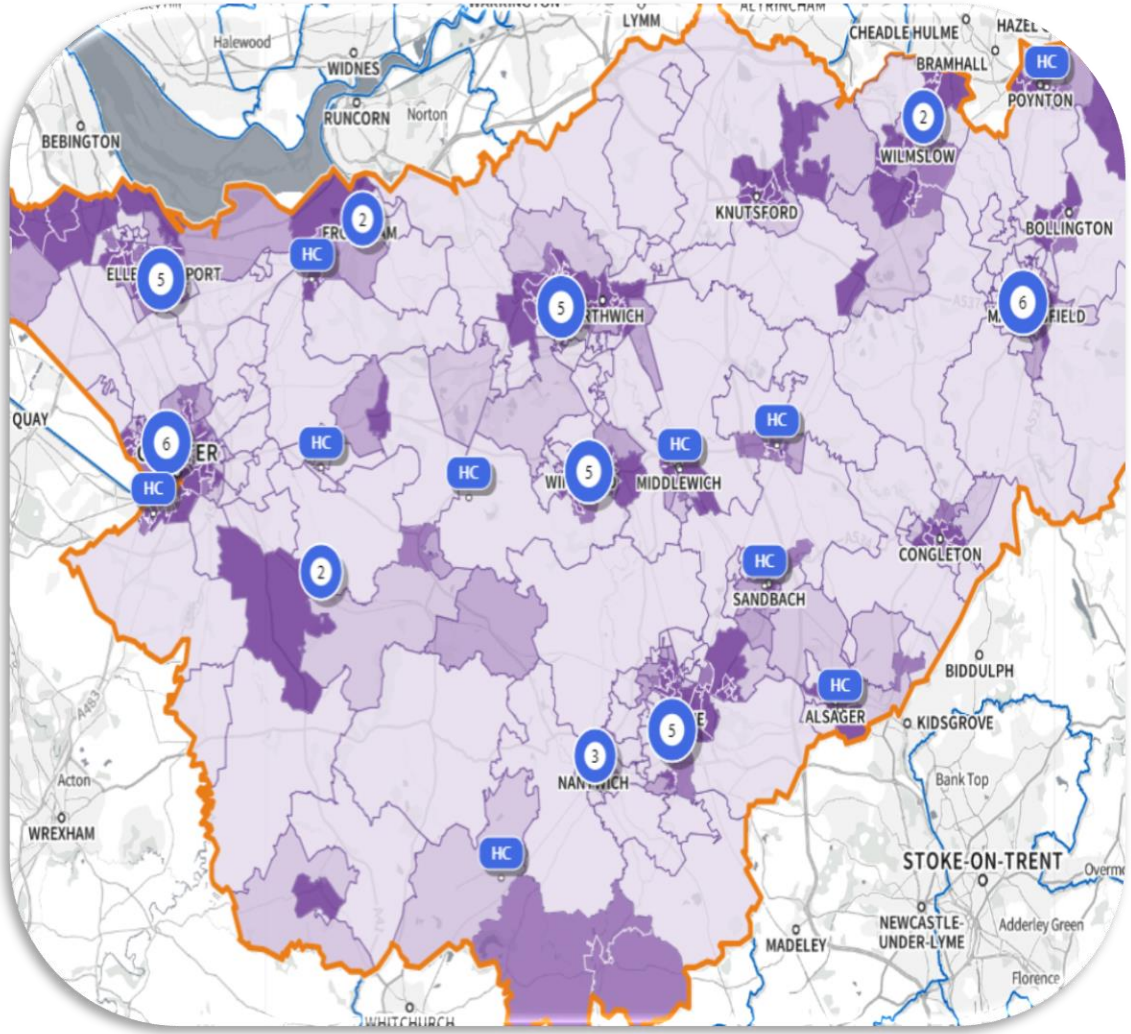
Where are we Now - Wirral Primary Care Estate



The Map below demonstrates two areas of interest. The distribution of sites for NHS Property Services and CHP across the region, With a particular focus on "Journey time to GP by public transport" (shaded purple). NHS Wirral CCG percentage of households with access to GP within 15 mins is 63.53%, compared to the average for the ICS System (75.79%) and England (70.7%). Furthermore, data from the National statistics office expects a 7.23% growth in the population by 2031.

Description	No of Sites
NHS Property Services	14
Community Health Partnerships	0
Primary Care - GP Practices	50
Secondary Care – Acute / Community	3
Secondary Care – Mental Health	1
Secondary Care – Trust HQ	3

Where are we Now - Cheshire Primary Care Estate



The Map below demonstrates two areas of interest. The distribution of sites for NHS Property Services and CHP across the region, With a particular focus on "Journey time to GP by public transport" (shaded purple). NHS Cheshire CCG's percentage of households with access to GP within 15 mins is 63.53%, compared to the average for the ICS System (75.79%) and England (70.7%). Furthermore, data from the National statistics office expects a 7.23% growth in the population by 2031.

Description	No of Sites
NHS Property Services	51
Community Health Partnerships	0
Primary Care - GP Practices	93
Secondary Care – Acute / Community	6
Secondary Care – Mental Health	5
Secondary Care – Trust HQ	4

Where are We Now – No. of Sites

The table below shows the number of sites across Cheshire and Merseyside Health and Care Partnership split by healthcare delivery at the sub-region level. This distribution of sites across the region reflects the population density of each area. North Mersey is home to a large number of sites because they have a high population density

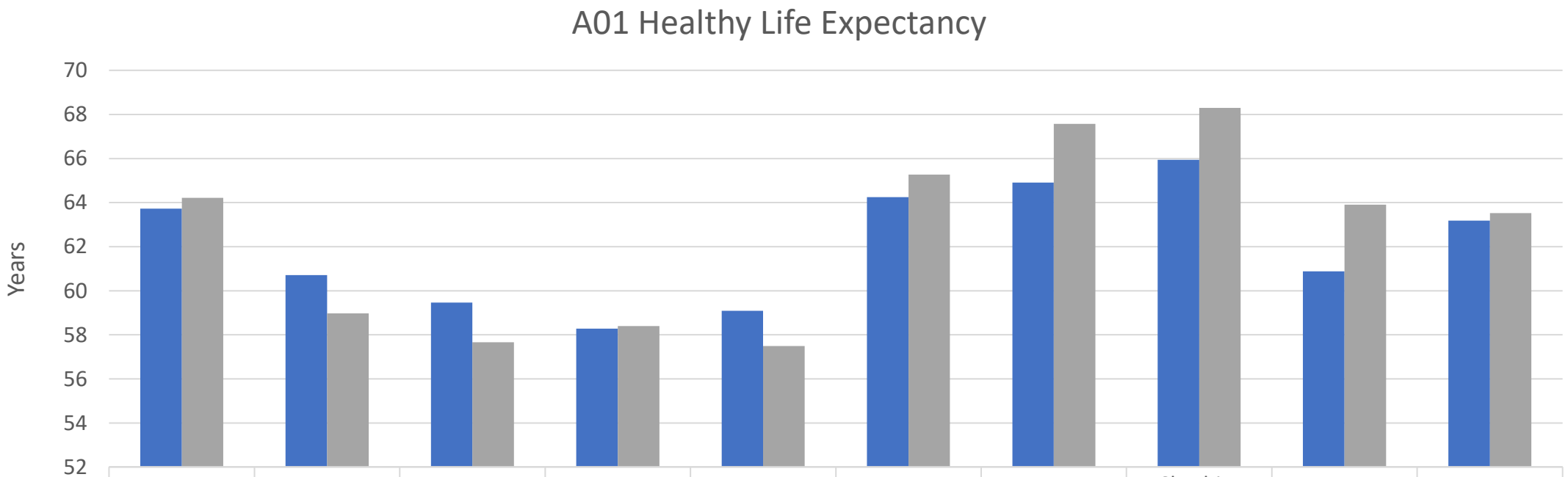
The opportunity for collaboration at scale can be seen as the following
- No of Sites - Non-Inpatient
- No of Sites - Support Services

	No of Sites - Acute hospital	No of sites - Specialist hospital	No of sites - Mental Health	No. of Sites Learning Disabilities	No of Sites Community hospital (with inpatient beds)	No of sites - Non inpatient	No of Sites - Support facilities	Sites occupied without charges
North Mersey	7	5	6	2	1	117	15	12
Cheshire	3	0	6	2	2	148	6	56
Mid Mersey	2	3	6	2	0	79	6	12
Wirral	1	0	6	2	1	12	6	12
Total	**13**	**8**	**24**	**8**	**4**	**356**	**33**	**92**

The table above has been sourced from SHAPE highlighting the complexity of Primary Care and NHS Trusts Estate across the Cheshire and Merseyside footprint

Where are we Now – Health Inequalities

Healthy life expectancy is a measure of mortality and morbidity. It shows the number of years someone can expect to live in good health, making it an important population index that sets the context for assessing any inequality gaps. The table below shows differences at the Place level. The average across England is 63.18 years for males and 63.5 years for females. Sefton, Warrington and Cheshire are the only four areas exceeding the average and the lowest Healthy Life Expectancy in the ICS geography shown as Halton. It should be noted, though; a healthy lifespan isn't just dependent on physical well-being but also on social factors like income levels or educational background.



	Sefton	Knowsley	Liverpool	St. Helens	Halton	Warrington	Cheshire East	Cheshire West	Wirral	England
Male	63.73	60.71	59.46	58.28	59.09	64.25	64.91	65.94	60.88	63.18
Female	64.22	58.97	57.66	58.4	57.49	65.27	67.57	68.3	63.91	63.52

Data Source – www.fingertips.phe.org.uk

Where are we Now – Health Inequalities

There are seven domains of deprivation that combine to create the index of Multiple Deprivation (IMD); the diagram below shows the area and the percentage that goes toward IMD's overall score

Income – 22.5%

- Measures the proportion of the population experiencing deprivation relating to low income

Employment – 22.5%

- Measures the proportion of the working age population in an area involuntarily excluded from the labour market

Education – 13.5%

- Measures the lack of attainment and skills in the local population

Health – 13.5%

- Measures the risk of premature death and the impairment of quality of life through poor physical or mental health

Crime – 9.3%

- Measures the risk of personal and material victimisation at local level

Barriers to Housing & Services – 9.3%

- Measures the physical and financial accessibility of housing and local services

Living Environment – 9.3%

- Measures the quality of both the indoor and outdoor local environment

Income Deprivations affecting Children's Index (IDACI)

- Measures the proportion of all children aged 0 to 15 living in income deprived families

Income Deprivation affecting Older People Index (IDAOPI)

- Measures the proportion of those aged 60+ who experience income deprivation

Data Source – www.gov.uk/indices-of-deprevation

Where are we Now – Health Inequalities

According to the Index of Deprivation, there are significant Health Inequalities between local authorities with CMHCP. The table below summarises the 2019 Index of Deprivation collection. The score is ranked from 1 to 317, where the lower the score, the high the level of deprivation for the domain. Key themes show for Health, and Disability domain is ranked materially low for all Local authorities except for Cheshire and Warrington. This has a self-perpetuating effect on those most in need and creates Health Inequalities that are hard to close with specific action.

Local Authority	Income	Employment	Education	Health & Disability	Crime	Living Environment	Barriers ot Housing & Services	Income Deprivation affecting Children (IDACI)	Income Depreviation Affecting Older People (IDAOPI)
Cheshire East	240	210	256	169	209	194	216	254	260
Halton	48	26	70	17	76	147	255	50	63
Liverpool	7	16	43	3	23	8	278	8	11
Sefton	67	39	162	37	147	90	310	108	83
Wirral	69	33	177	25	135	66	313	95	97
Cheshire West and Chester	180	157	217	120	197	157	260	177	201
Knowsley	3	1	6	2	82	52	220	12	10
St Helens	47	11	94	10	86	155	302	54	80
Warrington	179	148	205	92	158	190	243	203	168

Data Source – www.gov.uk/indices-of-deprevation

Where Are We Now – Performance In Numbers

The costs for managing Estates and Property maintenance cover the space where clinical and non-clinical services are delivered, including property repairs, cleaning services, and waste management, to name a few. Table 1 Estates maintenance £ per M2) shows the variation of cost between trusts within the CMHCP, with the average equating to £32.85 per M2 (the average across England is £41.0 per M2). Furthermore, when shown in comparison to the different Table 2 Gross Internal Area this highlights there is room for improvement.

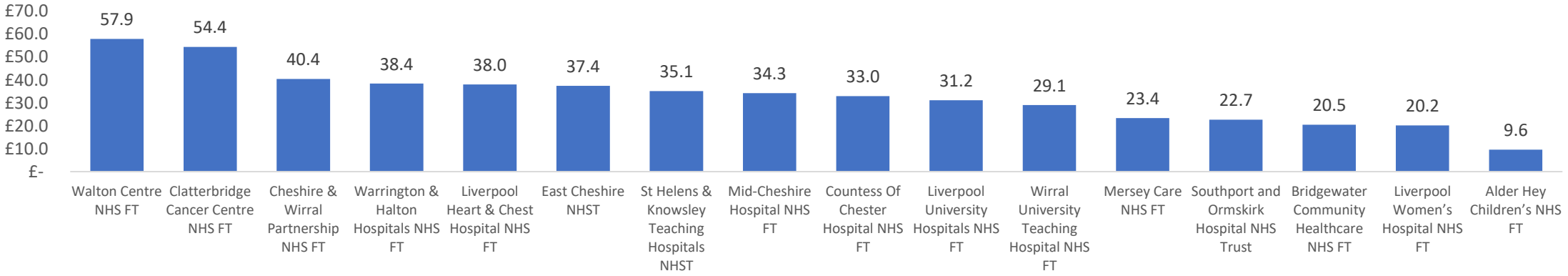


Table 1- Estates Maintenance (£ per m2)

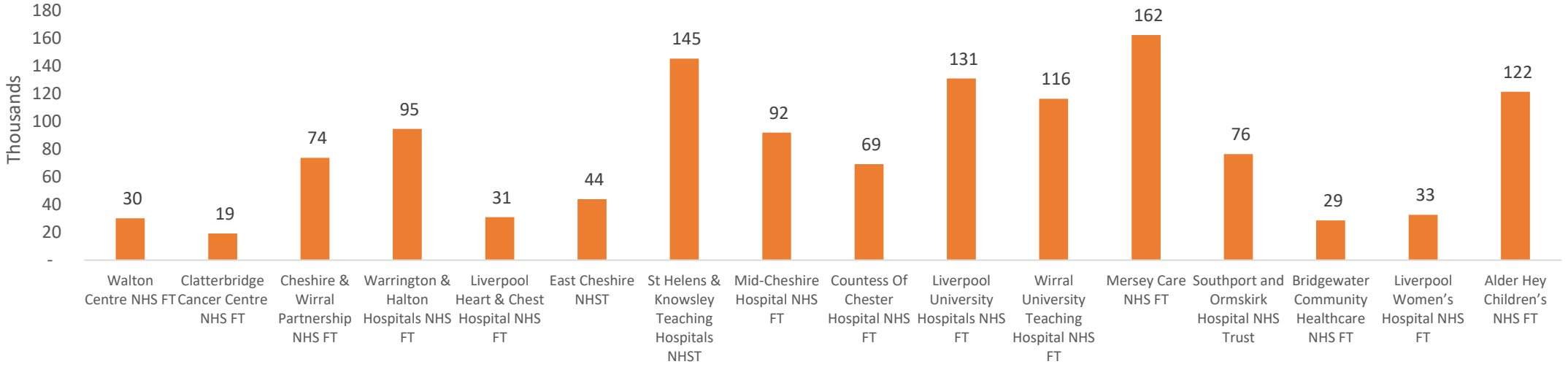
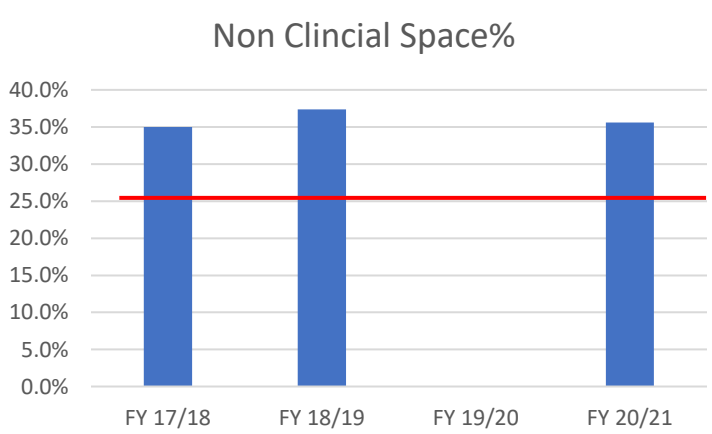


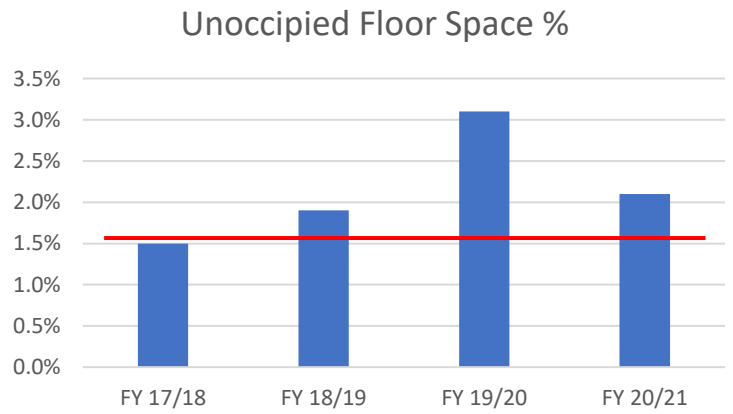
Table 2 - Gross Internal Area (GIA)

Where Are We Now – Performance In Numbers

As part of the Carter review, a national target was put forward for all Trusts to reduce non-clinical room allocation to 25% or below and unoccupied space to below 2.5%. Furthermore, another measure was put in place called the GIA (Gross Internal Area, where it was anticipated year on year movements should reduce the total space consumed across the system.

	National Benchmark	ERIC (FY 17/18)	ERIC (FY 18/19	ERIC (FY 19/20)	ERIC (FY 20/21
Non-Clinical Space %	Carter <35% LTP < 30%	35.0%	37.4%	Missing Data	35.6%
Unoccupied Floor Space %	Carter <2.5%	1.5%	1.9%	3.1%	2.1%





Where Are We Now Performance In Numbers

Backlog maintenance - cost to bring estate assets up to the standards in terms of their physical condition and compliance with mandatory fire safety requirements and statutory safety. This is a significant area in the overall Estates planning for the future and carries substantial investments, as shown below.

Backlog Maintenance	National Benchmark	Target £'000	Baseline (£'000)*	ERIC (FY 17/18) (£'000)	ERIC (FY 18/19) £'000	ERIC (FY 19/20) (£'000)	ERIC (FY 20/21) (£'000)
High Risk Backlog (£)	Reduction < 50%	9,560	19,120	4,693	4,383	40,047	27,356
Significant Risk Backlog (£)	Reduction <50%	72,617	145,233	46,178	45,353	372,342	117,059
Moderate Risk Backlog (£)	Reduction	TBC	120,040	55,309	74,970	95,107	254,774
Low Risk Backlog (£)	Reduction	TBC	75,712	78,485	89,807	80,294	54,260
Total Backlog Maintenance	**Reduction**		**360,104**	**184,666**	**214,513**	**587,790**	**453,450**
RAAC Adj						**(369,000)**	**(230,000)**
Revised Total Backlog Maintenance		**TBC**		**184,666**	**214,513**	**218,790**	**223,450**

*Baseline – based upon average of 4 years

Where Are We Now – Performance In Numbers

Estates management information / KPIs are crucial tools for understanding how our organisations perform. It helps to identify areas of good practice and areas that require improvement. Our Estates Strategy will set out a number of targets, of which two are shown below, including a target for the gross internal area (GIA). This is the total floor area of all buildings within the NHS estate.

Gross Internal Area (GIA m2)	Target (£,000)	ERIC (FY 17/18) M2	ERIC (FY 18/19) M2	ERIC (FY 19/20) M2	ERIC (FY 20/21) M2
North Mersey	TBC	624,045	659,204	665,781	884,240
Mid Mersey	TBC	274,443	255,714	268,677	271,124
Cheshire	TBC	276,001	276,800	279,077	281,952
Wirral		153,941	152,953	152,953	180,254
Total	**TBC**	**1,328,430**	**1,344,671**	**1,366,3488**	**1,617,570**

Where Are We Now – Performance In Numbers

The target is to reduce the backlog maintenance to below 50% for the baseline figure over the next 5 years. This will help ensure that our estate is fit for purpose and able to meet service needs as requirements change.

High Backlog Maintenance	National Benchmark	Target (£'000)	Baseline* (£'000)	ERIC (FY 17/18) (£'000)	ERIC (FY 18/19) (£'000)	ERIC (FY 19/20) (£'000)	ERIC (FY 20/21) (£'000)
North Mersey	Reduce < 50%	2,637	5,275	3,231	2,620	3,139	12,110
Mid Mersey	Reduce < 50%	416	832	555	752	904	1,117
Cheshire	Reduce < 50%	5026	10,052	209	231	29,016	10,753
Wirral	Reduce < 50%	1445	2,891	724	821	6,777	3,242
Total	**Reduce < 50%**	**9525**	**19,050**	**4,719**	**4,424**	**39,836**	**27,222**

Significant Risk Backlog Maintenance	National Benchmark	Target (£'000)	Baseline* (£'000)	ERIC (FY 17/18) (£'000)	ERIC (FY 18/19) (£'000)	ERIC (FY 19/20) (£'000)	ERIC (FY 20/21) (£'000)
North Mersey	Reduce < 50%	19,737	39,473	99,438	27,348	4,834	26,273
Mid Mersey	Reduce < 50%	3,593	7,186	17,081	7,849	1,392	2,423
Cheshire	Reduce < 50%	9,607	19,213	6,432	2,411	44,681	23,329
Wirral	Reduce < 50%	6,040	12,080	22,282	8,570	10,436	7,034
Total **	**Reduce < 50%**	**38,977**	**77,953**	**145,233**	**46,178**	**61,342**	**59,059**

*Baseline – based upon average of 4 years / ** Exclude RAAC Issue

Where Are We Now – Performance In Numbers

The 2020 interim estates strategy identified 25 active programmes for sites for possible disposal with an estimated value of £26m with the potential for approx. 684 new housing units.

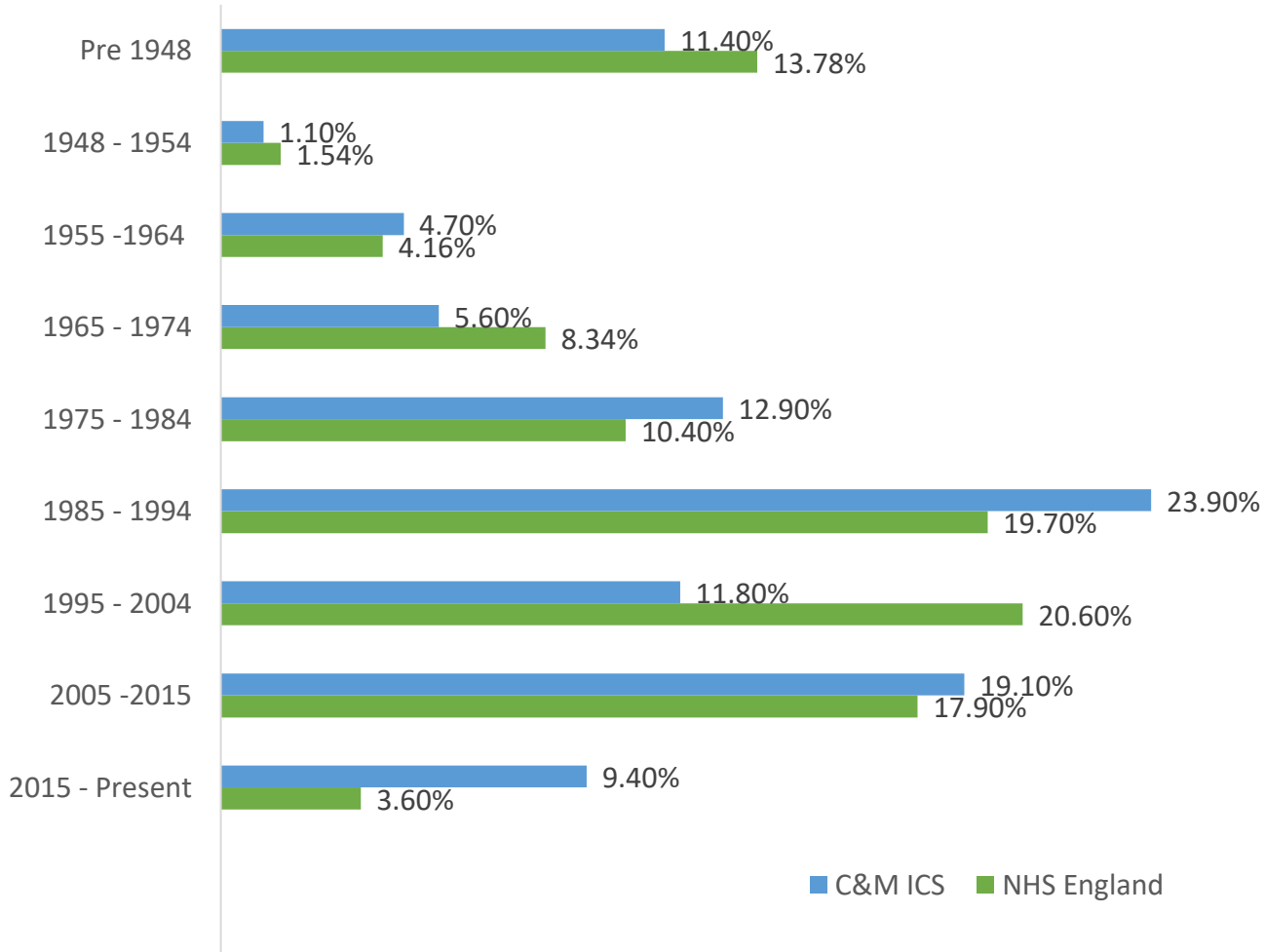
Many of the sites are dependent on the completion of feasibilities and, in some cases awaiting capital projects to be realised. The number of sites available and potential value will likely fluctuate as service changes and capital investment continues. Some disposals will be dependent on successful bids for capital monies which we know are limited.

Sub Region	No of Site	Land Area M2	Estimated Disposal Value (£'M)	Estimate Housing Units
North Mersey	12	13.6	54	TBC
Mid Mersey	10	13	14.1	265
Cheshire	8	9.46	27	195
Wirral	2	8.5	10	350
Total	**32**	**44.56**	**105**	**810 +**

Where do we Want To Be

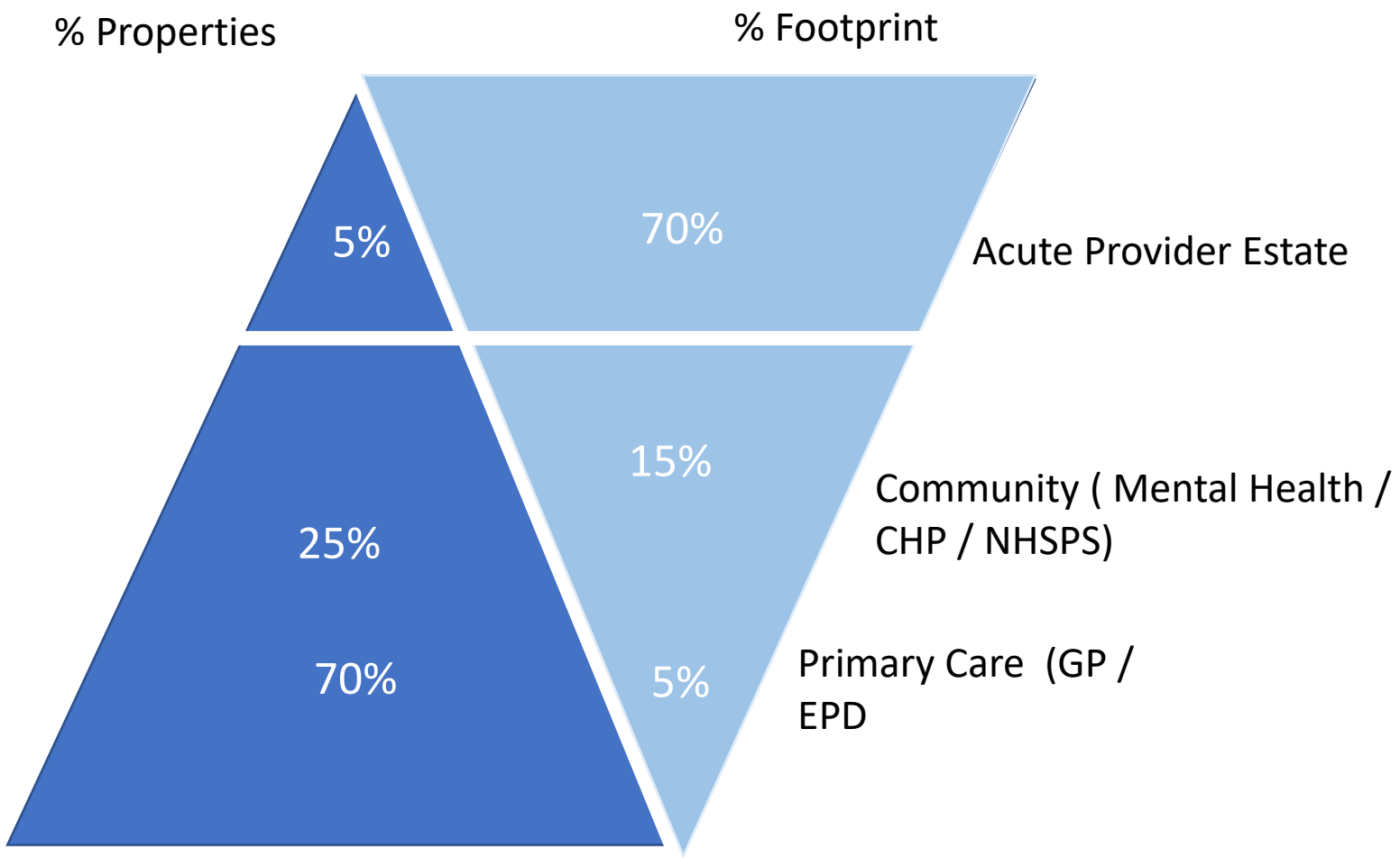
We know the condition of the NHS Estate is a concern for the Partnership and the wider health economy, and it has a direct impact on patient care. Poorly maintained buildings can lead to an increased risk of infection, accidents and injuries. Hence, it's important to review our estate stocktake, secondary and primary care. The table below shows the picture across NHS England, where 43% of the estate is over 40 years old compared to the CMHCP which is 35%. At the Partnership level, the aspiration is to set a clear baseline via a condition survey and action plan for assets that breach the age profile.

Time Frame	NHS England FY 20/21	C&M ICS As Is FY 20/21	C&M ICS To Be
2015 - Present	3.6%	9.4%	TBC
2005 -2015	17.9%	19.1%	TBC
1995 - 2004	20.6%	11.8%	TBC
1985 - 1994	19.7%	23.9%	TBC
1975 - 1984	10.4%	12.9%	TBC
1965 - 1974	8.34%	5.6%	TBC
1955 -1964	4.16%	4.7%	TBC
1948 - 1954	1.54%	1.1%	TBC
Pre 1948	13.78%	11.4%	TBC



Where Do We Want To be

The challenge is far greater than a debate against investment in primary care vs secondary care. However, there have been calls to move care out of hospitals and into the community and improve the conditions of existing buildings. The NHS has responded to these calls by investing in community diagnostic hubs and health on the high street initiatives. The Partnership will have a key role in demonstrating if these initiatives are right for the system. The diagram below shows that the majority estate's footprint % is held in secondary care. To what degree a shift of services moves from secondary to community and primary care services will require the engagement of those stakeholders and be driven by the specific objectives of the Partnership Clinical Strategy.



The Exam question

"To What degree does care/ service move into the community

Where Do We Want To Be - ICS Strategic Priorities

The Estate Strategy is the key to driving local plans and investments to the individual organisation and enabling the delivery of wider ICS strategic priorities. as shown below

The strategy will provide a roadmap for investment in order to improve the quality, safety and efficiency of care delivered across the primary, community, social care and acute settings. It sets out a series of programme-specific solutions which will be the basis for future planning and investment decisions. The successful delivery of the Estate Strategy will require a whole system approach intovolving all partners working together to assess, plan, projects in a way that contributes to achieving ICS objectives.

Principles	
• Estate Fit For Purpose	• Ensure Services in buildings are in the right place
• Maximise Utilisation	• Flexibility is built into the design of the estate
• Estate will be environmentally sustainable	• Optimise the use of Technology
• Maximise Value for Money and Economic Benefit / Social Value	• Work with Local public sector organisations to optimize usage

Improve Population Health and Healthcare

- Provide high equality, safe services
- Underpin improvements in health and healthcare with R&D

Support Broader Social and Economic Development

- Embed a commitment to social value in all our partner organisation

Tackling Unequal Outcome s and Access

- Develop ICP's in all 9 places. They will support communities and individuals to be resilient and healthy and access appropriate, timely support within their communities

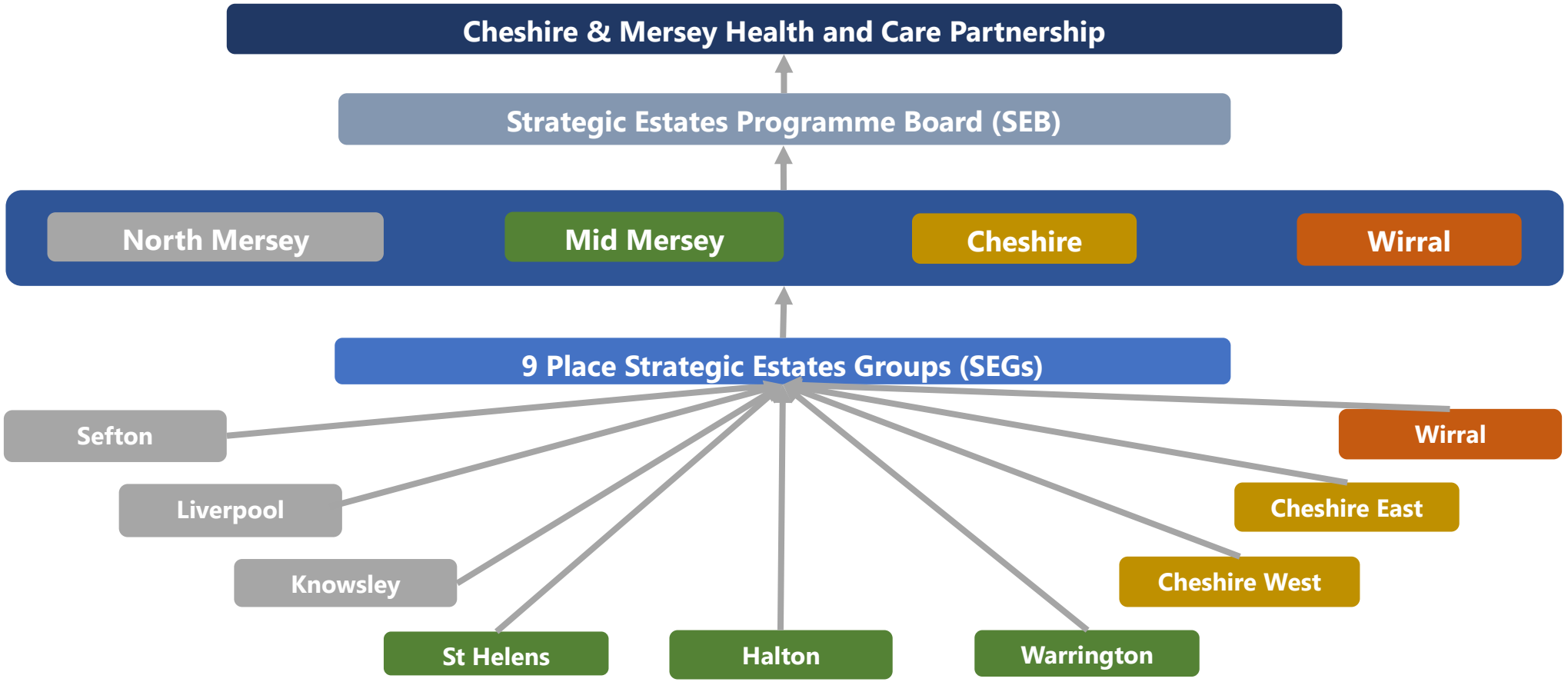
Enhance productivity and VfM

- Develop a whole system Estates Strategy
- Prioritise making greater resources available to prevention and well-being services
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale

Where Do We Want To Be - Governance

Our governance framework clarifies that as an ICS, we want to make a change to the issues that matter most to the population, that we are collectively responsible for and for which we can only make a change for the better by partnership working.

Our vision is to put the mechanisms in place to work more flexibly across our organisational boundaries and agree on a common set of transparent and flexible principles in achieving our strategic objectives over time. It is also important to recognise that we don't want to add layers of complexity or bureaucracy to our already complex system. As shown in the diagram below, Strategic Estates Group will include representatives from NHS Provider organisations, Primary Care Networks, CCG, Local Authorities, CHP and NHS Property Services.



Where Do We Want to be – A View from Stakeholders

What Does Good Look Like

- Estate's development to support new clinical models
- Reducing Health Inequalities, deliver savings and drive efficiencies
- Rationalisation of estate /Better quality estate
- Making collective best use of assets. Enable delivery of clinical strategies.
- Support primary care and PCNs to deliver new estate either via 3PD or NHS capital schemes
- Optimal use of asset base to deliver clinical strategy and system priorities

What Does Innovation Look Like.

- Align services to accommodation e.g., 24-hour service/out of hours in a base with blue light services
- Co-location of Services
- Collaboration – the shared use of Estate
- Making the most of technology opportunities in estates
- Use of vacant retail space- win-win- regeneration

Information We Should Monitor

- Compliance information
- Utilisation of bookable and demised space
- Cost of current estate
- Risks/incidents to clinical care/patient safety that estates drive
- Subsidy costs
- Reduction in non-clinical accommodation in clinical space/demise
- 6 Facet Surveys

Barriers / Risk Preventing delivery of Success

- Primary Care - Restrictions with Premises Directions can stifle new ways of working.
- Culture change / Competition
- Remove Silo working
- Not having 'oven ready' schemes as and when capital is announced
- Current organisations change and risk of loss of skills/knowledge in the system.
- Lack of strategic workforce planning

How Do We Get There – Voluntary Sector / Third Sector

We know that there are huge benefits across CMHCP in utilising our estate to support social prescribing initiatives for the community's health and wellbeing of the community. Utilising our space with both Third / Voluntary Sector organisations specifically aligns to objectives set out by the Partnership but also directly / indirectly reduces pressure on GPs and other Primary Care Services through: -

Use of space to support groups or other activities. This can help people to connect with others and feel supported.

Creation outdoor gym facilities. This can help people to get active and improve their physical and mental well-being.

Provide information on self-referral and community services. This can help people to access the support they need.

Involve community members in the design of facilities and build relationships with them to understand their needs and priorities. This can help to co-create initiatives that meet the needs of both patients and service.

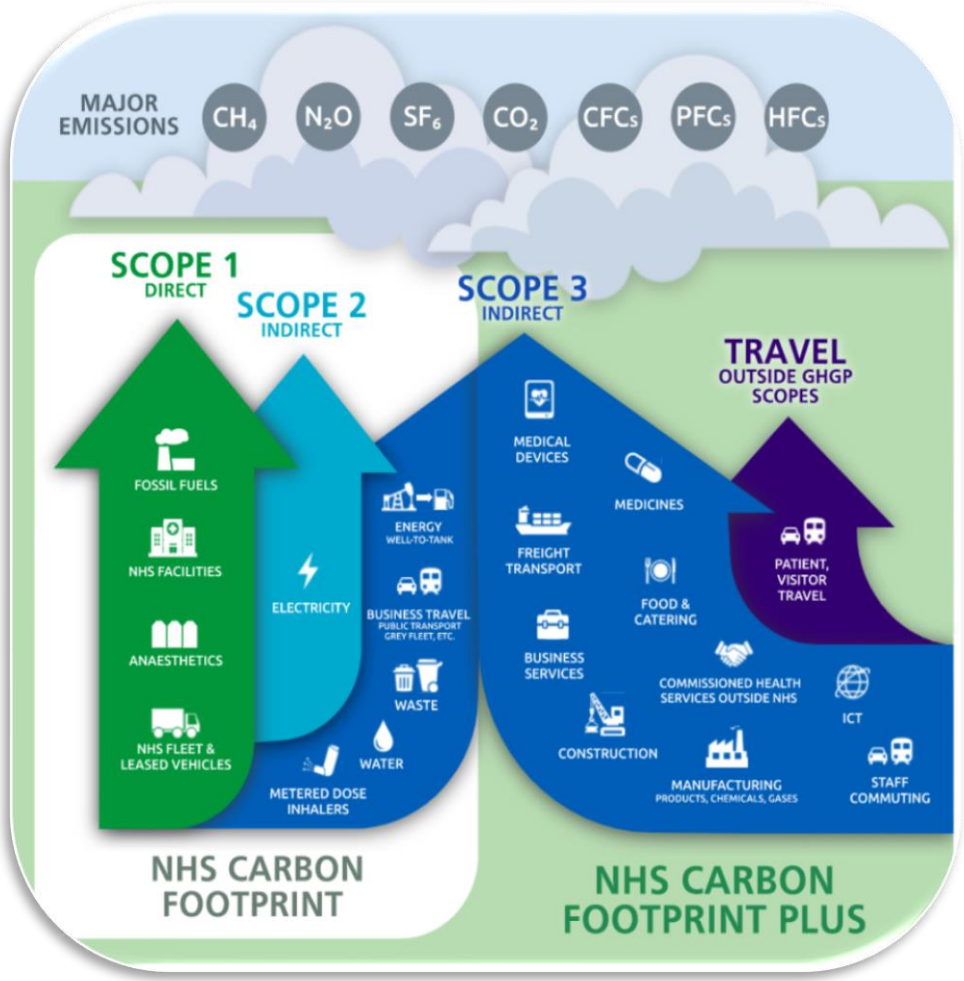
A more comprehensive list can be found - NHS Property Services, Creating Community Spaces for Patient Wellbeing (www.property.nhs.uk) and Community Healthcare Partnerships – CSR Strategy (www.communityhealthpartnerships.co.uk)

How Do We Get There – NHS Carbon Footprint

The NHS Green Plan sets out a number of key principles for how NHS Estates should be managed to reduce the health service's carbon footprint. One of these principles is the delivery of net carbon zero emissions by 2030 through operational efficiency and decarbonisation.

In Cheshire and Merseyside, we are committed to delivering this objective and have already started to explore a number of measures to reduce our carbon footprint. We are confident that by following the NHS Green Plan, we can make a significant contribution to reducing our carbon footprint and protecting our environment for future generations and have already put in place a number of initiatives to help us achieve it. These include:

- A comprehensive review of our energy use and associated costs to identify areas where we can make efficiency savings.
- The development of a low carbon strategy for our estates, which sets out how we will decarbonise our buildings and infrastructure.
- The introduction of a carbon management system across our estates will help us track our progress in reducing our emissions.
- Working with local authorities and other partners to deliver low carbon transport solutions, such as electric vehicle charging points and cycle storage facilities



How Do We Get There – Digital Transformation

Our Estates has a key role in ensuring that the basic infrastructure and digital capabilities are in place to release clinical time. This includes providing simple access to information that can drive quality improvement and patient safety.

Intra-operability and the ability for clinical systems to talk to each other across organisational boundaries is crucial to making the most of digital opportunities across the Cheshire and Merseyside estate.

Empowering staff to be flexible about how their job is undertaken will help services both primary and secondary care to make the most of modern and innovative ways of working, such as

- GP Video consultations
- Remove Access to Electronic Patient Records (Mobile Working)
- Population health management - aligning services to where the greatest need is ensuring the right care is given at the right time by the right person in the right setting.

Case Study - Appendix

How Do We Get There – Innovation / Cavell Centre / CDCs

Cavell Centre

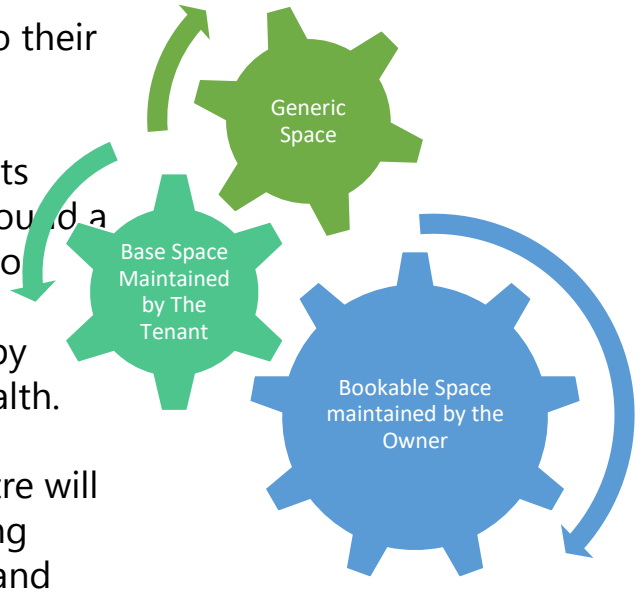
The NHS has identified that by 2025, they want all patients to have equitable access to great care and that people should be able to receive NHS services in their own homes or near their homes in the community.

The Cavell Centre falls under this NHS improvement plan as it is a community health and wellbeing building which will allow joining up health and social care services.

This will provide residents with easier access to their NHS services closer to home.

The Cavell Centre is unique and allows residents improved access to care. It is also designed around a core primary care offering and promotes the co location of community services, outpatients, diagnostics and other service provision, thereby helping support the wider determinants of health.

NHS staff members working in the Cavell Centre will have access to modern technology and working environments which will help deliver efficient and effective patient care.



Community Diagnostic Centre

Community diagnostic centres (CDCs) are a key part of our commitment to providing more efficient and effective care for patients.

By bringing together a range of services under one roof, CDCs will make it easier for patients to access the care they need.

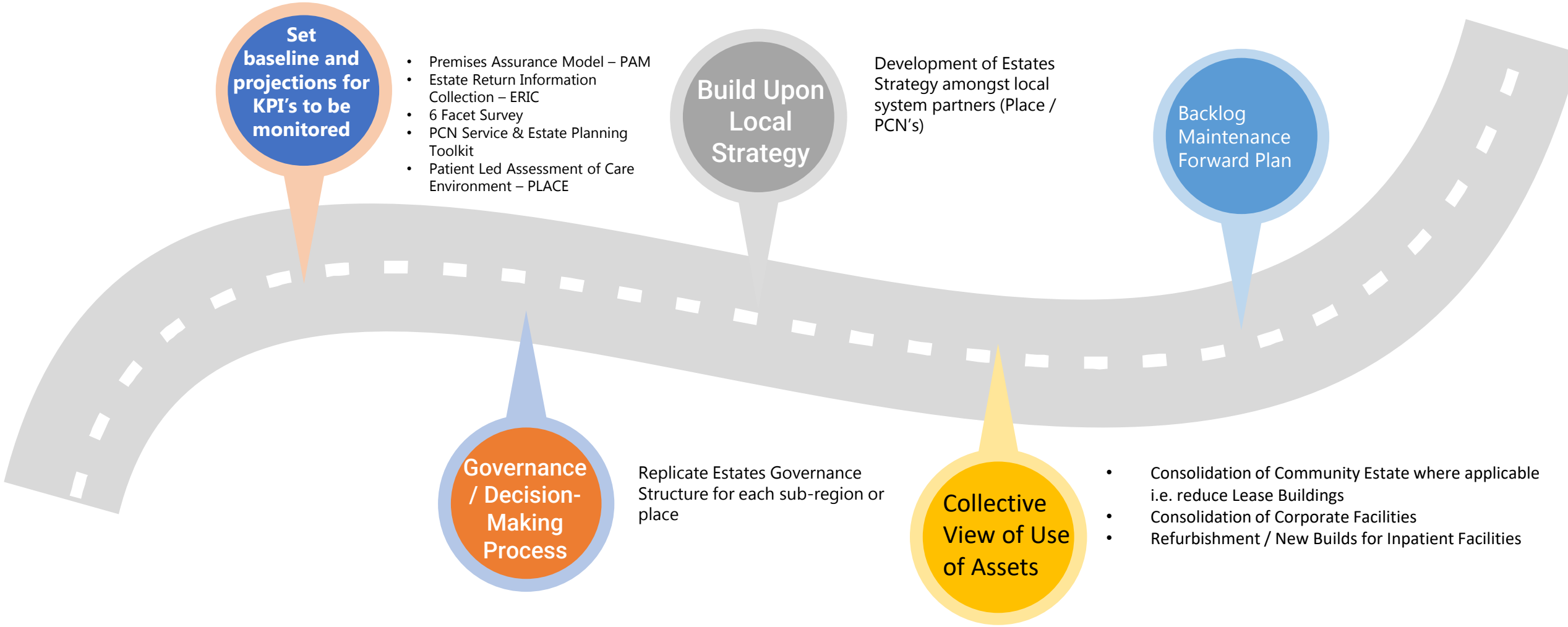
We are supportive of the programme to ensure that these facilities are located in the heart of the community, making it easier for patients to access care.

We believe CDCs will have a positive impact on estate infrastructures, freeing up space in hospitals for other uses and provide better value for money.

Additionally, CDCs could help to alleviate some of the pressures on primary care estate by providing a convenient place for patients to be seen by specialists.

Case Study - Appendix

How Do We Get There – Key Steps towards Our Priorities



How Do We Get There

The Our Estate Strategy sets out our plans for the next ten years to deliver world-class healthcare estates that are fit for the future. We will do this by ensuring that our buildings and facilities are safe, efficient and clinically effective, provide excellent value for money, and support our workforce to provide world-class care. We will achieve this by:

- Investing in innovation to drive down costs and improve outcomes
- Developing a more strategic approach to property management
- Making best use of our existing estate
- Disposing of surplus property
- Investing in new build where it is clinically and financially justified. Our ambition is to create world-class healthcare estates that are safe, efficient, sustainable, and productive and deliver improved patient care. We know that we cannot do this alone and we will work with our partners across the health and social care system and with patients, the public, and other stakeholders to achieve our vision.

Utilisation Study of Exiting Premises

- What amounts of space is really required
- As Services grow, how is existing space managed / PCN New Roles Impact
- Transparency in usage ie NHS PS, CHP, LiftCo, Provider Buildings

Disposals Programme/ Maximise Investment Opportunity / Lease Management

- Reduce the number of private landlord leases

Integration with wider stakeholders and NHS system partner

- Delivery of services in the community / Out of Hospital Care
- Collaborative working ie One Public Estate
- Engage with Local Authorities / Shared Backoffice Functions

Better use of technology and modern working practices

- Room Booking Solutions

How Do We Get There - Next Steps

Establish a Baseline prioritisation of Estate to develop a capital pipeline programme

Develop an Estates Investment policy that integrates the strategic ambitions stakeholders

Longer Term Priorities

- Alignment with Key Stakeholders (LA, wider Public Sector
- Monitoring at System Level (Model Hospital / PAM / ERIC

Ensure Strategy Aligns to forthcoming **Clinical Strategy** and acts as an enabler to Workforce Plans / Digital and Sustainability