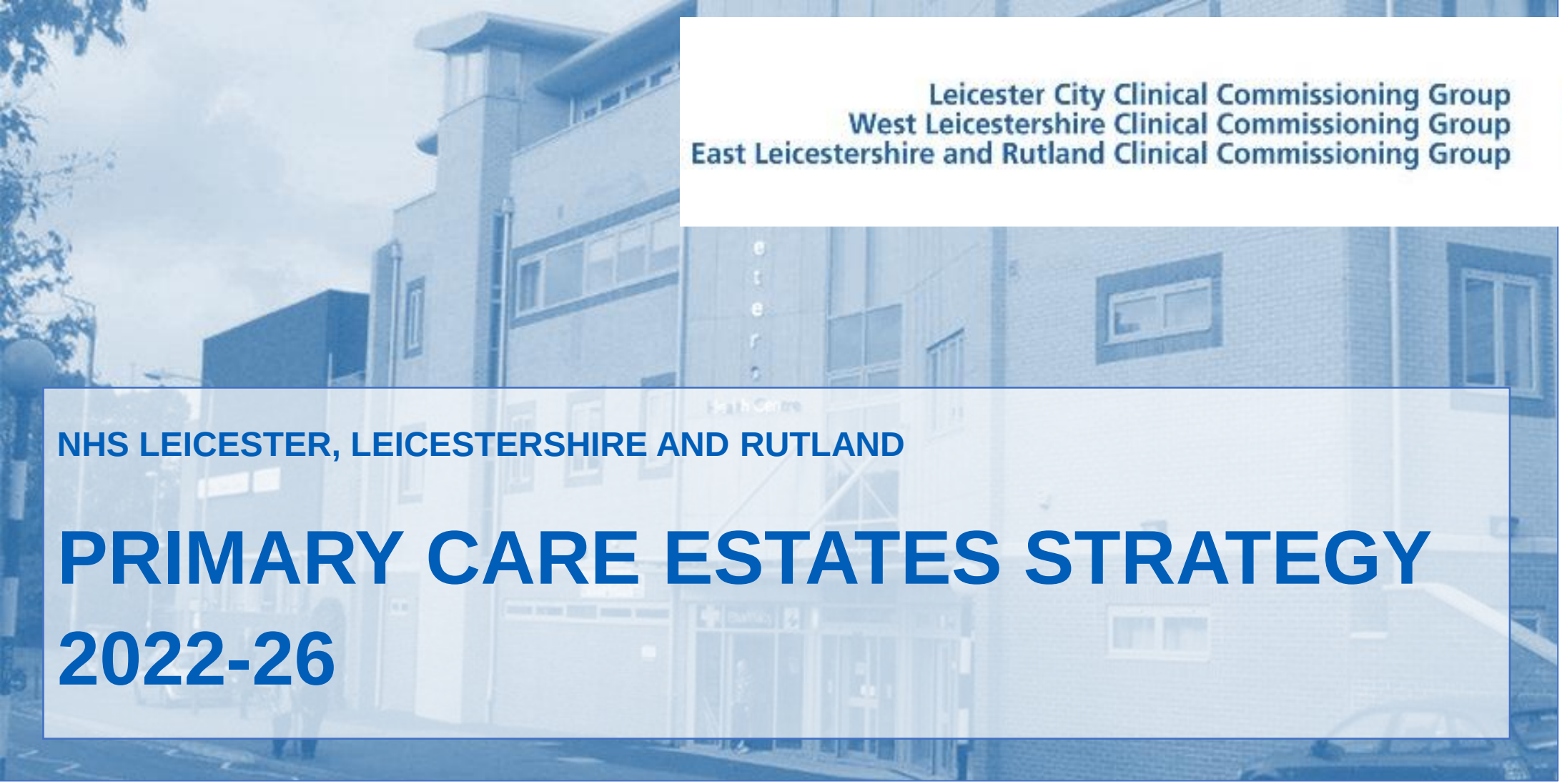


Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

NHS LEICESTER, LEICESTERSHIRE AND RUTLAND

PRIMARY CARE ESTATES STRATEGY 2022-26

April 2022 v1.0

Contents

Document Control

Issue Ref.	Version Date	Status / Summary of changes	Author	Owner
V0.1	December 2021	First Draft Overarching strategy document	C Rowlands Strategy and Planning	Sarah Prema Director of Strategy and Planning
V0.2	February 2022	Second draft following review by Director of Strategy and Planning	C Rowlands Strategy and Planning	Sarah Prema Director of Strategy and Planning
V0.3	March 2022	Third draft following review by Clinical Leads	C Rowlands Strategy and Planning	Sarah Prema Director of Strategy and Planning
V1.0	April 2022	Addition of references to the green agenda/challenge and confirmation of consideration of Health Inequality challenges as part of the premises prioritisation process. Document approved by PCCC subject to these additions	C Rowlands Strategy and Planning	Sarah Prema Director of Strategy and Planning

1. Introduction and background

1.1 Introduction

This document represents the next stage of development of the Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups Primary Care Estate Strategy (PCES).

This new PCES builds on the baseline information document completed in 2020/21 and the premises prioritisation process completed in May 2021. It has been produced as an **overarching strategy document** and does not repeat the detailed analysis contained in the baseline document referred to above. Together, they form a suite of PCES documents.

This is a live document spanning the period 2022 to 2026 and will be subject to regular review as strategies and plans continue to evolve in terms of – for example – the Integrated Care System and Primary Care Network development.

The PCES, supported by a five-year revenue investment plan and all other funding streams we can access during the life of the strategy, offers an exciting opportunity to make significant improvements to our GP primary care estate; helping address existing premises condition and capacity issues and to support development of new models of care.

The development of the LLR Integrated Care System (ICS) also enables us to improve our planning and utilisation of accommodation across the wider public estate and this PCES will be updated to reflect these opportunities as the ICS evolves.

Section 1.2 opposite summarises our PCES key aims and objectives.

Sarah Prema
Director of Strategy and Planning
NHS Leicester, Leicestershire and Rutland Clinical Commissioning Groups
April 2022

1.2 Aims and Objectives

Our aim is to support General Practice primary care services and our partners in the wider Integrated Care System (ICS) to provide high-quality services for all our patients delivered from modern, fit-for-purpose and flexible premises. Our key objectives are shown below:

- Gather data and intelligence to understand the condition, capacity and utilization of our GP primary care estate
- Prioritize those premises in need of improvement, expansion or replacement and implement a programme and framework to drive and support premises improvements
- Ensure systems are in place to challenge and support GP Practices, NHS and private landlords to maintain and invest in their premises including areas such as addressing backlog maintenance, health and safety and the quality of the premises
- Improve the quality and condition of the estate and the physical capability and capacity for primary care provision
- Support the development of Primary Care Networks, Place services and the delivery of new models of care
- Address population growth/housing developments through maximising the potential of developer contributions to support premises improvements and increased capacity
- Collaborate with ICS partners to manage and develop our combined estate at system, Place, neighbourhood and individual premises level
- Reduce risk & improve service resilience at local and system levels
- Increase efficiencies through improved utilization of existing primary care and the wider public estate
- Rationalise and dispose of surplus or unfit NHS estate
- Maximise future estate flexibility and develop a greener NHS through smart estate design solutions to support sustainable service models
- Support improvements in service efficiency and better outcomes for our residents.

1. Introduction and background

1.3 CCGs GP primary care estate overview

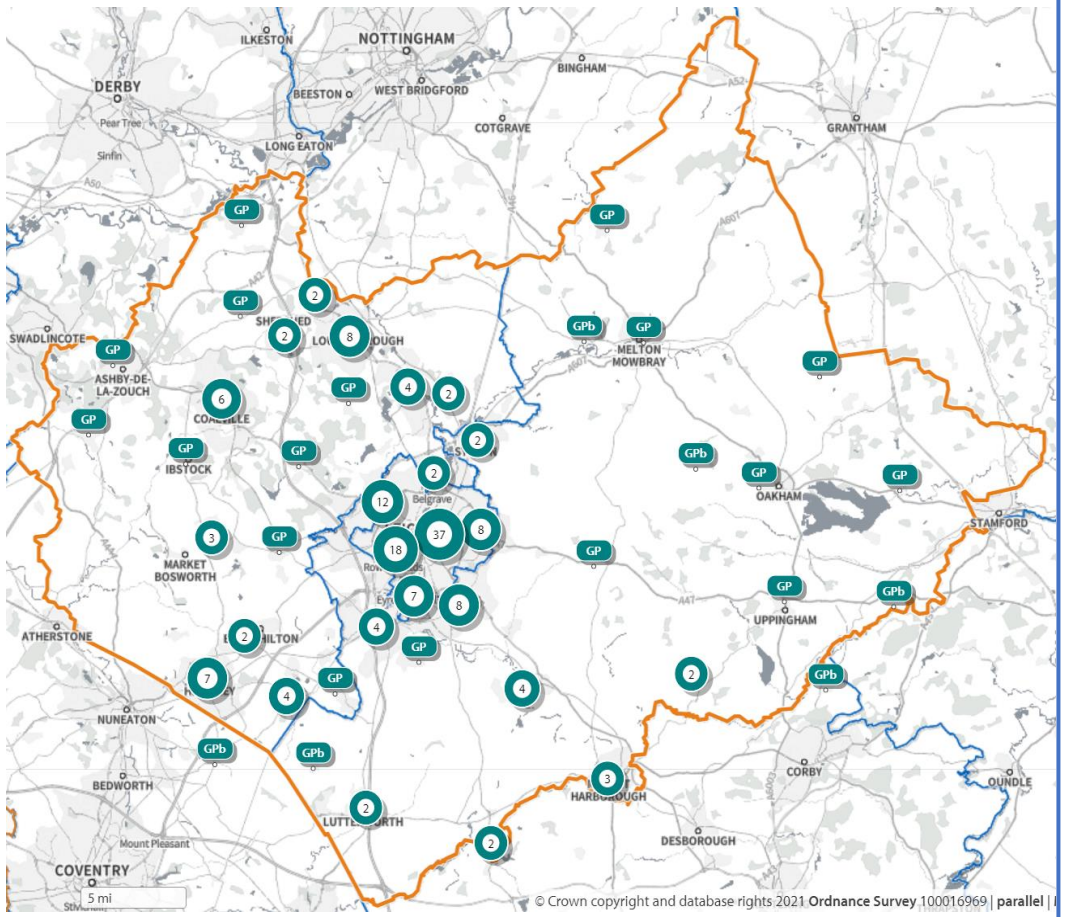
The combined GP Primary Care estate features:

- 135 GP Practices with a combined total of 174 GP main and branch surgery sites.
- 25 Primary Care Networks with their own emerging clinical models and future premises proposals.
- An initial 50 GP practices whose premises are identified as priorities for improvement, development or replacement over the next five years, with an acknowledgement that other priorities will also emerge during the life of this strategy.
- 10 GP practices housed in seven LIFT developments across Leicester City
- 14 GP practices housed in 14 NHS PS properties
- The remainder of the premises are a combination of GP-owned or are owned by a third-party landlord
- More than £16m reimbursed to GP practices to fund rent and rates costs under the NHS GP contract premises costs directions
- In excess of £7m risk and backlog maintenance costs across the GP primary care estate (source: six-facet survey results 2019)
- Circa. 580 pharmacy, dental and optometry premises
- Circa. 50 health Centres, Clinics and Walk-in Centres

The LLR PCES baseline Information Document contains a comprehensive record and analysis of the GP primary care estate and is available as part of a suite of documents and supporting information supporting this overarching document.

LLR CCGs map: The GP primary care estate

The map below shows the location of LLR commissioned GP premises across the LLR footprint.

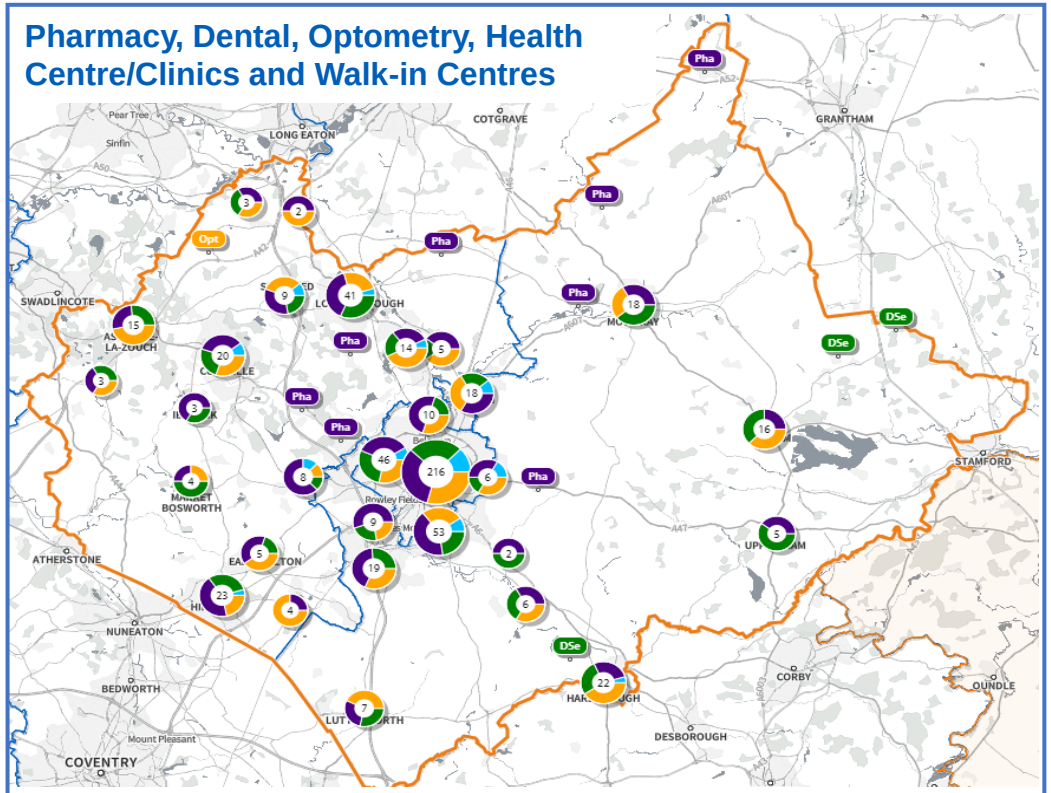


1. Introduction and background

1.4 LLR system NHS estate overview

In addition to the GP premises estate summarised in section 1.3, shown below is an overview of part of the LLR system NHS estate, highlighting the opportunities to increase collaboration across the system to make more efficient use of our shared NHS and wider public estate (which is not represented in these summaries but will be considered as part of future ICS strategic estate considerations). The maps show circa. 680 premises or part-premises, many which are close to or co-located with GP primary care services.

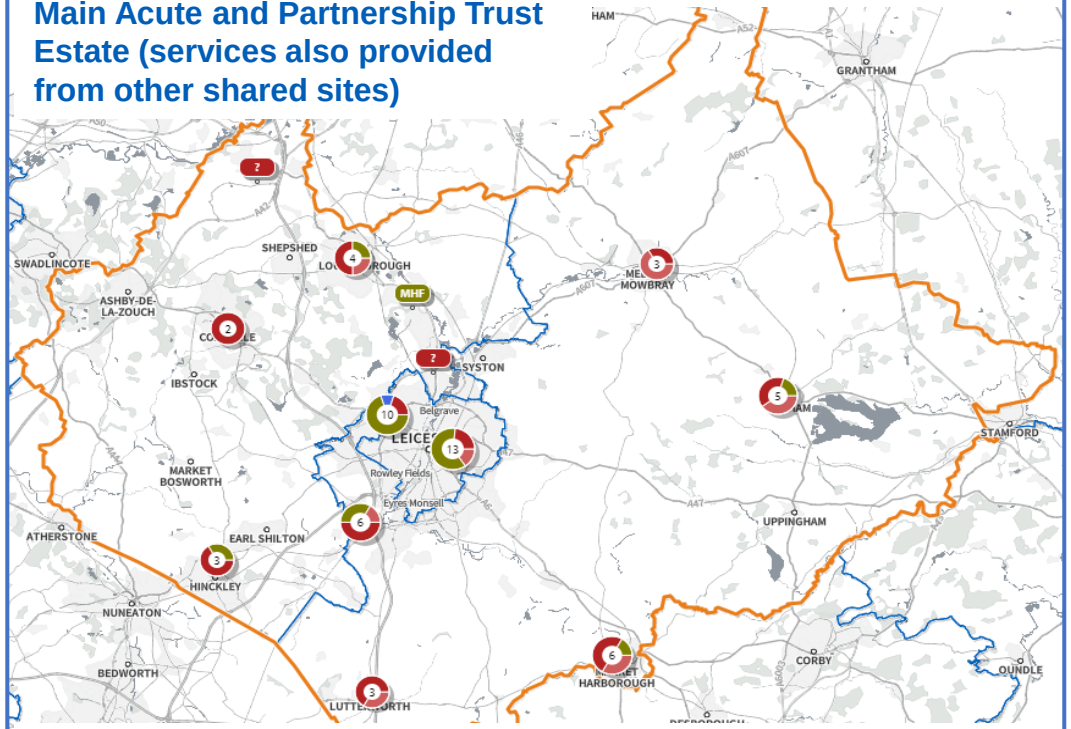
Pharmacy, Dental, Optometry, Health Centre/Clinics and Walk-in Centres



The map above shows clusters of premises/co-located services across different areas of the LLR geographical area. Key:

> **Purple**: 226 pharmacies
> **Amber**: 184 Optometrists
> **Sky blue**: 48 Health Centre/Clinic/Walk-in Centre
> **Green**: 166 Dental services

Main Acute and Partnership Trust Estate (services also provided from other shared sites)



The map above shows clusters of premises/co-located services across different areas of the LLR geographical area. The map shows larger sites only. In total, more than 700 different services are recorded on NHS Shape as being delivered from a wide variety of individual and shared sites across LLR. Key:

> **Red/Pink**: Acute/Community Hospital/Ambulance/Urgent Care site
> **Green**: Mental Health Services

2. The Leicester, Leicestershire and Rutland System

2.1 About Leicester, Leicestershire and Rutland

The Leicester, Leicestershire and Rutland system has an ambition to develop an outstanding, integrated health and care system that delivers excellent outcomes for its people. Partners have been working together over the last five years on a joint transformation programme but recognise that there is much more work to do to transform our services and deliver improved outcomes for our population and a sustainable system.

The system commissions and provides health and care services for over a million people and has a combined health budget of circa. £1.5 billion. We employ more than 20,000 NHS staff and more than 32,000 social care staff (including independent providers).

Our ICS partnership has a number of partners all providing a voice and a key stake in the health and well-being of our population.

There are currently three CCGs, three main provider Trusts, three Local Authorities and a range of other core partners summarised in the schematic opposite.

LLR System Core Partners

Other key stakeholders with a particular relevance to the primary care estate within or in addition to the core partner organisations shown above, will include for example district councils, police, fire and rescue services, charities, the voluntary sector and community groups.

2. The Leicester, Leicestershire and Rutland System

2.2 Clinical Commissioning Groups

LLR CCGs currently comprises of three CCGs with a combined management structure. We are:

- **Leicester City CCG :** responsible for commissioning health services in Leicester City for a population of 421,184 with 57 GP practices.
- **East Leicestershire and Rutland CCG**: responsible for commissioning health services in East Leicestershire and Rutland for a population of 339,121 with 30 GP practices.
- **West Leicestershire CCG**: responsible for commissioning health services in West Leicestershire for a population of 401,511 with 48 GP practices.

2.3 Key system challenges

The CCGs and the wider system face significant challenges, and all have a direct impact on primary care and therefore the primary care estate. These are summarised as:

Increased Demand

The NHS must treat more patients with complex conditions. By 2023 the population of LLR is estimated to increase by 5.2% to 1,124,300 people. With over 75s set to increase by 25.7%.

How we provide care

More patients have multiple long-term illnesses. Care now needs to involve a multitude of health and care agencies

Workforce

Shortages of doctors, nurses and other health professionals can lead to inequity and differential quality of care and can increase the cost of services as NHS organisations pay for expensive agency staff

Finance

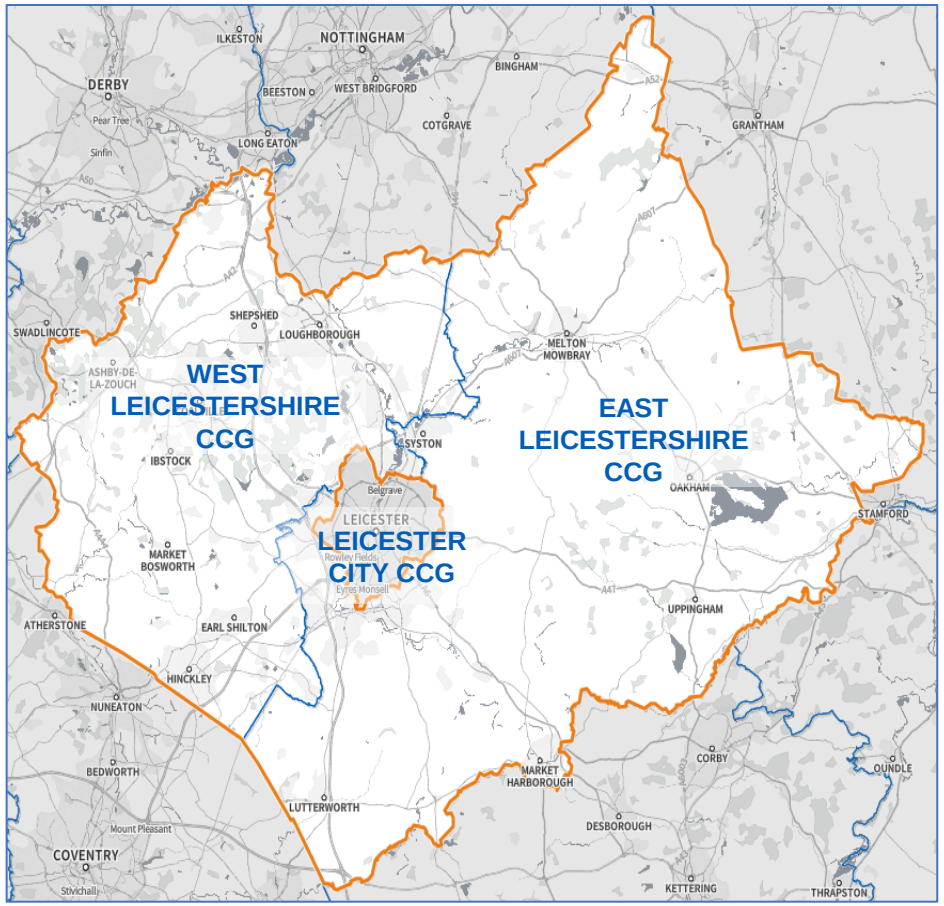
Demand is increasing quicker than available resources. As result our local health and social are services are under increasing financial pressure

Estate

Some NHS facilities are old and have high running costs, while some services are split across multiple sites undermining care quality, leading to duplication and increased cost

COVID-19

The COVID-19 pandemic has laid out in stark focus the impact on services, infrastructure, patients and our workforce



The map above shows the three CCG areas covering a combined footprint in excess of 2,500 square kilometers.

3. Strategic context

3.1 Introduction

Over the past 10 years, the health sector has seen unprecedented requirements to improve both quality and efficiency, improve patient outcomes whilst facing increasing demand and respond to an ageing demographic with increasingly complex service needs. Nationally, we have a population expanding by eight million people by 2032 and we now have almost three million people living with three or more long-term conditions.

The population of LLR is forecast to increase from circa. 1.1m to 1.3m over the next 20 years and our ICS area is marked by stark health inequalities, both within LLR and when compared to England. For example, a boy born today in the most deprived area of LLR could be expected to die up to 8.7 years earlier than a boy born in the least deprived area. The difference in the proportion of a person's life lived in good health is even more marked – again, with those from less affluent areas spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area.

The challenges facing our health and care services are enormous, and this has been further highlighted by the impact of COVID-19 on services and our workforce. Primary Care is at the forefront of demand for services and will continue to be the bed rock of NHS care as part of an integrated care system. The primary care service model which has traditionally been delivered at a very local level by individual GP Practices serving their registered populations is changing.

The direction of travel is towards integration of services across wider geographical areas and services to facilitate care alliances focussing on prevention as well as mental and physical wellbeing. Primary care and the development of networks designing and delivering services for their population is at the heart of this transformation.

The primary care service model could in 10 to 20 years' time be significantly different from what it is today as we continue the development and delivery of new models of care to ensure we can provide more resilient General Practice services at individual practice, neighbourhood, Place and system levels. Primary Care is more than ever dependent on the provision of a modern, fit for purpose and flexible premises from which to operate.

The early years of health sector reform created some unpredictability, but the Five Year Forward view (2014) gave greater clarity on the direction and requirements to meet the quality, demand and efficiency challenges. The General Practice Forward View, NHS England, April 2016 provided further direction for the future of primary care and The NHS Long Term Plan published in January 2019 set out the new service model for the 21st Century.

The LLR system is now taking to the next level the *Better Care Together* principles, priorities and plans first published in 2016 to support continuing development of the ICS, with primary care at the forefront of planning. Primary Care, digital, Place and other key and interdependent programmes of work or ongoing and our primary care estate is a key enabler to supporting all new out of hospital models of care.

3. Strategic context

3.2 National drivers for change

The NHS five year forward view envisages NHS estates as having a key role to play in supporting implementation of new care models, in improving efficiency and which meets the current and future needs for healthcare. It sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. This includes the right to online 'digital' GP consultations and redesigned hospital support which will avoid up to a third of outpatient appointments.

GP practices through Primary Care Networks will be funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and care staff. New expanded community teams will be developed to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes. The Long term plan focuses on:

- Strengthening the NHS contribution to prevention and health inequalities
- The NHS's priorities for care quality and outcomes improvement for the decade ahead.
- Tackling current workforce pressures which will bring new staff into primary care
- Upgrading technology and digitally enabled care across the NHS.
- Outlining a NHS funding settlement to ensure the NHS is on a sustainable financial path.

These changes will have significant impact on the primary care estate and in addition, the NHS published supplementary guidance: Accommodating additional Multi-Disciplinary Team staff appointed under the Network Contract DES in August 2020. This document advises on key steps in developing a local estates strategy at PCN level which is highlighted later in this document.

In addition, there are a range of national strategies & programmes with a specific focus on improving our management of the NHS estate, including:

- The Naylor Review, March 2017
- The requirement to develop Sustainability and Transformation Partnership (STP) Estate Strategies including the primary care estate
- Developing a greener NHS estate
- The One Public Estate Programme.

The ongoing COVID-19 pandemic has also changed the way we work now and in the future, both in a positive way by accelerating progress towards new and innovative ways of working, but also to highlight the capacity and demand issues facing primary care, including workforce and premises constraints.

3. Strategic context

3.3.1 Local drivers for change: Developing an Integrated Care System (ICS)

This purpose, principles and priorities outlined below describe the ambitions of the NHS and partners for the ICS and for local people.

Purpose

Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives.

Principles

Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to:

- Ensure that everyone has equitable access to health and care services and high quality outcomes
- Make decisions that enable great care for our residents
- Deliver services that are convenient for our residents to access
- Develop integrated services through co-production and in partnership with our residents
- Make LLR health and care a great place to work and volunteer
- Use our combined resources to deliver the very best value for money and to support the local economy and environment.

Transformational Priorities

We will transform the following areas, ensuring we take steps to improve the equity of access and outcomes:

- **Best Start in Life:** We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances
- **Staying Healthy and Well:** We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities
- **Living and Supported Well:** We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently
- **Dying Well:** We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

The purpose, principles and priorities are supported by a range of operational priorities including to work together across health and care to transform access to the health and care services, with a focus on primary care, urgent care, chronic conditions and mental health services.

One of the key delivery vehicles to achieve the ambitions and operational priorities is the development of models of care to deliver integrated care services at place and system level. The development process underway across LLR is outlined on the next page.

ICS strategic estates strategy

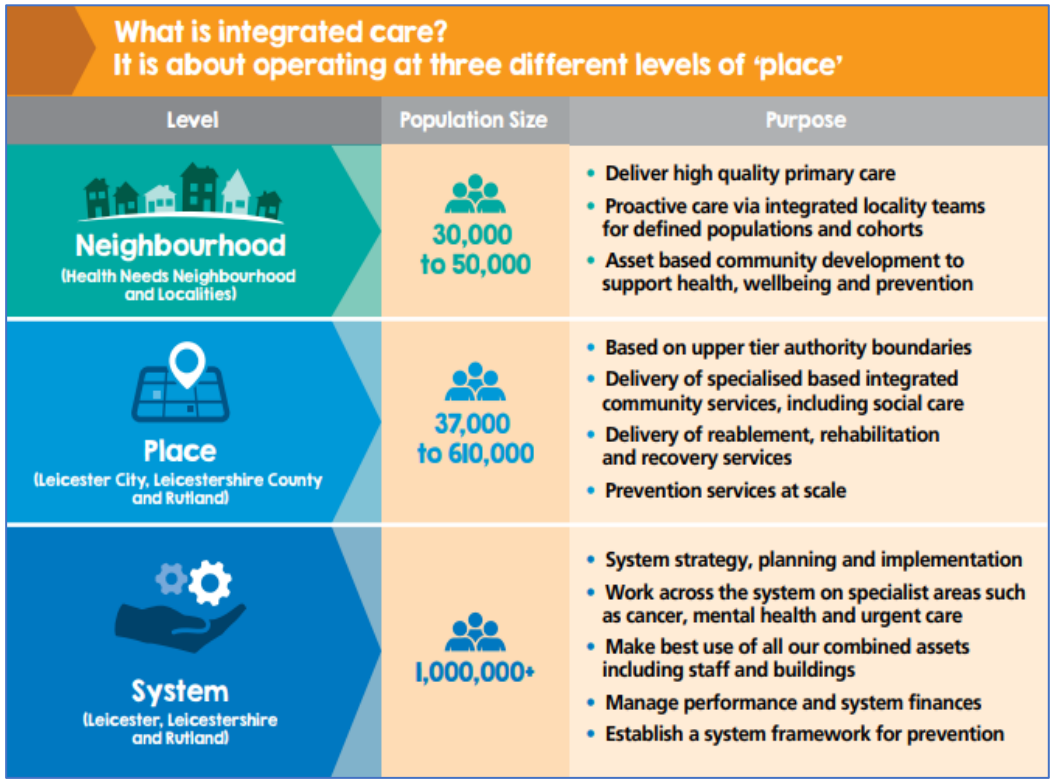
The formation of the LLR ICS will lead to the need for an updated system-wide ICS estates strategy for all services, building on the first ICS estates strategy produced in 2018. The PCES suite of documents and plans form a key element of the system-wide estates strategy and it is essential that we work in close collaboration with all ICS partners to adopt a combined public estate approach and to ensure that the needs of primary care estate are properly recognised an acted upon as part of the wider planning and financial landscape.

3. Strategic context

3.3.2 Local drivers for change: ICS Place development

The LLR ICS model and Place and neighbourhood structure for the LLR system are outlined below. There are three Places which are coterminous with local authority boundaries and 12 Local Integration Hubs based around a combination of distinctive communities, neighbourhoods and/or district councils.

LLR ICS model



LLR ICS Place and Neighbourhood structure

Integrated Care System: Leicester, Leicestershire and Rutland

Place

- Leicester
- Leicestershire
- Rutland

Neighbourhoods

Place	Local Integration Hubs
Leicester	Central; South; North West; North East
Leicestershire	North West Leicestershire; Hinckley; Blaby & Lutterworth; Charnwood; Melton & Rutland; Harborough, Oadby & Wigston
Rutland	Rutland

Work is ongoing to develop and implement Place integrated care service models across LLR with GP practices and Primary Care Networks at the heart of existing and future models of care.

Planning includes the primary care premises and wider public estate needed to enable further integration of services and PCES planning considers both the needs of individual practices and their patients, but also the wider opportunities to share services and the estate.

3. Strategic context

3.3.3 Local drivers for change: Primary Care Networks (PCNs)

PCNs are a key part of the NHS Long Term Plan. They build on current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively delivering care for the people and communities they serve. The networks will have expanded neighbourhood teams which will comprise a range of staff across health and care services.

In LLR our practices have formed into 25 PCNs ranging in size from 30,000 to 107,000 all with Accountable Clinical Directors in place to lead their development. The networks provide the structure for services to be developed locally, in response to the needs of the patients they serve.

LLR PCNs will form the fundamental building blocks of our ICS, both at a Neighbourhood (PCN) and Place (Local Authority) level. They will be both a vehicle for localised commissioning and service delivery in the community, but also the means to giving General Practice an even stronger voice within the wider ICS.

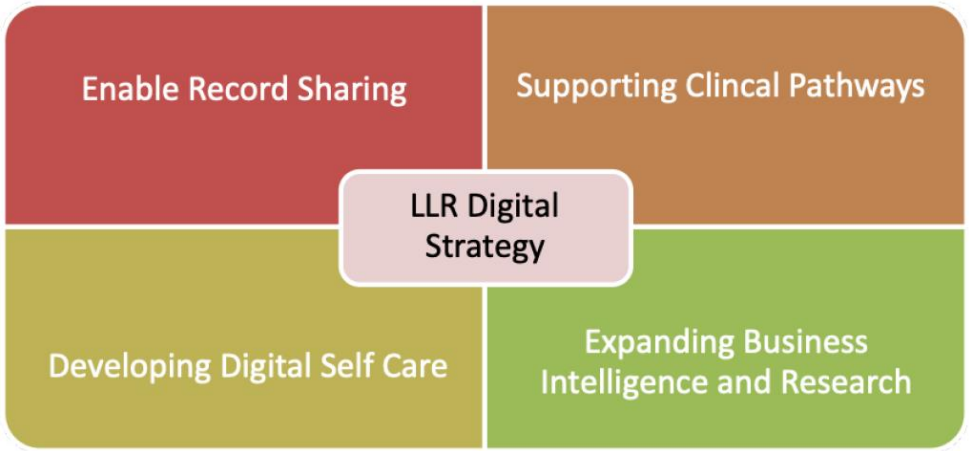
PCNs provide the structure on which Primary Care and all other key ICS stakeholders can begin to focus on defined patient populations, working together within agreed frameworks to define and achieve local outcome ambitions. PCNs will be strengthened by the development of the key enablers around them (estates, IM&T and workforce, finance) and the scale of transformation is reliant on the maturity of the relationships between General Practice working at scale and their local provider partners.

3.3.4 Local drivers for change: Digital strategy

In 2019 the Government's vision of a technical future for the NHS was announced. Key to this vision was the end of IT systems that prevent delivering effective care. To respond to the NHS vision, LLR have developed a new digital strategy and road map.

General Practice systems play a key role in the ambitions to have a robust shared access to paperless patient records across all clinical interfaces. The aim is to achieve better value from existing systems through training and optimisation so that patients are treated more efficiently and are more empowered in their own management.

The overarching strategic objectives are shown opposite and the impact of the COVID-19 pandemic has seen an acceleration towards digital ways of working and accessing services both in primary care and across all services.



3. Strategic context

3.3.5 Local drivers for change: General Practice

The primary care service model will in 10 to 20 years' time be significantly different from what it is today as we continue the development and delivery of new models of care to ensure we can provide more resilient General Practice services at individual practice, neighbourhood, Place and system levels. The drive towards delivering new models of Primary care in LLR began prior to the publication of the General Practice Five Year Forward View, but the focus and finance this policy introduced galvanised our system to produce our Blueprint for General Practice in 2017.

The LLR Primary Care Strategy 2019/20-2023/24 clearly states that strong General Practice and Primary Care services are essential if we are to have a high quality and responsive NHS, fit for the future. The strategy sets out our high-level commissioning intentions and approach to delivering change over a five-year period and includes the following high level strategic aims for primary care by 2023/24:

Strategic Vision
Empowering patients and the public: We will enable patients and carers to play a more active role in their own health and care, involving local communities at Neighbourhood and PCN footprints, in shaping services, giving people greater involvement in GP services.
Empowering clinicians: We will ensure high quality support for innovation and improvement, developing PCNs to allow more rapid spread of innovation, supporting general practice in developing new models of provision, and releasing time for patient care and service improvement.
Defining, measuring and publishing quality: We will improve information about quality of services both to strengthen accountability to the public, clarity on what the public can expect, and to support clinical teams in continuous quality improvement.
Joint commissioning: we will work as a system to develop a joint, collaborative approach to commissioning general practice and PCN level services, with a stronger focus on local clinical leadership and ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital service
Supporting investment and redesigning incentives: we will support a shift of resources towards general practice and PCNs and 'wraparound' community services, developing the new national GP and PCN contract to support the delivery of the Long Term Plan.
Managing the provider landscape: We will ensure that all general practices and PCNs meet essential requirements, responding effectively to improving the quality of care. We will work closely with acute and community service providers, enabling feedback mechanisms to and from primary care to further improve services.
Workforce, premises and IT: We will work with national and local partners to develop the new and broader general practice workforce, develop improvements in primary care premises and sustain improvements in information technology services and the digital offer for patients.

The primary care strategy is currently under review as we approach establishment of the LLR ICS and as the new system evolves. Also, the ongoing COVID-19 pandemic has also changed the way we work now and in future, and this will be reflected as part of the new strategy and supporting plans.

3. Strategic context

3.3.6 Local drivers for change: Housing and population growth

The baseline information document produced by Leicester LIFTCo and completed in April 2020 and supplemented with a further housing and population growth update in October 2020, details the current LLR local authority housing plans up to 2036. Local Plans evolve and are regularly refreshed and there is currently a Leicester and Leicestershire growth options study in progress demonstrating the range of growth opportunities available within Leicester & Leicestershire for the period up to 2050.

There are a high number of housing developments across LLR either recently completed, in progress or planned to commence in the near future and also a high number of planned housing commitments and allocations included in the Local Plans (either adopted or in consultation). However there remains some uncertainty as to the detailed location of longer-term commitments and allocations beyond the next five years which adds to the strategic service and estate planning challenge when calculating the impact on GP practices and the wider integrated care services.

In order to meet the requirements within the National Planning Policy Framework, there will be circa 200,000 new homes built in LLR between 2011 and 2050. Assuming an average occupancy of 2.0 to 2.5 residents and therefore patients per household, this equates to a potential additional 400,000 to 500,000 patients accessing health and social care in LLR by 2050.

Housing and population growth is included as a key criteria in the primary care premises prioritisation process, supported by an assessment of demographic, health and socio-economic factors impacting on individual GP practices.

Developer contributions

The CCGs actively engage with the LLR planning authorities to maintain a current picture of housing plans and progress, and to secure access to developer contributions in line with the individual planning authority Section 106 and Community Infrastructure Levy policies and guidelines. To support us in managing the impact of housing growth on services, we are strengthening our systems and processes to:

- Collect and interpret information regarding the need for housing and other development;
- Understand population growth planning
- Consider infrastructure implications;
- Ensure site-specific allocations with major growth proposals;
- Respond constructively to major planning application consultations.

4. LLR Primary Care Estates Strategy: progress to date

4.1 PCES Background Information Document

The LLR CCGs commissioned Leicester LIFT Company Limited to produce the PCES baseline information document. The document was completed in April 2020 and was supplemented with a housing and population growth update in October 2020.

The document and supporting information provided a rich source of information upon which to develop our PCES to the detailed planning stage and included the following key outputs:

- ✓ Six-facet surveys completed for all appropriate GP main and branch surgeries
- ✓ A socio-economic, demographic, health needs and housing profile for each of the Council areas.
- ✓ Premises assessments, key issues and risks/implications at HNN/PCN level.
- ✓ Identification of LLR 'hotspots' as a result of housing and population growth.
- ✓ High-level financial summaries outlining premises risk & backlog costs, anticipated GIA shortfall and planning/build costs, plus potential total costs for the LLR system in terms of primary care premises.

The background information document and premises prioritisation process (described opposite) are available as part of a suite of documents that together form the LLR PCES.

This new PCES builds on the baseline information document and premises prioritisation. It has been produced as an overarching strategy document and does not repeat the detailed analysis contained in the baseline document referred to above.

4.2 PCES Premises Prioritisation Process

In order to move the Baseline Information Document into something that could be implemented a process of prioritisation was developed and undertaken. The prioritisation process was developed in the following way:

- Task and Finish Group established to develop the prioritisation process.
- Key information from the Baseline Document was used together with demographic data to establish a set of criteria.
- A score and weighting was established for each criteria and each practice was scored against each criteria.
- Scenario testing was undertaken to ensure the robustness of the scoring and weighting as result adjustments were made to the weighting.
- The process identified three overarching areas where practices could potentially need investment into their premises:
  - **Practices affected by housing and population growth**
  - **Practices that have insufficient space/facilities**
  - **Practices that have poor quality or unsuitable premises.**

In addition to the three headline categories shown above, the process also took into account demographic, health & socio-economic factors and service changes impacting on primary care services.

The outcome of the process resulted in identification of circa. 50 priority GP practices which, together with existing live schemes and a number of other GP practices who will benefit from developer contributions as a result of housing developments, forms the basis of a five-year development programme.

A summary of the prioritised GP practices is included in **Appendix A** and an overview of the six-facet survey results at Place level is included in **Appendix B**.

3. Primary Care Estates Strategy: Progress to date

4.3 PCES progress in 2021/22

Following completion of the background information document in 2020 and the prioritization process in May 2021, there has been further progress to take forward the PCES over the intervening months up to production of this document. Progress during 2020/21 is summarised below and the next steps are outlined in section five of this document.

Task	Progress
Housing and population growth	> Baseline assessment completed > Systems implemented with planning authorities for regular review of plans and progress > Ongoing contribution to Local Plan and Growth Options Study consultations
Developer Contributions	> Single Section 106/Community Infrastructure Levy Tracker developed (ongoing) > Improved systems and process developed and additional resources agreed to support the new systems
Prioritisation process	> Completed May 2021 and approved by the Primary Care Commissioning Committee June 2021
Directorate leads, governance and resources	> Directorate leads identified for priority practices/geographic areas based on prioritisation process outcomes > New strategic estate lead and supporting posts agreed and planned to be in post early 2022 > Terms of reference for new Estates Review Group prepared with planned implementation April 2022
Premises development funding	> 5-year cumulative £2.35m revenue plan approved > s106/CIL funding/applications ongoing
5-year premises development programme	> Work has commenced to develop the 5-year premises programme > Live ETTF programme; three schemes in planning/progress > Current 'live' and planned (subject to confirmation) legacy premises schemes confirmed/identified
Primary Care Data Gathering Programme (Phase 4)	> Significant data collected, now in final stage with GP direct engagement > Comprehensive LLR Estates data set included on SHAPE PCDG atlas > Access granted to key staff in LLR to support strategic and operational planning

5. Plans for the GP primary care estate

5.1 Introduction

This section summarises the 'where do we want to be' and ' how do we get there' through building on the progress already made over the past two years. Our strategic aim is to support General Practice primary care services and our partners in the wider Integrated Care System to provide high-quality services for all our patients delivered from modern, fit-for-purpose and flexible premises.

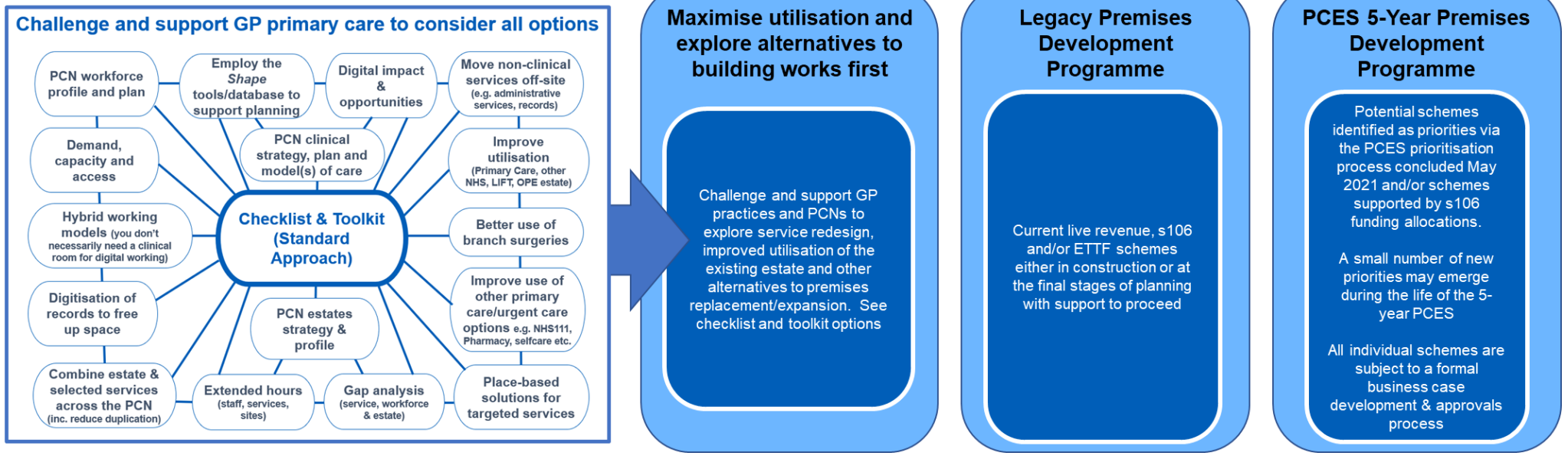
Where do we want to be?

We have already acknowledged that the primary care and wider integrated care delivery model will in future be different from what it is today. This PCES will need to be reviewed and updated at regular intervals to reflect progress surrounding the national and local drivers for changes described earlier, including emerging clinical models and changes in how and where services are delivered. However, GP practices and therefore their premises will remain at the centre of local services and whilst plans will need to be flexible, we will make significant progress towards the key objectives included in section 1.3 of this document over the five-year period.

How do we get there?

We will progress towards our key objectives through a combination of three main areas of work are outlined below. The first option should always be to explore alternatives to new or extended premises before a planning a major premises scheme.

Premises improvement options



5. Plans for the GP primary care estate

5.2 PCES work programme

The remainder of this section outlines the PCES key tasks over the coming year, followed by a summary of short-term key milestones in section six..

GP primary care estates governance arrangements

Review and update the GP primary care estates governance arrangements including establishment of a new Premises and Estates Steering Group to review potential premises schemes on behalf of the CCG and reporting to the LLR CCGs Primary Care Commissioning Committee.

Strategic estates resources

The appointment of the strategic head of estates post and supporting management infrastructure agreed as part of the development of the LLR CCGs. The team (working within the Strategy and Planning Directorate) will oversee the PCES and its ongoing review and development.

Optimum use of the existing primary care estate

Challenge and support GP practices and PCNs to explore service redesign, improved utilisation of the existing estate and other alternatives to premises replacement/expansion prior to supporting work to develop a major premises scheme.

NHS Property Services, Community Health Partnerships and the wider public estate

Work more effectively with NHS PS and CHP to manage and develop our estate including to improve utilisation of void and bookable space and to increase responsivity to estates remodelling & development and agreement on a development plan to support service transformation. Also ensure we consider opportunities within the wider public estate with our ICS partners including NHS provider trusts, local authorities/district councils and police, fire and rescue services. Opportunities could include for example reuse of existing vacant space or new opportunities created by the reconfiguration of the acute hospital estate.

Premises development programme

Subject to the consideration and rejection of alternatives to a major premises schemes, identify schemes for further development and the resources (if indicated) to support those schemes. This initially includes schemes planned for the next five years up to 2026. The programme will be developed based on the circa. 50 prioritised GP practices identified via the PCES prioritisation process, current live (legacy) revenue schemes, s106/CIL schemes and/or ETTF schemes either in construction or at the final stages of planning with support to proceed, and GP practices with allocated s106 or CIL funding for spend prior to 2026.

Lead directorates have already been identified to lead on prioritised GP practices/geographic areas and where appropriate, potential GP practice schemes are included in wider strategic estate and service reviews where, for example, there is a review of community hospital and other local integrated care services.

COVID-19 pandemic

Planning will also take into account the short and longer-term impact of the COVID-19 pandemic on service delivery and the estate.

(Continued on next page).

5. Plans for the GP primary care estate

5.2 PCES work programme (continued)

Housing/population growth and developer contributions

Continue strengthening our systems and processes to understand and plan for the impact on estate and services from housing and the associated population growth; including, collect and interpret information regarding the need for housing and other development; understand population growth planning; consider infrastructure implications; maximise site-specific developer contributions to support major growth proposals; and respond constructively to major planning application consultations.

Primary care, PCN, Place and ICS clinical and service planning

Ensure systems are in place for estates & premises plans to be refreshed to reflect the evolving requirements of Place based care and Primary Care Networks, in addition to the requirements of neighbourhood and individual GP primary care services and the wider ICS partner organisations.

Digital services

The estates and digitisation teams will continue to work in partnership to deliver local and national priorities including for example interoperability between systems & services across the estate and in the community, the Integrated Shared Care Record and sufficient infrastructure/bandwidth/connectivity to support multiple/specialist services across the estate.

LLR ICS strategic estates strategy

Contribute to the development of the ICS estates strategy expected to be updated during 2022/23 in line with the planned establishment of the LLR ICS and publication of new national templates and planning guidelines.

Communications and engagement

Ensure systems are in place to inform and update GP practices, PCNs and the wider stakeholder groups regarding the PCES and supporting plans; including the outcome of the prioritisation process, next steps and resources.

Premises and Land Disposal Opportunities

Continue to focus on potential premises and land disposal opportunities resulting from changes to both NHS services impacting on the estate and opportunities arising from the emergence of the integrated care system and services changes.

(Continued on next page).

5. Plans for the GP primary care estate

5.2 PCES work programme (continued)

PCN service and estate strategies

NHSEI in partnership with Community Health Partnerships have developed a PCN Service and Estate Planning Toolkit to provide a national framework that will support PCNs and ICS systems to identify their primary care estate change and investment requirements. The toolkit is an extension to the guidance publication *Primary Care Networks: Critical thinking in developing an estate strategy* (2020), and takes it forward to provide a set of practical tools for use and application in the development of PCN service and estate planning. Funding is being provided to support Places and PCNs to develop clinical and estate strategies during 2022-23.

One of the challenges facing the CCGs and primary care is the roll-out of the Additional Roles Reimbursement Scheme (ARRS), where PCNs and GP practices will need to accommodate the additional workforce in terms of both physical space and to implement new ways of working. The PCN service and estate strategy development process will support us to identify physical and/or service model solutions for these expanded services.

GP training programme

In addition to the ARRS roll-out, there are also imminent changes planned to the GP training programme during 2022-23. This includes both an increase in the number of GP trainees and changes to the programme where trainees will spend more time in primary care rather than secondary care across the 3-year programme. The impact on physical space will be considered as part of the PCN service and estate strategy work outlined above.

Developing a greener estate and sustainable models of care

The LLR ICS Green Plan is currently in development and will seek to address wider sustainability priorities including carbon emissions, waste, elimination of single use plastic, travel and air pollution, site greening for patient and staff well-being, sustainable models of care across the region and collective efforts to reduce the impacts of medical processes (particularly anaesthetics) and the use of sustainable medicines, and sustainable procurement.

This Green Plan will provide a system wide strategy including a high-level vision, strategic objectives and supporting actions. It will include a focus on the primary care estate and service models and will initially cover the period 2022-25.

In addition to the longer-term strategic objectives and actions, commissioners and providers are developing plans to manage rising energy costs and the CCGs will work with primary care to pursue all opportunities to minimise the impact on GP Practices and primary care services.

5. Plans for the GP primary care estate

5.3 Funding strategy

NHS Capital funding

There is currently no national capital funding available for GP primary care unless these are housed in NHS-owned premises (e.g. NHSPS buildings through the potential allocation of system capital). Whilst we still have a small number of schemes progressing through the ETTF scheme, the scheme is closed to any new applications and a replacement capital programme has yet to be identified for individual GP premises schemes.

Any future national capital scheme will likely result in rent abatement periods similar to those already in place for ETTF and s106 funded schemes (5,10 or 15 years depending on the scheme cost), but the longer term solution will need to be a combination of revenue and capital schemes, with all schemes having revenue implications.

We will endeavour to access any additional capital funding streams that come available to primary care during the life of this strategy.

Developer contributions

Some GP practices/geographic areas will have access to developer contributions to fund premises schemes during the next five years. These contributions are subject to the same abatement periods outlined above. There may be potential for a combined developer contribution and revenue solution for GP practices with a high prioritisation ranking in more than one category (e.g. practices affected by housing growth requiring expansion and where the existing premises are poor quality or unsuitable) and we will continue to work with all our Local Authorities to support equitable access to developer contributions across the ICS.

Revenue funding

The LLR CCGs have supported a recurrent **£2.35m** revenue investment plan for the period 2022/23 to 2026/27 to support the PCES development programme. The budget will grow incrementally over the five years to reach £2.35m and these funds will be employed to offset self-funded solutions by practices/PCNs by means of the District Valuer revaluing and subsequently uplifting the level of rental reimbursement in line with the GP Contract Premises Costs Directions. The total revenue budget will support a high number of developments based on a combination of small, medium and larger schemes.

Potential premises solutions

Therefore, in the absence of NHS capital funding, the current options for GP premises developments are as follows:

- Developer contributions (with rent abatement)
- Self funded (with a rent reimbursement uplift)
- Third Party Development (with a rent reimbursement uplift)
- Optimum use of the current GP and wider NHS/ICS estate
- Combining estate across PCN and/or Place based solutions with partners.

6. Conclusions and Next Steps

Conclusion

This new PCES builds on the baseline information document completed in 2020/21 and the premises prioritisation process completed in May 2021. This suite of documents represent the current LLR CCGs estates position and together, they form a suite of PCES documents and provide a solid foundation to support progress towards our GP primary care estate strategic aims and objectives.

Primary care and the wider health and care system faces many challenges and is in the midst of a period of significant change due to a combination of strategic drivers and challenges impacting on service demand and delivery models. In addition, the scale of housing development and associated population growth presents a huge challenge for primary care and all integrated care services.

Estates is an enabler to support change and our plans will need to evolve to support the changing primary care and wider ICS landscape, but the outcome of the prioritisation process and the £2.35m five-year revenue investment and developer contributions provide a framework and resource to make significant progress during this period. It takes time plan and approve larger scale developments and this will help us to plan for and respond to service model changes as they evolve.

The challenge facing the GP primary care estate will take far longer than five years to resolve following years of under investment in the primary care estate and the challenge is further complicated by the current lack of access to NHS capital for GP premises development, together with construction cost inflation.

However, additional investment in the estate is only part of the solution and there are many opportunities to improve utilisation and make more efficient use of our existing estate without significant additional investment. An important part of the PCES work programme is to challenge and support GP practices and PCNs to work differently and consider all of the other options outlined in this document as an alternative to building bigger buildings as the default option.

Next Steps

The work programme outlined in section five summarises the main areas of work to support delivery and continuing development of the PCES. The key strategic milestones from the work programme for the first six months of 2022 are shown below.

Key Milestones for January – June 2022	MM/YY
PCES launch for GP practices and other key stakeholders	02/22
Produce toolkits and templates to support potential premises schemes' planning	03/22
PCES approval (this document)	03/22
Appointment of Strategic Head of Estates and other team resources	03/22
Complete implementation of systems and processes to monitor planning applications and developer contributions	04/22
Complete development of the detailed work programme/project plan to take forward the PCES over the next 12 months; including confirmation of plans and timescales to develop PCN service and estate strategies	05/22
Implement updated CCGs primary care governance arrangements (reporting to the PCCC)	05/22
Produce first phase GP premises development programme for prioritised schemes (building on current live schemes programme)	05/22
Commence programme of work to develop PCN service and estate strategies	06/22
Review and update housing commitments, allocations and strategic plans to refresh the impact on GP practices, PCNs and geographic areas	06/22

7. Appendices

Appendix A: PCES Prioritisation and Directorate leads

The table below shows the outcome of the PCES prioritisation process completed in May 2021. The first column shows the lead CCG directorates for GP practices/groups of practices (usually grouped into geographic areas and often where the directorates in question are already undertaking planning work/wider projects). The scores highlighted in green are those where the GP practices in question were ranked in the 'Top 20' for one or more of the three main categories: housing and population growth; Practices that have insufficient space/facilities; and Practices that have poor quality or unsuitable premises. In addition to the three headline categories, the process also took into account demographic, health & socio-economic factors and service changes impacting on primary care services.

Area/Practice	NHS Contract Code	Practice Name	PCN Area	Housing and Population Growth	(Un)Suitability of Current Premises Inc. GIA Score	(Un)Suitability of Current Premises Exc. GIA Score	Lead Directorate
Market Harborough	C82001	South Leicestershire Medical Group (The Old School Surgery)	Cross Counties	165	125	65	S&P Lead
	C82009	Market Harborough Medical Centre	Market Harborough & Bosworth	140	117	42	
Shepshed	C82064	Forest House Surgery	Beacon	115	123	63	S&P Lead
	C82656	Field Street Surgery	Beacon	115	76	76	
City North & Surrounding Border Areas	C82094	Beaumont Lodge Medical Practice (The Surgery)	Millenium	150	114	84	S&P Lead
	C82003	Greengate Medical Centre	Watermead	115	130	55	
	C82628	Groby Surgery	Bosworth	115	132	57	
	C82627	Silverdale Medical Centre	Watermead	115	87	42	
	C82678	Thurmaston Health Centre	Watermead	115	56	56	
	C82091	Birstall Medical Centre	Watermead	115	57	42	
	C82056	Glenfield Surgery	North Blaby	115	110	50	
	C82624	The Practice - Beaumont Leys	City Care Alliance	150	128	68	
	C82623	Heatherbrook Surgery (Dr F Rizvi & Partner)	Aegis Healthcare	140	143	68	

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Appendix A (Continued)

Area/Practice	NHS Contract Code	Practice Name	PCN Area	Housing and Population Growth	(Un)Suitability of Current Premises Inc. GIA Score	(Un)Suitability of Current Premises Exc. GIA Score	Lead Directorate
City Central	C82116	Highfields Surgery	Leicester Central	35	137	92	I&T Lead
	C82651	Dr KS Morjaria & Partner (Broadhurst Street MP)	Belgrave & Spinney Hill	35	155	80	
	C82088	Evington Medical Centre (Halsbury street)	The Fox's	35	123	78	
	C82099	Al-Waqas Medical Centre (Dr KA Choudhry)	The Fox's	35	123	78	
	C82653	Dr S Shafi (Westcotes GP Surgery)	Millenium	35	78	78	
	C82114	Dr UK Roy	City Care Alliance	35	122	77	
	C82122	Clarendon Park Surgery	Aegis Healthcare	35	121	76	
	C82119	Narborough Road Surgery	The Fox's	35	121	76	
	C82614	Spirit Asquith Surgery	City Care Alliance	35	151	76	
	C82063	East Leicester Medical Practice	Aegis Healthcare	35	91	76	
	C82024	Spinney Hill Medical Centre (Dr Pancholi & Partners)	Belgrave & Spinney Hill	35	140	65	
	C82662	Walnut Street Surgery	Leicester City South	105	130	55	
	C82030	Downing Drive Surgery	Salutem	115	100	55	
	C82086	Fosse Medical Centre	Leicester Health Focus	35	130	55	
	C82084	Dr B Modi (Canon Street)	Belgrave & Spinney Hill	35	130	55	
	C82676	St Elizabeth's Medical Centre (Dr J A Wood)	Salutem	115	74	44	
	Y00137	Dr Roshan (Willows MC)	Aegis Healthcare	115	40	40	

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Appendix A (Continued)

Area/Practice	NHS Contract Code	Practice Name	PCN Area	Housing and Population Growth	(Un)Suitability of Current Premises Inc. GIA Score	(Un)Suitability of Current Premises Exc. GIA Score	Lead Directorate
Loughborough	C82111	Student Medical Centre	Carillon	115	165	90	S&P Lead
	C82070	Woodbrook Medical Centre	Carillon	115	113	68	
	C82035	Park View Surgery	Carillon	115	125	80	
	C82026	Bridge Street Medical Practice	Carillon	115	100	40	
	C82011	Pinfold Medical Practice	Carillion	115	110	50	
Melton	C82038	Latham House Medical Practice	Syston, Vale and Melton	135	123	63	S&P (Strategic) and Contracts (Practice S&P lead for strategy re: Coalville CH
Coalville	C82045	The Whitwick Road Surgery	North West Leicestershire (Hub 3)	95	135	60	
Rutland	C82044	Empingham Medical Centre	Rutland	155	121	61	S&P Lead
Measham	C82017	Measham Medical Unit	North West Leicestershire (Hub 1)	95	142	82	Contracts Lead
Castle Donington	C82007	Castle Donington Surgery	North West Leicestershire (Hub 3)	120	100	55	I&T Lead
Soar Valley	C82644	Highgate Medical Centre	Soar Valley	90	144	69	I&T with contracts input
	C82034	Quorn Medical Centre	Soar Valley	65	151	76	
	Y00252	Cottage Surgery	Soar Valley	65	140	65	
Hinkley	C82082	The Centre Surgery	Hinckley Central	80	130	55	S&P Lead
	C82061	Barwell & Hollycroft Medical Centre (Barwell)	Fosseway	55	123	78	
North Blaby / Oadby & Wigston	C82098	Hazelmere Medical Centre	South Blaby & Lutterworth	70	143	68	Contracts Lead
	C82021	The Central Surgery	Oadby & Wigston	70	158	83	
	C82055	The Limes Medical Centre	North Blaby	70	138	63	
Scraptoft Area	C82022	Billesdon Surgery	Cross Counties	115	109	79	S&P Lead

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Appendix B: Overview of the six-facet survey results (at Place level)

Key

Facet Area	Grade													
Q1. Physical Condition	**A**	As new (built within last 2 years) and can be expected to perform adequately over its design life. (No Cost within the next 5 years).	**B**	Sound, operationally safe and exhibits only minor deteriorations (Costs to sustain condition B sub-elements in condition B during the financial year).	**B/C**	Currently in B but may fall to C within 5 years (The cost to bring B(C) sub-elements up to condition B at the future point during the next 5 years).	**C**	Operational but major repair or replacement may be needed soon	**D**	Runs a serious risk of imminent breakdown	**X**	Applied to "C" or "D" ratings (i.e.. Cx or Dx) indicating that nothing other than a total rebuild or relocation will suffice		
Q2. Functional Suitability	**A**	Very satisfactory, no change needed	**B**	Satisfactory, minor change needed	**C**	Not satisfactory, major change needed	**D**	Unacceptable in present condition	**X**	Supplementary rating to "C" or "D", to indicate that nothing but a total rebuild or relocation will suffice, i.e. improvements are either impractical or too expensive.				
Q3. Space Utilisation	**E**	EMPTY - empty or grossly-under used at all times (excluding temp closure)	**U**	UNDER-USED - generally underused; utilisation could be significantly increased	**F**	FULLY USED - a satisfactory level of utilisation	**O**	OVERCROWDED - overcrowded, overloaded and facilities generally over stretched.						
Q4. Quality	**A**	A facility of excellent quality	**B**	A facility requiring general maintenance investment only	**C**	A less than acceptable facility requiring capital investment	**D**	A very poor facility requiring significant capital investment or replacement	**X**	Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice (improvements are either impractical or too expensive to be tenable).				
Q5. Fire H&S	**A**	Building complies with all relevant standards and guidance; equal to a new building	**B**	Action will be required within the current period to comply with relevant guidance and statutory requirements	**C**	Known contravention of one or more standards - which falls short of "B"	**D**	Dangerously below "B", e.g.: " that have been subject to adverse external inspections	**X**	Supplementary to "C" or "D", indicating that nothing but a total rebuild or relocation will suffice (too impractical or expensive to remedy)				
Q6. Environmental	**A**	Energy Performance Operational Rating: 0 > 25	**B**	Energy Performance Operational Rating: 26 > 50	**C**	Energy Performance Operational Rating: 51 > 75	**D**	Energy Performance Operational Rating: 76 > 100	**E**	Energy Performance Operational Rating: 101 > 125	**F**	Energy Performance Operational Rating: 126 > 150	**G**	Energy Performance Operational Rating: 150+
	*****	Supplementary rating added to the Energy Performance Operational Ratings A > G, to indicate a presumed estimate for the buildings DEC ranking i.e. C*, D*		This tells how efficiently energy has been used in the building. The numbers do not represent actual units of energy consumed; they represent comparative energy efficiency. The higher the Energy Performance Operational Rating, indicates that there is opportunity to improve the buildings efficiency.										

7. Appendices

Appendix B: Overview of the six-facet survey results (at Place level)

Leicester City:

70 premises including branch premises

Leicester City (70 premises including branch premises)						
Q1. Physical Condition	A	B	B/C	C	D	X
	A*: 12 A: 3	23	26	6	0	0
Q2. Functional Suitability	A	B	C	D	X	
	14	B*: 12 B: 29	15	0	0	
Q3. Space Utilisation	E	U	F	O		
	0	U*: 12 U: 17	39	2		
Q4. Quality	A	B	C	D	X	
	9	B*: 12 B: 27	22	0	0	
Q5. Fire H&S	A	B	C	D	X	
	4	B*: 12 B: 40	14	0	0	

Q6. Environmental	A	B	C	D	E	F	Not Surveyed	*	This tells how efficiently energy has been used in the building. The numbers do not represent actual units of energy consumed; they represent comparative energy efficiency. The higher the Energy Performance Operational Rating, indicates that there is opportunity to improve the buildings efficiency.
	1	B*: 1 B: 4	C*: 8 C: 7	D*: 19 D: 5	E*: 3 E: 4	F*: 4	14	Supplementary rating added to the Energy Performance Operational Ratings A > G, to indicate a presumed estimate for the buildings DEC ranking i.e. C*, D*	

7. Appendices

Appendix B: Overview of the six-facet survey results (at Place level)

Leicestershire:

94 premises including branch premises

Leicestershire (94 premises including branch premises)						
Q1. Physical Condition	A	B	B/C	C	D	X
	4	47	33	C*: 1 C: 9	0	0
Q2. Functional Suitability	A	B	C	D	X	
	34	42	C*: 1 C: 17	0	0	
Q3. Space Utilisation	E	U	F	O		
	0	17	66	O*: 1 O: 10		
Q4. Quality	A	B	C	D	X	
	31	39	C*: 2 C: 22	0	0	
Q5. Fire H&S	A	B	C	D	X	
	8	71	C*: 2 C: 13	0	0	

Q6. Environmental	A	B	C	D	E	F	Not Surveyed	*	This tells how efficiently energy has been used in the building. The numbers do not represent actual units of energy consumed; they represent comparative energy efficiency. The higher the Energy Performance Operational Rating, indicates that there is opportunity to improve the buildings efficiency.
	A*: 1	B*: 1 B: 2	C*: 14 C: 15	D*: 17 D: 14	E*: 10 E: 10	F*: 7 F: 2	1	Supplementary rating added to the Energy Performance Operational Ratings A > G, to indicate a presumed estimate for the buildings DEC ranking i.e. C*, D*	

7. Appendices

Appendix B: Overview of the six-facet survey results (at Place level)

Rutland:

7 premises including branch premises

Rutland (7 premises surveyed)												
Q1. Physical Condition	A	B	B/C	C	D	X						
	0	7	0	0	0	0						
Q2. Functional Suitability	A	B	C	D	X							
	6	1	0	0	0							
Q3. Space Utilisation	E	U	F	O								
	0	2	4	1								
Q4. Quality	A	B	C	D	X							
	6	1	0	0	0							
Q5. Fire H&S	A	B	C	D	X							
	0	6	1	0	0							
Q6. Environmental	A	B	C	D	E	F	Not Surveyed	*	This tells how efficiently energy has been used in the building. The numbers do not represent actual units of energy consumed; they represent comparative energy efficiency. The higher the Energy Performance Operational Rating, indicates that there is opportunity to improve the buildings efficiency.			
	0	B*: 1	1	D*: 2	E*: 1	F*: 1 F: 1	0	Supplementary rating added to the Energy Performance Operational Ratings A > G, to indicate a presumed estimate for the buildings DEC ranking i.e. C*, D*				

8. References and Bibliography

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- LLR CCGs: PCES premises prioritisation process (2020/21)
- LLR CCGs: LLR 2019/20-2023/24 Primary Care Strategy (June 2019)
- LLR ICS/STP development plans in progress (various, 2021)
- LLR STP: STP Estates Strategy and Plan (July 2018)
- LLR STP: Better Care Together Sustainability and Transformation Plan (November 2016)
- LLR STP Better Care Together: Next steps to better care in LLR (August 2018)
- LLR STP: Digital Strategy & Roadmap 2018-21 (February 2019)
- LLR Six-Fact Survey results (various, 2019)
- NHSE: Five Year Forward view (2014)
- NHSE: The General Practice Forward View (April 2016)
- NHSE: The NHS Long Term Plan (January 2019)
- NHSE: Accommodating additional Multi-Disciplinary Team staff appointed under the Network Contract DES (August 2020)
- NHSE/I & CHP: PCN Service and Estate Planning Toolkit (November 2020)
- NHSE/I: Primary Care Networks: Critical thinking in developing an estate strategy (2020)

9. List of Abbreviations

CCG(s)	Leicester, Leicestershire and Rutland Clinical Commissioning Groups
CHP	Community Health Partnerships
CIL	Community Infrastructure Levy
ETTF	Estates and Technology Transformation Fund
DES	Direct Enhanced Services
GP	General Practitioner
IT	Information Technology
ICS	Integrated Care System
LIFT / LIFTCo	Local Improvement Finance Trust (Company)
LLR	Leicester, Leicestershire and Rutland
NHSE/I	NHS England and NHS Improvement
NHS PS	NHS Property Services
PCES	Primary Care Estate Strategy
PCN	Primary Care Network
S106	Section 106 (planning agreement)
STP	Sustainability and Transformation Partnership/Plan