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Bridgend Local Health Board

An Integrated Healthcare Strategy for Primary Care Premises

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1.0 Executive Summary

1.1 This report summarises the Bridgend Local Health Board's (the LHB) strategic proposals for the redevelopment of the estate from which primary care services are provided to the 146,000 people who currently use them. It outlines changes to the make up of the estate based on the evolution of a new model of service over the next decade.

1.2 To develop this strategy the LHB has worked with the support of management consultants to answer three key questions:

- **Where are we now?** This describes and quantifies the baseline from which change will take place. The baseline outlines the main geographic and demographic characteristics of the area that the LHB serves, identifies and assesses the performance of the main premises that comprise the current estate and describes and assesses the model used to organise the delivery of current day services.
- **Where do we want to be?** This has enabled the LHB and its partners to develop a vision for future service delivery and premises quality that outlines where it wants to improve on the situation described in its planning baseline and how it wants these improvements to benefit patients, the general public and staff and independent contractors providing services.
- **How do we get there?** This has led the LHB, its partners and a wide range of stakeholders to consider different options for organising the delivery of services in the future and to choose a preferred option based on its expected performance in terms of delivering non-financial benefits, providing value for money and minimising risk. Answering this question has enabled them to develop the concept of a new model of service into costed proposals for new premises that are more suited to that model.

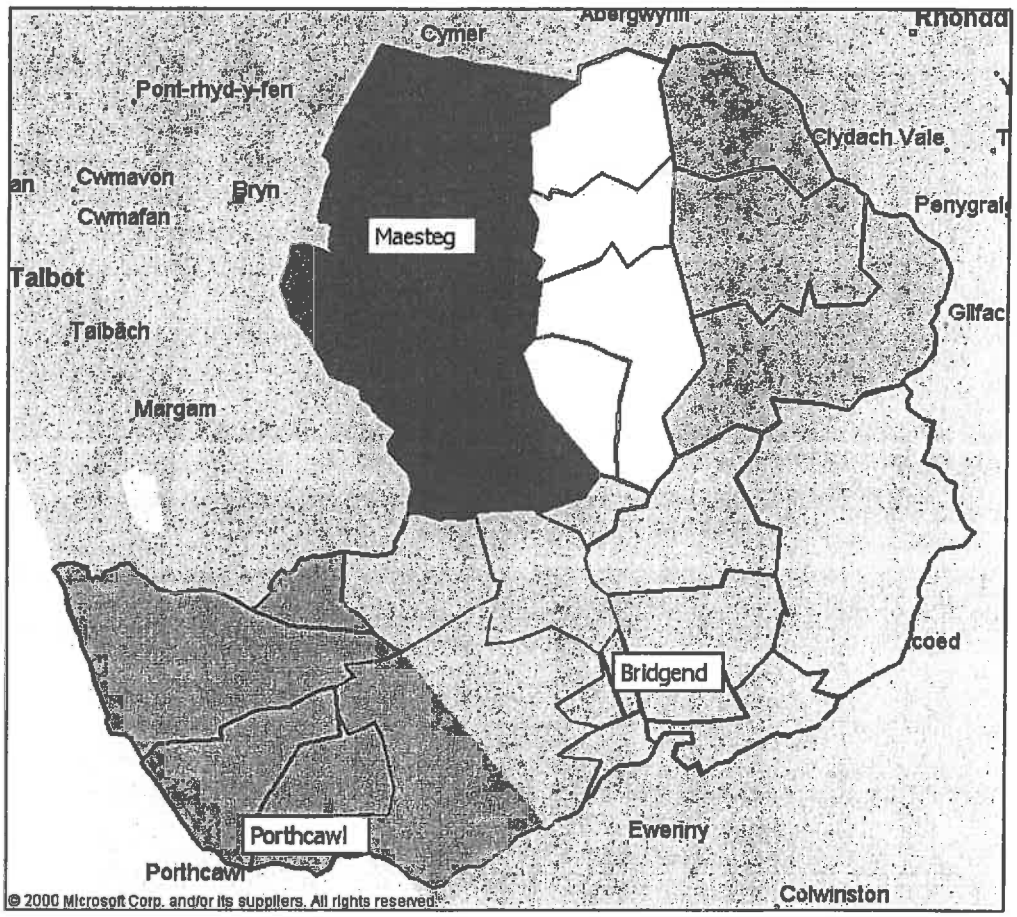
1.3 The approach to this work has been:

- **Evidence based**, using robust data to quantify and benchmark local characteristics and estate performance. This has included data from local authority population analyses, data from the Office of National Statistics, records and planning documents of the LHB and the Bro Morgannwg NHS Trust and the review of primary care premises in Wales commissioned by Welsh Health Estates.
- **Inclusive** by engaging a wide range of stakeholders in the subjective processes of assessing the current performance of services and their strategic fit, visioning the future in terms of targets for change and the non-financial benefits expected from it, identifying and evaluating different ways of organising the delivery of services in the future.

- **Innovative** by raising awareness of factors that are requiring health and social care services to change to meet the challenges of modern society, including emerging good practice, peoples' expectations, advancing technology and changes in the law.

1.4 The strategic proposals for service change and subsequent estate investment contained in this report have been significantly influenced by an understanding that the LHB area (coterminous with the boundary of Bridgend County Borough) is split into five localities. They are defined more or less by natural geographical features and reinforced by the transport network radiating from Bridgend town that is the natural consequence of that geography. The following map identifies these localities as:

- The Llynfi Valley (Black on the following map)
- The Garw Valley (White)
- The Ogmore Valley (Medium grey)
- The Porthcawl/Cornelly/Kenfig Hill coastal area (Dark grey)
- The Bridgend/Pencoed area between the coast and the valleys. (Light grey)



1.5 The geography of the valleys acts as an insurmountable barrier to transport between them over most of their length. The coastal area communities naturally look to Porthcawl. The communities in the area between the valleys and the coast naturally look to Bridgend town as the main population centre. Maesteg, Pontycymmer and Ogmore Vale are the natural centres for the Llynfi, the Garw and the Ogmore Valleys respectively.

1.6 The other features that have affected thinking about the way that services should be delivered in the future and how this should be supported by appropriate premises have included:

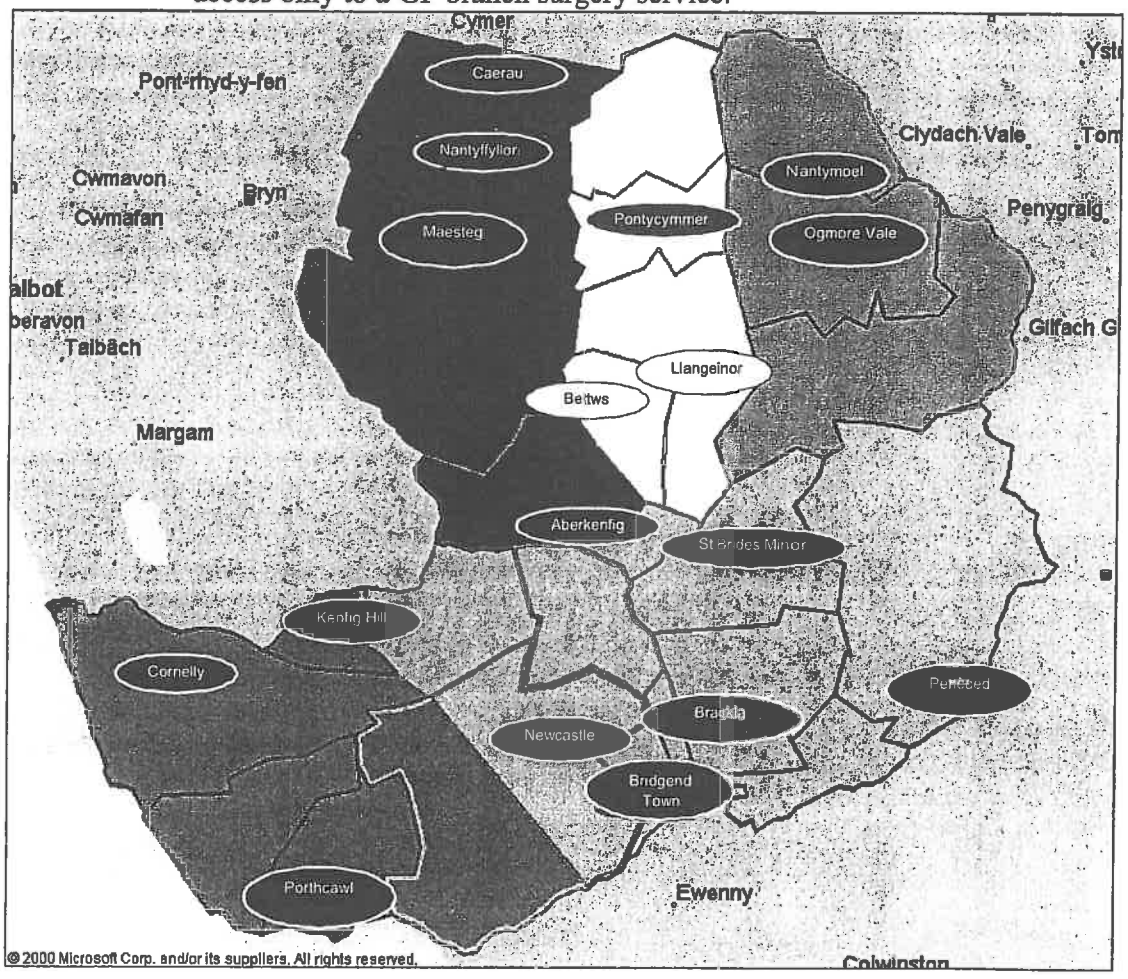
- Expected growth in the size of the population, especially in the number of older people and in communities to the west, north and east of Bridgend town.
- Higher rates of live births per 1,000 population.
- Higher numbers of low birth weight babies.
- A higher infant mortality rate.
- A standardised mortality rate for all causes for males which is high, 33 per cent above the national rate.
- A standardised mortality rate for all causes for women which is low; 20 per cent below the national rate.
- Poor performance against most indicators of positive lifestyle behaviour. A lower proportion of people living in Bridgend County Borough eat adequate amounts of fruit or vegetables in their diet than in Wales as a whole. The same is true for negative lifestyle factors. Bridgend County Borough has higher rates than Wales as a whole for people who smoke, drink alcohol above sensible limits and are obese.
- The sparsely populated nature of most areas of the County Borough with twenty one out of twenty eight of the electoral divisions in the County Borough having population densities of less than 10 people per hectare.
- Concentrations of children in specific areas within the County Borough such as Bettws, Llangeinor and Brackla. Similar concentrations of older people in and around Porthcawl town.
- High levels of deprivation in the more remote areas of the three valleys with implications for raised levels of health need combined with difficulties accessing services.

1.7 Generally stakeholders involved in the process were aware of the delivery of services in Bridgend being organised along traditional lines with:

- General practice services being provided mainly from GP owner occupied premises that provide, in some cases, limited community health services but no wider primary care services.

- Community Health Services being provided from clinics and health centres that are not used in the main to provide general practice services or any other primary care services.
- Little or no provision within general practice and community health services premises for secondary health services, social care services or other services related to health.
- Generally separate provision of accommodation for independent contractors providing general dental services, optometry services and pharmacy services.

1.8 The following map identifies the communities where existing services were based at the time of the review. In the communities represented by a black symbol on the map there is a cluster of nearby premises from which a range of providers (e.g. a GP practice, the Bro Morgannwg NHS Trust, independent contractors) separately provide services. The white symbols represent communities that have local access only to a GP branch surgery service.



1.9 The development of the strategy took into account that the 75 whole time equivalent general practitioners in the County Borough have an

average list size of 1950 compared to the all Wales average of 1700. The numbers of patients on GP lists ranges between 1527 and 2630.

1.10 Based on the estate surveys commissioned by Welsh Health Estates, the estate used by GPs in Bridgend LHB ranks 13th out of 22, where the LHB ranked 1st has the lowest cost per square metre to bring the estate to an acceptable standard in respect of its physical condition, statutory compliance and environmental management.

1.11 The total expenditure required to bring both the GP estate and the community health services estate to an acceptable standard at the time of the Welsh Health Estates Survey was £731,022. This included 24 GP practice premises and 11 community clinics. The expenditure for clinics excludes compliance with the Disability Discrimination Act 1995. The overall expenditure requirement includes two surgery premises Oldcastle Surgery and Brackla Branch Surgery that have now been replaced by the newly constructed Oaktree Surgery at Brackla. When the costs associated with these two properties are deleted the expenditure requirement of £731,022 falls to £644,572.

1.12 The stakeholders involved in the workshop based process generally recognised that the development of the Estate Strategy provides a significant opportunity to respond to both local issues and a range of factors that are affecting the way health and social care services will be provided in the future. It was recognised particularly that this would mean services being provided in a way that is more relevant to the present and emerging needs and expectations of the population of Bridgend.

1.13 The external factors that were recognised as drivers for change in the way that primary care services could be provided included:

- **New technologies** – drugs, human genome project, robotics, internet, telemedicine.

- **Changes in society** – responding to an ageing population, growth in consumerism, global economy, 24 hour society.

- **Patient's needs/expectations** – pressure for quicker and more flexible access to treatment, good quality relationships with health professionals, to be more and better informed about treatments, choice etc.

- **Health Policy Agenda** – requires a greater emphasis on primary care, integration of health and social care, changing roles of healthcare professionals. In relation to this factor the workshops

took into account the policy imperatives set out in such documents as:

- Improving Health in Wales: A plan for the NHS with its partners.
- The Future of Primary Care: A Consultation Document.
- Dereck Wanless's review of the provision of health and social care in Wales commissioned by the Welsh Assembly Government.

1.14 Consideration of such factors means that the estate strategy is based on an expectation of significant change in the way services are delivered. Nevertheless participants at workshops felt that it was important that services in the Bridgend LHB area continued to benefit from what is already done well. This would include the development of specialist clinics for the management of disease conditions such as Hypertension and Coronary Heart Disease and locally accessible diagnostic services.

1.15 They also recognised that there was a need to make changes in primary care services that would include:

- Co-locating services to make them work in more integrated ways.
- Improving the sharing of skills.
- Making services easily accessible.
- Ensuring that services are delivered in the most appropriate place.
- Creating patient centred pathways of care.
- Increasing prevention and proactive assessment.
- Increasing support for clients and patients in taking responsibility for their health and well being.
- Matching the provision of premises to the service need.

1.16 It was felt that realistic opportunities for change would arise from factors such as:

- The GMS new contract (subject to resources and especially investment in practice management).
- Targets for improvement (subject to the development of radical programmes to address the determinants of ill health).
- Partnership working at strategic and operational levels leading to integrated service delivery.
- Improved resource streams e.g. PFI schemes, WAG Capital.
- Improved information and communications technology, including telemedicine, electronic records and diagnostic links.
- Government investment in health and professional training.
- Increased flexibility in the skill mix of the NHS workforce of the future.
- Better informed patients with increased responsibility for their own health and well being.

1.17 Factors that might impose change could include:

- Increased regulation and monitoring to increase accountability to government for both the quality of clinical care provided and the efficient use of resources e.g. CHI (The Commission for Health Improvement).
- Government policy for the integration of service delivery and the removal of traditional barriers between primary and secondary care and between health and social care.
- The target of 24 hour access in primary care.
- National Service Frameworks that demand the achievement of standards for defined groups within the population.
- New legislation and regulations affecting issues such as the access for people with disabilities and health and safety at work.
- The demand for child friendly working hours.
- The responsibility that Local Health Boards will acquire for commissioning dental services.
- The pressure from raised public expectations generally.

1.18 Having recognised this general case for change the workshops considered a range of specific options for organising the delivery of services in the future. The process for identifying and evaluating these options is described in detail in the main body of the report. It followed the principles set out in the NHS Capital Investment Manual. Its main features were:

- Inclusive involvement of stakeholders.
- Use of innovation and creativity to identify options as imaginative solutions to existing and expected service delivery problems.
- Development of options as broad conceptual models for organising the delivery of services rather than detailed plans for the make up of the estate.
- Development of a long list of options, then reduced to a manageable shortlist for purposes of detailed evaluation.
- A structured and disciplined approach to evaluation that covered the potential for options to achieve non-financial benefits, deliver value for money and avoid susceptibility to risk.
- Weighting of non-financial benefit criteria to reflect their relative importance and the extent to which their achievement should influence the choice of the preferred option. Five different sets of weights were used to maximise the robustness of the appraisal process. Initially benefit criteria were weighted from the three perspectives of patients' views, the general public's views and views of staff and independent contractors. These were combined into an overall weighting and an equal weighting was also calculated.

- Use of weighted benefit scores to distinguish between options in terms of their ability to achieve non-financial benefits. These were calculated using the overall weightings referred to in the previous bullet point. The other weightings were used to test the robustness of the appraisal process.
- The use of net present costs, calculated using a recognised discounting technique, to distinguish between options in terms of value for money.
- The use of an accredited risk assessment technique to determine the robustness of the assumptions made about the potential of each option to achieve non-financial benefits and the costs of each option in the light of future uncertainty.
- The selection of a preferred option based on its expected performance in relation achieving non-financial benefits, value for money and a low level of susceptibility to risk in an uncertain future.
- An assessment of the relative affordability of options based on a comparison of additional capital charges incurred as a result of investment in new premises offset by the expected reduction in current rent and rates reimbursements to GPs and in capital charges on community clinics.

1.19 The workshops considered nine options that are outlined below. A more detailed description of each option is included in the main body of the report.

- **Option 1 - Do nothing,** i.e. continue to organise services along existing traditional lines without any improvement in the premises from which services are provided.
- **Option 2 - Do minimum,** i.e. continue to organise services along existing traditional lines with only those improvements in the premises from which services are provided to ensure that they comply with statutory requirements.
- **Option 3 - Traditional service model provided from premises that are fully suitable for the purpose.**
- **Option 4 - Centralised service model,** involving the provision of services from three conveniently located bases, each providing a full range of primary care services.
- **Option 5 - Decentralised service model,** involving the provision of a wide range of primary care services from bases in each natural community.
- **Option 6 - Structured access service model,** this involves the provision of a tiered service from bases ("spokes") providing core services in each community supported by "hubs" in primary care centres or resource centres providing a very wide range of specialist services in a primary care setting. It was agreed that two

sub options involving this service model should be considered as follows:

- **Option 6A - Multi hub sub option**

  In this sub option "spokes" could be supported by up to five to six specialist centres, based in population centres such as Maesteg, Pontycymmer, Ynysawdre, Ogmore Vale, Porthcawl, Bridgend, Pencoed and Pyle / Cornelly.

- **Option 6B - Single hub sub option**

  In this sub option "spokes" would be supported by one single hub based if feasible at the Princess of Wales Hospital in Bridgend.

- **Option 7 – Provision of services from bases in each centre of population made up of a cluster of premises that are nearby each other.**

- **Option 8 – Using information and communications technology to facilitate access to primary care services.**

1.20 For the reasons detailed in the main body of the report this long list of options was reduced to a shortlist of five for purposes of detailed evaluation including:

- **Option 1: Do nothing**
- **Option 2: Do minimum**
- **Option 5: Decentralisation**
- **Option 6A: Hub and Spoke (Multiple Hubs)**
- **Option 6B: Hub and Spoke (Single Hub)**

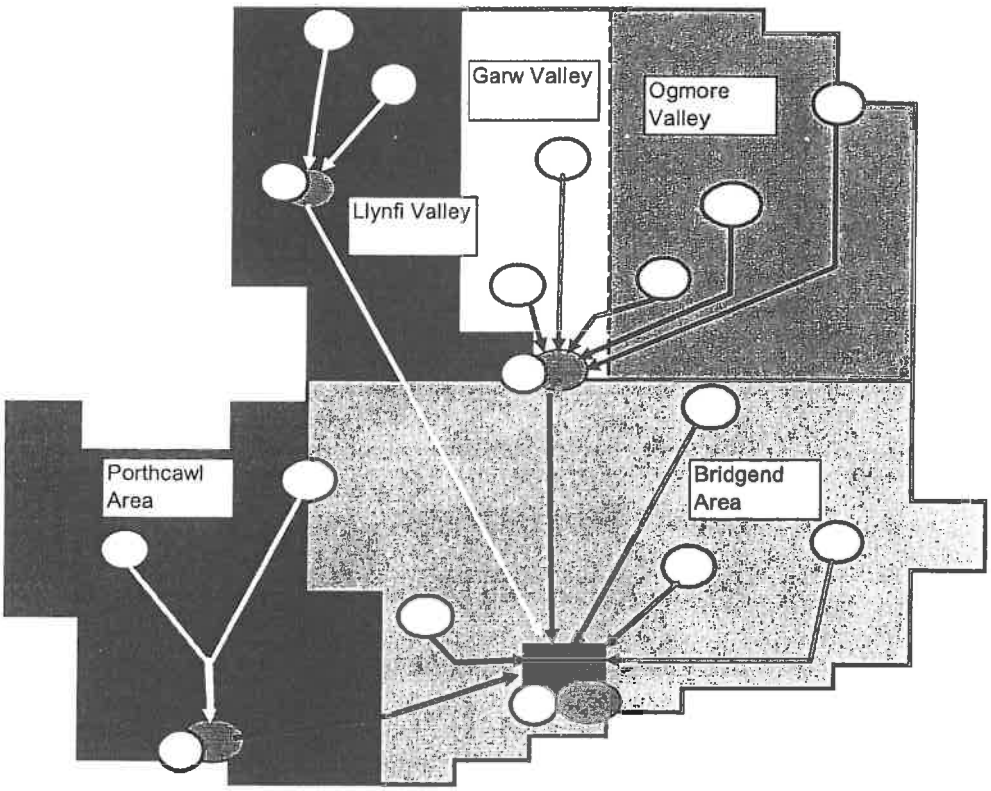
1.21 The following list sets out the benefit criteria (with their assigned overall weights in brackets) that were used to evaluate the expected performance of these options:

- Easily accessible services (Weight 29)
- Effective and efficient services (Weight 2)
- Highly skilled and motivated workforce (Weight 29)
- Integrated, responsive and patient centred care (Weight 24)
- Positive health outcomes (Weight 6)
- Good quality physical environment (Weight 5)

- Support and information to enable self care (Weight 5)

1.22 The result of the appraisal of options against non-financial benefit criteria with overall weights showed that Option 6A: the Hub and Spoke (Multiple Hub) service model was preferred by a wide margin. It was also shown to be a robust option as it achieved the highest weighted benefit score under scenarios using the other weighting sets referred to in paragraph 1.18. This option was also shown to be the option that offered best value for money and was least susceptible to risk.

1.23 The option, which is described in specific detail in the main body of the report, will mean the evolution of a model of service that will organise the delivery of services in ways that differ from the present traditional service model. The new model is illustrated by the following diagram.



1.24 The background shading in the diagram represents the five localities in the County Borough. It recognises that people living in the Garw and Ogmore Valleys could share access to some services if they were located at the point where they meet.

1.25 The black, white and grey symbols represent communities where services would be available in the new model. The shape and colour of the symbol distinguishes the level and range of services that could be available in the community. The arrowed lines represent the pathways that patients would follow to gain access to the services available.

1.26 In the communities represented by white symbols people would have local access to core primary care services (defined in more detail in the main body of the report).

1.27 In some cases the services would be provided by visiting staff from a neighbouring community or the nearest main population centre (Porthcawl, Maesteg or Ynsawdre). People living in these communities would be able to access more specialist services (defined in more detail in the main body of the report) based in the nearest population centre or, for very specialist services, in Bridgend town. In more populated communities (e.g. Pencoed, Kenfig Hill/ Pyle and Pontycymmer) core services would be permanently available locally. Access to specialist services would be available in the nearest population centre or Bridgend town depending on the level of specialism.

1.28 In the communities represented by grey symbols (Maesteg, Porthcawl and Ynsawdre) people would have local access to both core and specialist services and access to very specialist services in Bridgend town.

1.29 The black square for Bridgend means that the population of the town would have local access to all three levels of service.

1.30 The facilities that would be needed to support this model of service and that will therefore make up the future estate are:

- A primary care resource centre in Bridgend that would accommodate the core services for the local community, specialist services for all communities in the Bridgend locality and very specialist services for the whole of the County Borough.
- Two primary care centres that would accommodate core services for the populations living in and around the towns of Maesteg and Porthcawl and specialist services for the Llynfi Valley and the Porthcawl locality respectively.
- A further primary care centre at Ynsawdre that would accommodate core services for the populations living in that

community and specialist services for the Garw and Ogmore Valleys.

- Practice centres located in each of the communities identified by a white symbol on the above diagram to accommodate core services or visiting services for the communities they are located in. Initially these centres would be made up of the clusters of premises that already exist nearby each other in most of these communities and accommodate services offered by a range of different providers. Over the next decade the strategy envisages that about 75 per cent of local primary care services will be provided from a single practice centre for the community operating as a "one stop" shop that will have replaced these facilities. Two of these developments one to fill a service gap in an expanding area to the west of Bridgend town and one to replace unsuitable accommodation in Pencoed could have an early place in the implementation programme. Practice centres will also be incorporated into the primary care resource centre in Bridgend town and the primary care centres in Porthcawl, Maesteg and Ynsawdre.
- Satellite practice centres in the smallest of the communities that are represented in the diagram by white symbols. In the main it is expected that existing premises will meet this need.

1.31 The capital cost to the local health and social care economy of changing the make up of the estate in this way would be £36.4m. The direct revenue implications of this investment would be an extra £1.5m to the LHB to cover increased capital charges offset by reductions in rent and rate reimbursements and current capital charges.

1.32 In return for this the benefits to the local health and social care economy would be a strategy that:

- Provides an imaginative and innovative way of dealing with the increasing burden of work falling on primary care services and of creating capacity in primary care that can where safe and effective to do so avoid secondary referral.
- Enables the LHB's service strategies to be implemented by ensuring that the estate will match the service needs in terms of its size, location, functional suitability and quality.
- Provides modern, high quality and efficient buildings appropriate for delivering modern primary care services in the 21st Century.
- Improves the utilisation of the LHB's property portfolio by clearly identifying those buildings that are needed to deliver the service i.e. it is a service driven Integrated Healthcare Strategy for Primary Care Premises.

- Minimises the need to fund expenditure on backlog maintenance on existing buildings by concentrating services in those buildings with least backlog and by disposing of those with major expenditure requirements.
- Provides a phased, incremental approach to developing and modernising the LHB's property portfolio and thereby provides flexibility to cope with the inevitable changes in service delivery in the future.
- Provides a clear plan for change that enables progress towards agreed goals to be measured.
- Provides a strategic context in which detailed capital investment plans and business cases can be developed and evaluated.
- Demonstrates to the public, patients and staff that the LHB has positive future plans to invest in improving primary care services and facilities in Bridgend County Borough.
- Moves the LHB in the direction of turning the aspiration of a "primary care led health service" into a reality.

1.33 The main body of the report contains a detailed examination of the funding and procurement options that the LHB might consider to achieve delivery of the proposed strategy. It highlights the significant benefits of the Local Improvement Finance Trust (LIFT) approach that is available to PCT's in England, especially in relation to supporting a coherent programme of strategic change. There is undoubtedly an opportunity to use this approach to advantage in Bridgend if the WAG can be persuaded to launch the process in Wales. In any event it is clear that any one particular option on its own is unlikely to be able to underpin the implementation of the whole strategy. The LHB may need to see the procurement solution as a combination of many or all of the funding options. This will be particularly true in the meantime as the LHB embarks on implementation in the absence of any opportunity to use the LIFT approach.

2.0 Introduction

2.1 The Bridgend Local Health Board has undertaken to develop an integrated healthcare strategy for primary care premises that will identify, in broad terms, their property and premises needs over the next decade. This report describes the proposed strategy that has emerged from this process and the service model on which it is based.

2.2 The Strategy describes the LHB's existing primary care estate and all the changes proposed to it over the next decade. It is one component of the LHB's overall vision of the future and, together with their service strategies and business plans, will enable them to achieve the

aims and objectives set out in *Improving Health in Wales: A Plan for the NHS with its partners.*

2.3 The Strategy aims to describe in one document:

- Those characteristics of the Bridgend County Borough that determine the health of the population, its need for health and social care services and the way that they have been provided and will be provided in the future.
- The portfolio of primary care and related services currently provided and the model for organising their delivery.
- The LHB's existing estate, and an analysis of its condition and performance as an asset.
- Proposals for adopting a new model of service delivery in the future.
- A comprehensive estate investment programme including all the capital expenditure proposals for:

  (i) Developing a primary care estate that will meet the needs of a modern primary care service based on the proposed new model.
  (ii) Meeting statutory and non-statutory standards.
  (iii) Reducing backlog maintenance.
  (iv) Upgrading and refurbishment of existing buildings.

3.0 The Process

3.1 The process adopted for developing the Strategy has broadly followed the guidance described in the NHS Estates document "Developing an Estate Strategy". The exercise has been carried out by the LHB with assistance from Welsh Health Estates and external management and technical consultants. The process asks three basic questions in relation to the LHB's estate:

- Where are we now?
- Where do we want to be?
- How do we get there?

Where are we now?

This initial stage was aimed at developing a comprehensive analysis of the current position and performance of the estate in relation to the services that the LHB currently provides. The key objective of this stage was to establish a baseline that reflects the overall estate provision, against which the development of options for change can be set.

Where do we want to be?

This stage was concerned with understanding the implications for the estate of the long-term plans for health services and the impact of a number of well-recognised drivers for change in the NHS such as:

- New technologies and drugs
- New ways of working
- Social and economic change

How do we get there?

This final stage in the process involved using the information and outputs from the preceding stages to develop realistic and feasible options for organising the delivery of services in the future and for the make up of the estate needed to support different models. These options were then evaluated in terms of benefits, costs and risks, and a preferred option was identified.

4.0 The Approach

4.1 The approach to the exercise has had a particular emphasis on multi-discipline and multi-agency working. The aim of this approach being to utilise the process of developing the strategy to promote partnership working, maximise the opportunities for collaboration, explore the potential benefits of co-location and to facilitate "new ways" of working that can deliver benefits for patients, staff and the local population. This approach was considered to be particularly relevant for this project since in addition to it inherently involving the five localities within the LHB, the Integrated Healthcare Strategy for Primary Care Premises will have wider implications for a range of health, social and local authority services across the local area.

4.2 A series of multi-discipline / multi-agency workshops were held with wide representation from the LHB, General Practitioners, stakeholders, the local authority, the local NHS Trust. Patient, public and voluntary sector interests were represented by the Community Health Council. These workshops were used as the main vehicle for working through the process described earlier and for developing the ideas and proposals contained in this Integrated Healthcare Strategy for Primary Care Premises.

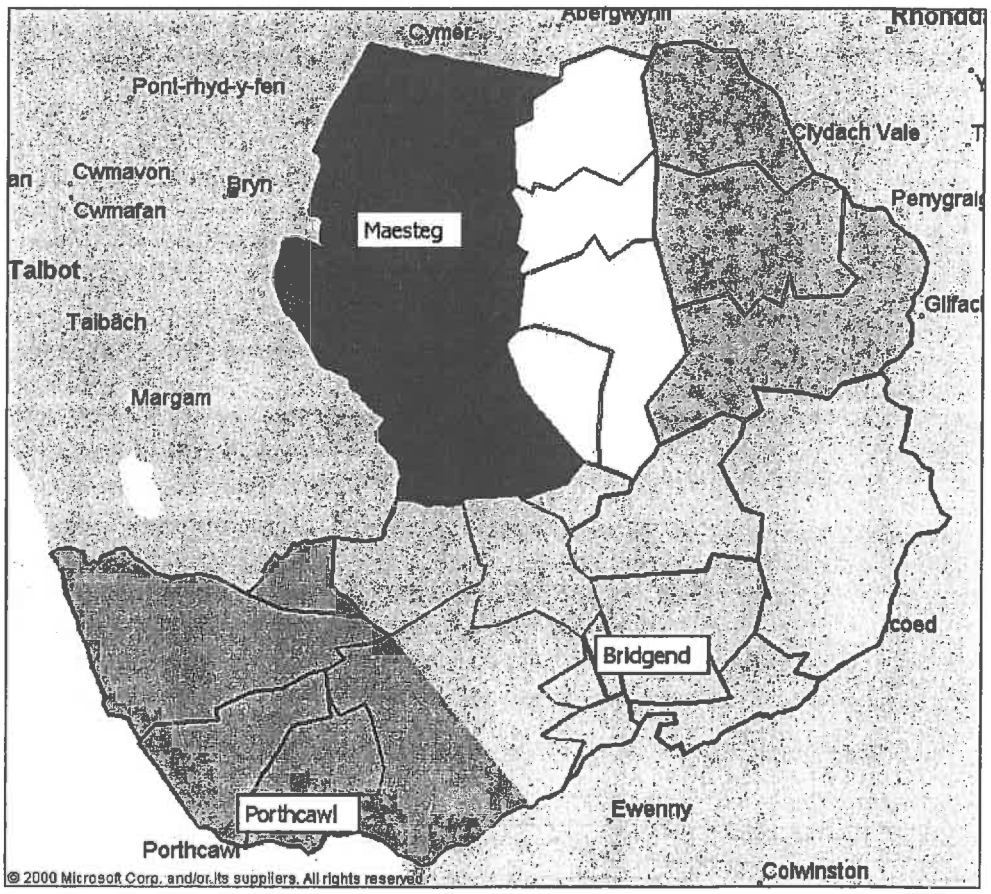
Section 1: Where are we now?

5.0 Characteristics of Bridgend County Borough

5.1 Bridgend Local Health Board commissions the provision of primary care services for people living in the County Borough of Bridgend. The Bridgend County Borough extends within South Wales from the Bristol Channel between the cities of Cardiff and Swansea to the heads of the Llynfi, Garw and Ogmore Valleys. It is divided naturally into three valleys and one distinct coastal area and an area between the two surrounding Bridgend town as follows:

- Llynfi Valley (Black on the following map)
- Garw Valley (White)
- Ogmore Valley (Medium grey)
- Porthcawl/Cornelly/Kenfig Hill (Dark grey)
- Bridgend/Pencoed (Light grey)

5.2 The following map illustrates these aspects of the County Borough's geography.



5.3 The geography of the valleys acts as an insurmountable barrier to transport between them over most of their length. The coastal area communities naturally look to Porthcawl. The communities in the area between the valleys and the coast naturally look to Bridgend town as the main population centre. Maesteg, Pontycymmer and Ogmore Vale are the natural centres for the Llynfi, the Garw and the Ogmore Valleys respectively.

5.4 The County Borough has a resident population of approximately 128,000 although around 146,000 people are registered with general medical practitioners based within its boundaries.

5.5 Based on Welsh Health Statistics for 2001 the proportion of people aged over 65 and living in the County Borough is lower than the proportion for Wales as a whole. Nevertheless estimates of population growth sourced from "A Profile of Bridgend County Borough" published by the former Mid Glamorgan County Council suggest that the total population and the proportion of older people will both grow by 2006. In that period the proportion of older people in the population is expected to increase from below 20 per cent to between 20 and 25 per cent.

5.6 Also based on Welsh Health Statistics for 2001 and compared to Wales as a whole Bridgend County Borough experiences:

- Higher rates of live births per 1,000 population.
- Higher numbers of low birth weight babies.
- A higher infant mortality rate.
- A standardised mortality rate for all causes for males which is high, 33 per cent above the national rate.
- A standardised mortality rate for all causes for women which is low; 20 per cent below the national rate.
- Poor performance against most indicators of positive lifestyle behaviour. A lower proportion of people living in Bridgend County Borough eat adequate amounts of fruit or vegetables in their diet than in Wales as a whole. The same is true for negative lifestyle factors. Bridgend County Borough has higher rates than Wales as a whole for people who smoke, drink alcohol above sensible limits and are obese.

5.7 Most of the County Borough is thinly populated. Twenty one out of twenty eight of the electoral divisions in the County Borough have population densities of less than 10 people per hectare. Of the remaining seven only one has a density higher than 30 people per hectare.

5.8 The electoral divisions of Bettws, Llangeinor and Brackla have comparatively high proportions of children aged under five in their populations. In the electoral divisions of Porthcawl West and Porthcawl East over 25 per cent of residents are aged 65 or over.

5.9 There is well documented evidence of a high correlation between socio economic deprivation and ill health. Some of the results of such deprivation, such as low level of car ownership, make it difficult for people to access the services that they need. The data available suggest that the numbers of deprived people in the population are greatest in the Ogmore and Garw Valleys with a concentration of deprived population in Caerau in the Llynfi Valley. Generally the valley areas are more deprived than the coastal area.

6.0 Current Service Provision

6.1 The current model of primary care service provision organises the delivery of services along traditional lines with:

- General practice services being provided mainly from GP owner occupied premises that provide, in some cases, limited community health services but no wider primary care services.
- Community Health Services being provided from clinics and health centres that are not used in the main to provide general practice services or any other primary care services.
- Little or no provision within general practice and community health services premises for secondary health services, social care services or other services related to health.
- Generally separate provision of accommodation for independent contractors providing general dental services, optometry services and pharmacy services.

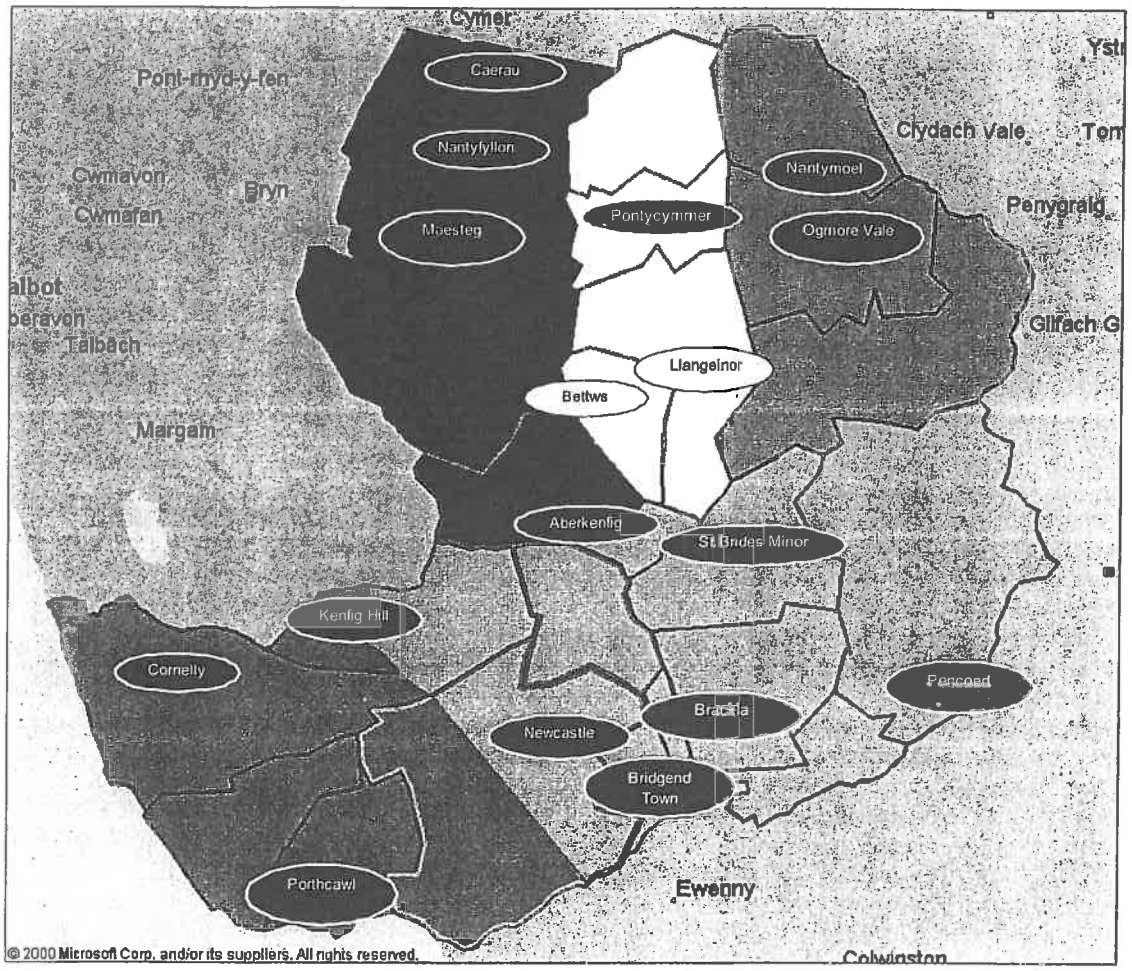
6.2 The numbers of doctors in Bridgend County Borough are shown in the following table.

Locality	Electoral Division	Surgeries	Current GP numbers (WTE)
Llynfi Valley	Caerau	Caerau	3.75
Llynfi Valley	Maesteg West	Llynfi/ Bronygarn	8
Llynfi Valley	Nantyffyllon	Nantyffyllon	1
Garw Valley	Pontycymmer	Cwmgarw	4
Ogmore Valley	Nant-y-moel	Nant-y-moel	2
Ogmore Valley	Ogmore Vale	Ogmore Vale/	2
Bridgend	Laleston/ Merthyr Mawr	Newcastle	2.5
Bridgend	Oldcastle	Riversdale	8.5
Bridgend	Oldcastle	Oldcastle	7
Bridgend	Oldcastle	Ashfield	4
Bridgend	Pencoed	Medical Centre/ New Surgery	9
Bridgend	St Bride's Minor	Tyncoed	4.5
Bridgend	Ynysawdre	New Street	2
Porthcawl	Cornelly	North Cornelly	4
Porthcawl	Porthcawl West	Victoria Ave/ Portway	9
Porthcawl	Pyle	Heathbridge/ Stormybrook	3.75
		TOTALS	75

6.3 In 2001 the average GP in Wales had a list of less than 1,700 patients. In Bridgend County Borough the average figure was approximately 1,950, within a range extending from 1527 to 2630.

6.4 General practice services are provided from main surgeries in significant population centres such as Maesteg, where they are clustered together with community health services and other independent contractor services provided in the main from separate buildings. In more remote areas practices have established branch type surgeries that are generally the sole local service provision for such areas.

6.5 These arrangements are illustrated in the following map. Communities with access to a wide range of services from a cluster of separate premises are black. Communities served by a branch surgery only are white. The names given to the communities identify the main location of the services provided.



7.0 The Existing Primary Care Estate

7.1 There are 24 individual properties in the Bridgend County Borough from which General Medical Practitioners deliver services. The distribution of these premises in the five localities is shown in the following table.

Locality	Number of properties
Llynfi Valley	4
Garw Valley	3
Ogmore Valley	3
Porthcawl	5
Bridgend	9
Total	24

7.2 There are three further premises located outside the County Borough boundary.

7.3 The properties range from very small properties (90 square metres) through to quite large purpose built facilities (1000 square metres). In terms of type of properties they range from converted residential or retail premises to purpose built GP surgeries. The following table shows the average property size across the three localities.

Locality	Average property size (square metres)
Llynfi Valley	223
Garw Valley	197
Ogmore Valley	140
Porthcawl	359
Bridgend	379
Total	279

7.4 In addition to the GP owned estate, there are numerous facilities throughout the area that are owned by the Bro Morgannwg NHS Trust that provides community health services in the County Borough and by independent contractor pharmacists, dentists and optometrists to deliver front line primary care services.

8.0 The Condition and Performance of the Existing Estate

8.1 The development of the Strategy is based on a desktop analysis of a comprehensive audit of the GP owned properties that was commissioned by Welsh NHS Estates covering:

- Physical condition
- Energy performance
- Compliance with fire and Health & Safety Legislation
- Compliance with the Disability Discrimination Act 1995(DDA)
- Functional suitability
- Space utilisation
- Expansion/Development potential

8.2 Due to the timing of this survey it covered two properties (Oldcastle Surgery and its branch surgery at Brackla) that have now been replaced by the newly constructed Oaktree Surgery at Brackla. Not only has this meant the relocation of these services into a previously underprovided area but it has improved the performance of the estate.

8.3 The results of the audit are summarised as follows:

- The audit identified a total expenditure requirement of £499,347 for all of the properties that were appraised. An analysis of this expenditure across the four facets costed is shown in the following table.

Facet	Total Expenditure requirement (£)	% of Total
Physical Condition	24166	4.8
Energy	0	0.0
Health & Safety Compliance	55425	11.1
DDA	419756	84.1
Total	499347	100.0

- The table shows that the majority of expenditure is required to address issues of non-compliance with Health & Safety and DDA standards. The expenditure on these two facets accounts for 95% of the total expenditure requirement and clearly, given the nature of these issues it is important that they are addressed as a matter of urgency. The exclusion of Oldcastle Surgery and Brackla Branch Surgery from these figures reduces total cost by £86,450 and the cost of compliance with legislation including Fire and DDA by £84,618.

- In terms of functional suitability, the audit identified that few of the buildings are unsatisfactory as shown in the following table. In the Llynfi Valley, Ogmore Valley and Porthcawl localities all buildings are assessed as being satisfactory in terms of functional suitability. When Oldcastle Surgery and Brackla Branch Surgery are excluded from these results only two premises (7.69%) are assessed as being unsatisfactory in relation to this facet.

Locality	Functional suitability (Number of buildings unsuitable)	Number of buildings in the Locality	Functional suitability (% of buildings unsuitable)
Llynfi Valley	0	4	0.0
Garw Valley	1	3	33.3
Ogmore Valley	0	3	0.0
Porthcawl	0	5	0.0
Bridgend	1	9	11.1
Outside Borough	1	3	33.3
Total	3	27	11.1

- The appraisal of space utilisation shows the number and

percentages of buildings that were given ratings other than "fully used" by the Welsh Health Estates survey. Alternative ratings to "fully used" are "empty", "overcrowded" and "underused". The two properties in the table below were both rated "overcrowded". One of these is Oldcastle Surgery that has been replaced by the new Oaktree Surgery at Brackla.

Locality	Space Utilisation (Number of buildings not fully used)	Number of buildings in the Locality	Space Utilisation (% of buildings not fully used)
Llynfi Valley	0	4	0.0
Garw Valley	1	3	33.3
Ogmore Valley	0	3	0.0
Porthcawl	0	5	0.0
Bridgend	1	9	11.1
Outside Borough	0	3	0.0
Total	2	27	7.4

- The information available about the current gross internal areas of GP premises in the Welsh Health Estates Survey enabled an objective analysis to be undertaken comparing space available in **main surgeries** with space allowed by the GMS (General Medical Services) contract schedule of fees and allowances. The following table shows the results of this comparison by locality. Although the replacement of Oldcastle Surgery reduces the additional space requirement by around 1,000 square meters, there remains a gap between current space and allowed space equivalent to the amount of space currently provided.

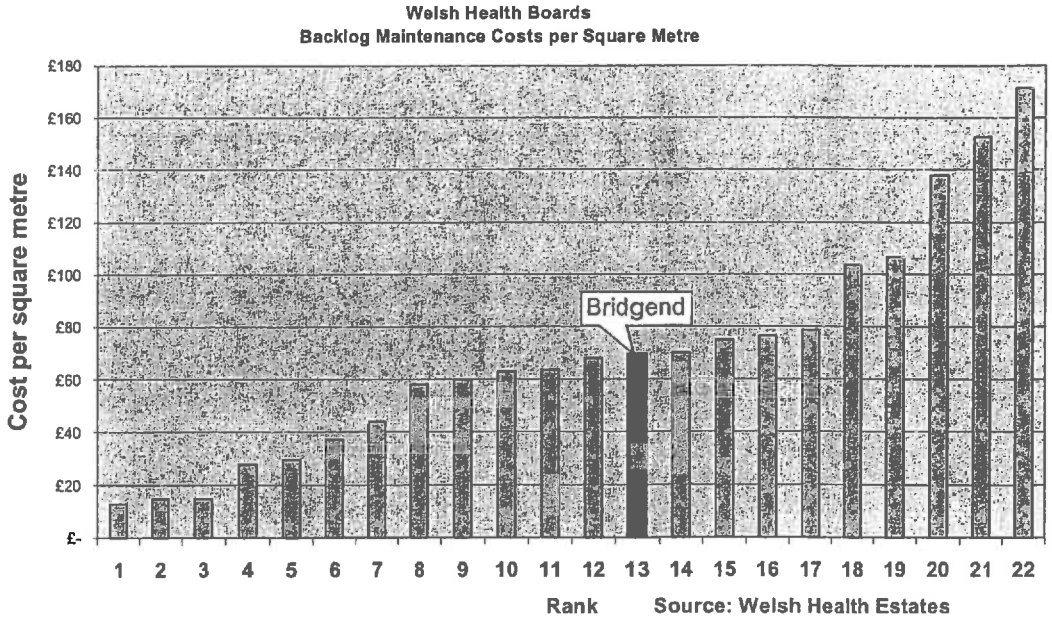
Locality	Space Currently Available (Square metres)	Total Space Required	Additional Space required (Square metres)	Space required as % space available
Llynfi Valley	890	2226	1336	127.6
Garw Valley	350	836	486	138.9
Ogmore Valley	420	1175	755	179.8
Porthcawl	1455	2903	1448	99.5
Bridgend	3190	6924	3734	117.1
Outside Borough	Branches only			N/A
Total	6305	14054	7759	123.1

- The table below shows in broad terms the number of properties used as **main surgeries** which have some potential to be expanded

and developed.

Locality	Number with some expansion potential	Number of Buildings in the Locality	Percentage with some expansion potential
Llynfi Valley	0	4	0.0
Garw Valley	1	3	100.0
Ogmore Valley	0	3	0.0
Porthcawl	1	5	25.0
Bridgend	1	9	12.5
Outside Borough	Branches only		
Total	3	24	15.8

8.4 The information from the Welsh Health Estates surveys also made it possible to benchmark Bridgend LHB against other LHBs in Wales in terms of expenditure required per square metre in respect of physical condition and compliance with the Disability Discrimination Act. The results of this analysis are shown in the following chart.



8.5 Further information about the premises used to provide community health services in the County Borough was provided by Bro

Morgannwg Healthcare NHS Trust. This covers the following 11 community clinic locations:

- Aberkenfig M.&C.W. Clinic
- Caerau Clinic
- Bryntirion M.&C.W. Clinic
- Kenfig Hill M.&C.W. Clinic
- Maesteg Health Clinic
- Ogmore Vale Clinic
- Pontycymmer M.&C.W. Clinic
- Pencoed M.&C.W. Clinic
- North Cornelly Clinic
- Bryncethin (Sarn) M.&C.W. Clinic
- Quarella Road Clinic

8.6 This information provided information about the performance of these premises covering the following facets:

- Physical condition
- Energy performance
- Compliance with fire and Health & Safety Legislation, excluding DDA.

8.7 The Trust has yet to carry out an accredited assessment of compliance with DDA for its premises.

8.8 The results shown by a desktop analysis of this information are shown in the following table:

Locality	Expenditure requirement by facet (£)				Percentage
	Condition	Energy	Compliance, excluding DDA	Total	
Llynfi Valley	**46,038**	**0**	**0**	**46,038**	**19.9**
Garw Valley	**10,175**	**0**	**0**	**10,175**	**4.4**
Ogmore Valley	**0**	**0**	**0**	**0**	**0**
Porthcawl	**22,430**	**0**	**0**	**22,430**	**9.7**
Bridgend	**133,032**	**8,000**	**12,000**	**153,032**	**66.0**
Total	**211,675**	**8,000**	**12,000**	**231,675**	**100.0**
Percentage	**91.4**	**3.4**	**5.2**	**100.0**	

8.9 Clearly the Local Health Board is not responsible for this expenditure. The purpose for including this data in the consideration of the Integrated Healthcare Strategy for Primary Care Premises is to inform an overall assessment of the capacity of the whole primary care estate to support planned service delivery.

8.10 In addition to the premises referred to above the Bro Morgannwg NHS Trust provides a range of community mental health services from rented premises.

9.0 Current Issues to be addressed by the Integrated Healthcare Strategy for Primary Care Premises

9.1 The workshop groups identified a significant number of current issues that the Strategy should aim to address. Whilst it was recognised that many of these issues cannot be resolved solely by changes to the property portfolio, it was considered that the Strategy could make a worthwhile contribution to their resolution.

9.2 Significant Issues:

9.3 The workshop groups generally recognised that the development of the Estate Strategy provides a significant opportunity to respond to the drivers to provide services in a way that is more relevant to the present and emerging needs and expectations of the population of Bridgend.

9.4 Participants at that workshops felt that it was important that services in the Bridgend LHB area continued to do the following things well:

- Provide clinics specialising in the management of disease conditions such as Hypertension and Coronary Heart Disease.
- Providing local access to diagnostic services such as blood testing.
- The relationship between individual patients and their General Practitioners, although there was concern that the new contact may have changed this.
- The creation of disease specific and patient participation groups to support people with chronic illnesses.
- Maintaining people in their own homes.
- The Out of Hours Service.
- Coping with stress of the job.

9.5 They also recognised that there was a need to make changes in primary care services that would:

- Organise services in the future so that key professionals were co-located where they needed to work together to provide integrated healthcare or bridge the boundaries between health and social care. Examples of where co-location would be beneficial were in the provision of integrated primary and secondary care and the integration of core primary care services with Therapies, Social Services, Education and other Local Government services.
- Improve the sharing of skills.
- Increase access in terms of consulting time with health

professionals, availability of the appropriate professional, and access to services 24 hours a day.

- Ensure that services are delivered in the most appropriate place.
- Create patient centred pathways of care.
- Increase prevention and proactive assessment.
- Increase support for clients and patients in taking responsibility for their health and well being.
- Match the provision of premises to the service need.
- Ensure that the skills offered by staff employed in primary care match service and patient needs.
- Provide access to alternative therapies.
- Improve equality of access to care especially to doctors, nurses and dentistry.
- Make it easier to access care needed from Nurse practitioners, dieticians, CPR, 24-hour nursing and mental health services.
- Raise quality.
- Increase availability of G.P Specialists – e.g. vasectomy.
- Improve training of nurses, particularly nurse practitioners.
- Improve access to day care.
- Increase service uptake in deprived areas.
- Widen the range of mental health care services based in primary care settings.
- Widen the range of optometry services that can be provided and paid for.

9.6 It was felt that realistic opportunities for change would arise from:

- The GMS new contract (subject to resources and especially investment in practice management).
- Targets for improvement (subject to the development of radical programmes to address the determinants of ill health).
- Partnership working at strategic and operational levels leading to integrated service delivery.
- Improved resource streams e.g. PFI schemes, WAG Capital.
- Improved information and communications technology, including telemedicine, electronic records and diagnostic links.
- Government investment in health and professional training.
- Increased flexibility in the skill mix of the NHS workforce of the future.
- Better informed patients with increased responsibility for their own health and well being.

9.7 Factors that might impose change could be:

- Increased regulation and monitoring to increase accountability to government for both the quality of clinical care provided and the

efficient use of resources e.g. CHI (The Commission for Health Improvement).

- The new GMS contract – e.g. future of branch surgeries – quality standards – opting out.
- Government policy for the integration of service delivery and the removal of traditional barriers between primary and secondary care and between health and social care.
- The target of 24 hour access in primary care.
- National Service Frameworks that demand the achievement of standards for defined groups within the population.
- New legislation and regulations affecting issues such as the access for people with disabilities and health and safety at work.
- The demand for child friendly working hours.
- The responsibility that Local Health Boards will acquire for commissioning dental services.
- The pressure from raised public expectations generally.

Section 2: Where do we want to be?

10.0 Plans for Service Development & Change

10.1 In addition to the need for the Integrated Healthcare Strategy for Primary Care Premises to address the significant issues identified in relation to the current situation and the condition and performance of the existing primary care estate, there is clearly a need for it to facilitate and enable future changes in service provision.

10.2 The Integrated Healthcare Strategy for Primary Care Premises will need to respond to plans for service development arising from National and Local Service Strategies. Therefore, the development of the Strategy has sought to understand how changes from these sources will determine the model of primary care services needed in the future and the make up of its supporting estate. By doing this it is a plan to ensure that the estate can meet the future needs of services in terms of its size, functional suitability and quality.

10.3 Improving Health in Wales: A plan for the NHS with its partners highlights the following issues that are particularly relevant to the development of the Integrated Healthcare Strategy for Primary Care Premises:

- The need to improve performance further in relation to the maintenance of health.
- To contribute significantly to population health improvement.
- To tackle inequalities in health.
- The need to improve the infrastructure by investment in buildings, information technology and medical equipment.

10.4 The Future of Primary Care: A Consultation Document describes the Welsh Assembly Government's clear commitment to renewal of the primary care estate. A key part of the objective being the development of primary care resource centres as a base for the development of a comprehensive range of services in a local setting.

10.5 The Welsh Assembly Government commissioned Dereck Wanless to review the provision of health and social care in Wales. His report highlighted the need for change across all services to ensure sustainability, efficiency and effectiveness. It also highlighted the need for greater integration of planning and service provision between the NHS and local government. The strategy for primary care premises needs to reflect this policy direction. It also needs to be an integral part of the Health Social Care and Well-being Strategy for Bridgend that is being developed by the Local Health Board and Bridgend County

Borough Council, working with all partner organisations. Due to be finalised by March 2005, this will provide the framework for service delivery to meet the needs of individuals and communities within the County Borough. Primary care will have a key role to play in meeting the objectives and priorities in the Health Social Care and Well-being Strategy.

10.6 Primary care services are changing at an unprecedented rate, driven by:

- **New technologies** – drugs, human genome project, robotics, internet, telemedicine.
- **Changes in society** – responding to an ageing population, growth in consumerism, global economy, 24 hour society.
- **Patient's needs/expectations** – pressure for quicker and more flexible access to treatment, good quality relationships with health professionals, to be more and better informed about treatments, choice etc.
- **Health Policy Agenda** – requires a greater emphasis on primary care, integration of health and social care, changing roles of healthcare professionals.

10.7 The workshop groups examined each of these drivers for change with a view to understanding the implications of these changes for primary care services and premises in Bridgend. The consensus around the current issues to be addressed was in part informed by a review of the current situation in the context of the main drivers. They concluded that whilst it is difficult to be precise about the implications of such change, there is little doubt that overall, the new primary care services that are likely to develop over the next decade will mean the evolution of new service models that will require to be supported by modern and appropriately equipped premises. Indeed, many of the developments and changes required in primary care services cannot be delivered without changes in premises.

10.8 Targets for change

10.9 Health policy agenda

10.10 In terms of the major changes proposed in the health policy agenda, in particular those relating to the Plan for the NHS in Wales, the workshop groups were generally optimistic that in the longer term there could be a major shift in service provision and activity from the secondary care setting to the primary care setting, provided the right

levels of resources (finance, manpower, buildings, equipment etc.) were forthcoming and that the benefits/cost ratios were attractive.

10.11 The need for integration of services, particularly between health and social care providers was a clear theme of the Plan for the NHS in Wales. The effective provision of care for vulnerable people and the promotion of good health are increasingly seen to depend on the removal of tradition barriers between health and social care. A closer partnership between all agencies delivering each type of care is seen to be a way of ensuring pathways that ensure continuity of appropriate care. There is strong anecdotal evidence that co-location of agencies will contribute to the achievement of such partnership working at a practical level.

10.12 The Plan for the NHS in Wales makes a number of proposals to "breakdown the barriers between NHS staff". The intention behind these proposals being to provide the most appropriate professional for a patient's needs at a particular time. It is envisaged that this will include enhanced roles for nurses (nurse led services) and wider roles for other health professionals including pharmacists, health visitors and midwives. The Strategy must aim to ensure that property does not become a constraint on the development of these changing roles for professionals.

10.13 The new General Medical Services contract for general practitioners was seen by workshop participants as potentially a major catalyst for change that will give doctors incentives to initiate changes in the way that they work and create demands for premises that better suit such ways of working. Whilst the strategy was being developed one practice in Bridgend was moving to more suitable and appropriately located premises. The LHB will want to encourage such initiatives in line with a strategy that ensures that investment in premises is coordinated to give the greatest health gain from the money invested.

10.14 New Initiatives

10.15 There was a general recognition in the workshop groups that the local health community was not fully utilising some of the well established technologies such as video conferencing and email and that these had a growing role to play in the delivery of services over the next few years. However, it was also recognised that the uptake of even some of the basic technologies such as email and video conferencing was likely to take some time given the levels of deprivation in some areas of the Bridgend.

10.16 Examples of well proven technology that may be increasingly used in the delivery of health and social services included:

- Use of email and voice mail for repeat subscriptions.
- Video conferencing/telemedicine for some speciality and outreach clinics.
- Near patient testing.

10.17 In addition to the above, it was recognised that the following are likely to be common place within the strategic planning period which we are considering:

- Electronic health and patient records.
- Patient self monitoring/interactive TV.
- Health access points in other settings – shopping centres, leisure facilities etc.
- Doctors on-line – web sites.
- Expert systems-medical, nursing, technical.

10.18 The workshop groups expressed some reservations in relation to the predictability of the uptake of some of the more complex technological developments such as robotics, genetics, etc. This is because too often the focus is on what is technologically possible, not what is socially and ethically acceptable. However, it was recognised that the maximum flexibility should be incorporated into the Strategy to enable the LHB to cope with future scenarios that might result in unpredictable changes driven by these new and more radical technologies.

10.19 Changes in Society

10.20 Changes in society influence both the health of individuals and their expectations of health and social services. Whilst these were discussed at some length during the workshops, it was thought that the major issues likely to influence the Strategy were:

- Increasing expectations in terms of extended access times for services – evenings, weekends etc. This will have implications for both the design of buildings and their use over time.
- People will become both more informed (internet access etc.) and expect more information about choices in relation to treatment, services etc. Premises may need to facilitate more access to information – internet cafes, health libraries etc.
- People are increasingly choosing a different work/life balance and have expectations for greater flexibility around when and where they work. Again, this has implications for the design and use of buildings.
- Multi-discipline/multi-agency working will require a different approach to the provision of facilities. Even the basic

consulting/examination room will need to be re-assessed in the light of these new ways of working.

10.21 The future patient – What does the patient need, want, expect?

10.22 The workshops discussed this driver for change and issues such as:

- Patients also want more flexible access to services, including access to services outside traditional working hours.
- The quality of the professional patient relationship is central to patients' perceptions of the care they receive.

10.23 Clearly, these issues are wide ranging and solutions are complex. Whilst it is unlikely that premises provision can address such issues alone, it is clear that it does have a bearing and must therefore be a significant consideration in the development of options and the choice of a preferred strategic option.

Section 3: How do we get there?

11.0 Development of Options

11.1 In order to tackle both the service and premises issues raised in the earlier stages of the development of the Integrated Healthcare Strategy for Primary Care Premises, the LHB and its stakeholders jointly examined priorities and considered options available for the provision of primary care services and premises in Bridgend.

11.2 Through a series of workshop sessions attended by LHB Managers, GPs and representatives of all the main stakeholders, a range of options for future provision of premises were developed. Inevitably with a property portfolio as large and varied as that of the LHB, there are a considerable number of options and permutations of sub-options. However, the workshop groups were concerned with identifying broad strategic models of premises provision that could support both existing and future models of service delivery and were less concerned with the use of any particular existing or potential future property. The intention of these options being to provide a broad framework and strategic direction within which the future premises portfolio can be procured and developed.

11.3 At this stage, the workshop groups were not concerned with evaluation or eliminating options, merely with identifying them. Also, the groups were assuming that over the longer term, significant investment would be available for investing in the development of primary care services (staff, buildings, equipment etc.) and therefore, when developing options, the key question being addressed was "What would be the focus for this future investment in primary care premises?"

11.4 The options identified are summarised below.

- **Option 1 - Do nothing,** i.e. continue to organise services along existing traditional lines without any improvement in the premises from which services are provided. It was noted that it would be necessary to subject this option to detailed evaluation for purposes of comparison.

- **Option 2 - Do minimum,** i.e. continue to organise services along existing traditional lines with only those improvements in the premises from which services are provided to ensure that they comply with statutory requirements. It was noted that it would also be necessary to subject this option to detailed evaluation for purposes of comparison.

- **Option 3 - Traditional service model provided from premises that are fully suitable for the purpose.** It was agreed that this option should not be evaluated in detail as it would not on its own be able to achieve the benefit of giving access to the integrated, responsive and patient centred care that was desired. It was acknowledged that the best features of this model could be retained in other options considered especially the decentralised and structured access service options.

- **Option 4 - Centralised service model** involving the provision of services from three bases, each providing a full range of primary care services. The bases would serve Bridgend, Porthcawl and an area covering the Llynfi, Garw and Ogmore Valleys respectively and would be sited to allow the most convenient access for people living in the area they would serve. It was agreed that this option would also not be evaluated in detail, as it was clear that it would not meet the very important criterion of providing convenient local access to services.

- **Option 5 - Decentralised service model** involving the provision of primary care services from bases in each natural community, the services being targeted at local populations of between 10,000 and 30,000 residents. The bases would collocate GP, pharmacy, optometry, podiatry, dental and community nursing services and provide for sessions for visiting professionals. It was agreed that a detailed evaluation of the possible non-financial benefits of this option should be undertaken.

- **Option 6 - Structured access service model** This involves the provision of bases in each community that would enable people to access core primary services locally supported by primary care centres or resource centres that would facilitate access to a very wide range of specialist services in a primary care setting. It was agreed that two sub options involving this service model should be considered as follows:

  - **Option 6A - Multi hub sub option**

    This sub option would involve access to a network or campus of local core primary services. It was anticipated that many of these bases would be made up of existing premises wherever these were in appropriate locations and of suitable size and condition. It was noted that some expansion of the number of existing bases would be needed in areas where populations were increasing and no local services were available. These "spokes" could be supported by around five to six specialist centres. These would provide services such as visiting

specialist GPs, outreach consultant clinics, social care assessment, visiting alternative therapies, citizens advice, voluntary service input, IT based health information access, blood tests, district nursing, health visiting, allied health professional services, optometry, dentistry, pharmacy, healthy café, midwifes, sexual health, psychiatrist services, prescription for exercise and school health services. Centres could be based in population centres such as Maesteg, Pontycymmer, Ynysawdre, Ogmore Vale, Porthcawl, Bridgend, Pencoed and Pyle/Cornelly.

- **Option 6B - Single hub sub option**

  This sub option would also involve access to a network or campus of local core primary services. It was anticipated that many of these bases would be made up of existing premises wherever these were in appropriate locations and of suitable size and condition. It was noted that some expansion of the number of existing bases would be needed in areas where populations were increasing and no local services were available. These "spokes" would be supported by one single hub based if feasible at the Princess of Wales Hospital in Bridgend. It would provide services in the range set out in option 6A together with all secondary care, a 24 hour walk in primary care centre including out of hours emergencies, STD/GUM clinics, diagnostic direct access clinics and services provided by specialist primary care professionals.

- **Option 7 – Provision of services from bases in each centre of population made up of a cluster of premises that are nearby each other.** It was agreed that this option would not be evaluated in detail as it would be impractical as a total solution. However its underlying theme could be incorporated into the decentralised and structured access options as dictated by local circumstances.

- **Option 8 – Using information and communications technology to facilitate access to primary care services.** It was agreed that the development of technology was not expected to advance to the point where this would work as a standalone option in the foreseeable future. However as with option 7 it could be incorporated into other options to facilitate service access where appropriate.

11.5 Rationalisation of options

11.6 Further development of the ideas behind the long list of options led to a number of them being disregarded. However, as the strategy

progresses into the business case stage, these options are likely to be reconsidered as elements of the total solution. The options disregarded for detailed evaluation were options 3, 4, 7 and 8 in the list above. The rationale for this is summarised in the description of each option.

12.0 The Short-list of Options

12.1 The rationalisation of options led to a short list of options to be taken forward to the option appraisal exercise. This shortlist comprised:

- **Option 1: Do nothing**
- **Option 2: Do minimum**
- **Option 5: Decentralisation**
- **Option 6A: Hub and Spoke (Multiple Hubs)**
- **Option 6B: Hub and Spoke (Single Hub)**

13.0 Evaluation of Options

13.1 It is clear from the number of options listed above that there are choices to be made in terms of how primary care premises can be developed in the future. It is crucially important that these choices are made in a structured, logical and well informed way. Therefore, the LHB carried out a comprehensive option appraisal exercise that examined each of the options in terms of:

-
- The non-financial benefits to patients, staff and public that can be expected from the options.
- The risks associated with the options – risks to service delivery, risks associated with retention and recruitment of staff etc.
- The costs of implementing the options – both initial costs (building etc.) and long term running costs (premises renewal and maintenance etc.).

13.2 The evaluation of options in terms of non- financial benefits

13.3 Non-Financial Benefit Criteria

13.4 In preparation for a comprehensive option appraisal exercise the workshop groups spent some time developing a set of non-financial benefit criteria against which options will be examined. These non-financial benefit criteria were developed by addressing the question

"What is important to us in making these decisions about the options for future provision of premises for primary care services in Bridgend?"

13.5 The non-financial benefit criteria developed by the workshop groups are summarised below.

- Locally available wide service range.
- Quality time with clinicians leading to good care and communication.
- Appointments when convenient.
- Effective recruitment.
- Engenders very good job satisfaction.
- Creates good opportunities for personal and professional development (based on job profiles).
- Enables improvements in the care process/pathway to ensure speedy response when appropriate and shortened wait.
- Reduced ill health.
- Reduced need to go to hospital.
- Integrated working, without inter professional and agency barriers.
- Better environment – safety, privacy, comfort, access.
- Appropriate 24 hour access.
- Demonstration of effectiveness and efficiency.
- Assurance of competence standards of staff.
- Opportunity to extend role.
- Access to the clinician of choice.
- Buildings that match service need.
- Very good access to information leading to complaints reduction.
- Engender personal responsibility.

13.6 The long list of non-financial benefit criteria was considered by the workshop groups, rationalised into a short-list and then weighted to reflect each criterion's relative importance.

13.7 The process for short listing consisted mainly of identifying themes that were common to a number of the benefits suggested in the long list and combining them together under the heading of these themes into a more manageable list of fewer options. For example five of the detailed benefits in the long list were seen to have in common the wider benefit of enabling access to a highly skilled and motivated workforce. These detailed benefit criteria were the assurance of competence standards of staff, effective recruitment, the opportunity to extend the roles of some staff groups, very good job satisfaction and good personal and professional development opportunities. Therefore any option that would have been capable of achieving any one of these

would have also been capable of enabling access to a highly skilled and motivated workforce.

13.8 The process for weighting consisted of making decisions as a workshop group about the proportion of 100 available weights that should be allocated to each benefit criterion. The allocation of a high number of weights to a benefit criterion means that workshop participants thought that it was more important for change to achieve it than to achieve benefits embodied in other criteria. Any option that was therefore thought to be likely to achieve the higher weighted benefit criteria would be more likely to emerge as the preferred option. For example it was considered much more important for options to be able to achieve the benefit criteria of ease of access to services, access to a highly skilled and motivated workforce and access to integrated, responsive and patient centred care than the other four criteria listed in the next table.

13.9 The weighting was carried out from three different perspectives; patients using the service, the general public and professional and other staff delivering primary care services. These were combined to give an overall weighting. The results of this stage of the process are set out in the following table. It also contains an equal weight that was used in the sensitivity analysis described later in this report.

Benefit Criterion	Patient Weight Mean	Public Weight Mean	Professional Weight Mean	Overall Weight	Equal weight
Easily accessible services	32	34	8	29	14.3
Effective and efficient services	2	2	3	2	14.3
Highly skilled & motivated workforce	13	13	58	29	14.3
Integrated, responsive & patient centred care	32	25	18	24	14.3
Positive health outcomes	3	13	3	6	14.3
Good quality physical environment	8	8	5	5	14.3
Support & Information to enable self care	10	5	5	5	14.3
TOTAL	100	100	100	100	100

13.10 Scoring of options

13.11 A key stage in the option appraisal process was the scoring of options against the non-financial benefit criteria. This was carried out at a workshop attended by a wide range of representatives from the LHB and stakeholders including GPs, managers, healthcare professionals

and public/patient representatives. The methodology adopted by the workshop closely followed that described in the NHS Capital Investment Manual and involved:

- Scoring the options against the non-financial benefit criteria (determining how well each option is expected to perform in terms of delivering each non-financial benefit).

- Multiplying the scores by the weights to arrive at a "Weighted Benefit Score" for each option. This "Weighted Benefit Score" is simply a measure of how well the workshop participants felt that the options would deliver the required non-financial benefits.

- Comparing the "Weighted Benefit Scores" of options to identify a preferred option in terms of non-financial benefits.

13.12 The following table illustrates how the "weighted benefit score" is calculated using the "Do Nothing" option as an example.

Benefit criterion		Weight	Score out of 10	Weighted score
No	Description			
1	2 (As agreed by workshop participants)	3 (As allocated by workshop participants)	4	5 Column 3 times Column 4
1	Easily accessible services	32	4	128
2	Effective and efficient services	2	4	8
3	Highly skilled and motivated workforce	13	3	39
4	Integrated, responsive and patient centred care	32	3	96
5	Positive health outcomes	3	4	12
6	Good quality physical environment	8	4	32
7	Support and information to enable self care	10	3	30
TOTAL		100	25	345

13.13 The "Weighted Benefits Scores" that resulted from the scoring of the options against the non-financial benefit criteria are shown in the table overleaf for the three scoring scenarios:

- Consensus score – the score agreed by the majority of the workshop delegates.
- Pessimistic score – the score recorded when some delegates felt that the consensus score was too high.
- Optimistic score – the score recorded when some delegates felt that the consensus score was too low.

13.14 The weights used for calculating the weighted non-financial benefits scores shown in the table were the overall weightings proposed by participants at the option development workshop.

WEIGHTED SCORES BASED ON OVERALL WEIGHTINGS

Option		Weighted Benefit Score		
No	Description	Consensus	Optimistic	Pessimistic
Option No 1	Do nothing	342	383	287
Option No 2	Do Minimum	378	417	323
Option No 5	Service decentralisation	542	639	514
Option No 6a	Multiple hub structured access	736	799	649
Option No 6b	Single hub & structured access	403	531	174

13.15 The table clearly shows that Option No 6a: "The multiple hub structured access" option has the highest weighted non-financial benefit score. The table also shows that this is true under all three scoring scenarios. Therefore, the strategic option that, in the views of the workshop delegates, is most likely to maximise the most important non-financial benefits required from the strategy is Option No 6a: "The multiple hub structured access" option.

13.16 Sensitivity Analysis

13.17 Given the subjective nature of the scoring and weighting exercise, it was important to examine the sensitivity of the results to changes in underlying assumptions. Therefore, the weighted non-financial

benefits scores were recalculated under the following scenarios.

- Using the non-financial benefit criteria weights arrived at from the three different perspectives covered at the option development workshop.

- Using equal weights for all the non-financial benefit criteria i.e. assuming all criteria are equally important.

13.18 The results of these sensitivity analyses are shown in the following tables.

WEIGHTED SCORES BASED ON PATIENT WEIGHTINGS

Option		Weighted Benefit Score		
No	Description	Consensus	Optimistic	Pessimistic
Option No 1	Do nothing	345	380	298
Option No 2	Do Minimum	368	401	321
Option No 5	Service decentralisation	557	650	521
Option No 6a	Multiple hub structured access	744	805	638
Option No 6b	Single hub & structured access	377	466	182

WEIGHTED SCORES BASED ON GENERAL PUBLIC WEIGHTINGS

Option		Weighted Benefit Score		
No	Description	Consensus	Optimistic	Pessimistic
Option No 1	Do nothing	357	382	317
Option No 2	Do Minimum	380	403	340
Option No 5	Service decentralisation	550	647	521
Option No 6a	Multiple hub structured access	741	795	643
Option No 6b	Single hub & structured access	389	480	197

WEIGHTED SCORES BASED ON PROFESSIONAL AND STAFF WEIGHTINGS

Option		Weighted Benefit Score		
No	Description	Consensus	Optimistic	Pessimistic
Option No 1	Do nothing	319	390	240
Option No 2	Do Minimum	385	453	306
Option No 5	Service decentralisation	534	618	510
Option No 6a	Multiple hub structured access	716	802	677
Option No 6b	Single hub & structured access	437	632	143

WEIGHTED SCORES BASED ON EQUAL WEIGHTINGS

Option		Weighted Benefit Score		
No	Description	Consensus	Optimistic	Pessimistic
Option No 1	Do nothing	357	414	314
Option No 2	Do Minimum	400	443	357
Option No 5	Service decentralisation	571	643	529
Option No 6a	Multiple hub structured access	743	800	686
Option No 6b	Single hub & structured access	386	486	200

13.19 The tables show that under all weighting scenarios, Option 6a remains the option with the highest weighted non-financial benefits score.

13.20 Further sensitivity analysis was carried out by calculating the change in the differences between weighted non-financial benefit scores that would be required for each other option to become the preferred option based on overall weightings applied to consensus scores. The following table shows the results of this.

Option		Preferred Option Overall Weighted Score	Next Option Overall Weighted Score	Change Required to be Preferred Option	
No	Description			Number of Weighted Benefit Points	% of Option Weighted Benefit Score
1	Do nothing	736	342	394	115.2
2	Do minimum	736	378	358	94.7
5	Service decentralisation	736	542	194	35.8
6a	Multiple hub structured access	736	736	0	0.0
6b	Single hub structured access	736	403	333	82.6

13.21 The table shows clearly that there would need to be a very significant change in the scores given to options to bring about a change in their ranking.

13.22 The conclusion drawn from the sensitivity analysis is that the choice of Option No 6a: "The multiple hub structured access" option as the preferred option is a very robust one and is unlikely to change without very significant changes in scoring and/or weighting.

13.23 The evaluation of options in terms of costs

13.24 Capital costs for the main new developments in each of the options were estimated by developing indicative accommodation schedules and establishing a detailed cost for the proposed accommodation using the costing methodologies for outline business cases set out in the capital investment manual. The smaller developments were costed using unit costs derived from the main new development costs applied to the overall functional content of each development.

13.25 The capital costs of options are shown in the table overleaf.

Option		Expenditure Requirement			Rank
No.	Description	New Build/ Refurb (£000)	Backlog (£000)	Total (£000)	
1	Do Nothing	0	0	0	1
2	Do Minimum	0	516	516	2
5	Service decentralisation	44,018	104	44,122	5
6a	Multiple hub structured access	36,305	128	36,433	3
6b	Single hub structured access	36,848	128	36,976	4

13.26 The table clearly shows that only the "do nothing" and "do minimum" options that offer no opportunities for service modernisation and improvement are lower cost than Option 6a and 6b which are broadly equivalent in terms of capital costs. The service decentralisation option is shown to the most expensive capital option by a significant margin.

13.27 The capital costs and annual revenue life cycle costs (i.e. annual costs of maintaining and renewing buildings over their expected lives) have been used to determine the net present costs of each option using a standard discounting technique over a 60 year life at the Treasury recommended discount rate of 3.5 per cent. These are shown in the following table.

Option		Net Present Cost		Rank	
No.	Description	Value (£000)	Value per benefit point (£000)	Value	Value per benefit point
5	Service decentralisation	84,745	156	3	2
6a	Multiple hub structured access	72,910	99	1	1
6b	Single hub structured access	76,407	190	2	3

13.28 The table shows that option 6a is the preferred option in terms of net present costs and is therefore the best value for money option. This is further confirmed by it having the lowest cost per expected "weighted benefit point". The "weighted costs per benefit point" in this table has been derived by dividing the net present value of each option by the weighted benefit point score for each option based on consensus scores and overall weightings.

13.29 The additional capital expenditure would have consequences in terms of revenue funding since it would attract capital charges, Private Finance Initiative tariffs or rental payments depending on the procurement and funding option adopted. Hence, it could produce an affordability issue for the LHB, the Bro Morgannwg NHS Trust and other local partners if the Integrated Healthcare Strategy for Primary Care Premises resulted in significantly increased revenue costs compared to the existing situation.

13.30 This affordability issue has been examined by comparing the capital charges (interest and depreciation) that the LHB would attract by implementing the Strategy with the LHB's current costs associated with rent reimbursement. The results are shown in the following table.

Option	Future New Capital Charges			Existing Costs		Total Future Costs £'000	Indicative Revenue Gap £'000
	Depreciation £'000	Notional Interest £'000	Total £'000	Total £'000	Retained £'000		
5	1100	1541	2641	850	170	2811	-1961
6a	908	1271	2178	850	213	2391	-1541
6b	921	1290	2211	850	213	2423	-1573

13.31 The additional revenue funding required to implement the Strategy will need to be addressed by the LHB and its partners through discussions locally and with the Welsh Assembly Government as they develop business cases for individual projects.

13.32 The evaluation of options in terms of risk

13.33 A desktop exercise was undertaken and agreed with the Integrated Healthcare Strategy for Primary Care Premises Project Team. The purpose of the exercise was to assess risks and it identified the following key areas of risks:

- **Non-financial benefits** – Clearly, the exercise described earlier, where the options were evaluated in terms of expected non-financial benefits, is a subjective one. Therefore, there is a risk that in practice the expected non-financial benefits will not be achieved.

- **Deliverability** – Given the long term nature of the Strategy and the fact that it comprises a relatively large number of different projects there is a risk that it will prove difficult to deliver. For instance, there are risks associated with finding the necessary sites for the new buildings and getting planning permission for the required developments. Similarly, there are risks that funding may not be forthcoming for all or parts of the Strategy.

- **Human resources issues** – Any primary care Strategy is inevitably heavily dependant upon a wide range of medical and other healthcare professionals being available to deliver the required changes in services. Therefore, there is a very real risk that some of these professionals may not be available at the required time – failure to recruit GPs, community nurses etc.

- **Costs** – The capital and revenue costs that have been estimated for the options are subject to a number of possible risks such as:

  - Overrun on construction costs.
  - Dealing with the impact of the negative equity issues.
  - Impact of varying asset lives.
  - Revenue cost levels/savings not achieved.

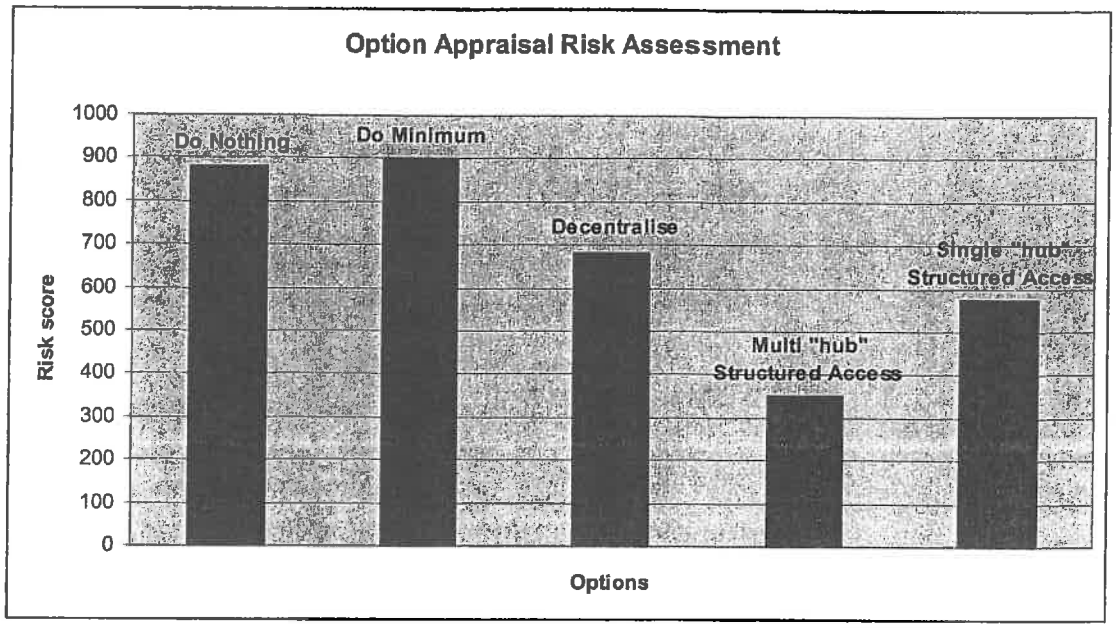
13.34 The exercise examined each of the options against these risk headings in a structured way by assessing both the impact and probability of each risk. For each risk heading the probable impact of the risk was assessed on a five point scale:

- Negligible.
- Minor.
- Moderate.
- Major.
- Catastrophic.

It then assessed the probability of the risk occurring on a five-point scale:

- Unlikely.
- Remotely possible.
- Possible.
- Probable.
- Almost certain.

13.35 A proprietary software system was used to translate the assessments into a risk score for each option. The results of this risk assessment are shown in the chart overleaf.

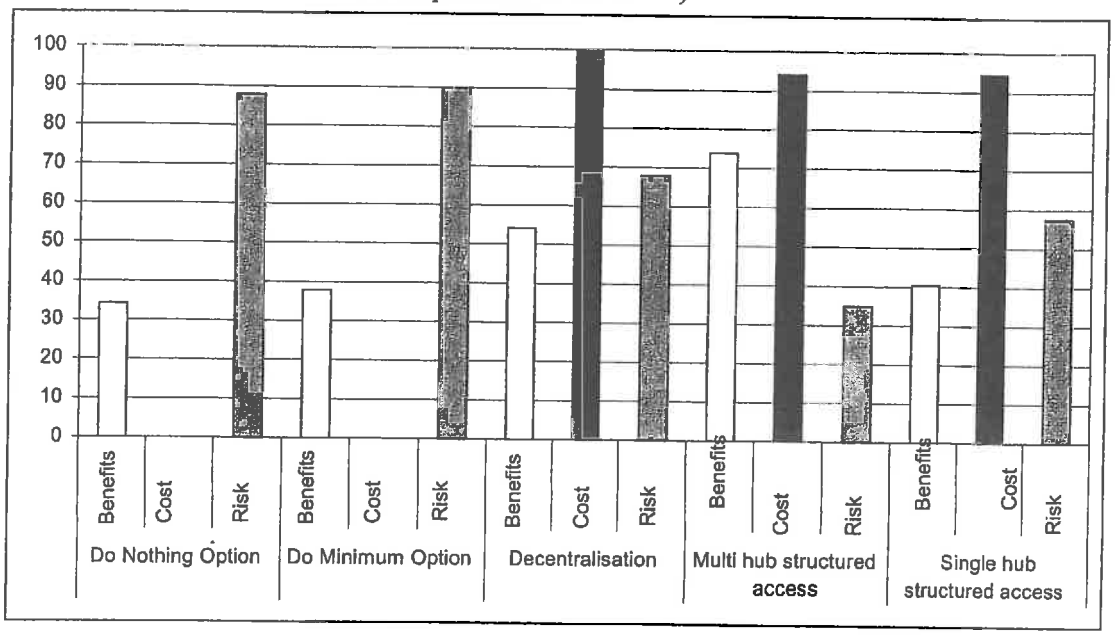


13.36 The chart clearly shows that there are very significantly increased risks associated with the "Do nothing" and "Do minimum" options which is reflected in their high risk scores. This was primarily due to the relatively poor provision and quality of a number of the existing primary care premises which, when combined with the need to significantly increase the amount and range of primary care services in the future was likely to lead to high risks of failure.

13.37 In contrast, the three options involving significant change and investment in primary care premises were considered to be relatively low in terms of risk. Of these three options, the decentralisation model was considered to be most risky given its huge dependence on attracting the numbers of staff required to make it work successfully. The "Single site Hub and Spoke" option was thought to be exposed particularly to risks of staff not being prepared to move with services to a single centre. The rationale behind the "Multiple site Hub and Spoke" option having the lowest risk score is based on its unique combination of utilising the best of the existing premises but investing in replacing the poorest premises. Furthermore, this option provides maximum flexibility over the longer term for the premises to be developed in an integrated way with evolving and changing service models.

14.0 Combining Non-financial Benefits, Capital Costs and Risks

14.1 The option appraisal exercise described above aims to identify a preferred option that maximises the non-financial benefits from the strategy at an affordable cost with acceptable risks and provides good value for money. Hence, the work of evaluating the non-financial benefits, costs and risks of options can be brought together to provide a "picture" of the performance of the options. The graph below shows this in relation to non-financial benefits, net present values of capital and life cycle costs and risks (all values are presented on a scale of 0 to 100 to enable relative comparisons to be made).



14.2 The chart shows that Option 6a (the multi hub structured access option) has the potential to outperform all other options in terms of non-financial benefits, value for money and risk. It is therefore a strongly dominant option and should form the basis of the LHB's strategy for primary care service and estate development.

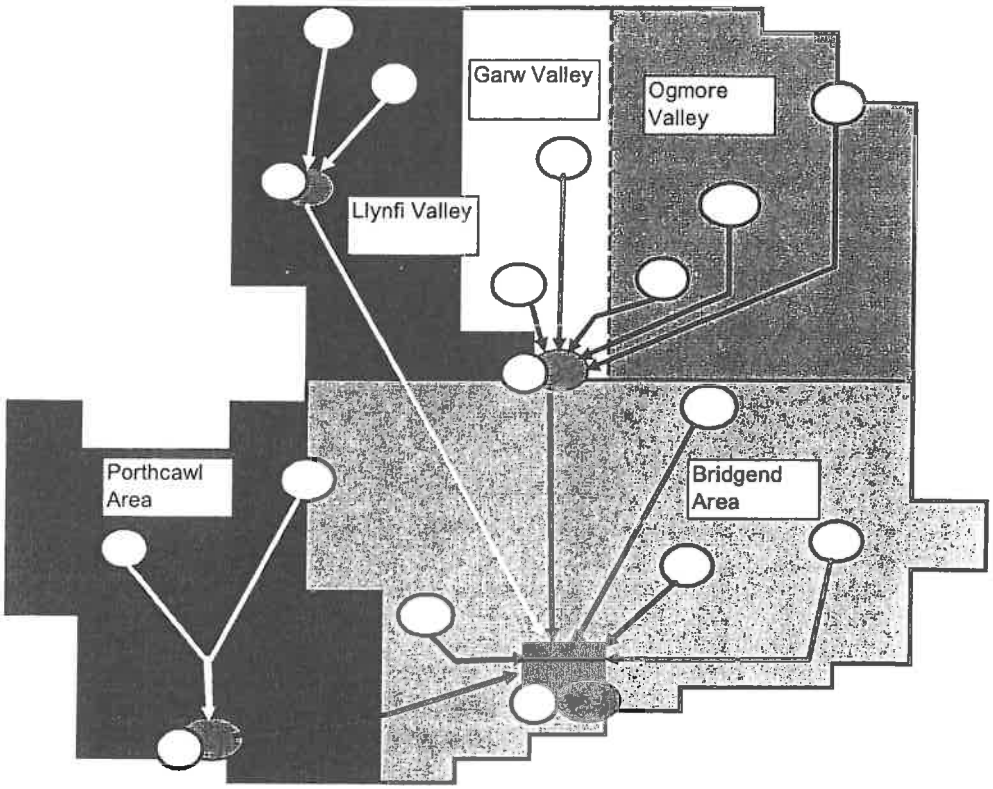
15.0 The Preferred Option

15.1 The option appraisal process and the subsequent analysis of the non-financial benefits, costs and risks have led the LHB and its stakeholders to conclude that Option 6a: "Multi Site Hub and Spoke" is the preferred option.

15.2 Further development work has been carried out to identify the practical way in which this option could be implemented and the diagram below

shows in broad terms where the "Hubs" and "Spokes" would be located and the structure of each network (The "Hubs" are shown in grey with a "major hub" shown as a black square. The "Spokes" and "satellite spokes" (see paragraph 15.15) are shown as white symbols. The arrowed black and white lines represent patient pathways within the model. The background colours distinguish the five localities within The Bridgend LHB area and recognise that Ynsawdre acts as the hub for both the Garw and Ogmore Valley localities.)

15.3 This representation of the "Hub and Spoke" model is an initial concept of what the model could look like; it is likely to be subject to change throughout the business case process.



15.4 The underlying theme of this option is to provide the widest possible range of services as locally as is practical and commensurate with safe clinical practice.

15.5 The combination of the "Hub" and the "Spokes" provides the best of both the "Centralised" and "Decentralised" options. It should enable a good range of services to be provided locally with referral to the "Hub" for more complex procedures and services. Since the "Hubs" are also relatively local then this will significantly improve the local access to a wide range of services.

15.6 This option provides a very flexible solution to local needs since it will enable each "Hub" and "Spoke" to uniquely evolve and develop and facilitate the development of new ways of working and the adoption of new technologies to proceed at different paces in different localities and sub-localities.

15.7 This solution has the potential to provide a dynamic network of premises and service provision which in turn should facilitate the development of clear clinical networks, focused on patient's needs and where the "patient journey" is as direct and convenient as possible.

15.8 The integration of all primary care professionals into strong and well-supported teams is one of the key aims of the LHB. This option provides the infrastructure, in terms of property, to enable that goal to be achieved.

15.9 The Role, Service Content and Locations of "Spokes"

15.10 The general role of a "spoke" is to provide a full range of the primary care services that people should have access to in their own communities. They would be the first line of access to primary care services.

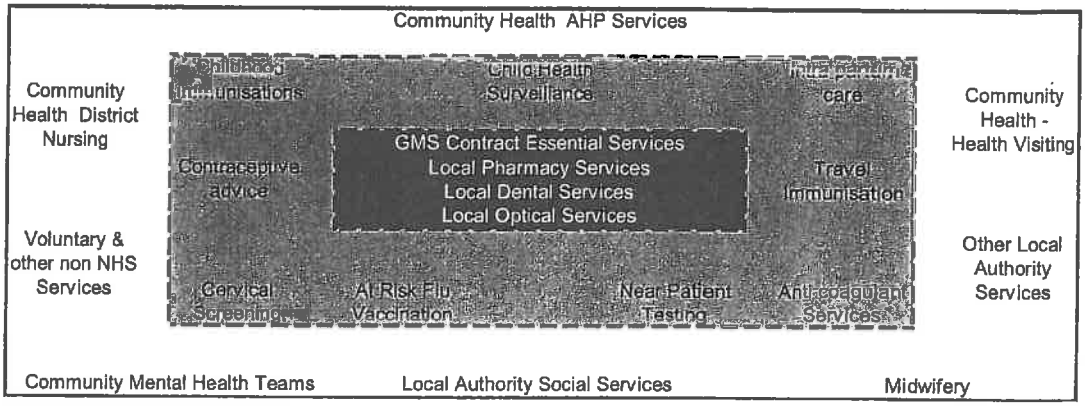
15.11 They would therefore provide all core general practice services including those services provided from within practices by professionals other than doctors. They would provide practices with the opportunity to expand and enhance services in line with the aspirations of the new General Medical Services contract, where it was economical to provide these services to a local community with a small population.

15.12 They would also provide the core community health, social work and pharmacy, dental and optometry services that people need to access in their local community.

15.13 They would enable these diverse core primary care services to work together to provide "one stop" local access to health and social care.

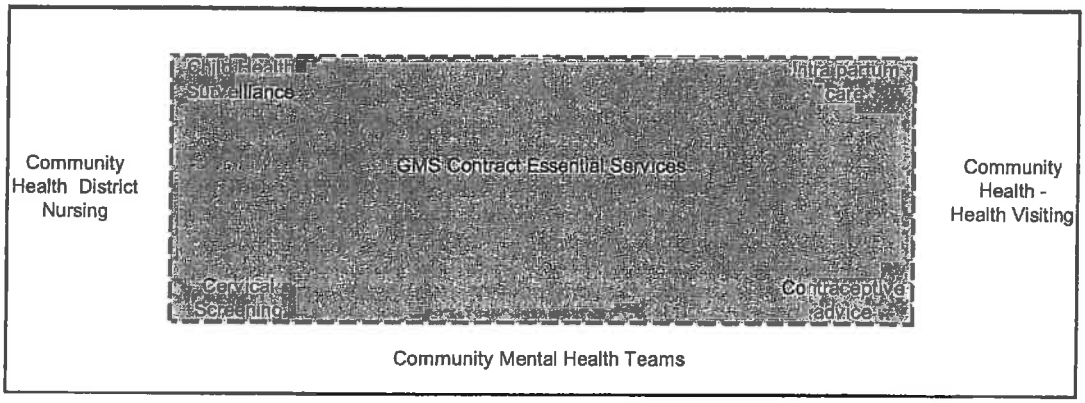
15.14 The following diagram illustrates the levels of service that could be available in a "spoke" in the proposed model. Services referred to in dark box at the centre of the diagram are core services that would be permanently based in most "spokes". The surrounding grey box contains further core services that could be provided in a "spoke" subject to the contract between the practice providing the services and the LHB. In the case of both "hubs" and "spokes" the illustrations show the current thinking on the placement of services provided under the new GMS contract. The outer white box contains services that could be provided by staff outreaching from another base.

STANDARD SPOKE SERVICES



15.15 A further illustration (following) using the same conventions sets out the typical service content of a satellite spoke.

SATELLITE SPOKE SERVICES



15.16 In the main the communities where main general practice surgeries have been developed are the centres of population that are large enough to support a "spoke". There are three exceptions to this. The first is the community in the Brackla electoral division of the County Borough that has grown over recent years and where services have recently been developed to provide local access for that community to the range of services that it needs. The others are areas of current and significant population growth to the west of Bridgend town and north of the town towards Ynsawdre. Developments are still needed to meet the needs of these communities and have been allowed for in this strategy.

15.17 Other "spokes" would be around the existing general practice bases in the County Borough as indicated on the schematic diagram referred to in paragraphs 15.2 and 15.3.

15.18 The Facilities Required to Accommodate the Service Content of a "Spoke"

15.19 The ideal way of accommodating these services would be in a single practice centre that would house all the services provided at this level in each community. It could operate as a "one stop shop" for service users living in its local community catchment area.

15.20 Whilst this would be a long term aim, it is recognised that the existing pattern of development in most communities is for general practice surgeries, community clinics, dental surgeries, pharmacies and optometrists shops to be built nearby each other. This means that, particularly where these premises provide sufficient good quality accommodation to sustain the range of services needed, they could work together to provide integrated services to the local community. The intention in the short term would therefore be to continue to use these "clusters" of premises in a more integrated way than has been the case in the past.

15.21 Over time General Practitioners, other independent contractors and other providers could be encouraged by the LHB to come together to plan the replacement of existing premises with buildings that could accommodate the full range of services available at local community level. Such moves could be particularly encouraged where the development of an appropriate service range is being hindered by a shortage of suitable accommodation. Modelling of existing space provision against future service requirements referred to earlier in this document (see table at page 23) shows the need for a considerable expansion in the space available at general practice level. In view of this the LHB could look to support sufficient initiatives from local service providers to enable up to seventy five per cent of services to be provided from new "one stop shops". The development of facilities to provide the services needed at "hub" level might also create opportunities to improve the accommodation available for local community level services.

15.22 The accommodation in the practice centres will typically comprise generic and specialist clinical accommodation for a range of professionals to consult with and treat patients, offices and meeting areas for administrative support, staff development and self help activity and shop space for dispensing or selling pharmaceutical and optical products.

15.23 The Role, Service Content and Locations of "Hubs"

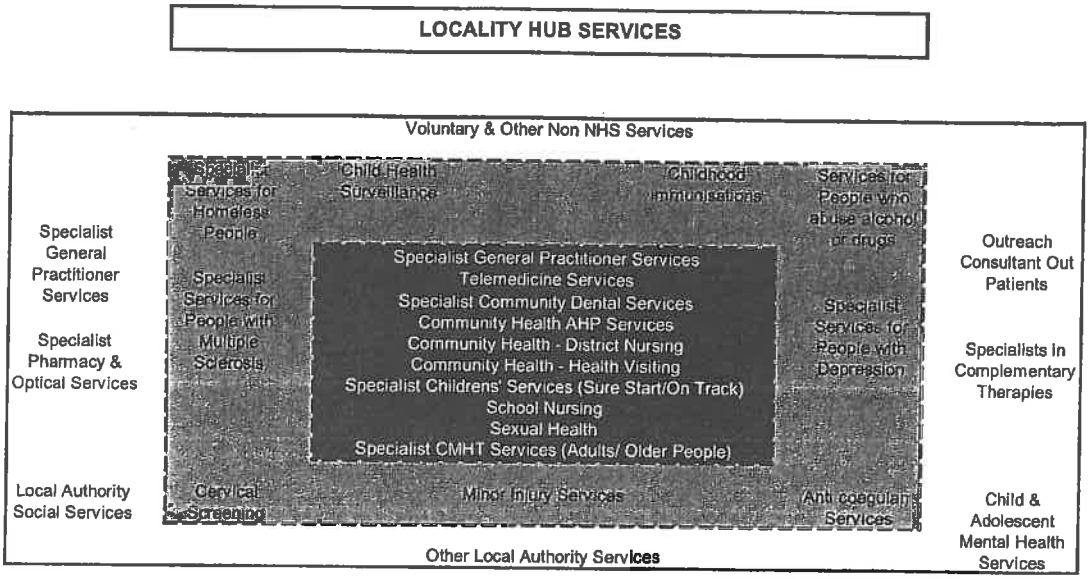
15.24 The general role of a "hub" is to provide a full range of the specialist primary care services that people should have access to as locally as possible but that it is not economical to provide in their own communities. They would be the second line of access to primary care services. They complement the services provided in "spokes"; they do not duplicate them. However in some cases, as further explained later in this section of the report, both "spoke" and "hub" services may be provided together in the same Primary Care Centre.

15.25 As such "hubs" are a resource to support the extended role of locally based primary care staff. Each "hub" would work with a network of "spokes" in its catchment area. The precise range of services to be provided will vary according to the size and health needs of the population served and the extent of other local service provision.

15.26 The services in "hubs" will be provided by teams comprising specialist general practitioners, hospital consultants, community dentists and pharmacists, optometrists, social workers, nurses and health visitors, allied health professionals, specialists in complementary therapies, housing and welfare benefit staff and voluntary agencies. "Hubs" could also be the focus for developing telemedicine services in the County Borough.

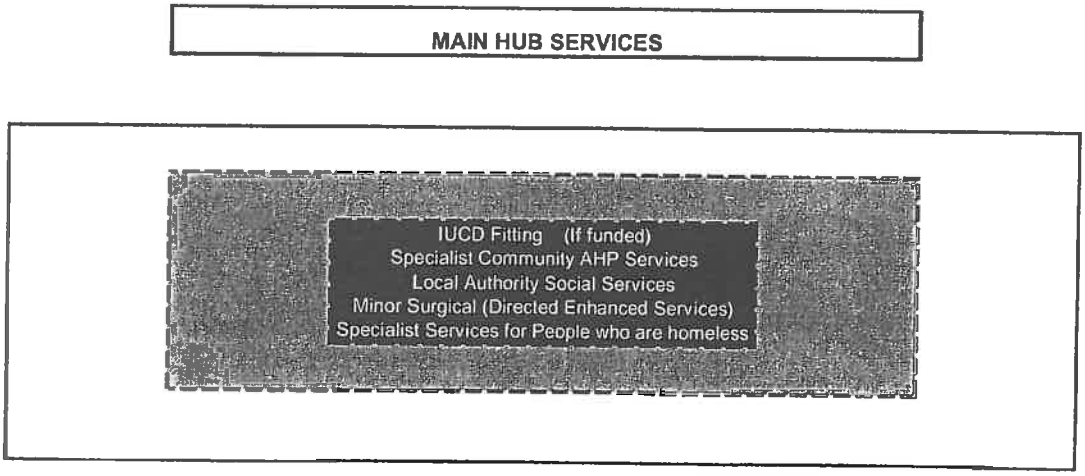
15.27 Practices in the "hub" catchment area that have General Practitioners with a specialist interest would be able to develop services to support that interest in the "hub".

15.28 The following illustration indicates the typical service content of a "hub".



15.29 One of the "hubs" probably located in Bridgend town and therefore at the centre of transport routes in the County Borough could be designated as a "main hub". As such it could provide access to very specialised services and services needing special equipment or accommodation (such as speech therapy, audiology, podiatry and physiotherapy) and could accommodate team bases for community nursing staff, allied health professionals and social work staff who would provide peripatetic services at other "hubs" and some "spokes". It could also be the main base for services provided by visiting hospital consultants.

15.30 This larger "hub" could contain the ***additional*** services set out in the following illustration.



15.31 "Hubs" would enable these diverse specialist primary care services to work together to provide "one stop" access to specialist health and social care as locally as is practicable.

15.32 The location of "hubs" needs to balance the economies of scale of providing services to as many people from one place as possible with the access difficulties created by the geography of the County Borough in general and the valley areas in particular.

15.33 This balance is best achieved by providing "hubs" in four main locations indicated as darker grey and black symbols on the schematic diagram referred to in paragraphs 15.2 and 15.3.

15.34 These four could have different roles in relation to the communities that they would serve as follows:

- ***Bridgend*** – providing services to people in Pencoed, Bridgend town and the areas in the Bridgend locality immediately to the west and north of the town. Due to its location this is likely to be the main "hub" and the 75,337 people registered with Bridgend locality GPs in Laleston/Merthyr Mawr, Oldcastle, St Bride's Minor, Ynysawdre and Pencoed could also access its services.
- ***Ynsawdre*** – providing services to communities in the Garw and Ogmore Valleys and local primary care services in Pontycymmer, Nant y Moel and Ogmore Vale. Registered population – 15,629.
- ***Maesteg*** – providing services to communities in the Llynfi Valley and local primary care services based in Maesteg, Caerau and Nantyffyllon. Registered population – 22,553.
- ***Porthcawl*** providing services to communities surrounding Porthcawl and local primary care services in Porthcawl West. Cornelly and Pyle. Registered population – 33,079.

15.35 The Facilities Required to Accommodate the Service Content of a "Hub"

15.36 The ideal way of accommodating these services could be in a primary care resource centre that would contain the services needed in the "main hub" at Bridgend. This would be supplemented by three primary care centres (Maesteg, Ynsawdre and Porthcawl) each of which would accommodate services for its catchment area, some of which would be available as permanent services and others would be provided by staff visiting from the main "hub". Each of these facilities could also operate as the "spoke" for service users living in its local community catchment area.

15.37 No premises currently exist in the areas where the development of "hubs" is proposed that are large enough to accommodate the range of services required. Therefore as part of any programme for

implementing the estate strategy, these facilities would involve the provision of new accommodation.

15.38 The accommodation in them will comprise clinical accommodation for consulting with and treating patients, team bases for groups of staff that provide outreach services and administrative support and staff development.

16.0 The Benefits of the Integrated Healthcare Strategy for Primary Care Premises

16.1 Much of the work of developing the Strategy has focused on identifying the benefits of the strategy to patients, public and staff. The rigorous approach that has been adopted for the appraisal of options in terms of benefits has resulted in a robust choice of a preferred option that clearly maximises these required benefits.

16.2 In addition to those benefits previously identified for patients, public and staff there are wider benefits for the LHB in implementing the Strategy:

- It provides an imaginative and innovative way of dealing with the increasing burden of work falling on primary care services and of creating capacity in primary care that can where safe and effective to do so avoid secondary referral.
- It enables the LHB's service strategies to be implemented by ensuring that the estate will match the service needs in terms of its size, location, functional suitability and quality.
- It provides modern, high quality and efficient buildings appropriate for delivering modern primary care services in the 21st Century.
- It improves the utilisation of the LHB's property portfolio by clearly identifying those buildings that are needed to deliver the service i.e. it is a service driven Integrated Healthcare Strategy for Primary Care Premises.
- It minimises the need to fund expenditure on backlog maintenance on existing buildings by concentrating services in those buildings with least backlog and by disposing of those with major expenditure requirements.
- It provides a phased, incremental approach to developing and modernising the LHB's property portfolio and thereby provides flexibility to cope with the inevitable changes in service delivery in the future.
- It provides a clear plan for change that enables progress towards agreed goals to be measured.

- It provides a strategic context in which detailed capital investment plans and business cases can be developed and evaluated.
- It demonstrates to the public, patients and staff that the LHB has positive future plans to invest in improving primary care services and facilities in Bridgend County Borough.
- It moves the LHB in the direction of turning the aspiration of a "primary care led health service" into a reality.

17.0 Implementing the Integrated Healthcare Strategy for Primary Care Premises

17.1 The magnitude of the capital expenditure required to deliver the Premises Strategy and the complexity of property ownership will make implementing the Strategy a complex and challenging task for the LHB. It is clear that any one particular option on its own is unlikely to be able to underpin the implementation of the whole strategy. The LHB may need to see the procurement solution as a combination of many or all of the funding options.

17.2 It is widely recognised that the funding and procurement mechanisms used in the past to procure and fund the primary care estate have led to a lack of flexibility for Health Authorities and LHBs and independent contractors and are a contributing factor in the current backlog of investment needed in the primary care estate.

17.3 Changing Government policy and organisational change in the NHS is leading to an increasingly "corporate" approach to delivering primary care and the ability for GPs to practice as individuals is circumscribed by the need to function and take decisions as part of a larger group with common objectives. This highlights the need for LHBs to become the focus of policy and strategy development. Premises provision is inextricably linked to service strategy and the LHBs will need to exert greater control over premises provision in order to influence service strategy. This is leading to new and different funding and procurement options being developed. The Welsh Assembly Government (WAG) has already acknowledged the difficulties of premises development in deprived areas and the introduction of new "flexibilities" have been welcomed. The LHB need to work with the WAG to develop these "flexibilities" further, especially in relation to the future ownership of primary care premises and the role and powers of the District Valuer.

17.4 The options available for procurement and funding are:

- GP funded and owned with reimbursement through the "Red Book" rent and rates scheme.
- Third party developer led schemes.

- NHS owned, using private or exchequer funding.
- Private Finance Initiative (PFI) schemes.
- NHS Local Improvement Finance Trust (LIFT) schemes.

17.5 Some of these procurement and funding options are well established whereas others are still in their infancy. These existing and newly emerging procurement and funding options have been examined in relation to their suitability for implementing this Integrated Healthcare and Premises Strategy and a commentary on them follows.

17.6 GP funded and owned

17.7 Traditionally, primary care premises have largely been procured, funded and owned directly by independent practitioners who have been reimbursed the cost of owning or renting premises through the "Red Book" – Rent and Rates Scheme. Premises can be accepted into the scheme if they meet the minimum standards described in the "Red Book".

17.8 The "Red Book" minimum standards requirement has led to a large variation in the condition and performance of properties with some practices offering state of the art, purpose built facilities incorporating space for a wide range of other professionals but in some places services continue to be delivered from sub standard, inappropriate facilities.

17.9 This procurement route is dependent on the GPs being pro-active and being prepared to invest in developing and modernising the primary care estate. The economics of the property market in some parts of Wales, the changing demographics of the GP workforce and the changing expectations of young doctors means that this funding and procurement option is becoming less attractive to practitioners. Newly qualified doctors are increasingly unwilling to take the risk of buying into practice premises and investing in further development.

17.10 The "Structured Access" model of service provision proposed in the Integrated Healthcare and Premises Strategy places considerable emphasis on providing a wide range of "integrated" services within one building and implies a multi-disciplinary primary care team within which GPs may no longer be the majority, and a scale of development and cost that many GPs may find daunting.

17.11 The Strategy is concerned with long term planning of premises reprovision and development. Inevitably, this will mean that the LHB will be planning development opportunities before knowing who the occupiers will be, and may have to act as the lead in the procurement process. There may also be a need to sanction some investment before GPs are recruited, in order to support recruitment. Evidently, close

working and continuous communication with the WAG are vital to the process and its successful conclusion especially with regards to the development of future policy and legislation concerning the powers and role of the LHB.

17.12 A new generation of salaried GPs will probably not want to have responsibility for premises development and ownership. It is imperative that the LHB has the ability to procure first class accommodation for the recruitment of GPs and the delivery of primary care services in the future.

17.13 The LHB acknowledges that certain premises within The Bridgend LHB area are of a high standard and fit strategically within the proposals for the new primary care estate. However, the reliance on this traditional method of procuring and funding primary care premises for implementing this ambitious and capital-intensive Premises Strategy is unlikely to provide the flexibility and control needed by the LHB. In particular, the need to successfully implement the Strategy in a timeframe that is compatible with the need to improve and change services will require a much more proactive and strategic approach.

17.14 NHS funded and owned premises development

17.15 A potential funding option would be for the LHB to develop and own the new buildings required by the Strategy. This has happened in the case of Primary Care Trusts in England who can own health centres, community hospitals and administrative centres. In fact, the PCT model is generally one of a "mixed economy" with both GP and PCT owned properties making up the primary care estate. The LHB will need to work with the WAG to ensure that appropriate statutory changes are made to ensure that Local Health Boards have the same or similar powers as PCTs.

17.16 It is acknowledged that managing a capital programme and scheme is a challenging task for the LHB requiring resources and expertise. Similarly, ownership of the estate would bring with it serious statutory and management responsibilities requiring an on-going estate/property management function within the LHB and access to a funding stream that ensured that backlogs of deferred maintenance did not build up. In planning the implementation process the LHB would have to ensure that all these issues are addressed and resourced accordingly.

17.17 The LHB will have to ensure that the funding consequences of the whole strategy are identified up front as part of the business case process. This should help ensure that capital funding is not just secured for the first stage of implementation and that a rolling programme of improvements and new developments can be properly planned and managed.

17.18 Third party developer schemes

17.19 In recent years a number of primary care premises have been procured through third party developer schemes. Under these arrangements the ownership of the premises is retained by the developer who usually funds all the costs associated with procuring and owning the building i.e. land, design, construction and maintenance. The developer obtains a return on his investment through a lease with the GPs, which in turn is covered by rent reimbursement. The developer also retains the responsibilities, risks and obligations of ownership including maintenance of the premises to standards agreed with the users.

17.20 The principle of the scheme is that where there is a demand for new premises the open market rental value of that property (assessed by the District Valuer) should justify the creation of new or refurbished premises and hence, current market rent (CMR) levels can be used to reimburse GPs.

17.21 The majority of the successful schemes procured using this approach have been in areas where property values are fairly strong and where the GPs and the local developers are proactive.

17.22 This approach has required GPs to be committed to a long-term lease, which may not be attractive to GPs approaching retirement. Furthermore there is an increased expectation that buildings will be occupied by multiple users such as LHB services, Local Authority services, independent contractor services and retail services. This may also lessen the willingness of GPs to hold the head lease. These issues could be overcome by the LHB taking on the role of head lessee and subsequently sub-letting to GPs and other users on more flexible leasing arrangements. This could be beneficial for both GPs (who could potentially take on more flexible and short term leases) and developers (who generally perceive numerous individual tenants as presenting a higher risk than a single entity such as a PCT or LHB).

17.23 If this approach were to be adopted it would require the LHB to take the lead role and work much more closely with the GPs in proactively instigating schemes and funding the initial work of finding and evaluating sites, evaluating developer proposals and negotiating contracts.

17.24 In summary, this procurement and funding option could be used as an element of the whole solution. It becomes a more effective option if the LHB can take the head lease on properties. The WAG is in the process of formalising the extent of powers to be granted to Local Health Boards and the indications are that LHBs will be property-owning bodies. This new authority will enable Bridgend LHB to enter into

preliminary discussions with various third party developers to establish their interest in the implementation programme.

17.25 Private Finance (PPP/PFI) schemes

17.26 Under the Private Finance Initiative and Public Private Partnership approaches, the private sector finances the design, construction and operation of the building for a public sector client and owns the building. The client pays an annual charge to lease the building, usually for a period of 25 or 30 years.

17.27 PPP/PFI as a means of designing, building, financing and operating new facilities now has an established track record in secondary care where some £4 billion worth of new buildings have been procured through this means.

17.28 The PPP/PFI consortia that have been formed to bid for health building schemes are, for the most part building contractor led in close collaboration with a facilities management service provider and are focussed on large, single building schemes of £20 million plus. In the past, contractors have had a negative view of the viability of PPP/PFI for smaller schemes, mainly due to the cost of bidding given the lack of relationship between size of scheme and its associated facilities management costs and contractors' bid costs. However, this situation is changing as the PPP/PFI process is becoming more familiar to clients and bidders and standardised documentation and contracts are being adopted. As a result, a number of smaller projects such as community hospitals are being procured through this route. However packaging schemes for health economy wide PPP/PFI procurement may prove more attractive to potential bidders than single schemes.

17.29 In theory, there is no reason why the PPP/PFI route could not be used for procuring the Premises Strategy. In practice, it is likely that only the larger new buildings – the "Primary Care Centres" would attract the contractors who lead PFI consortia where a single building is procured. Hence, it may only provide, at best, a partial solution to the LHB's funding needs. Also a contract with a PPP/PFI developer only covers a specific project. Future changes to the accommodation provided under such a contract are generally the subject of potentially expensive contract variations. Any further buildings require a new project and possible the appointment of a different developer.

17.30 NHS LIFT

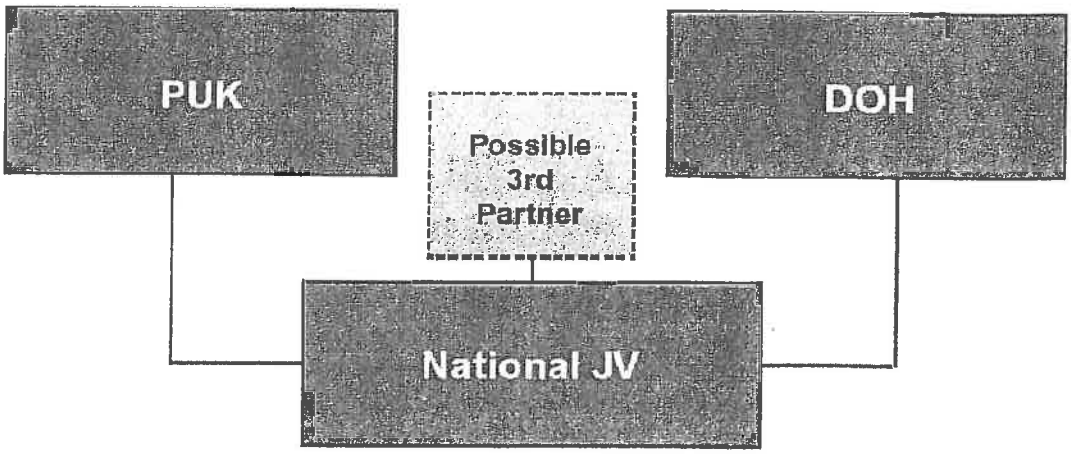
17.31 NHS LIFT (Local Improvement Finance Trust) is a new means of attracting private sector finance and management expertise into primary care premises development. In England, where it is being introduced, it assumes a PCT-wide or wider health economy strategic

approach where all premises development needs of one or more PCTs are brought into the scheme including existing and potential assets as well as any new buildings.

17.32 The NHS and Partnerships UK (a public-private partnership set up to develop the PPP market) have established a new national joint venture company "Partnership for Health" to take forward the "LIFT" initiative. Each will contribute funding that will be used to support the establishment of a local "LIFT" company (LIFT Co) and to invest in the local schemes. The Department of Health in England pump primed £195 million to address obstacles to new solutions being developed locally, such as site constraints or particular issues relating to existing premises i.e. negative equity long term leases on premises not fit for purpose and without break clauses. The national joint venture has three key roles in developing the new market for public private partnerships for primary care in the health and social care economy:

- Enabling, by working with the local stakeholders to prepare a scheme that can be taken into procurement, by initiating a competitive process for a private sector partner and possibly making funding available to meet essential preliminary costs.
- Supporting local development in a number of forms, including for example, assisting in the development of the documentation to initiate the procurement and making available a range of advisors in all of the key disciplines likely to be needed in a local procurement competition on centrally negotiated terms.
- Investing in local development possibly as one of the equity participants in this local joint venture, alongside local stakeholders and the private sector partner. The LIFT Co will be responsible for delivering investment and services over a long agreement period, and so there is likely to be a flow of new investment requirements for the national joint venture to support during the agreement's operational life.

17.33 The following diagram illustrates the structure of the National LIFT joint venture.



17.34 Local health and social care stakeholders; such as PCTs, local authorities and individual practitioners will hold a minority equity stake in the LIFT Co, as will Partnerships for Health. Hence, GPs will be able to invest equity in their LIFT Co and, if opting to do so, would own a share in all the properties owned by the company rather than owning the freehold of their own premises.

17.35 It is the intention that the existing rent reimbursement mechanisms will continue to apply even when a LIFT Co is established, so GP tenants of the LIFT Co will receive rent reimbursement in exactly the same way as they do now.

17.36 One of the key objectives of the local LIFT Co would be to bring together the various local stakeholders, interests and users that comprise the local health economy. This is intended to overcome the fragmentation of responsibilities under existing arrangements that inhibit co-ordinated planning, service delivery and investment and work towards supporting the regeneration strategy of the local economy.

17.37 Local schemes would be led by the LHB as the statutory health body responsible for primary care. It would form the point of contact for prospective private sector partners and will bring forward investment opportunities that are based on the integrated and co-ordinated health and social care strategy set out in its integrated healthcare and estate strategy.

17.38 This approach will mean that procurement will focus on identifying a partner in the local community that will not only deliver and manage services and implement investments, but also work with the local health commissioners and service providers to plan future needs and requirements, and how they can best be delivered.

17.39 With the support of the national joint venture, the local procurement would be run on the basis of an established model with standard documentation, so that the cost and time incurred in the actual procurement can be minimised. The local procurement will reach an agreement with a private sector partner to establish a LIFT Co to provide services to the area. The local stakeholders and users are likely, at that point, to be able to become part of the LIFT Co, alongside the national joint venture and the private sector partner.

17.40 The principal functions of the LIFT Co would be to:

- Plan future estates service requirements, to meet the care service objectives and needs of the local community.
- Support the ongoing development of the Strategic Service development Plan (SSDP).
- Implement agreed investments.
- Deliver agreed services.
- Receive payment for delivering investments and services to agreed standards.

17.41 The private sector partner will bring into the LIFT Co its skills in areas such as property development and management, construction and services contracting and project management.

17.42 The integration of the planning of estates requirements with a service strategy for the local health economy, and private sector involvement in planning future estates requirements to meet that strategy as well as in managing and delivering services, are key features of the LIFT approach. They aim to transform the way that investment in primary care is managed and delivered.

17.43 The services provided by the LIFT Co, alongside the on-going planning and liaison on existing and future requirements, generally include:

- Investment in new one-stop health centres, providing an integrated range of primary and intermediate care services;
- Leasing premises to individual primary care service deliverers, such as GPs, on flexible terms that can respond and adapt to changing requirements over time;
- Management of the facilities provided over the whole life of the assets, providing all energy and utility requirements and equipping the premises.
- Determining in collaboration with other partners plans for dealing with premises that become surplus to service requirements.
- Determining the affordability and overall viability of proposals for the development of the estate portfolio to meet emerging service needs.
- Encouraging third party income to the developments, to the benefit of LIFT Co.

17.44 NHS "LIFT" is now becoming well established with the third wave projects in England now reaching the stage of selecting a preferred private sector partner. There are many un-answered questions in relation to "LIFT" but it certainly has the potential for meeting the complex property requirements of NHS organisations such as the LHB who have a clear strategic vision of their future property requirements.

17.45 The WAG along with Welsh Health Estates has established links with Partnerships (UK). As Bridgend LHB has now developed a Premises Strategy more detailed discussions can now be undertaken to investigate the applicability of "LIFT" to the Welsh context. It is also open to the LHB to pursue a self managed process to seek a single development partner and create a joint venture company along LIFT lines. Whilst such an approach would have many of the advantages of LIFT it would lack the management, technical and financial support that is available from the national joint venture.

17.46 Overall conclusions on funding and procurement options

17.47 The examination of both the existing and newly emerging procurement and funding options has shown that there is no simple answer to how best the LHB can procure and fund the implementation of the Premises Strategy.

17.48 What is clear is that the traditional route of procurement and funding of primary care premises by GPs is only a partial answer to the overall solution. The whole strategy is an ambitious programme of modernising and remodelling the primary care services and the estate that supports their delivery.

17.49 NHS "LIFT" which, is based on a whole area strategic approach would appear to be compatible with the requirements of the Premises

Strategy. Particular benefits that would be available to the LHB from LIFT would include:

- The increased opportunity to target investment to areas of greatest need to tackle high levels of socio-economic and health need.
- The greater potential for integrated community renewal and the general improvement of the built and economic infrastructure of the County Borough.
- Greater flexibility for future change to enable the process of service modernisation to continue unhindered.
- A requirement to continue effective partnership working throughout the planning of initial investments and over the lifetime of the LIFT partnership.
- More rapid completion of the whole programme to respond in particular to the current lack of facilities that are capable of providing "one stop" services and the need to comply with safety and access legislation.
- The potential that LIFT has to remove planning obstacles and standardise planning and design development processes due to the managerial, technical and financial support available from the national joint venture company.
- The ongoing commitment of a commercial partner to investment in modernisation and service development of premises as needs change and to the care and maintenance of premises.

17.50 However, there are many unanswered questions in relation to it and in the absence of an established LIFT programme for Wales progress would depend upon negotiations with WAG and Welsh Health Estates about how best to enable the LHB to procure the new premises it can now demonstrate that it needs.

17.51 The development of the Premises Strategy by the LHB is recognised as "breaking new ground" for primary care services in Wales. This pioneering work will need to be further developed by more detailed work on developing a procurement and funding strategy that will ensure that the Strategy can be implemented successfully. In order to do this the LHB will need to engage with Welsh Health Estates and the Welsh Assembly since it is likely to require fundamental change, possibly at national level, to enable new and innovative options to be developed or existing ones to be adapted to meet the needs of the Premises Strategy. The localities within the three valleys and the coastal area and the area between them around Bridgend town vary widely and as such each has specific and different primary care needs. The strategy reflects these differences, therefore when the funding solutions are considered the outcome is likely to be a combination of options.

18.0 Implementation Plan and Programme

18.1 The inclusive process that Bridgend LHB has followed to develop its strategy means that it has selected a preferred option that will have the support of a wide stakeholder base. However the LHB wishes to broaden the base of understanding of the strategy by the widest possible range of partners in its delivery, including patients and the general public, and thereby maximise stakeholders' support for it. This means that it will initially approve the strategy for consultation at its meeting in December 2003 and only finally approve it in March 2004 following feedback from and further discussion with the broadest possible range of stakeholders.

18.2 One of the key advantages of the preferred option for the Integrated Healthcare Strategy for Primary Care Premises is that it provides considerable flexibility in terms of implementation.

18.3 The model of four "Hub and Spoke" networks across the Bridgend LHB area allows the development of the "Hubs" and "Spokes" to proceed at different paces in each locality. This is important given the complexities of property ownership and the need to work in partnership with GPs and the wider primary care community to implement the Strategy.

18.4 A business case should be prepared to reflect the implementation of the whole strategy, but with each "Hub and Spoke" prioritised. Thus, the aim would be to make the overall implementation plan and programme a "corporate learning experience" for the LHB where the knowledge, expertise and experience of the whole primary care team was co-ordinated and channelled into optimising the long term performance of the property portfolio in supporting and improving services.

18.5 The LHB is keen to ensure that the considerable benefits to patients and staff that will arise from implementing the Strategy are delivered sooner rather than later. Hence, the overall implementation programme would ideally be as short as possible. However, the LHB recognises that there are constraints on achieving a short timescale for implementation. These include:

- The uncertainty around the funding and procurement options available to the LHB. In particular, the probable necessity to move towards new and innovative funding and procurement options which are likely to be "ground breaking" for the NHS in Wales and therefore, are likely to require approval from the Welsh Assembly.

- The complexities of property ownership across the LHB especially in relation to some GP owned properties and the implications that this may have on the future contracting arrangements with GPs.

- The need for the Strategy and the changes proposed in it to gain acceptance by GPs, the wider primary care team and the public in Bridgend. The LHB intends to consult widely on the proposals contained in this strategy document once they are approved in principle by the Board. This consultation will be undertaken as part of the public engagement in the review of its overall service strategy.

- The Strategy is based on an integrated model of service provision and there will be a need to convince the wider primary care team such as pharmacists, dentists and optometrists to become part of this new culture. These practitioners have property related issues to be resolved, often different from those of the GPs such as the need to support income from NHS work with commercial activities.

- In addition to the significant capital expenditure required for implementation there is also an affordability issue in relation to the additional revenue funding that the LHB will need to resolve with its commissioners.

18.6 In conclusion the implementation programme is likely to be one that takes between five and ten years to fully complete. An indicative implementation and capital investment programme is being developed by the LHB in collaboration with its partners.

19.0 Conclusion

19.1 A wide range of stakeholders have contributed to this strategy and the LHB feels that their views are reflected in this document. Whilst it is acknowledged that this is a ten-year strategy the LHB is keen to implement it in a far shorter timeframe. The LHB is committed to start the process immediately.

19.2 Following approval of the Integrated Healthcare Strategy for Primary Care Premises by the Board, the LHB will engage in discussions with Welsh Health Estates and the Welsh Assembly Government on how best to proceed with implementation of the Strategy.