Capital development and estates strategy
- Primary care
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Foreword

This local primary care estates strategy is an essential element of our ability to develop sustainable primary care services that are fit for the future. It is important for the CCGs to understand the capacity of the estates and facilities across Chorley, South Ribble and Greater Preston in order to utilise, reduce or develop these in the most appropriate way to meet the needs of the population, now and in the future.

The strategy has been developed in conjunction with the CCGs membership, local authorities, NHS England, individual GPs, providers, neighbouring commissioners and NHS property companies. This collaborative input has helped to ensure that this is a comprehensive primary care estates strategy for central Lancashire to shape the way that estate are used as an enabler for change.

Bilfinger GVA (BGVA) was appointed by the CCGs to provide a capital development and estate strategy capable of supporting the overall vision for Primary care over the next five years. The attached report includes the detailed findings including the gaps, risks and immediate priorities.

Within the health economy’s programme of change, ‘Our health Our Care,’ we want to create a radically new healthcare system that is patient centered, efficient and effective, combines improvements in patient experiences, provides better health outcomes for patients from healthcare providers, and makes better use of wider NHS resources.

We have set out our aspirations to do things differently and have quickly developed strong and effective relationships with key stakeholders in the wider health economy to deliver our plans. We have defined our aspirations within the central Lancashire local delivery plan (LDP), which is available at [www.chorleysouthribbleccg.nhs.uk/plans-publications-and-policies](http://www.chorleysouthribbleccg.nhs.uk/plans-publications-and-policies) and [www.greaterprestonccg.nhs.uk/plans-publications-and-policies](http://www.greaterprestonccg.nhs.uk/plans-publications-and-policies). Through this plan we will work with our partners to deliver new models of care under the ‘Our health Our Care’ banner.

The NHS five year forward view set out an integrated agenda and proposed new care models. In addition, ‘Our Health Our Care’ outlines the evidence base for re-evaluating the utilisation and value of NHS estate in central Lancashire, which will be progressed via the Lancashire and South Cumbria Sustainability and Transformation (STP) plan. The development of this estates strategy reflects the central Lancashire’s primary care estates provision.

Our vision is that in the future patients will have far more proactive personalised healthcare choices, be supported to ‘navigate’ the system, have access to 24/7 care at the appropriate level and location, have access to information and technology to pro-actively manage their conditions and greater support and guidance to enable them to manage their care, delivered as far as possible at home.

There will be ‘no decision about me, without me’ and GPs and their practices will be the patient advocate, supporting and coordinating individualised care for their patients and population. Local GPs are at the centre of this system and are leading the changes needed to deliver our ambitions.
We also need our estates to be part of the response to the needs of our local population which is increasing under the “city deal”. To respond to this population growth we need to change how services are organised and delivered locally. The services available will be proactive, accessible, coordinated, integrated and provide continuity, with a flexible, holistic approach to ensure every contact counts. This will be primary care led, organised around communities and geographically coherent populations, at scale, encouraging practices to work together (federate) to deliver services based on population needs.

The CCGs for Chorley, South Ribble and Greater Preston, their member practices and partners are committed to the following principles to ensure that the primary and community care infrastructure facilitates the required service transformation:-

- Improve seven day access to effective care
- Ensure there is sufficient training and workforce development capacity
- Ensure there is sufficient capacity in primary and community settings for services to be transferred out of hospital settings into communities in line with population needs
- Advance technological solutions that reduce the need for face-to-face consultations, better equip patients to self-manage their needs, enable more preventative care and strengthen communication and collaboration between organisations
- Ensure any changes are beneficial to patient access and do not exacerbate health inequalities
- Maximise the use of space through exploring with partner organisations how space can be reconfigured to deliver maximum value to the public sector

We are at the start of an exciting five year journey, during which we will work with key stakeholders to transform the way that health services are provided in our area. This strategy identifies some of those drivers for change, sets out where we are now and where we want to be, and what we will do to realise our ambitions.
Introduction

Bilfinger GVA (BGVA) were appointed by the (Greater Preston and the Chorley and South Ribble CCGs) to provide a Capital development and Estates Strategy capable of supporting the overall vision for primary care over the next five years. BGVA has prepared a detailed technical report that supports this publication.

This is set in the context of changing local population, rising patient expectations, greater provision of services in the community, the existing urgent care transformation programme, local challenges including the sustainability of existing properties, and the Preston and Lancashire ‘city deal.’

The ‘city deal’ is programmed to deliver over 17,000 new houses up to 2023/24. This will have a considerable impact on the delivery of primary care in the area and so needs to be sufficiently planned for. The capital development and estates strategy will help the CCGs to identify what is needed to provide a fit for purpose GP estate, and will help to identify a series of short and long term intervention and/or development proposals that will provide for future needs.

BGVA implemented a three stage approach, which has incorporated: a review of existing primary care provision across the estate; a review of wider public sector assets; a review of future residential development proposals and an assessment of the impact of these on each of the practices; and the development of short, medium and long term plans for an effective GP and local health economy.

The three stage approach includes:

- Stage 1 – Where are we now?
- Stage 2 – Where do we want to be?
- Stage 3 – How do we get there?
Stage 1 – Where are we now?

The Estate

There are 64 GP practices across both Chorley, South Ribble and Greater Preston CCGs, 31 are in Chorley and South Ribble and 33 are in Greater Preston.

Across the two CCG areas there are a total of 64 properties occupied by practices, 30 in Chorley and South Ribble and 34 in Greater Preston. Once the practices of Dr Chakrabarti, Dr Jha and Dr Shahid in Greater Preston have relocated from their current properties into The Old Methodist Church, Deepdale Road, this will lead to a revised total number of properties across the two CCG areas of 32 in Greater Preston and 30 in Chorley and South Ribble.

Data Collection

Visits to each practice took place in July and August 2015. The majority of data was collected either during the site visits or is based on data sets from March to May 2015 provided by the CCGs. GP work time equivalent (WTE) data was collected directly from GPs between March and May 2016.

To assist with data collection, each of the existing and future properties within the estate was given a ‘GVA Premises ID’. For the properties in Greater Preston this began with a ‘P’ and for those properties within Chorley and South Ribble this began with ‘CSR’. The ID for each of the properties can be found in the GP master list at appendix I. The master GP list also details the unique P-code (practice code) for each of the practices.

Master Map

A master map, which can be found in appendix II, was created to show the location of each property, the GVA Premises ID, and the practices occupying each property by P-code. Branch surgeries within the estate have been clearly marked on the map with a letter ‘B’. Where a practice is not marked as a branch it is a main surgery.

The catchment boundary for each practice has been digitised and added to the map (where inner and outer boundaries are agreed with NHS England, the outer boundary has been used for the purpose of mapping). Furthermore, an 800m radius (as the crow flies) has been shown around each of the practices in the estate. The 800m walking distance is derived from the Manual for Streets (MfS) (published in 2007), which highlights that walkable neighbourhoods are typically characterised by having a range of facilities within 10 minutes’ (up to about 800m) walking distance of residential areas, which residents may access comfortably on foot.

The CCGs’ Integrated Neighbourhood Team (INT) areas and the CCGs’ boundaries as per the layers available on the NHS England website have also been added to the master map.

In addition to the above, much more information is shown on the master map, but this is detailed further in subsequent chapters of this report.
Properties – data findings

**Number of GP occupiers**

The number of GPs occupying each of the properties is shown in table 1 as follows.

Table 1 – Number of GP occupants by property

<table>
<thead>
<tr>
<th>Number of GP occupiers</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>58</td>
<td>90.6</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>6.3</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

*Source: BGVA, August 2015*

The majority of properties (90.6%) are currently utilised by just one GP occupier, with only 9.5% of the properties being occupied by multiple practices. The four properties that are occupied by two GP practices are:

- The Chorley Health Centre (CSR7), which is occupied by Y00347 and P81127 (both main surgeries);
- The New Hall Lane Practice and Geoffrey Street Surgery (P4), which is occupied by P81071 and P81093 (both main surgeries);
- The Health Centre, Flintoff Way (P12), which is occupied by P81067 and P81785 (both main surgeries); and
- Cottam Lane Surgery (P21), which is occupied by P81664 and P81700 (both main surgeries).

The property that is occupied by three practices is The Eccleston Health Centre (CSR2), which is occupied by the main surgery of P81733 and by the branch surgeries of P81655 and P81173.

The only property occupied by four GPs is ISSA Medical Centre (P7). This property is occupied by P81196 and P81667. The other two GP practices, which are located in ISSA are the branch surgeries of P81152 and P81176 (practices where Dr Zak Patel of ISSA Medical Centre has taken on the contracts).

This data indicates that, on the face of it, there may be opportunities for increased co-location of multiple practices in locations where patient demand is high and/or where properties require significant investment / relocation.

**Ownership**

Data was collected regarding the ownership status of all the properties across the estate. The proportions of the different property ownership across the estate are summarised in table 2 as follows.
Table 2 – Property ownership

<table>
<thead>
<tr>
<th>Ownership Type</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP owner occupied (GPOO)</td>
<td>40</td>
<td>62.5</td>
</tr>
<tr>
<td>Third party GP landlord (TPGP)</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>Private landlord (PL)</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>NHS PS landlord (NHSPS)</td>
<td>10</td>
<td>15.6</td>
</tr>
<tr>
<td>Other NHS landlord (ONHS)</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>Other Public Sector landlord (OPS)</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The majority of properties across the estate (63%) are GP owner occupied, and for some of these practices which are in situations where funding is difficult to access / where there is existing high mortgage debt, this is a barrier to expansion or relocation. Of the remainder 9% of properties are occupied by private landlords, 9% are owned by a third party GP landlord and 16% are owned by NHS Property Services.

Type/age of building

GP properties by building type and age are shown in table 3 as follows.

Table 3 – Building type/age

<table>
<thead>
<tr>
<th>Building type/age</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose built health centre (post 1980)</td>
<td>32</td>
<td>50%</td>
</tr>
<tr>
<td>Purpose built health centre (pre-1980)</td>
<td>13</td>
<td>20%</td>
</tr>
<tr>
<td>Converted house (terrace / semi)</td>
<td>12</td>
<td>19%</td>
</tr>
<tr>
<td>Converted house (detached)</td>
<td>5</td>
<td>8%</td>
</tr>
<tr>
<td>Converted office</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Converted shop</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other (to be stated)</td>
<td>2</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The majority of properties (69%) within the estate are purpose built health centres, with half of the estate built after 1980. 28% of the estate are converted houses either terraced or detached. Two properties (3%), Beeches Medical Centre (CSR22), which is occupied by P81692, and The Chorley Surgery (CSR31), which is occupied by P81038 do not fall into any of the categories. Of these, CSR22 Beeches Medical Centre is a converted bomb proof BT hub and CSR31 The Chorley Surgery is a converted pre 1960’s community building.

There are no properties within the estate that are converted offices or shops.
**Age of building**

Five age brackets were used to classify building age as part of the strategy, which we summarise in table 4 as follows.

Table 4 – Building age

<table>
<thead>
<tr>
<th>Building age</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre 1960s</td>
<td>21</td>
<td>32.8</td>
</tr>
<tr>
<td>1960 – 1979</td>
<td>11</td>
<td>17.2</td>
</tr>
<tr>
<td>1980 – 1999</td>
<td>25</td>
<td>39.1</td>
</tr>
<tr>
<td>2000 – 2009</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>2010 and later</td>
<td>5</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The analysis shows that a high proportion of the properties (32.8%) are over 55 years old and will increasingly be costly to maintain, in need of refurbishment, have inadequate Equality Act 2010 compliant access and are more likely to have room layouts that are less conducive to the delivery of 21st century primary care.

The majority of the estate (56.3%) was built between 1960 and 1999. These properties are again are likely to have maintenance / refurbishment pressures.

3.1% (2 properties) were built between 2000 and 2009, these include Avenham Lane Practice (P5), built in 2000 and occupied by P81770; and ISSA Medical Centre (P7), built in 2009 and occupied by P81667 and P81196 (and by branch surgeries of P81152 and P81176).

Only 7.8% (five properties) were built in 2010 or later. The five newest properties include The Eccleston Health Centre (CSR2) built in 2013; Buckshaw Village Health Centre (CSR6) built in 2012; Ribble Village Surgery (P2) built in 2013; Cottam Lane Surgery (P21) built in 2010; and the branch surgery of Penwortham St Mary’s (P31) in the Foster Building UCLAN (exact date of construction unknown).

**Physical condition and maintenance liabilities**

Data was collected by building surveyors from BGVA regarding the physical condition and maintenance liabilities of the properties in the estate. The review was at a high level for indicative purposes only, and not based on a detailed property inspection / survey. The results of the data collection are detailed in table five as follows.
Table 5 – Physical condition

<table>
<thead>
<tr>
<th>Physical condition</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – Excellent</td>
<td>16</td>
<td>25.0</td>
</tr>
<tr>
<td>As new and can be expected to perform adequately over its expected shelf life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B – Good</td>
<td>37</td>
<td>57.8</td>
</tr>
<tr>
<td>Sound, operationally safe and exhibits only minor deterioration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C – Acceptable</td>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td>Operational but major repair or replacement will be needed in the relatively near future (within 3 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D – Improvement required</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Runs a serious risk of imminent breakdown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X – Data not collected (unable to collect sufficient data)</td>
<td>3</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The data findings show that the majority of properties, 57.8%, are in a good physical condition (B), with 25% in an excellent physical condition (A). There are, however, a minority of properties (12.5%), which are in an acceptable condition (C).

There are no properties identified where immediate significant improvement is required. This is as expected, as it is the role of NHS England to ensure through the GP contracts, and of the Care Quality Commission through its inspections, to make sure that services are provided from premises that are fit for purpose.

Data was not collected for the three practices that are in the process of relocating into The Old Methodist Church.

**Fitness for purpose**

Data was also collected by building surveyors from BGVA regarding the fitness for purpose of the properties in the estate (i.e. their functional suitability in terms of internal space relationships etc.). Again, the review was at a high level for indicative purposes only, and not based on a detailed property inspection / survey. The results of the data collection are detailed in table six as follows.
The vast majority of properties, have either been scored as good (B), 65.6%, or excellent (A), 26.6%. Two properties, 3.1%, scored acceptable (C) and both of these properties were also identified as having a physical condition of C, suggesting that they are in clear need of investment.

There were no properties identified as improvement required (D), which again would be expected within the regulatory environment of NHS England and the CQC.

**Quality**

A third set of data was collected by building surveyors from BGVA regarding the quality of the properties in the estate (i.e. their amenity, comfort engineering and design). Again, the review was at a high level for indicative purposes only, and not based on a detailed property inspection / survey. The results of the data collection are detailed below in table seven as follows.

### Table 6 – Fitness for purpose of the estate

<table>
<thead>
<tr>
<th>Fitness for purpose</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – Excellent</td>
<td>17</td>
<td>26.6</td>
</tr>
<tr>
<td>No change needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B – Good</td>
<td>42</td>
<td>65.6</td>
</tr>
<tr>
<td>Minor change needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C – Acceptable</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Major change needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D – Improvement required</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate in its current condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X – Data not collected (unable to collect sufficient data)</td>
<td>3</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

### Table 7 – Quality of the estate

<table>
<thead>
<tr>
<th>Quality</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – Excellent</td>
<td>14</td>
<td>21.9</td>
</tr>
<tr>
<td>A facility of excellent quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B – Good</td>
<td>38</td>
<td>59.4</td>
</tr>
<tr>
<td>A facility requiring general maintenance investment only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C – Acceptable</td>
<td>9</td>
<td>14.1</td>
</tr>
<tr>
<td>A facility requiring capital investment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D – Improvement required</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A poor facility requiring major capital investment or replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X – Data not collected (unable to collect sufficient data)</td>
<td>3</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015
The majority of properties, 59.4%, have been scored as being of good quality (B), with 21.9% being scored as excellent quality (A). 14.1% of the estate has been scored as acceptable (C). 6 of the 9 properties were identified as being of quality condition C were also identified as physical condition C, therefore there is again a clear pattern of those properties that are in greatest need of investment.

Number of third party occupiers

The number of third party occupiers that occupy each property across the estate was also recorded. Third party occupiers are occupiers that reside in a set space within the property and are not necessarily associated with the practice also located there. Examples of third party occupiers include pharmacies, dentists, and other health care providers like Lancashire Care or Virgin Care. The data collected in relation to the number of third party occupiers is detailed in table 8 as follows.

Table 8 – Number of third party occupiers

<table>
<thead>
<tr>
<th>Number of Third Party Occupiers</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>44</td>
<td>68.8</td>
</tr>
<tr>
<td>1</td>
<td>15</td>
<td>23.4</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>6.3</td>
</tr>
<tr>
<td>3 or more</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

As can be seen, 68.8% of properties do not have a third party occupier, 31.2% of properties have one or more third party occupier, with one property, ISSA Medical Centre having seven third party occupiers including HBS Pharmacy, Virgin Care, Deepdale Dental Centre, About Health, and Chorley Medics.

It is worth noting that the most common third party occupiers within the estate are pharmacies, as shown in table nine as follows.

Table 9 – Pharmacy provision

<table>
<thead>
<tr>
<th>Pharmacy provision</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pharmacy on site</td>
<td>53</td>
<td>82.8</td>
</tr>
<tr>
<td>Pharmacy on site</td>
<td>11</td>
<td>17.2</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The 11 properties with a pharmacy on site (17.2%) include: Coppull Medical Practice; The Ryan Medical Centre; Sandy Lane Surgery; Ribble Village Surgery; Ribbleton Medical Centre; The New Hall Lane Practice & Geoffrey Street Surgery; ISSA Medical Centre; Cottam Lane Surgery; Great Eccleston Health Centre; Penwortham St Mary’s (main surgery); and St. Fillan’s Medical Centre.

There are a number of practices within the estate, which include dispensary services. Dispensaries are not classed as pharmacies in this context.
Opportunity for expansion

The opportunity for expansion at each of the properties was determined through the interviews undertaken with practice managers and through on-site observations. The results of the assessment for each property are provided in table ten as follows.

Table 10 – Opportunity for expansion

<table>
<thead>
<tr>
<th>Opportunity for expansion</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constrained Site (CS)</td>
<td>23</td>
<td>35.9</td>
</tr>
<tr>
<td>There is no opportunity for any expansion at the property as it stands i.e. there is no space within the property or land surrounding the property which could be developed to provide an extension to the property</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited Opportunity (LO)</td>
<td>23</td>
<td>35.9</td>
</tr>
<tr>
<td>There is some limited opportunity for expansion at the property e.g. there is underutilised space within the property which could be redesigned to provide additional usable room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Opportunity (GO)</td>
<td>18</td>
<td>28.1%</td>
</tr>
<tr>
<td>There is a good opportunity for expansion at the property e.g. there is a piece of land adjacent to the properties which is in the ownership of the practice and could be developed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The data shows that only 28.1% of properties have a good opportunity to expand, albeit this does not include an assessment of associated costs / technical feasibility. 35.9% of properties are constrained sites, which means that practices may not be able to cater for future population increases if they remain on their current sites.

A further 35.9% have limited opportunity for expansion, which may help cater for future needs, but these are often limited expansion opportunities that involve converting currently unused parts of the buildings (for example, roof spaces) and in reality this may not be feasible.
Practices - data findings

Number of operational properties

As part of the estate audit the number of properties used by each practice was identified. Some practices operate from a single ‘main surgery’ whilst others operate from a main and an additional ‘branch surgery’. The number of properties used by practices across the estate is summarised in table 11 as follows.

Table 11 – Operational Properties

<table>
<thead>
<tr>
<th>Operational properties</th>
<th>Number of properties</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>One operational property</td>
<td>56</td>
<td>87.5</td>
</tr>
<tr>
<td>Two operational properties</td>
<td>7</td>
<td>10.9</td>
</tr>
<tr>
<td>Three operational properties</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

The data shows that the vast majority of the practices operate from one property, representing a percentage of 87.5%. There is only one practice that operates from three properties: - P81067 (Dr CM Wilson & Partners), which has its main surgery at The Health Centre, Flintoff Way, and two branch surgeries located at 157 Sharoe Green Lane and at Longsands Medical Centre.

Of the 7 (10.9%) of the practices that operate from two properties, not all are full time branch surgeries. Two of the practices P81152 (Drs Robb & Robb), and P81176 (Moor Park Surgery) operate Saturday morning branch surgeries at ISSA Medical Centre. A further two practices, P81655 (Dr Ahmad) and P81173 (Dr Garg & Partner) operate part time branch surgeries from Eccleston Health Centre.

The remainder are full time branch surgeries:

- **P81664** (The Park Medical Practice) has a full time branch surgery on New Hall Lane (Preston) with all back office functions provided from the main surgery – Cottam Lane Surgery;
- **P81213** (Penwortham St Mary's) has a full time branch surgery at the University of Central Lancashire (UCLAN) servicing the student population in Preston; and
- **P81103** (Dr DC Patel & Partners) has a full time branch surgery at Ingol Health Centre.

Number of GP partners

This refers to the number of GPs actively providing clinical services for each practice. The number of GP partners per practice across the estate is summarised in Table 12 as follows.
Table 12 – Number of GP partners

<table>
<thead>
<tr>
<th>Number of GP partners</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4</td>
<td>6.3</td>
</tr>
<tr>
<td>1</td>
<td>24</td>
<td>37.5</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>15.6</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>10.9</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>10.9</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: BGVA, March – May 2016

There is a clear range in the numbers recorded across all the practices within the estate, reflective of the different list sizes. The most common number of GP partners for a practice to have is 1. These practices are identified by the CCG as ‘single-handers,’ many of which simply have one GP staffing the practice overall.

As practices continue to work much more closely together in the future it is likely that a number of practices will increase their GP partner headcount. Also, as practices continue to federate bringing services together under multiple contracts, it is likely that the number of practices where there are no GP partners actively providing clinical services will also increase – this is because if contracts have been ‘bought out,’ GPs that were previously partners will now be salaried GPs.

The number of GP partners may also reduce in the future as GP partnership often goes hand in hand with taking a stake in the property. As the cost of property ownership continues to rise, it is likely that less and less GPs entering the profession will see property ownership as a viable option, and they may prefer to continue as a salaried GP instead.

**Number of Salaried GPs**

Data was also collected for the number of salaried GPs (not partners) at each practice. The breakdown is detailed in table 13 as follows.

Table 13 – Number of salaried GPs

<table>
<thead>
<tr>
<th>Number of salaried GPs</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>29</td>
<td>45.3</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>25.0</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>21.9</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Source: BGVA, March – May 2016
As stated above, this mix is likely to change in the future as GPs continue to federate, and given the barriers to property owning partnership. However, many practices advised that they are struggling to recruit salaried GPs, which may counteract these predicted trends. This is in part driven by the negative perception by some of the NHS and the associated ‘brain drain’ of trained GPs who are leaving the UK to work abroad, and the perceived reluctance of new and junior doctors to become GPs. This is a key issue that the April 2016 Primary Care Forward View looks to address at a national scale and this issue will need to be carefully considered locally in the implementation of this estate strategy over the next 5 years.

**GPs retiring in 0-5 years**

Along with the GP partner and salaried GP data, data was collected on the number of practices having GPs retiring in 0-5 years and this is presented in table 14 as follows.

<table>
<thead>
<tr>
<th>Number of retiring GPs</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>31</td>
<td>48.4</td>
</tr>
<tr>
<td>1</td>
<td>24</td>
<td>37.5</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>4.7</td>
</tr>
</tbody>
</table>

*Source: BGVA, March – May 2016*

The total number of GP partners across the CCG areas is 160, and the total number of salaried GPs is 63 respectively. The overall total number of GPs is therefore 223. Of these, based on the data in the table above, 45 are due to retire in the next 5 years. This equates to approximately 20% of the overall total.

Where these are ‘single handers’, many of whom are close to retirement, a key question is what will happen to their contracts / the provision of primary care for their lists. Many of the ‘single handers’ also operate from older premises that will not necessarily be suitable for the provision of primary care in the years to come. This question comes into even sharper focus when the planned new housing for the CCG areas is considered. These issues must be considered in the shaping of the estate strategy.

**GP work time equivalent (WTE)**

The WTE of the GPs actively providing clinical services in each practice has been calculated based on the data provided by the practices. The WTE calculation includes GP partners, salaried GPs and long term locums (where applicable), but excludes trainee GPs and advanced nurse practitioners. The WTE spread across the practices is summarised in Table 15 as follows.
The data indicates that the GP WTE ranges from 0.9 to 8.3 across all the practices in the estate. 15 of the 64 practices have a WTE of 1.0 or less. These are the smaller single handed practices, and their future sustainability must be considered as part of this strategy.

The practice with the largest WTE is P81213 (Penwortham St Mary’s), and as one would expect, this is also a practice with one of the largest list sizes.

**Training practices**

Some practices are training practices, where trainee GPs may be based for a period of time. The number of training practices across the CCG areas is detailed in table 16 as follows.

**Table 15 – GP WTE**

<table>
<thead>
<tr>
<th>GP WTE</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>15</td>
<td>23.4</td>
</tr>
<tr>
<td>1.1 – 2.0</td>
<td>10</td>
<td>15.6</td>
</tr>
<tr>
<td>2.1 – 3.0</td>
<td>11</td>
<td>17.2</td>
</tr>
<tr>
<td>3.1 – 4.0</td>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td>4.1 – 5.0</td>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td>5.1 – 6.0</td>
<td>5</td>
<td>7.8</td>
</tr>
<tr>
<td>6.1 – 7.0</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>7.1 – 8.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>&gt; 8.1</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: BGVA, March – May 2016

Over a third of practices in the CCG area are training practices, which is important for the continuity of GP provision in the NHS. Practices were, however, limited in their ability to either take on trainee GPs or to take on more trainees due to a general pressure on space in their properties and a lack of room to expand.

This clearly demonstrates that property could be seen as a future limiting factor on the ability of practices to bring GPs through the ranks within the CCG area, ultimately risking the future of primary care provision in the locality.

**List size**

The list size for each of the 64 practices as at May 2015 has been recorded. Whilst this data is a year old, the list sizes are unlikely to have changed significantly for practices comparatively (i.e. the largest practices are still likely to be the largest practices). The spread of list sizes is summarised in table 17 as follows.

**Table 16 – Training practices**

<table>
<thead>
<tr>
<th>Practices</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>24</td>
<td>37.5</td>
</tr>
<tr>
<td>Not training</td>
<td>40</td>
<td>62.5</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015
The smallest list size recorded is 1,388 and there are a further nine other practices with a list size under 2,000.

The five largest practices with list sizes over 12,000 are:

- P81057 (Worden Medical Centre) – list size of 12,762;
- P81067 (Dr CM Wilson & Partners) – list size of 13,717;
- P81664 (The Park Medical Practice) – list size of 14,015;
- P81213 (Penwortham St Mary’s) – list size of 16,357; and
- P81044 (Library House Surgery) – list size of 16,475.

**List Size : GP WTE ratio**

For each practice, the list size has been divided by the GP WTE in order to give an estimate of the numbers of patients per GP. These ratios are summarised in table 18 as follows.

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1,000</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>1,001 – 1,500</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>1,501 – 2,000</td>
<td>30</td>
<td>46.9</td>
</tr>
<tr>
<td>2,001 – 2,500</td>
<td>17</td>
<td>26.6</td>
</tr>
<tr>
<td>2,501 – 3,000</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>&gt; 3,000</td>
<td>3</td>
<td>4.7</td>
</tr>
</tbody>
</table>

It is understood from Monitor Report ‘Improving GP service: commissioners and patient choice’ (June 2015) that in 2014, based on Health and Social Care Information Centre (HSCIC), on average across England, there were about 1,700 patients for every GP WTE.
15 of the 64 practices fall below this national average, whilst the remaining 49 practices exceed this national average.

Locally, the average number of patients per GP WTE is clearly higher. Based on our data set, the average is 1,989 patients per GP for the two CCG areas. 36 of the practices have a ratio of lower than this figure, and 28 of the practices have a ratio higher than this figure.

Data analysis carried out by ‘GP’ magazine in December 2014 calculated averages nationally for each CCG area by combining GP workforce census data published in early 2014 and October 2014 data on patient populations from the HSCIC. Their analysis found that the average for Chorley and South Ribble CCG was 1,936 patients per GP WTE, and the average for Greater Preston CCG was 1,873 patients per GP WTE. Averaging these two figures gives a combined CCG average of 1,905 patients per GP WTE.

Applying the GP magazine ratio, 30 of the practices have a ratio of lower than this figure, and 34 of the practices have a ratio higher than this figure.

The GP to WTE ratio is important to understand as it shows the capacity of practices to accommodate more patients in the context of the ‘city deal’ housing growth, but this should not be viewed in isolation. Some practices may have a lower ratio of patients per GP WTE due to property constraints, such as lack of consulting room availability.

Property aspirations

During the meetings with the Practice Managers and GPs they were asked about their property aspirations. These have been broadly categorised as per table 19 as follows:

Table 19 – Property Aspirations

<table>
<thead>
<tr>
<th>Aspirations</th>
<th>Number of practices</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>14</td>
<td>21.9</td>
</tr>
<tr>
<td>Refurbish</td>
<td>4</td>
<td>6.3</td>
</tr>
<tr>
<td>Expand/reconfigure</td>
<td>29</td>
<td>45.3</td>
</tr>
<tr>
<td>Relocate</td>
<td>13</td>
<td>20.3</td>
</tr>
<tr>
<td>Both expand/reconfigure and relocate</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: BGVA, August 2015

It is perhaps not surprising that the majority of practices (76.6%) have some aspirations in the future to refurbish, reconfigure, expand or relocate. Such plans and aspirations have considerable funding / delivery implications and as such, each opportunity will need to be carefully considered on its merits. The aspirations of the practices in relation to their properties are key to informing the later stages of this strategy as deliverability is a very important factor to consider.

Where practices do not have aspirations for change (21.9%), these practices are typically either in new build or newly extended premises that are modern and future proofed, or they are a smaller practice with no desire for change, for example, a ‘single hander’ who is close to retirement may have no appetite for investing further.
Qualitative questions

In addition to categorising the property aspirations of each practice, the practices were asked a series of qualitative questions to gather an understanding of their property challenges, the positive attributes of their property, barriers to achieving their property aims, their attitudes to co-location and their awareness of / plans to deal with planned housing growth.

The findings of this qualitative questioning are set out in the bullet points below, some of which have been touched on in the previous analysis.

Current challenges faced by practices in terms of their properties:

- Many practices identified a lack of space, in particular: for the provision of further clinical / locality services; for the provision of administrative functions; for medical records storage; and to provide GP training for students which is impacting upon the flow of new GPs into general practice (alongside increased trend of GPs moving overseas).
- Some practices identified that they have a lack of appropriate accessibility for the disabled community.
- Some practices identified a lack of car parking for staff and patients as a challenge.
- Some practices stated that issues with the sound proofing of existing rooms are preventing rooms from being used effectively.

Positive property attributes:

- Above all, practices saw the location of their properties as a key attribute.
- Those practices with more modern buildings that are fit for purpose saw this as a positive attribute.
- Some properties provide a ‘reception only facility’ which provides increased privacy for phone calls and is seen as positive.
- Some practices with small patient population / catchment boundaries felt that means that GPs know their patients more personally and therefore they have good relationships.
- Those practices that are located in larger centres considered accessibility by a range of means of transport as a positive attribute.
- Practices that are situated on one level were considered by some practices to be better for disabled patients.

Common barriers to achieving property aims:

- No funding available / being assigned for required changes was identified as the overriding barrier to achieving desired property aims. This was coupled with a lack of understanding regarding the current funding regime including who is eligible and what needs to be submitted to apply for the funding. (Albeit, it must be noted that the Primary Care Transformation Fund / the Estates and Technology Transformation Fund has progressed since the interviews were undertaken in July / August 2015).
Another common barrier was that often, where a practice has a desire to relocate, they cannot find an appropriate site, or sometimes do not know how best to start looking for a site (particularly in areas where residential land values must be paid).

A further barrier identified was the issue of needing to agree the delivery of property aims with the property owner where a property is not in the ownership of the practising GP(s). In some instances the property owners cooperation / support has not been forthcoming.

Many practices identified that the current costs of buying into practices for new GPs are too high and/or that GPs no longer want to take a property owning partnership role.

**Attitudes to GP co-location / public sector co-location**

- Practices had mixed attitudes to co-location and public sector co-location - some said they would consider it (if they are not already co-located) and some said that they would not consider it.
- There was less appetite for public sector co-location than GP co-location, likely to be due largely to the generality of the question and the uncertainty of how such co-location would work in practice.

**Awareness of the ‘city deal’ housing growth and plans to address this**

- There was a mixed response in terms of the awareness of the ‘city deal’ housing growth; there were more practices unaware than those that were aware.
- Some practices welcomed the idea of more patients joining their practices; however some were already at capacity and said that they could not absorb further patients.
- There was an appetite amongst those informed practices to assist in meeting the future needs of the population.
Stage 2 - Where do we want to be?

Stage 2 has consisted of the following workstreams:

- Review of the CCGs strategy for primary care
- Definition and understanding of future housing growth locations; and
- Public sector co-location opportunities.

CCGs’ five year strategic plan - ‘Our strategy for commissioning better health 2014-2019’

The CCGs’ five year strategic plan sets out the ‘vision for the future of primary care’ for the two CCG areas.

It states that the CCGs want to see accessible and equitable, high quality sustainable primary care services for the people of Chorley, South Ribble and Greater Preston and. It identifies that by working with the CCGs local health economy partners, future primary care provision will:

- Be accessible to all people regardless of who they are, where they live, or what health and social problems they may have;
- Provide improved quality including patient experiences of services, reduction in health inequalities, improved outcomes, coordinated care across provider boundaries and fewer hospital admissions;
- Provide integrated services within primary care, offering continuity of care consisting of multi-disciplinary teams of health and social care professionals and the integrated health and wellbeing team;
- Use clinical pathways for consistent and effective care, with referral processes for specialist consultations;
- Use connected information and data systems, including electronic patient records to optimise clinical activity and information/data facilitating quicker and more effective decision making;
- Delivered in localities to provide sustainable primary care services closer to home;
- Be supported by primary care workforce plans, which include career pathways for practice staff, clinical and non-clinical development opportunities and the recruitment of appropriately skilled staff for potentially new roles within primary care; and
- Provide suitable facilities and infrastructure including digital healthcare, to provide a range of access options to patients.
They state that the successful delivery of the programme will result in:

- Improved access to primary care;
- Improved overall patient experience of primary care;
- Improved health outcomes for patients;
- Improved quality of clinical patient centered care in general practice with an emphasis on multi-disciplinary approaches to the care and management of the patient;
- Reduction in the inappropriate use of expensive secondary care resources;
- Multi-disciplinary teams in place to manage patient care; and
- Community assets routinely used in the provision of primary care services.

This is an important context clearly setting out where the CCGs want to be in terms of clinical strategy by 2019. The implications of this in terms of estate requirements are important to consider as part of formulating this strategy.

**Definition and understanding of future housing growth locations**

**Data sources**

Housing data was sourced from the local authorities covering the CCG areas (Preston City Council, Chorley Council, South Ribble Borough Council, Ribble Valley Borough Council, Wyre Council and Fylde Borough Council). Housing data was sought for both local plan allocations for residential development (where available), and for committed developments (sites with the benefit of planning permission). Sometimes sites benefit from both an allocation and planning permission. Sites that do not benefit from an allocation but that have planning permission are known as ‘windfall’ sites.

Data regarding ‘city deal’ housing developments was also provided by Lancashire County Council (LCC).

The main limitation to the data gathered is its age (data on housing development sites rapidly goes out of date); as well as the different base dates for the data from each of the different authorities, meaning that the data gathered does not represent a single point in time.

**Master Map**

In association with the data collection on future housing growth, the following layers were added to the master map in appendix II at stage 2:

**District Boundaries**

Each of the local authority boundaries have been mapped – Preston, South Ribble, Chorley, Ribble Valley, Wyre and Fylde.
GVA Ref Sites over 90 dwellings

Each site or group of sites totalling over 90 dwellings has been given a unique ‘Bilfinger GVA allocation ref’ number. This layer of the master map therefore, identifies by BGVA reference number the development sites / groups of sites that are over 90 dwellings. This layer appears as a blue boundary and includes in blue letters the BGVA reference number.

A threshold of 90 dwellings was chosen to ensure that the key development sites impacting all practices were identified (100 was initially chosen as the cut off but this would have meant a key development site in Great Eccleston was not captured).

Housing Allocations > 90 dwellings

This layer maps all the adopted housing allocations of over 90 dwellings within Preston, Chorley and South Ribble. It shows the allocations in green shading.

A label showing the number of dwellings for both the housing allocations of more than 90 dwellings and the windfall development sites is embedded within this layer. This indicates the number of dwellings left to develop on each site (therefore completed dwellings are not included in the count).

Windfall developments >90 dwellings

This layer maps all the windfall sites over 90 dwellings within Preston, Chorley, South Ribble, Ribble Valley, Wyre and Fylde on sites that do not benefit from an allocation. This layer appears as a black outline within the blue BGVA reference boundary.

Sites < 90 dwellings & other committed developments

This layer maps all the allocations under 90 dwellings in Preston, South Ribble and Chorley. As per the other allocations layer, these are shown with green shading. It also maps all of the committed development data across the six authorities, where it has been provided in map form, for sites with the benefit of planning permission that are not included on the ‘windfall developments > 90’ layer described above. These commitments are shown with a black outline and it is possible to see by using this layer which of the allocations over 90 dwellings also benefit from planning permission.

Housing Totals Table

A housing totals table by sub area is included in appendix III. This sets out the total number of houses in each sub area (defined within stage 3) left to be constructed. The Housing Totals Table picks up all of the remaining housing numbers included in the data sourced from the individual councils.

The table includes separate columns detailing the total number of dwellings by sub area for: allocations of 90+ units; allocations of less than 90 units; windfalls of 90+ units, and windfalls of less than 90 units. The table then concludes as to the total number of units to be developed in each of the sub areas.

It is important that sites of all sizes are included in the overall count, as over the relevant council area the total number of dwellings on such sites can be substantial, particularly in rural areas where development sites tend to be smaller and more scattered.
Public sector co-location opportunities

A standardised set of questions were prepared and meetings / conference calls held with all key public sector stakeholders (between November 2015 and January 2016) to determine potential opportunities for co-location in the CCG areas.

These meetings focused on three discrete component parts of the public sector, all of whom are either actively engaged in the local health economy or considered to potentially be able to offer co-location opportunities:

- **Health** – Lancashire Teaching Hospitals NHS Foundation Trust (LTHT), Lancashire Care Foundation Trust (LCFT), and NHS Property Services (NHSPS);
- **Local authorities** – Preston, Chorley, South Ribble, Ribble Valley, Wyre & Lancashire County Council (LCC); and
- **Emergency services** – fire, police, ambulance.

**Health**

*Lancashire Teaching Hospitals NHS Foundation Trust (LTHT)*

As part of the ‘Our Health Our Care’ programme, LTHT will review their estates and facilities at local hospital sites, ensuring they are modern, fit for purpose, fit for the future and support the rebalancing of the health economy to enable community and primary care to be delivered at scale. This challenges traditional thinking and critically has an ethos of ‘no unnecessary waiting, no unnecessary cost and no compromise on quality’ as key standards.

The aims are to:

- Continue to deliver safe and effective care
- Continue to provide good patient experiences
- Provide care that is more flexible and not tied to ‘buildings’
- Provide services that are sustainable into the future and ‘can move with the times’

We anticipate that once the models of care have been agreed and sized, and after any required consultation, that Lancashire Teaching Hospitals Trust will then start a process of modernising its hospital estate to ensure that it is efficient and fit for the future.

LTHT also commissions a significant level of non-urgent activity to Ramsay Health Care UK, which provides services locally from two main facilities at Fulwood Hospital and Euxton Hall Hospital.

*Lancashire Care Foundation Trust (LCFT)*

LCFT confirmed that it has no formal surplus land and three key assets namely:

- Ribbleton Hospital (closed March 2015 but to be retained for future trust use);
- 16 & 18 Elston Lane, Chorley; and
- Leasehold space at Chorley and South Ribble Hospital and Royal Preston Hospital.
LCFT is also the lead party working with Chorley Council and the CCGs in progressing the development of long running proposals for a local community health hub at Friday Street in Chorley. LCFT owns the Friday Street site and intends to relocate services from four separate locations in the area to provide a single hub for the delivery of primary and community care services in east Chorley. The site is planned to provide accommodation for GP practice(s).

In addition to the space allocated for LCFT and the GPs, the proposed development includes the provision of ten bookable clinical rooms to meet the requirements of the CCGs emerging outpatient strategy, and this has been modelled to demonstrate the capacity it will provide.

LTHT is also a partner in the project and the feasibility of proving a joint children’s service from the new facility is being considered. The development will also include a community pharmacy.

If some form of primary care funding is secured, work could start on site in early 2017 with a completion in spring/summer 2018.

*NHS Property Services (NHSPS)*

NHSPS owns a number of properties across the estate and GP practices are co-located with LCFT in many of the NHSPS buildings.

Within Greater Preston, it has an interest in 22 properties, five of which are occupied by a GP practice. Within Chorley and South Ribble it has an interest in 18 properties, seven of which are occupied by a GP practice.

NHSPS has indicated that it would work with the CCGs in trying to meet any requirements for primary care provision within the estates.

NHSPS has also prepared the CCGs’ local estate strategy (LES), as mandated by NHS England and this was submitted to them in December 2015. The LES is focused on achieving estate efficiencies through improving space utilisation and property disposals.

Another point to note in terms of NHSPS that may have an impact on the delivery of this strategy is its recently announced changes from full cost recovery for freehold rent to a market rent charge for the 2016/17 financial year.
Local Authorities

Preston City Council

Preston City Council’s property department confirmed that it has been rationalising its property assets in recent years to consolidate into freehold stock. It has now released all of its leasehold estate.

It confirmed that the city centre is the focus of its property assets, with further freehold disposals in the pipeline to provide capital funds to re-invest in core services.

Revenue income is a key focus, with city centre investments (shops etc.) contributing to this. The Council continues to consider other investments on an opportunistic basis.

Any freehold disposals will provide capital to re-invest to help fill any financial gap.

It confirmed that there is no opportunity for co-location or need for a ‘one stop shop’ outside of the city centre, nor are any satellite locations needed.

Chorley Council

Following the disposal of a number of assets, Chorley Council’s property department stated that it does not have a large property portfolio and has also transferred a lot of properties to Chorley Community Housing in recent years. It used to own the Friday Street site, which was sold to the Primary Care Trust in 2008, and ‘gifted’ to LCFT.

The Council operates out of two main administration buildings, namely the Town Hall and the Union Street property. It also owns five community centres (Adlington, Astley Village, Eaves Green, Clayton Brook and Tatton) and two more are in the pipeline (Buttermere and Buckshaw Village). There may be some opportunities for use of the space within a limited number of these buildings.

The Council also owns 19 – 23 Gillibrand Street, which it is currently holding vacant to accommodate short term accommodation needs that are likely to arise in association with an extra care development which will displace some occupiers. This, however, is seen as a long term option for primary care redevelopment.

The Council confirmed it would not be averse to taking a property owning role to facilitate primary care estate development, as long as the proposal is cost neutral.

South Ribble Borough Council

South Ribble Council’s property department confirmed that it was out to tender at the time for a ‘property asset review’ to provide strategic direction for the future of its operational estate.

It has a mixture of freehold and leasehold assets with a specific focus on assets that provide a revenue stream. The Council’s key operational properties are the Civic Centre; Moss Side Depot; Worden Hall and Park Buildings; and Leyland Market.
It confirmed that there is underutilised space of circa 8,000sqm at the Civic Centre over 2.5 floors that it is considering the feasibility of renting to third parties.

Ribble Valley Borough Council

Ribble Valley Council confirmed that a limited number of properties are in its ownership. It stated that in Longridge it owns the old fire service building on Berry Lane which is leased to the County Council, and that it owns the Civic Hall, which is leased to the Civic Hall Committee. It stated that it does not own any land in the Longridge area.

Wyre Council

Wyre Council confirmed that it does not own any properties with opportunities for co-location in the Great Eccleston area.

Lancashire County Council (LCC)

LCC is currently trying to achieve a long term reduction in its corporate property portfolio to align with the aspirations of its corporate strategy, and to enable the future successful delivery of public services. It is doing this through producing a property strategy.

In November 2015, a paper was taken to the Council’s Cabinet requesting approval to implement a proposed property reduction strategy and for the delivery of a series of multi-functional neighbourhood centres which would provide a range of targeted front facing publicly accessed council services compared with the present approach which relies heavily on single function premises, e.g., libraries, children’s centres.

The paper states that the County Council’s property portfolio, excluding schools, is a significant asset comprising in the order of 500 operational sites. A total of 220 premises were selected from the total property holdings of the County Council to be considered in the proposed review. Certain premises were out of scope, identified as being completely unsuitable for front facing public service delivery e.g. homes for older people, children’s homes, outdoor education establishments, landfill sites etc.

It was proposed that the reduction in premises from 220 be based upon need assessments in a series of 34 service planning areas (SPAs) across the county using the 2015 English Indices of Multiple Deprivation. LCC concluded that the application of this approach would deliver a reduction of 108 premises. LCC’s SPA areas are also shown on the master map in appendix II in brown dashed lines.

Cabinet approved the proposed approach and LCC has since produced a further paper, which was taken to Cabinet for approval on 12 May 2016 ahead of a planned 12 week public consultation.

The May paper sets out that overall, 222 premises have been reviewed along with 28 externally commissioned children’s centres. The review identified a total of 130 premises as preferred for retention as neighbourhood centres that will form the basis for service delivery, including premises from the County Council’s holdings and 16 buildings currently accommodating externally commissioned children’s centre services.

106 premises have been identified as no longer being required to deliver the Council’s future pattern of service delivery. Of these, 12 are buildings that currently accommodate externally commissioned children’s centre services. 14 premises have been taken out of the review
and a further 2 LCC premises remain under consideration as they provide an opportunity to accommodate public facing services.

LCC plans to report back the outcomes of its consultation to Cabinet in September 2016.

In addition to progressing its property strategy, we also understand that LCC is in the process of modelling future population growth across the CCG areas using specialist ‘PopGroup’ software. The results of this modelling will be important for the CCGs to obtain and digest, to enable refinement of this strategy.

**Emergency Services**

**Lancashire Fire and Rescue**

Lancashire Fire and Rescue confirmed that its three yearly emergency cover review would commence in January 2016 and its outcome is awaited.

It stated that it would consider co-location with the ambulance service, and already has a shared site with the police.

It is responsible for 40 properties in the region, all freehold, but may reduce in number in the future dependent upon the outcome of the review. Seven of their properties, that are all operational span across the CCG areas – see below:

- Fulwood (HQ and fire station);
- Preston (not fit for purpose, shared with ambulance service);
- Penwortham;
- Bamber Bridge;
- Leyland;
- Chorley;
- Longridge.

**Lancashire Police**

Lancashire Police confirmed that it has a number of assets, with 35 freehold stations in Lancashire overall (reduced from 50 in 2010). Police properties in the CCG areas include:

- Policy HQ, Hutton;
- Chorley police station (freehold);
- Leyland police station (freehold);
- Bamber Bridge police station (freehold but underutilised and in a good strategic location);
- Coppull (freehold);
- Longridge;
- Clayton Brook, small neighbourhood offices (leasehold and might vacate); and
- Lindle Lane (home to the mounted branch, dog school and operational staff).
It is currently reviewing its estate and considering opportunities for co-location and collaboration with the wider public sector. There may also be opportunities for co-location with other neighbourhood offices.

The Police force are currently considering implementation of a hub and spoke model.

*North West Ambulance Service*

North West Ambulance Service confirmed that its estate consists of 135 properties, with only 4 sites in the CCG areas, namely:

- Chorley – Highfield Industrial Estate (freehold);
- Leyland – Cross Street (freehold);
- Walmer Bridge – Liverpool Road (long-term leasehold); and
- Broughton – Ambulance HQ (freehold).

It is also considering implementation of a hub and spoke model. Its estate strategy looks to reduce its carbon footprint and generate revenue income. Capital receipts are only reinvested if there’s a particular focus such as a new build project. One option would be to create a single Training Centre for the service in the North West at Bamber Bridge.
Stage 3 – How do we get there?

Stage 3 focused on the following work streams:

- Delivery options;
- Sub-area strategies; and
- Principles for prioritisation of premises investments.

Delivery options

The means by which primary healthcare can be delivered is a key consideration for the CCGs, GPs and this estate strategy. Ultimately this strategy will help to inform bids for funding enabling the delivery of the strategy.

We consider below the options open to GPs in bringing forward new / upgraded properties and the potential funding that they may be able to access.

Options for new development / property occupation

Development is set within the parameters of the NHS Premises Costs Directions (April 2013). The onus is on the GP practice to ensure that they have everything in order. If they do not follow the directions then they could be liable for significant sums. Therefore, it will be important as opportunities arise for GPs to seek professional advice.

Primary care providers across the UK are recognising the need to work together to address the challenges facing GP practices in particular to develop organisations that can respond to emerging opportunities – this is resulting in GP federation and changing property requirements.

The following three options in table 20, as follows, are the most widely considered delivery options for bringing forward new GP properties.

Table 20 – GP property delivery options

<table>
<thead>
<tr>
<th>Owner Occupied</th>
<th>Third Party Developer</th>
<th>LIFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Built by the occupying practice(s). Capital put into the property from other sources.</td>
<td>A full repairing lease is agreed and an actual rent is applied. A Service Charge is also applied.</td>
<td>A Lease Plus Agreement (LPA) is agreed which is a fully serviced, full repairing lease including Facilities Management.</td>
</tr>
<tr>
<td>VAT not applicable</td>
<td>VAT applicable</td>
<td>VAT applicable</td>
</tr>
</tbody>
</table>

Source: BGVA

A further option is to occupy a building developed / owned by NHSPS. Consistent with initiatives being introduced more widely in central Government to improve value for money in property occupancy arrangements, the financial arrangements associated with the occupation of NHSPS owned / controlled properties are changing. This is as per the
NHS Chorley and South Ribble CCG and NHS Greater Preston CCG  
Capital development and estates strategy - Primary care

Table included in the letter from NHS England to CCGs titled ‘NHS Property Services Charging Policy 2016/17’ dated 22 January 2016 (table 21 as follows).

CCGs are advised to work with their providers to ensure that the impact of the charging regime is neutral in 2016/17 as a transition year.

We understand that the Department of Health will reimburse the additional costs for the first year, but has not said what will happen after April 2017. We understand that further information on this will be provided during June 2016.

Table 21: Changes to NHSPS property arrangements

<table>
<thead>
<tr>
<th>Description</th>
<th>15/16 Policy</th>
<th>16/17 Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freehold Rent</td>
<td>Full cost recovery</td>
<td>Market rent</td>
</tr>
<tr>
<td>Leasehold rent</td>
<td>Actual rental charge</td>
<td>Actual rental charge</td>
</tr>
<tr>
<td>Freehold management fee</td>
<td>Apportioned share of actual costs</td>
<td>None (included in market rate)</td>
</tr>
<tr>
<td>Leasehold management fee</td>
<td>Apportioned share of actual costs</td>
<td>5% (of rent) fixed charge</td>
</tr>
<tr>
<td>Service charges</td>
<td>Actual cost recovered</td>
<td>Actual cost recovered</td>
</tr>
<tr>
<td>Landlord Service charge – management fee</td>
<td>Apportioned share of actual costs</td>
<td>10% (of landlord services) fixed charge</td>
</tr>
<tr>
<td>FM Services</td>
<td>Actual costs recovered</td>
<td>FM Contracts established</td>
</tr>
<tr>
<td>Void space</td>
<td>Allocated to lead commissioner</td>
<td>Vacant space policy applies (see below)</td>
</tr>
</tbody>
</table>

Source: Letter from NHS England, 22nd January 2016

** Estates & Technology Transformation Fund (ETTF) **

In terms of funding, the main option for public sector funding of infrastructure projects is the recently re-named Estates & Technology Transformation Fund (ETTF). This was previously known as the Primary Care Transformation Fund (PCTF), and prior to that the Primary Care Infrastructure Fund (PCIF).

This is a £1 billion investment programme over four years to improve access and the range of services available in primary care, through investment in properties, technology, the workforce and support for working at scale across practices.

The ‘fund’ is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS five year forward view.

As per guidance published in May 2016, CCGs are expected to submit recommendations that will contribute to improving extended access to effective care across local services, and may include a wide range of projects, large and small, principally in support of GMS, PMS or APMS contractors. Proposals may include, but are not limited to:
i. Improvements or extensions to existing facilities used for primary medical care services;

ii. Refurbishment of unused or under-utilised premises to increase clinical capacity;

iii. Construction of new premises; for example for the co-location of practices to facilitate primary care at scale or to promote patient access to a wider range of services;

iv. Implementation of IT systems that support the development of primary care at scale and integrated working practices (for example to support integrated care models and record sharing);

v. Technology systems, which enable the delivery of a service that is paper free at the point of care (for example, through the use of integrated digital care records);

vi. Technology, which enables the public to have better access to services (for example, to enable electronic prescribing and new forms of clinical consultations via email, webcam, telephone or clinical decision support).

All CCG recommendations, whether premises or technology related, will be considered against a number of core criteria. CCGs should demonstrate how improvement in access to care is at the heart of recommendations. The core criteria are:

i. Improved access to effective care;

ii. Increased capacity for primary care services out of hospital;

iii. Commitment to a wider range of services as set out in the CCGs commissioning intentions to reduce unplanned admissions to hospital; and

iv. Increased training capacity.

The guidance states that CCGs should submit their recommendations, whether for premises or technology funding, using the secure access programme portal which would remain open until 30 June 2016.

Importantly, the guidance also states that it is not anticipated, at this stage, that a further national round of submissions will be offered as it is expected the fund will be fully committed and the pipeline fully populated following this second invitation for schemes. However, the regional NHS England teams will work with CCGs to introduce new schemes should the opportunity and funding become available.

The guidance also states that NHS England will work with the Department of Health to introduce revisions to the NHS (GMS - Premises Costs) Directions from September 2016 to fund up to 100 percent of the costs of premises developments, rather than the previous cap of 66 percent funding.

**Housing developer contributions**

There are a number of options that exist for practices to work with developers for the delivery of new primary care premises, where it is deemed that the development / the new population will create increased demand for facilities that cannot be accommodated by existing infrastructure. In order to deliver an occupied premises associated with new housing
Developments it is important that there is either an interested practice that would accommodate an extension to their registered list, or NHSE would need to procure a new contracted practice service.

The options are:

- A capital contribution by a developer to premises improvement where infrastructure is directly impacted by increased demand as a result of development;
- Identification of a site in a masterplan / site layout with a site then gifted or part gifted to a practice to bring forward their own development;
- The developer could build a shell of a building for occupation under leasehold or to gift to a practice / practices for their own fit out; or
- The developer could build a complete fitted out building for occupation under leasehold or to gift to a practice / practices for occupation.

In some past situations, the property has been gifted to a PCT and such properties are now in the ownership of NHSPS.

Traditionally, such provision was secured through Section 106 agreements as part of the planning permission granted to the developers. However, in 2010, the Community Infrastructure Levy (CIL) was introduced as a tool for local authorities to help deliver infrastructure. A CIL (usually charged to developers on a per sqm of development basis) is only chargeable if the relevant local authority has chosen to adopt a CIL.

If the CIL is adopted, that charging authority will adopt a Regulation 123 List, which sets out those projects or types of infrastructure that it intends to fund, or may fund, through the levy.

The CIL has changed the developer payment landscape by changing when councils can seek a section 106 obligation. Section 106 requirements should be sought only for those matters that are directly related to a specific site, and are not set out in a Regulation 123 list.

As the levy provides infrastructure to support the development of the wider area, section 106 planning obligations are often still considered to be necessary to enable particular impacts of development to be mitigated. To ensure that planning obligations and the levy can operate in a complementary way, and to avoid developers paying double for the same infrastructure, there are limits on the use of planning obligations.

Where the Regulation 123 list includes a generic type of infrastructure (such as education), section 106 agreements should not be sought on specific projects in that category. Site-specific contributions should only be sought where this can be justified with reference to the underpinning evidence on infrastructure planning.

There are three councils within the CCG areas which have an adopted CIL - Preston, Chorley and South Ribble. An overview of each local authority's CIL and what primary care infrastructure is included on the Regulation 123 list is provided below. Ribble Valley, Wyre and Fylde have not yet adopted a CIL Charging Schedule.

Representatives of these three councils confirmed at a meeting in November 2015 that they would not be likely to consider seeking further site specific contributions from developers of housing sites for health infrastructure, as all infrastructure needs have already been tested in terms of development viability through the independent examination of their CIL charging schedules.
Within Preston’s adopted Regulation 123 list, the following health related developments have been identified:

- New Preston Health Centre - £3.5million – 2016 – 2021;
- Extension to Ingol Health Centre - £0.5million – 2011-2021; and
- New North West Preston Health Centre - £3.5million – 2016-2026.

Chorley Council has recently updated its Regulation 123 list following representations made by BGVA on behalf of the CCGs. The new list includes:

- Local Community Health hub, Friday Street – no information on cost or dates

Chorley Council confirmed that the recent revision was intended as a ‘tidying up’ exercise rather than a full review; however it is planning a much fuller consultation exercise in the next 12 to 18 months. Chorley Council’s original Regulation 123 list included an extension to Euxton Medical Centre, and an enhancement of Eccleston Medical Centre, both of which the Council has stated have been completed.

Within South Ribble’s adopted Regulation 123 list, the following health related developments have been identified:

- New Leyland Medical Centre - £6.5million – 2016 – 2026;
- New primary care facility at Penwortham / Lostock Hall - £3.5million – 2021-2026; and
- Redevelopment and relocation of Bamber Bridge Clinic - £0.2million – 2011-2016 [this is an NHSPS property not occupied by any practice].

In due course, it will be important for the CCGs to monitor the progress of CIL and any updates planned to the Regulation 123 lists in order that the case for developer funding can be made to each council at the appropriate time (as per Friday Street).

In addition, it will be important to liaise with the councils going forward to understand when CIL monies may become available, if indeed they ever will. Just because an item of infrastructure is on a Regulation 123 list, it does not automatically mean that it will receive any funding, or the full amount of funding. In the case of ‘city deal’, it is understood that all monies received by the councils are currently being invested in highways infrastructure, therefore there is little available to be spent on health provision.

Whilst the position of the local authorities is acknowledged in that there is likely to be limited chance for contributions outside of CIL, there is nothing to stop a practice, or the CCGs on their behalf, approaching a developer to look at infrastructure delivery options or the availability of land to bring forward their own development. It may be that by providing a piece of infrastructure on site directly as part of a planning application, that a developer can take advantage of provisions within the regulations to make a ‘payment in kind’ (i.e. their requirement to pay CIL would be offset).
Sub-Area Strategies

In order to prepare a strategy for the GP estate it has been important to breakdown the vast geographical area into 9 more manageable sub areas which reflect the operation of the GP health economy and communities on the ground. The sub area boundaries are shown in purple dashed lines on the master map in appendix II.

The sub-area formulation was particularly informed by council boundaries, physical features such as major roads / rivers, practice catchment boundaries and future housing development locations. The CCGs boundaries (or the CCGs locality groups) were deliberately not used in setting the extent of the sub areas.

Some of the sub-areas can be characterised as ‘urban’ and some can be characterised as ‘rural’. Each sub area has, where required, been split into ‘locality sub areas’ and given a ‘high priority immediate action’, ‘future priority’ or ‘currently low priority’ rating, based on the need to invest to meet the future needs of the population, and in particular to cater for planned new housing. This overall sub area prioritisation is shown in table 22 as follows:

Table 22: Sub area prioritisation

<table>
<thead>
<tr>
<th>Sub area</th>
<th>Urban / rural</th>
<th>Locality sub area</th>
<th>Priority level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preston West</td>
<td>Urban</td>
<td>North &amp; West Preston</td>
<td>High priority immediate action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deepdale Road &amp; Blackpool Road</td>
<td>Future priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Central &amp; East Preston</td>
<td>Future priority</td>
</tr>
<tr>
<td>Clayton le Woods, Whittle le Woods, Buckshaw Village &amp; Euxton</td>
<td>Urban</td>
<td>Clayton le Woods &amp; Whittle le Woods</td>
<td>High priority immediate action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buckshaw Village &amp; Euxton</td>
<td>Future priority</td>
</tr>
<tr>
<td>Chorley</td>
<td>Urban</td>
<td>Central Chorley</td>
<td>High priority immediate action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coppull</td>
<td>Future priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adlington</td>
<td>Future priority</td>
</tr>
<tr>
<td>Preston East &amp; Longridge</td>
<td>Rural</td>
<td></td>
<td>High priority immediate action</td>
</tr>
<tr>
<td>Bamber Bridge, Penwortham &amp; Longton</td>
<td>Urban</td>
<td>Lostock Hall, Penwortham &amp; Kingsfold</td>
<td>Future priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bamber Bridge</td>
<td>Future priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Longton</td>
<td>Future priority</td>
</tr>
<tr>
<td>Leyland</td>
<td>Urban</td>
<td>-</td>
<td>Future priority</td>
</tr>
<tr>
<td>Great Eccleston</td>
<td>Rural</td>
<td>-</td>
<td>Currently low priority</td>
</tr>
<tr>
<td>Withnell &amp; Rural East Chorley</td>
<td>Rural</td>
<td>-</td>
<td>Currently low priority</td>
</tr>
<tr>
<td>Croston &amp; Eccleston</td>
<td>Rural</td>
<td>-</td>
<td>Currently low priority</td>
</tr>
</tbody>
</table>

Source: BGVA / CCG, May 2016
Preston West

Sub-area overview

Preston West is occupied by 25 practices (plus Penwortham St Mary’s located at UCLAN). The sub area has 26 properties in total, albeit this reduces to 24 when The Old Methodist Church replaces the three practices relocating on Deepdale Road.

11 of the properties in the area are converted houses (terraced, semi, or detached). 12 of the properties are purpose built health centres post 1980. NHSPS owns / has a headlease of 3 properties (Avenham Health Centre, Geoffrey Street Health Centre and Ingol Health Centre).

Overall the sub area serves a combined list size of 133,685 with 66.6 GPWTE, equating to 2,007 patients per GP, higher than both the national and local average.

The housing locations and the planned housing / development progress are summarised in Figure 1 below.

Figure 1: Preston West housing growth summary

Source: BGVA, May 2016

To the North West of Preston, it is anticipated that 3,206 dwellings will be built by 2026, and in the longer term, the total number of dwellings is expected to reach over 6,000. Development has already started and this area is being developed by numerous developers / housebuilders, as summarised on the plan in figure 2 as follows.
In Central Preston it is anticipated that 2,635 dwellings will be built by 2026. 1,056 of these are likely to be student housing.

In addition to the houses in the main housing development areas identified in figure 1, an additional 1,196 dwellings will be built across the sub area, leading to an overall total of 7,037 dwellings for Preston West.

If each of the dwellings generates 2.3 additional people (which is seen as a worst case scenario, especially given the number of student units planned), then the new dwellings could generate 16,185 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 149,870.

At the local average number of GPs per patient, this would equate to a requirement for 78.7 GP WTE. This is 12.1 more than the existing number of GPs.

**Sub-area practice review and strategy**

Due to the size of Preston West, we have split the sub area into 3 locality sub areas. These are shown in figure 3 as follows.
The colours in the figure indicate the following locality sub-areas:

- Red = North and West Preston;
- Green = Deepdale Road and Blackpool Road;
- Blue = Central and East Preston.

**North and West Preston**

There are six practices in the North and West Preston area, occupying seven properties, which will be heavily impacted by the large scale development of new housing – as stated above, there are 3,000 to 6,000 houses planned in North West Preston and development has started.

The closet practices are Dr. Patel at Broadway Surgery and Ingol Health Centre; Beech Drive Surgery; and Cottam Lane Surgery. Briarwood Medical Centre and Dr. Wilson’s Sharoe Green Lane branch surgery are also close by. Dr. Wilson’s Longsands Medical Centre branch surgery is also in the north of Preston.

Ingol Health Centre and Broadway Surgery have a combined list size of nearly 10,000. Ingol Health Centre is an NHS PS purpose built property that also houses LCFT, and the practice would like to expand their provision here. Discussions are ongoing with NHS PS and it is understood that separately there is a section 106 agreement with one of the developers of the North West Preston housing scheme for the expansion of Ingol Health Centre.
The NHSPS LES identifies Ingol Health Centre as an opportunity for improving quality / refurbishment and better utilisation. It is assumed that the utilisation point relates to space not used by the practice. Broadway Surgery (the main surgery) is a much smaller converted detached house with no room for expansion. The practice has recently submitted an ETTF bid.

Beech Drive Surgery is a ‘single hander’ located in an undersized converted terraced house. The practice has aspirations to expand / reconfigure but the site is constrained.

Cottam Lane Surgery houses both Park Medical Practice and Dr Nath a ‘single hander’ GP who operate with joint administration functions. Across the two practices there are nearly 16,000 patients. Park Medical Practice also has a branch surgery on New Hall Lane. The practices occupy a new purpose built GP owner occupied building with a pharmacy. There is no capacity for further expansion on site, however, Park Medical Practice is keen to work with the CCGs to understand how they may be able to cater for new residents.

Briarwood Medical Centre has approximately 6,000 patients and is located in an undersized converted detached house. The practice has submitted two ETTF bids, to support its aspiration to expand.

Dr. Wilson’s two branch surgeries contribute to servicing an overall list size of nearly 14,000. All premises are owned by third party GP(s) and purpose built buildings. The practice has put forward a case for ETTF funding to support its aspiration to develop the Flintoff Way site.

Whilst there are some large and well established practices in the North and West of Preston, the locality is not ready in terms of primary care to take the scale of new development proposed.

The need for new primary care facilities in North and West Preston has been identified by the Council - an extension to Ingol Health Centre (£0.5m) and a new North West Preston Health Centre (£3.5m). Some of the funding for this may come from the Council’s CIL, taking contributions from housing developers however, currently the majority of such funding is being directed to highways infrastructure.

A new build solution in the heart of the new housing development is clearly needed. Delivery mechanisms for this must be explored with the Council and / or developers at the earliest opportunity to ensure that there is no time lag in arrival of the new residents and suitable primary care provision being available as close by as possible.
Deepdale Road and Blackpool Road

The primary care landscape in this locality sub area has been subject to much recent change, for example by the co-location of three practices on Deepdale Road.

Ten practices are located in this part of Preston and subject to the implementation of co-location plans, they will be located in six properties in the future.

These practices are likely to cater for some of the demand from the large housing development to the North West of Preston, and for some of the approximately 1,500 homes planned in the central Preston area (including the Former Sharoe Green Hospital site but excluding the student housing sites).

ISSA Medical Centre is home to ISSA Medical Centre and St Wallburge’s Medical Practice with a combined list size of over 12,000. It was recently developed by a third party developer who acts as private landlord and who has let space to numerous private and public care providers including Virgin Care, Deepdale Dental and About Health.

Drs. Robb & Robb and Moor Park Surgery, have a combined list size of over 10,000. Their current two buildings are undersized converted terraced houses that are condition C, both are in the process of reviewing their premises.

Lytham Road Surgery has a list size of nearly 11,000 and is located in an older purpose built building that is significantly undersized. They are in the process of reviewing their current premises needs.

In addition to these plans, three practices on Deepdale Road are co-locating into the Old Methodist Church, which has been converted into a new primary care facility by a third party developer and is to be known as Guttridge Health Centre. Those relocating are three ‘single handers’ - Dr. Chakrabarti, Dr. Jha and Dr. Shahid. All three practices are relocating from converted terraced houses, two of which are significantly undersized. These practices have a combined list size of 6,198 and are very close to a planned site for 300 new homes.

The remaining three practices are Flintoff Way (Dr. Wilson’s main surgery building); St Paul’s Surgery; and Medicom – The Health Centre (Dr. Rossall).

Flintoff Way is the main surgery for Dr. Wilson and contributes to servicing an overall list size of nearly 14,000; the two branch surgeries are located further north in the Preston urban area. Flintoff Way premises are owned by third party GP(s) and is a purpose built building with a third party occupier (Redbridge Associates / Smart Dental Care). However, it is understood that they have submitted an ETTF bid redevelop their Flintoff Way site.

St Paul’s Surgery is a ‘single hander’ GP operating from a suitably sized property which is identified as purpose built but essentially is a converted residential property.

Lastly, Medicom – The Health Centre is run by Dr. Rossall - a ‘single hander’ GP, the current building is appropriately sized and purpose built, with one third party occupier (Redbridge Associates / Smart Dental Care).

It can be concluded that in this particular part of Preston, the GP practices are taking the lead in establishing their property needs and seeking to future proof their provision. It is likely that the review of their premises that they are undertaking – such as the redevelopment of Flintoff Way, will provide the required expansion space.
Central and East Preston

Central and East Preston is home to 11 practices located in 10 properties. These practices are likely to cater for some of the approximately 1,500 homes planned in the central Preston area (including the Former Sharoe Green Hospital site) and the planned student housing (approximately 1,000 units).

The furthest west of the practices is Doclands Medical Centre, which has a list size of nearly 7,000 and is currently located in a third party GP owned building, which is significantly undersized. This has led the practice to seek an alternative site at Tulketh Brow and they have achieved planning permission for a new build. They have made an ETTF bid to support a revision to their proposals.

Located in the heart of the planned student houses is the UCLAN housed medical centre, provided by Penwortham St Mary’s which has their main surgery in the Bamber Bridge, Penwortham & Longton sub area. The practice is likely to cater for the student patients that will be living in the new student accommodation (and it is assumed that UCLAN would facilitate any required property expansion).

Also located to the south west of Preston is Fishergate Hill Surgery, which has a list size of 6,000. The building is currently significantly undersized and the practice has a two stage aspirational plan.

Three practices are located in the Avenham and Frenchwood area. Park View Surgery has a list size of 5,000 and is located in a converted terraced house that is no longer suitable. At the national average of patients per GP they have theoretical capacity but the current property is likely to be a limiting factor. They are currently reviewing their premises aspirations.

Avenham Lane Practice is a ‘single hander’ with a list size of 3,000. The property is sublet from NHSPS (owned by Contour Housing) and also occupied by LCFT. There is a lack of space internally and limited car parking.

Frenchwood Surgery is again a ‘single hander,’ with a list size of 2,000. The property is a converted detached house identified as condition C. The building is old and the practice has aspirations to refurbish it.

To the east of the city centre, there are two properties located on New Hall Lane.

Closest to the city centre is the NHSPS property – Geoffrey Street Health Centre which accommodates two practices – The New Hall Lane Practice and Geoffrey Street Surgery, who have a combined list size of over 9,000. This property is adjacent to the site of 114 planned new homes.

Geoffrey Street Surgery is a ‘single hander’ practice co-located with a pharmacy and LCFT. The property, whilst old, is purpose built and was identified as condition A. The New Hall Lane Practice are reviewing their premises requirements. Consideration of the future of the practices / the Geoffrey Street Health Centre building must also ensure that the recommendation of the NHSPS LES are factored in.
Further along New Hall Lane is the branch surgery of Park Medical Practice. This property is a converted terraced house but is identified as condition A. Back office functions are provided from the Cottam Lane main surgery. The branch surgery site is not big enough and the site itself is constrained.

Beyond New Hall Lane to the far east of the sub area are two further practices located in the Ribbleton area. Ribble Valley Surgery is a ‘single hander’ with a list size of nearly 3,000 operating out of a recently constructed purpose built health centre.

Ribbleton Medical Centre has a list size of over 8,000 and is a purpose built older building, which is undersized. There are two third party occupiers – a pharmacy and PPCC Ltd.

To conclude, the east of this part of the sub-area, Doclands and Fishergate Hill will benefit from PCIF (and possibly ETTF) funding which will assist them in catering for future demand.

UCLAN are likely to be in a position to assist the student branch surgery with any required expansion plans.

In the Avenham and Frenchwood area and the New Hall Lane area, there is clear potential to consider a collaborative new build / co-location project across the three ‘single handers.’ Any co-location project would benefit from detailed discussions with NHSPS who are the owner / head leaseholder for two of the properties and there may be some opportunity to secure funding through them.

The need for new primary care facilities in central Preston has been identified by the Council - a new Preston Central Health Centre (£3.5m). Some of the funding for this may come from the council’s CIL, taking contributions from housing developers (however currently the majority of such funding is being directed to highways infrastructure). There may also be an opportunity to work with the central developers, however sites are tight and space is likely to be at a premium.

**Potential projects**

Based on the above, the following have been identified as potential projects for this sub area:

- A new build health centre in the heart of the new housing development in North West Preston;
- The extension / redevelopment of Ingol Health Centre;
- The upgrade / expansion of Briarwood Medical Centre;
- The Robb & Robb, Moor Park and Lytham Road review;
- The redevelopment of Flintoff Way;
- The relocation of Doclands;
- Ensuring UCLAN can deliver the required capacity for additional students;
- The extension of Fishergate Hill; and
- A potential collaborative project / number of projects in the Avenham and Frenchwood and New Hall Lane areas for Avenham Lane Practice, Frenchwood Surgery, Park View Surgery, The New Hall Lane Practice and Geoffrey Street Surgery, plus potentially the branch surgery of Park Medical Practice if they wish to be involved.
Opportunities for co-location

Across the Preston West sub area, there are longer term potential proposals that may provide further opportunities for GP provision, including LTHT’s locality hub proposals, one of which is likely to end up in Preston.

LCFT also closed Ribbleton Hospital in 2015 but the site is being retained for trust use. This could again be an opportunity.

LCC is also reviewing its estate requirements (albeit less than elsewhere across the two CCG areas due to the needs in Preston).

Preston Council may also have some potential disposals, which could provide opportunities for new developments – availability of land was identified by practices as a critical limiting factor when implementing their plans.

The fire and ambulance services have some form of rationalisation / relocation proposals in Preston – the fire station is not fit for purpose and the ambulance service are considering a hub near Royal Preston Hospital with LCC. All of these opportunities should be explored in further detail to understand the opportunities for primary care co-location.

Clayton Le Woods, Whittle Le Woods, Buckshaw Village & Euxton

Sub-area overview

Clayton Le Woods, Whittle Le Woods, Buckshaw Village and Euxton is occupied by five practices. The sub-area has five properties in total – one practice in each property. Four of the properties are GP owner occupied and one is an NHSPS headlease with Eric Wright Group (Buckshaw Village Health Centre).

Four of the properties in the area are purpose built – one pre-1980, and the other three post 1980. The remaining property is a converted detached house.

Overall the sub area serves a combined list size of 28,063, with 16.4 GPWTE, equating to 1,711 patients per GP, close to the national average.

The housing locations and the planned housing / development progress are summarised in figure 4 as follows.
In addition to the houses in the main housing development areas identified in figure 4, an additional 156 dwellings will be built across the sub-area, leading to an overall total of 2,051 dwellings for Clayton Le Woods, Whittle Le Woods, Buckshaw Village and Euxton.

If each of the dwellings generates 2.3 additional people, which is seen as a worst case scenario, then the new dwellings could generate 4,720 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 32,783.

At the local average number of GPs per patient, this would equate to a requirement for 17.2 GP WTE. This is 0.8 more than the existing number of GPs.

**Sub-area practice review and strategy**

We have split Clayton le Woods, Whittle le Woods, Buckshaw Village and Euxton into two locality sub areas:

- Clayton le Woods and Whittle le Woods;
- Buckshaw Village and Euxton.
Clayton le Woods and Whittle le Woods

There are three practices in the Clayton le Woods and Whittle le Woods locality sub area, where over 900 houses are expected and development proposals are all well progressed.

Clayton Brook Surgery, which has been awarded PCIF funding is condition C and will still likely be a priority for investment; and Dr Hamad, a 'single hander', whose premises are significantly undersized. At the national average of patients per GP, Clayton Brook Surgery has theoretical capacity to accommodate more patients, and it is likely that the existing property is a limiting factor in this being achieved.

A more radical solution in Clayton Brook is therefore likely to be required – the combined list size of the practices is approximately 6,500, but the location of any new property would need to be considered in relation to the specific needs of the local population.

Whittle Surgery has a large list size of nearly 10,000 and is significantly undersized and they wish to relocate. They have PCIF funding for a new build. At the national average of patients per GP, the practice has theoretical capacity to accommodate additional patients, but the existing property is a limiting factor. The nearby development proposals are well progressed but approaches could be made to the housebuilders / a wider site search exercise may be required.

Buckshaw Village and Euxton

There are two practices in this locality sub-area. Buckshaw Village has seen huge numbers of new houses developed in recent years and there remains over 950 houses yet to be developed in and around Buckshaw Village and Euxton, which are well progressed / relatively immediate.

Buckshaw Village is a new build NHSPS building, which is unlikely to be a priority for investment. Additionally, the practice have identified opportunities to improve utilisation, of the building.

Euxton Medical Centre is quite big, albeit it does require modernisation. The NHSPS LES identifies the property as part of their LES. NHSPS own the land but the practice owns the building so any exit from the site in terms of freehold ownership would be difficult to achieve. More likely, NHSPS may choose to dispose of their occupational leasehold interest, which relates to non-GP space occupied within the building (occupied by LCFT). At the national average of patients per GP, there is theoretical capacity for the practice to accommodate more patients, and it is likely that there is space in this building for this to be achieved.

Potential projects

Based on the above, the following have been identified as potential projects for this sub area:

- A collaborative solution or separate solutions for the Clayton le Woods practices;
- A new development for Whittle Surgery;
- Opportunity to improve utilisation / increase space in occupation at Buckshaw Village; and
- Opportunity to increase space in occupation at Euxton Medical Centre, if required.
Opportunities for co-location

This strategy will be shared with both our member practices and service stakeholders and opportunities for potential co-location will be explored.

Chorley

Sub-area overview

Chorley is occupied by nine practices and the sub area has eight properties in total. Each property is occupied by a single practice with the exception of Chorley Health Centre, which is occupied by two practices (a third moved out into their own premises recently).

Three of the properties in the area are purpose built health centres, four of which were built post 1980. NHSPS owns the freehold of two properties (Chorley Health Centre and Coppull Clinic).

Overall, the sub-area serves a combined list size of 62,460 with 30.0 GPWTE, equating to 2,082 patients per GP, higher than both the national and local average.

The housing locations and the planned housing / development progress are summarised in figure 5 as follows.

Figure 5: Chorley housing growth summary

In addition to the houses in the main housing development areas identified in figure 5, an
additional 509 dwellings will be built across the sub area, leading to an overall total of 2,069 dwellings for Chorley.

If each of the dwellings generates 2.3 additional people which is seen as a worst case scenario, then the new dwellings could generate 4,759 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 67,219.

At the local average number of GPs per patient, this would equate to a requirement for 35.3 GP WTE. This is 5.3 more than the existing number of GPs.

**Sub-area practice review and strategy**

We have split Chorley into three locality sub-areas:

- Central Chorley;
- Coppull;
- Adlington.

**Central Chorley**

There are six practices and around 1,200 houses planned in Central Chorley.

Two practices are located in Chorley Health Centre (Dr Baghdjian & Partner and Dr Carlos), one in Gillibrand Street (Dr Bamford & Partners), and one is Eaves Lane Surgery.

The Friday Street project is a long running proposal that has also been added to the Council’s CIL infrastructure list, which may mean some funding is made available from housebuilders in due course, and it is earmarked for ETTF funding / the subject of a current bid.

As individual properties, Gillibrand Street is a recent move for Dr Bamford & Partners (from Chorley Health Centre) so no immediate change is needed in relation to this property (albeit a recent ETTF bid has been received). The two remaining practices in Chorley Health Centre have aspirations for their premises and there is the opportunity to utilise the space vacated by Dr Bamford. This building is an NHSPS building and NHSPS LES identifies the building as a redevelopment opportunity therefore it may be that some form of funding can be accessed via them for improvements.

Eaves Lane Surgery is significantly undersized and condition C so should be a priority for investment. At the national average number of patients per GP, Eaves Lane Surgery has the theoretical capacity to accommodate additional patients, however their property is likely to be a limiting factor.

Also in Central Chorley is Regent House Surgery (list size of 8,000 and significantly undersized, although condition A). This has PCIF but only for access alterations. This is likely to be a priority for investment as they have aspirations to extend. At the national average number of patients per GP, the practice has the theoretical capacity to accommodate over 1,050 additional patients. Expanding the premises is likely to help improve this ratio.

Lastly, in Central Chorley there is Library House Surgery (list size of 16,500 and significantly
undersized, although condition A). This has PCIF funding for significant reconfiguration. The practice accommodates significantly more patients per GP than other practices in a comparatively small building and therefore it should be a priority for investment.

**Coppull**

There is one practice in Coppull - Coppull Medical Practice, and nearly 200 houses are planned – one large site of over 100 where development is already on site and several smaller ones. (There is also a site of approximately 350 homes, which is to the north east, removed from Coppull but which could be served to some extent by the Coppull practice).

The practice has a list size of approximately 7,800 and the property is NHSPS owned and undersized, it is condition B and the practice are in the process of defining their aspirations. To support this, the practice has submitted an ETTF bid.

Into the future these works are likely to be required to address building capacity considerations.

**Adlington**

There are two practices in Adlington, and around 200 houses planned, the majority of which are well progressed through the planning process. (Adlington may also to an extent serve some of the development to the south east of Chorley.)

Granville House has a list size of approximately 8,000 and is very close to the new build houses. The property is condition A, albeit undersized.

Adlington Medical Centre has a list size of under 2,000, and the property is condition C, one option could be to move the practice into the nearby Adlington Health Centre (an NHSPS property with no GP currently in occupation). If this is to be achieved, there may be a need for infrastructure upgrades at the Health Centre, which could potentially be achieved via NHSPS funding options (the NHSPS LES makes no recommendations about this property). At the national average or patients per GP, the practice has a theoretical capacity of over 300 additional patients, however the current property is likely to be a limiting factor.

**Potential projects**

Based on the above, the following have been identified as potential projects for this sub area:

- The redevelopment of Chorley Health Centre;
- The delivery of the Friday Street project (which will be dependent on identifying whether GP practices still have a relocation requirement as due to the delays in delivery they are identifying alternative arrangements; and may override the need for other potential projects in this list);
- The upgrade of Dr Bamford & Partners (Gillibrand Street);
- The upgrade of Eaves Lane Surgery;
- The upgrade of Regent House Surgery;
- The upgrade of Library House Surgery;
- The upgrade of Coppull Medical Practice; and
- A solution for Adlington Medical Centre.
Opportunities for co-location

Alongside Friday Street (with LCFT), there are longer term potential proposals that may provide further opportunities for GP provision, including LTHT’s locality hub proposals.

There is also a possible longer term option of utilising space near to Dr Bamford’s new property on Gillibrand Street (the Council also owns 19-23 Gillibrand Street). There could also be opportunities to work with the emergency services on relocation or co-location projects.
Preston East and Longridge

Sub-area overview

Preston East and Longridge is occupied by two practices. The sub-area has two properties in total – one practice in each property. Both properties are GP owner occupied and are purpose built health centres built post 1980.

Overall the sub area serves a combined list size of 17,383, with 10.0 GPWTE, equating to 1,738 patients per GP, close to the national average.

The housing locations and the planned housing / development progress are summarised in figure 6 as follows.

Figure 6: Preston East and Longridge housing growth summary

In addition to the houses in the main housing development areas identified in figure 6, an additional 631 dwellings will be built across the sub area, leading to an overall total of 1,950 dwellings for Preston East and Longridge. This picks up a large number of dwellings planned for smaller sites in rural locations. It should also be noted that Ribble Valley’s local plan is under development and this could lead to further sites being allocated for development.

If each of the dwellings generates 2.3 additional people, which is seen as a worst case scenario, then the new dwellings could generate 4,485 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 21,868.

At the local average number of GPs per patient, this would equate to a requirement for 11.5 GP WTE. This is 1.5 more than the existing number of GPs.
Sub-area practice review and strategy

There are two practices in this sub-area, both based in the centre of Longridge – Berry Lane Medical Centre and Stonebridge Surgery. They are both large practices with a combined list size of over 17,000.

Both are significantly undersized and have aspirations to expand / reconfigure. Stonebridge Surgery is relatively constrained but could convert some loft space. At the national average of patients per GP, Stonebridge has the theoretical capacity to accommodate more patients, however the current property is a limiting factor. An ETTF bid has been submitted for reconfiguration and remodelling of the premises. There would be an associated need for a temporary relocation to Longridge hospital during the works.

Berry Lane Medical Centre has also submitted an ETTF bid to expand their practice, and some investment in these expansion options is likely to be required relatively quickly to assist these practices in catering for the needs of the residents of the new housing.

A longer term option could be to look at consolidating primary care provision into a single hub building, however, this is dependent upon both practices agreement.

NHSPS also owns Longridge Community Hospital, so there may be some opportunity for provision there in the future, and there may be some opportunity to work with the developers of the major sites, however, the developments are well progressed so this is likely to be limited.

Also, the proposed Medicom ‘hub’ at Grimsargh should also be considered as this may well reduce the pressure on the Longridge surgeries and accommodate some of the patients from the new developments, in particular, from the Whittingham Hospital developmentsite.

Potential projects

Based on the above, the following have been identified as potential projects for this sub area:

- Upgrade to Stonebridge and Berry Lane Surgeries; and exploration of potential option for a single hub (maybe utilising Longridge Community Hospital).
Bamber Bridge, Penwortham and Longton

Sub-area overview

Bamber Bridge, Penwortham and Longton straddles the two CCG boundaries and is occupied by 12 practices and the sub-area has 12 properties in total. Each property is occupied by a single practice.

Nine of the properties are GP owner occupied and two are in the freehold ownership of NHSPS (Longton Health Centre and Penwortham Health Centre) Eight of the properties in the area are purpose built health centres, five of which were built post 1980. Three of the properties are converted houses.

Overall the sub area serves a combined list size of 81,809 with 45.9 GPWTE, equating to 1,782 patients per GP, close to the national average.

The housing locations and the planned housing / development progress are summarised in figure 7 below.

Figure 7: Bamber Bridge, Penwortham and Longton housing growth summary

In addition to the houses in the main housing development areas identified in figure 7, an additional 735 dwellings will be built across the sub area, leading to an overall total of 3,616 dwellings for Bamber Bridge, Penwortham and Longton.
If each of the dwellings generates 2.3 additional people which is seen as a worst case scenario, then the new dwellings could generate 8,317 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 90,126.

At the local average number of GPs per patient, this would equate to a requirement for 47.3 GP WTE. This is 1.4 more than the existing number of GPs.

**Sub area practice review and strategy**

We have split Bamber Bridge, Penwortham and Longton into 3 locality sub-areas:

- Lostock Hall, Penwortham and Kingsfold;
- Bamber Bridge;
- Longton.

**Lostock Hall, Penwortham and Kingsfold**

There are three practices in Lostock Hall, two in Penwortham and one in Kingsfold (two in Chorley and South Ribble, one in Greater Preston, however these practices need to be considered collectively).

These practices will need to cater for the 2,000+ houses planned at Pickerings Farm.

Lostock Hall has three practices which are close to a large number of the houses – two of these are ‘single handers’ (Village Surgery and Medicare Unit Surgery), both of whom are in undersized properties.

The other practice has a relatively small list size of just under 4,000 (Lostock Hall Medical Centre) and is in an undersized property with aspirations to refurbish. Since our data collection, they have submitted an ETTF bid for a two storey rear extension to accommodate two further consulting rooms, a lift and additional services.

At the national average of patients per GP, the Village Surgery and Lostock Hall Medical Centre have theoretical capacity to accommodate additional patients, but the properties are likely to be a limiting factor to achieving this.

The Lostock Hall practices are unlikely to be able to cope with the potential patient influx and significant infrastructure change is likely to be required. The ETTF expansion proposed at Lostock Hall Medical Centre will help but will probably not go far enough to address future capacity issues.

Kingsfold Medical Centre is also very close to the planned new houses. The practice has a list size of 4,000 and the property is undersized. Again, infrastructure provision is required to cater for the future patient influx.
Penwortham has two practices – both with large list sizes. These practices are further away from the new housing to the south of the river but may be required to cater for the additional patient demand.

Penwortham St Mary’s has a list size of over 16,000 and operates from two buildings – one in Penwortham, owned by NHSPS (collocated with LCFT) and one in UCLAN to the north of the river (in the Preston West sub area). The practice does not have enough space and would like to expand at their main surgery, however this would require investment from NHSPS whose LES identifies Penwortham Health Centre as an opportunity for improving quality / refurbishment and better utilisation.

St Fillan’s Medical Centre has a list size of nearly 9,000 and is in an old, significantly undersized building. They have aspirations to refurbish, and possibly increase clinical space in the future. It is understood that PCIF funding has been agreed for refurbishment and extra clinical rooms.

The need for a new primary care facility in Lostock Hall / Penwortham has been identified by the Council (£3.5m) and some of the funding for this may come from the Council’s CIL, taking contributions from housing developers, however, currently the majority of such funding is being directed to highways infrastructure.

**Bamber Bridge**

Bamber Bridge has two practices – the Ryan Medical Centre and Roslea Surgery, which will serve the planned 500+ dwellings.

Without infrastructure improvements in Lostock Hall and Kingsfold, these practices could see increased patient numbers from the further 2,000 houses coming forward there.

The Ryan Medical Centre has a list size of 10,500 and is significantly undersized. The surgery has aspirations to expand and has PCIF funding agreed for additional clinical space and a new reception. At the national average of patients per GP, the practice has theoretical capacity to accommodate additional patients. The property as it currently stands is likely to be a limiting factor to achieving this.

Roslea Surgery has a list size of 8,500, and is not in a suitable property – it is a converted house and is condition C. It is significantly undersized.

A long term infrastructure solution for Bamber Bridge needs to be found, which could entail the relocation of Roslea and possibly the Ryan Medical Centre, possibly as part of the planned new housing development.

Near Bamber Bridge is Riverside Medical Centre in Walton-le-Dale. This has a large list size of over 11,000 and is significantly undersized. It is possible, particularly if Lostock Hall and Bamber Bridge upgrades do not take place, that this practice will have an influx of new patients. The building is undersized and infrastructure upgrades are likely to be necessary. There are a number of smaller housing sites in Coupe Green and Higher Walton that may also have patients that will travel to Walton-le-Dale.
Longton

Longton has two practices and New Longton has one practice. There is one large agglomeration of planned houses in Longton (200 houses), and multiple smaller sites scattered across the villages.

Two of the three practices are small with list sizes of around 1,500. Beeches Medical Centre (a ‘single hander’) has a building of about the right size. New Longton Surgery is undersized and has aspirations to expand / reconfigure. At the national average of patients per GP, the practice has theoretical capacity to accommodate patients, but the property is likely to be a limiting factor on the capacity of the GPs to treat patients.

The largest practice in Longton is Longton Health Centre (11,000 list size). This is an older NHSPS property that has some empty rooms that could be occupied by the practice that has aspirations to expand / reconfigure. The practice has secured PCIF funding to assist with the modernisation of former LCFT rooms to enable expansion. Such infrastructure upgrades are likely to be necessary given the amount of new development in this sub area. No specific plans are identified for the property in the NHSPS LES.

Possible projects

Based on the above, the following have been identified as possible projects for this sub area:

- New build premises for the Lostock Hall practices, with an extension to Lostock Hall Medical Centre in the interim;
- Upgrade to Kingsfold Medical Centre, or possible involvement in Lostock Hall newbuild;
- Upgrade to Penwortham Health Centre;
- Upgrade to St Fillan’s Medical Centre;
- Upgrade to The Ryan Medical Centre;
- A solution for Roslea Surgery, possibly co-location with The Ryan Medical Centre on a new site in the longer term;
- Upgrade to Riverside Medical Centre;
- Possible extension to New Longton Surgery; and
- Upgrade to Longton Health Centre.

Opportunities for co-location

LCC are reviewing their estate requirements and this may provide opportunities for GP redevelopment sites and / or for co-location of relocating services.

In terms of the emergency services, the Police HQ site at Hutton and the Lindle Lane site are not located in proximity to the proposed new housing so are unlikely to be potential sites for new GP buildings. The Bamber Bridge Police Station is identified as underutilised, and this could be a co-location opportunity.
Leyland

Sub-area overview

Leyland is occupied by six practices. The sub-area has six properties in total – one practice in each property. Four, and soon to be five of the properties, are GP owner occupied and the same five are purpose built health centres – three were built post 1980.

Overall the sub area serves a combined list size of 40,362, with 21.3 GPWTE, equating to 1,895 patients per GP, close to the local average.

The housing locations and the planned housing / development progress are summarised in figure 8 as follows.

Figure 8: Leyland housing growth summary

In addition to the houses in the main housing development area identified in figure 8, an additional 179 dwellings will be built across the sub area, leading to an overall total of 2,897 dwellings for Leyland.

If each of the dwellings generates 2.3 additional people (which is seen as a worst case scenario), then the new dwellings could generate 6,663 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 47,025.

At the local average number of GPs per patient, this would equate to a requirement for 24.7 GP WTE. This is 3.4 more than the existing number of GPs.
Sub-area practice review and strategy

There are six practices in this sub-area, and all are likely to be affected by new housing.

Longer term proposals for Leyland are the provision of a co-located practice building for most / all of the Leyland practices off West Paddock (council land) – at a cost of £6.5m. Some of the funding for this may come from the Council’s CIL, taking contributions from housing developers, however, currently the majority of such funding is being directed to highways infrastructure.

As individual practices, Station Surgery is closest to some of the new houses and the property is well sized, however the GP is a ‘single hander’ and the property is condition C. This is therefore likely to require modernisation.

Central Park Surgery is also close to some of the new houses, and is undersized. They have aspirations to expand supported by a PCIF bid.

Leyland Surgery is condition A but is an older property and the practice has aspirations to expand / reconfigure. At the national average of patients per GP, Leyland Surgery has theoretical capacity to accommodate additional patients, but it is likely that the current status of the property is a limitation to achieving this. It is understood that an ETTF bid has been received to support their premises aspirations.

Worden Medical Centre has a large list size (nearly 13,000) and is significantly undersized – they have submitted an ETTF bid to support their premises aspirations.

Sandy Lane also has a large list size (11,500) and is significantly undersized. They have aspirations to expand / reconfigure.

Moss Side is undersized and has aspirations to expand / reconfigure. The practice has PCIF funding to improve the building.

Further infrastructure investment within this sub-area may be required.

Potential projects

Based on the above, the following have been identified as potential projects for this sub area:

- Single co-located hub building for all practices in Leyland;
- If the above project is not deliverable, then each individual surgery in the area will require some form of upgrade or expansion. Moss Side and Central Park PCIF projects and the Leyland Surgery and Worden Medical Centre ETTF projects should be pursued.
Opportunities for co-location

Alongside the aspirational co-location project, there are wider potential proposals that may provide further opportunities for GP provision / relocation. There are a number of NHSPS properties in this sub-area not currently occupied by GPs. Whilst a number are office buildings, there could be an opportunity to diversify uses. There is also a proposal to redevelop Leyland Clinic, which could again be an opportunity for GP provision.

The council’s review of its property assets could also lead to further development site options or co-location opportunities.

There are limited plans for change amongst the emergency services.

Great Eccleston

Sub-area overview

Great Eccleston is occupied by one practice. The sub-area has one property in total occupied by the practice. The property is a purpose built health centre, albeit pre-1980.

The practice serves a list size of 7,437, with 4.0 GPWTE, equating to 1,859 patients per GP, close to the local average.

The housing locations and the planned housing / development progress are summarised in figure 9 as follows.
It is understood that currently this is the only housing development planned for those parts of Wyre and Fylde that are served by the practice. However, the Wyre and Fylde local plans are under development and this could lead to further sites being allocated for development.

If each of the dwellings generates 2.3 additional people, which is seen as a worst case scenario, then the new dwellings could generate 437 new patients. Added to the current list sizes across the sub area, the total number of patients would equate to 7,874.

At the local average number of GPs per patient, this would equate to a requirement for 4.1 GP WTE. This is 0.1 more than the existing number of GPs.

**Sub-area practice review and strategy**

As stated above, there is only one practice in this sub-area – Great Eccleston Health Centre.

The Health Centre is located in Wyre Council’s area and the surgery is outside of the CCG boundary (as per National Health Service England (NHSE) website). Due to the size of the catchment area, which is extensive, the CCGs have identified those settlements where the development of any housing is likely to impact on the surgery (in both Wyre and Fylde). The settlements are: Elswick; Great Eccleston; Hambleton; Inskip; Roseacre; Singleton; St Michaels; Treales; Weeton; and Wharles.

The 90 or so houses planned will be constructed in Great Eccleston itself.

The surgery is undersized and there is no room for expansion on the current site. The main difficulty is finding a suitable site for relocation. Subsequent to our data collection, an ETTF bid has been submitted for a new purpose build, turnkey operation funded by approval of notional rent.
This sub-area has limited additional houses planned and it is hard to justify significant investment here over other much more pressured locations. However, assistance should still be provided to the practice as far as possible to help them achieve their relocation aims.

**Potential projects**

Based on the above, the following have been identified as potential projects for this sub-area:

- Relocation of Great Eccleston Health Centre.

**Opportunities for co-location**

No opportunities for co-location or public sector disposals have been identified in the Great Eccleston sub area.

**Withnell and Rural East Chorley**

**Sub-area overview**

Withnell and Rural East Chorley is occupied by one practice. The sub-area has one property in total occupied by the practice. The property is owned freehold by NHSPS (Withnell Health Centre) and is a purpose built health centre, albeit pre-1980.

The practice serves a list size of 5,322, with 2.4 GPWTE, equating to 2,218 patients per GP, higher than the local average.

The housing locations and the planned housing / development progress are summarised in figure 10 as follows.
The figure above shows that there are no housing development sites over 90 dwellings in this sub area. We understand that across smaller sites a total of 89 dwellings are planned.

If each of the dwellings generates 2.3 additional people, which is seen as a worst case scenario, then the new dwellings could generate 205 new patients. Added to the current list size of the practice, the total number of patients would equate to 5,527.

At the local average number of GPs per patient, this would equate to a requirement for 2.9 GP WTE. This is 0.5 more than the existing number of GPs.

**Sub-area practice review and strategy**

As stated above, there is only one practice in this sub-area – Withnell Health Centre.

The surgery has aspirations to expand / reconfigure and is an older building. In new build standards it is adequately sized and NHSPS identifies the opportunity to improve utilisation at the property. There may be some opportunity to access funding from NHSPS for the required upgrades.

This area is not close to any significant new housing development and is therefore unlikely to be a priority for investment for the CCGs - it is hard to justify significant investment here over other much more pressured locations.
Potential projects

Based on the above, the following have been identified as potential projects for this sub-area:

- Upgrade of Withnell Health Centre.

Opportunities for co-location

No opportunities for co-location or public sector disposals have been identified in the Withnell and Rural East Chorley sub-area.

Croston and Eccleston

Sub-area overview

Croston & Eccleston is occupied by three practices. The sub-area has three properties in total – each practice occupies a property, and one of the properties (Eccleston Health Centre) also provides part time branch surgery space for the other two.

All three properties are identified as purpose built health centres, post 1980. Eccleston Health Centre is a new build with the freehold owned by NHSPS. The other two properties are GP owner occupied.

Overall the sub-area serves a combined list size of 11,538, with 5.1 GPWTE, equating to 2,262 patients per GP, higher than the local average.

The housing locations and the planned housing / development progress are summarised in figure 11 as follows.
The figure above shows that there are no housing development sites over 90 dwellings in this sub-area. We understand that across smaller sites a total of 261 dwellings are planned.

If each of the dwellings generates 2.3 additional people, which is seen as a worst case scenario, then the new dwellings could generate 600 new patients. Added to the current list size of the practice, the total number of patients would equate to 12,138.

At the local average number of GPs per patient, this would equate to a requirement for 6.4 GP WTE. This is 1.3 more than the existing number of GPs.

**Sub-area practice review and strategy**

As stated above, there are three practices in this sub-area – two are located in Croston and one is located in Eccleston.

The Eccleston practice is a new NHSPS building and it is concluded that any future expansion needs can be accommodated within that building working with NHSPS. There are no specific recommendations regarding this property in the NHSPS LES.

Each of the Croston practices as individual practices are in undersized buildings. However, the two Croston practices have under-utilised space in the Eccleston Health Centre, which could cater for further clinics if needed. An ETTF bid has been received from Croston Village Surgery (Dr Ahmad).

This sub-area has limited additional houses planned and it is hard to justify significant investment here over other much more pressured locations.
Potential projects

Based on the above, the following have been identified as potential projects for this sub-area:

- Croston surgeries – upgrade of the individual properties or a new build.

Opportunities for co-location

No opportunities for co-location or public sector disposals have been identified in the Croston and Eccleston sub-area.

Principles for prioritisation of premises investments

In tandem with the sub area strategies, the CCGs have developed a series of principles to assist them in their prioritisation of projects where funding is required to upgrade the GP estate. These are based on their clinical objectives and are set out in table 23 as follows. Each scheme will be rated as red, green or amber against each of the principles and a weighted score will be applied.

The principles can be reviewed annually to reflect changing priorities, and practices will be offered guidance as to the application process and investment principles. This process may need further refinement as necessary in light of any new premises directions from NHS England.

Once an application has been received, it will be assessed against the principles by members of the CCGs estates / support team. Applications for premises investments will be tabled at the Delegated Commissioning Committee alongside the supporting assessment scores. This will be produced as a ranking of schemes using a comparison table. It must be noted that the tool is a framework to support decision making, and it is not the only factor taken into account under delegated commissioning arrangements.

The scoring and ranking of schemes alone will not determine which investments should be approved. The Delegated Commissioning Committee will determine the timing and size of any investments to be made by the CCGs.
### Delivers value for money (benchmarking of £/rental/capita)

<table>
<thead>
<tr>
<th>Score</th>
<th>Rating</th>
<th>Assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Anticipated rental costs are in excess of the upper level £/m² recommended by the DV for the type of planned development</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Anticipated rental costs is lower than the upper level £/m² recommended by the DV for the type of planned development</td>
</tr>
</tbody>
</table>

### Prioritises greatest population need (as identified by the CCGs’ estates strategy)

<table>
<thead>
<tr>
<th>Score</th>
<th>Rating</th>
<th>Assessment categories</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td>Locality identified by estates strategy as being in a ‘currently low priority’ area</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Locality identified by estates strategy as being in a ‘future priority’ area</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Locality identified by estates strategy as being in a ‘high priority immediate action’ area</td>
</tr>
</tbody>
</table>

### Strategic Fit with Our Health, Our Care (as assessed against the following criteria)

#### Enables delivery of additional services

<table>
<thead>
<tr>
<th>Score</th>
<th>Rating</th>
<th>Assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td>Will not enable additional service delivery</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Enables delivery of level 2 services by practices for their own registered patients, where they were previously unable to provide these</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Enables delivery of a wide range of services in the locality, for patients registered with other practices</td>
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</table>

#### Enables delivery of 7 day access

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<thead>
<tr>
<th>Score</th>
<th>Rating</th>
<th>Assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td>No difference anticipated in 7 day working</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Enables the practice(s) to provide 7 day access, where this was not previously possible</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Enables the practice(s) to provide 7 day access, for patients registered with other practices</td>
</tr>
</tbody>
</table>

#### Enhances collaboration between practices and partner organisations

<table>
<thead>
<tr>
<th>Score</th>
<th>Rating</th>
<th>Assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td>Application is made in isolation by a single provider, with no clear collaborative approach</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Application is made and enables collaborative working with more than one provider</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Application is made collaboratively on behalf of more than one practice</td>
</tr>
</tbody>
</table>

#### Improves capacity for workforce development

<table>
<thead>
<tr>
<th>Score</th>
<th>Rating</th>
<th>Assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td>No significant improvements anticipated in workforce development capability</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Enables significant enhancement to existing practice workforce development programmes including GP training and other staff development initiatives</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Enables the practice(s) to commence GP training provision, or act as a key enabler of other CCG workforce initiatives e.g. leading on clinical pharmacist pilot or co-ordinating advanced nurse practitioner</td>
</tr>
</tbody>
</table>

Source: CCG, May 2016
Conclusions and recommendations

Strategy summary

Stage 1 included a detailed review of the existing primary care estate. This showed that the estate is very varied, with some practices providing services from modern new build premises, and some providing services from older converted houses that are no longer fit for purpose.

The estate is in a mix of ownerships, although the majority are GP owner occupied. The majority of the properties have a single GP resident (90%) and have no other third parties in occupation (69%).

There is a wide range of list sizes and number of GP WTE across the practices, that vary greatly. Property constraints are likely to be a limitation on the efficiency of this ratio and also the ability of practices to offer trainee GP posts.

Some practices are 'single handers' who are close to retirement, therefore there is a question as to what will happen to those practices and how will infrastructure upgrades that are required be delivered in future.

The majority of practices have some sort of aspirations for change to their properties (77%) with a lack of space within which to operate identified as a key issue. Funding, availability of sites and property ownership are identified as key constraints to achieving property aspirations. The current costs of buying into practices for new GPs were also identified as too high and / or GPs no longer want to take a property owning partnership role.

Stage 2 reviewed the CCGs Five Year Strategic Plan which seeks delivery of:

- Improved access to primary care;
- Improved overall patient experience of primary care;
- Improved health outcomes for patients;
- Improved quality of clinical patient centered care in General Practice with emphasis on multi-disciplinary approaches to the care and management of the patient;
- Reduction in the inappropriate use of expensive secondary care resources;
- Multi-disciplinary teams in place to manage patient care; and
- Community assets routinely used in the provision of primary care services.

In stage 2 a detailed understanding of the future housing growth locations across the CCG areas was also developed, alongside a review of public sector co-location opportunities.

Stage 3 reviewed delivery options for infrastructure, including for new build premises, the ETTF and housing developer contributions. Stage 3 also defined a series of sub-areas and smaller locality sub-areas and then set out detailed sub-area profiles / strategies. Table 24 as follows summarises the conclusions.

Stage 3 concluded with an explanation of the draft principles that the CCGs have developed to assist in their prioritisation of projects where funding is required to upgrade the GP estate. This will also assist the CCGs in complying with the latest ETTF guidance document when recommending schemes for investment to NHS England.
Next steps

The following are recommended as ‘next steps’ to facilitate the implementation of this strategy:

- In light of the strategy identified, and the likely lack of further rounds of funding under the ETTF to ensure as many infrastructure projects as possible have the potential for some public sector capital;

- Develop specific delivery plans for each of the potential projects identified in table 24. Clearly some projects are more significant / longer term than other proposals, and some are shorter term / meeting current requirements for infrastructure upgrades. Some will require significant facilitation / optioneering working with the practices involved, and others will simply require CCGs support and scrutiny where required;

- As part of the above, the CCGs should present this strategy to the local councils and seek more detailed engagement on the delivery of specific infrastructure projects, for example, the delivery of a new health centre for North West Preston;

- The CCGs should take a lead in setting up the Local Estates Forum under the NHS England guidance associated with the development of local estates strategies. In particular, engagement should be developed with local health economy partners and LCC to better understand future co-location opportunities / site rationalisation plans in the context of this strategy;

- The CCGs should also consider guidance / training for practices as to their delivery options – this could be through developing written guidance, running workshops etc. It could also be useful to run a specific delivery workshop with the CCGs SMT to discuss / agree options for infrastructure delivery / how more complex projects could be brought forward and funded; and

- The CCGs should build on the relationships established during the preparation of this strategy to foster better communication with local councils to ensure that the CCGs are always aware of planning applications and given the opportunity to comment; and similarly so that the CCGs have the chance to contribute to the development and update of CIL Regulation 123 lists to maximise the chance of securing developer funding for healthcare infrastructure.
Appendix I: GP master list

Available on request
Appendix II: master map

Available on request