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1 Executive Summary

1.1 Background and purpose

In June 2015 the Department of Health published guidance to CCGs on the development of local estate strategies “Local Estates Strategies A Framework for Commissioners” (June 2015), with the expectation that the majority of CCGs would have a local estate strategy in place by the end of December 2015.

NHS Property Services (NHSPS) and Community Health Partnerships (CHP) the two NHS property companies were mandated to assist their local CCGs in achieving this deadline.

NHSPS was formed in April 2013 at which point most of the community assets previously owned by Primary Care Trusts (PCTs) were transferred into their ownership. In instances where the PCTs leased properties, the lease was novated to NHSPS. They act as the landlord for the properties, recovering the costs of occupancy from the tenants.

Existing and future developments that used NHS Local Improvement Finance Trust (LIFT), a public, private partnership (PPP), as the procurement option are managed by CHP. They take on the role of head tenant and recover costs through lease agreements with the tenants.

Both organisations provide a regional strategic estates planning function for Clinical Commissioning Groups. East Surrey is not an area covered by NHS LIFT and therefore NHSPS was allocated to assist the CCG in the development of the Strategic Estates Plan.

The initial stage of preparing a Strategic Estates Plan is to establish the current position and a review of the current estate was initiated by NHSPS. This concentrated on the NHSPS owned assets and did not include the primary care estate, a critical asset for the delivery of the CCGs vision for out of hospital services.

In June 2016, further work was commissioned to incorporate the primary care estate into the review.

The objectives of the Strategic Estates Plan are to:

- Understand the health and social care needs that are driving the development of new models of care and how the estate will need to respond to these developments;
- Describe the East Surrey NHS estate as it is now, including opportunities and constraints;
- Establish how the estate can best be configured to facilitate the delivery of
the new models of care;

- Identify the priorities for investment and opportunities for savings, both short and long term; and
- Align the way forward for the CCG within the national context of NHSE’s “General Practice Forward View” (April 2016) by developing the primary care estate and investing in technology.

The estate review has been carried out using readily available data, recognising that there are gaps and potential inaccuracies with the current information, specifically with regard to the primary care estate.

The development of a robust estate strategy will be an iterative process and this document will be revised as and when new information becomes available. This is the third iteration.

The Strategic Estates Plan is a service driven strategy and complements the work the CCG is undertaking in partnership with the East Surrey GP Networks, developing new models of care and integrated service provision aligned to NHS England’s “Five Year Forward View”.

1.2 Key Drivers and Challenges

1.2.1 The Population

The population of East Surrey is growing and the health needs of the population change in response to this growth, be it the requirements to meet the needs of an ageing population or those of young families due to new housing developments within the area.

The current population of East Surrey is in the region of 181,600 and is due to increase at a rate of over 1% per year.

The key characteristics of the East Surrey population are:

- An increasingly aging population, currently 17% are over 65
- A generally healthier population, compared with the England average
- Lower than average deprivation, but a number of children still live in poverty
- Higher than average life expectancy for men (81 years) and women (84 years) with a difference in the life expectancy of men across Reigate and Banstead (7.4 years lower in the most deprived areas)
- A reduction in all causes of mortality rates and early death rates from cancer, heart disease and stroke, which are all better than the England average.
Alongside the growth in population there is a decline in the size of households which means that the number and types of houses offered needs careful consideration when planning new housing developments.

Both Reigate and Banstead Borough Council and Tandridge District Council are planning significant housing development over the next ten years. Health services will need to respond to the changing demographics that are a consequence of these developments.

With the primary care estate being a focal point for healthcare within the community it is imperative that it is fit for purpose and of adequate capacity to meet demand.

1.2.2 Out of Hospital Care

A key emerging theme from the work on the out of hospital strategy is the need to develop hubs that have the capacity to co-locate services in one location, improving access to diagnostics and providing primary and community care clinicians (including mental health) with the support that they need to better manage their patients in the community. Social care will be a key component in this integrated model of care to ensure that there is continuity of care when health services are no longer required.

The CCG describes these enhanced facilities as a health and social care campus where the integration of services is facilitated by co-location on one site and patients are able to access the services required with the minimum of travel.

The key areas within East Surrey that are being considered for these enhanced models are:

- Oxted
- Caterham
- Horley
- Redhill/Reigate
- Lingfield

1.3 New Models of Care

Throughout the country new models of care are being piloted which bring together providers, offering a range of integrated services with the aim of improving the health and well-being of the population served but also delivering a sustainable model of health and social care into the future.

To date the CCG has focused on developing a new model of care for the management of people with long term conditions and those with complex needs, with the aim of
improving health outcomes and quality of life. The new model will mainly be delivered on a network basis, moving to a more locally deployed, person centred and integrated model of care.

As these new models of care develop ESCCG will need to work closely with the NHS property companies and the local authorities to ensure that the estate becomes an enabler to these new ways of working rather than a barrier.

1.4 The Estate

The condition and functional suitability of the estate is variable, from purpose built health centres with adequate space to converted properties that do not meet statutory requirements with regards to disabled access or space.

As intelligence improves about the condition and suitability of the estate this will start to inform the investments that are required to future proof the estate and support the CCG’s strategic intentions for out of hospital care.

However, even at this early stage key areas have been identified where investment is required. These were submitted to NHSE via the Estate and Technology Transformation Fund for consideration. In total the CCG submitted bids in excess of £14 million.

Since the submissions another round of prioritisation has been undertaken with only three schemes being put forward for further consideration:

- Lingfield Practice redevelopment (successful in phase 3)
- Greystone House Practice (successful in phase 2); and
- Whyteleafe Practice (unsuccessful).

Three of the schemes not going forward are being considered for a minor improvements grant:

- Birchwood Medical Practice;
- Chaldon Road Surgery; and
- Caterham Valley Medical Practice.

1.5 Emerging Themes

1.5.1 Models of care

The development of the STP and place-based plan is enabling the CCG to contribute to plans that extend wider than its own boundary whilst ensuring that the health and care
systems, and the infrastructure that supports them, is fit for purpose and sustainable within East Surrey.

The emerging service model is closely aligned with an MCP and the opportunities to fully implement this and establish deliverable benefits will be influenced by the use of both the NHSPS community estate and the GP primary care estate. The Strategic Estates Plan should be driven by the model of care and therefore it is critical that this is established as soon as possible.

1.5.2 Community Services Estate

The review has highlighted a severe deficit in suitable accommodation available for the provision of clinic based community services. Currently services are operating in dispersed locations which compromise the opportunities for integration. Of the accommodation occupied some of it is below modern space standards and non-compliant with current guidance on control of infection.

With community services a key component in out of hospital care, the provision of suitable accommodation in the right location is critical for the realisation of a sustainable health and care system which delivers care locally.

1.5.3 Primary Care Estate

The primary care estate is variable with regard to capacity and condition. Some practices are housed in converted properties whilst others benefit from purpose built facilities. However, many of them, regardless of age or suitability, are already operating at capacity and have no space to absorb any future growth in list size or to extend the range of services provided in line with the expectations of modern primary care practice.

1.5.4 Future Housing Growth

The CCG has been advised through the local authorities that there will be progressive housing growth of approximately 1,000 units per year between 2015 and 2030. This needs to be verified for the consequences that this will have on health and care services and the CCG will need to ensure that the local authorities are cognisant of the funding required to deliver additional capacity.

1.5.5 Void Costs

The CCG are liable for void costs in all properties either owned or leased by NHSPS where there is unoccupied space. In 2016/17 the CCG is currently liable to pay in excess of £500,000 void costs. There are some significant opportunities for the CCG to work with NHSPS to reduce the void costs by either arranging for full occupation of vacant space or surrendering leases/disposing of properties where there are no future requirements identified.
1.5.6 Caterham Dene Hospital Site

The Caterham Dene Hospital, which is in the ownership of NHSPS, provides a significant opportunity for the CCG to realise the development of a purpose built modern facility that is aligned to the strategy for out of hospital services.

The site is large and has the potential to not only accommodate a future health and social care development but could also realise significant capital receipts if surplus land could be the subject of disposal.

An options paper has been prepared, for consideration by the CCG Governing Body, which sets out the high level options for development.

1.6 Conclusions

The key aspects of the estates plan are to ensure sustainability of primary care given the increased demographic growth & housing developments, support for development of the four primary care networks that will support the out of hospital model of care, provision of fit for purpose estate and delivery of the Five Year Forward View and GP Forward View, including suitable space for GP training.

A major challenge facing the CCG is the vulnerability of some of the practices with the potential for list closures and hence the practices’ inability to invest in the development of premises to meet future demand.

The availability of suitable property for conversion or land for new builds is scarce and provides a significant challenge for the CCG. The CCG is currently liaising with the county council who are participants in the One Public Estate programme, and is also working with other providers to look at all opportunities where the integration of services could provide opportunities for joint investment in the development of facilities.

The current financial position of the CCG places constraints on the investment that can be made and the future feasibility of primary and community care estate are contingent on the ability to access external funding sources.

Without investment in the estate and infrastructure required to support patient care some areas of the local health economy will see either a reduction or potentially a loss of primary care services at a time when expansion and transformation of out of hospital services are needed to prevent over reliance on acute hospital care.

The applications for funding via the ETTF aim to not only support the practices in facilities that are fit for purpose but that match the strategic ambition of the CCG in
transforming healthcare in East Surrey.

The development of the CCG’s Strategic Estates Plan is an iterative process that will be further refined as new models of care emerge and new ways of working become established. The work to date has provided the CCG with a good understanding of the current estate and facilitated the development of robust submissions for the Estate and Technology Transformation Fund.

As work continues to progress on the Sustainability and Transformation Plans (STPs), and specifically the place-based plans, the CCG will be working with partner organisations to ensure that strategic estates planning is undertaken across organisational boundaries. To better inform these plans further work needs to be undertaken to ensure that the most accurate and up to date financial information is made available. This would include full details of occupancy costs and any funding requirements for statutory compliance works or back-log maintenance.

1.7 Next Steps

The final iteration of the Strategic Estates Plan is contingent on some key decisions being made regarding the future model of care across East Surrey. Specifically confirmation will be needed on where the health and social care hubs are to be located, and the services to be provided, to inform future investment decisions.

By March 2017 the CCG should work towards:

- Establishing a Local Estates Forum;
- Confirming the locations of the health and social care hubs;
- Confirming services to be provided from these hubs;
- Making the decision on whether to proceed to Strategic Outline Case for the Caterham Dene site re-development;
- Pursuing the S106 money available in 2016/17;
- Identifying future requirements for primary care premises development and submitting applications to Reigate and Banstead Borough Council and Tandridge District Council for Community Infrastructure Levy funding;
- Putting in place a process for the prioritisation and allocation of the 2017/18 minor improvements grant funding; and
- Working with Surrey County Council to submit a bid to One Public Estate for funding to support further feasibility work on the Caterham Dene redevelopment and the wider public estate.
2 Introduction

Since the establishment of Clinical Commissioning Groups (CCGs), the two NHS property companies, NHS Property Services (NHSPS) and Community Health Partnerships (CHP), both wholly owned by the Department of Health, have managed community property and estates services.

Most of the community assets previously owned by Primary Care Trusts (PCTs) were transferred into the ownership of NHSPS in April 2013. As landlord for these properties they are responsible for the maintenance of the building and for either providing, or contracting, for the soft facility management (FM) services, for example, cleaning, catering, portering and security. NHSPS enter into lease agreements with the occupants to recover the costs of occupancy. In instances where the PCTs leased properties, the lease was novated to NHSPS and they act as head tenant, once again recovering the costs of occupancy from the tenants.

Existing and future developments that used NHS Local Improvement Finance Trust (LIFT), a public, private partnership (PPP), as the procurement option are managed by CHP. They take on the role of head tenant and recover costs through lease agreements with the tenants. The maintenance of NHS LIFT buildings is included within the LIFT contract and therefore CHP’s role is about the performance management of this contract. They are however, in the majority of schemes, responsible for contracting for soft FM services.

Both organisations provide a regional strategic estates planning function for Clinical Commissioning Groups. East Surrey is not an area covered by NHS LIFT and therefore NHSPS was allocated to assist the CCG in the development of the Strategic Estates Plan.

The initial stage of preparing a Strategic Estates Plan is to establish the current position and a review of the current estate was initiated by NHSPS. This concentrated on the NHSPS owned assets and did not include the primary care estate, a critical asset for the delivery of the CCGs vision for out of hospital services.

In June 2016, further work was commissioned to incorporate the primary care estate into the review.

As the national and local strategic focus falls on further development of integrated out of hospital care, concentration now needs to be given to investing in the infrastructure required to facilitate this transformation.

Achieving the efficiencies required by the Five Year Forward View will mean all parts of the health service will need to work with greater agility and greater cooperation. Good quality strategic estate planning is vital to making the most of these changes and will
allow the NHS to:

- Fully rationalise its estate;
- Maximise use of facilities;
- Deliver value for money; and
- Enhance patient experience.

To facilitate the vision of the Five Year Forward View NHS England has made available £1 billion of funding to invest in transforming primary care estate and technology (Estate and Technology Transformation Fund – ETTF). This offers GP practices the opportunity to review the condition and functionality of their estate for the following benefits:

- Co-location with community-based services, such as pharmacies, social care, district nursing and the voluntary sector;
- Investment in better access to diagnostic technologies in general practice;
- Investment in new and existing IT services to support general practice to offer new online services such as virtual booking, Skype-type consultation and access to patient records;
- Ensure release of s.106 and CIL monies by local government, to allow construction of GP premises in communities;
- Maximise the use of estates facilities; and
- Enhance patient experience.

Although the CCG is not directly responsible for managing the healthcare estate, it has a strategic role in working with all partners to understand and communicate the health needs of the population, the services required to meet these needs and the facilities in which they need to be delivered. The CCG also has a role in supporting practices in the development of their premises to ensure that they in turn support the CCG’s commissioning plan. In order to do this the CCG needs to understand the current healthcare estate, future requirements and how any deficits can be met.

2.1 Estates Review

The estates review has been carried out using readily available data, recognising that there are gaps and potential inaccuracies with the current information, specifically with regard to the primary care estate.

Site visits have been made to 18 of the 19 primary care premises. These visits included a meeting with the practice manager and a walk around of the premises to establish the
overall suitability and condition of the building and a review of each room for function, utilisation and suitability. NHPS properties have also been included within this review. The information has been captured in excel format.

This inspection does not constitute a condition survey, which would need to be undertaken by a specialist company of surveyors and comply with the core estates information required by NHS Estate CODE. These surveys provide the “minimum data set” of information necessary on which to base intelligent decisions about the future of estate.

A condition survey covers the following facets:

1. Physical Condition Survey (Fabric & Mechanical & Electrical)
2. Statutory Compliance Audit (including fire)
3. Space Utilisation Audit
4. Functional Suitability Review
5. Quality Audit
6. Environmental Management Audit

The final report would include a risk assessment of any findings, identifying any remedial work that requires urgent attention and the associated costs.

The commissioning of condition surveys would give a more accurate picture of the current estate and assist in developing a strategic plan that is cognisant of future investment required to maintain the estate in a usable condition. This would also identify areas where dis-investment and disposal may be the preferred option.

Gaining accurate financial information about the costs of the estate has also been challenging. Both NHSE and NHSPS are in the process of validating the information upon which they base rents and reimbursements. Once this has been completed the CCG will have an accurate picture of the true costs of the primary and community estate in East Surrey.

This plan is therefore reflective of the current known position. It will evolve as new and updated property information becomes available and will be refined taking into account emerging models of care and the service strategies that underpin their delivery.
2.2 Objectives and Scope

The aim of this Strategic Estates Plan is to:

- Understand the health and social care needs that are driving the development of new models of care and how the estate will need to respond to these developments;
- Describe the East Surrey NHS estate as it is now, including opportunities and constraints;
- Establish how the estate can best be configured to facilitate the delivery of the new models of care;
- Identify the priorities for investment and opportunities for savings, both short and long term; and
- Align the way forward for the CCG within the national context of NHSE’s “General Practice Forward View” (April 2016) by developing the primary care estate and investing in technology.

In the future we plan to expand these objectives and scope to include other public sector organisations in order that we can create an inclusive estate strategy that provides best value to the public. To support this we hope to leverage additional funding through the One Public Estate programme. One Public Estate (OPE) is a pioneering initiative delivered in partnership by the Cabinet Office Government Property Unit (GPU) and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners. Surrey County Council is already a member of the OPE programme and has indicated that they are supportive of working with the CCG to submit an application for funding. Whilst the East Surrey Hospital estate is not directly within the scope of this Strategic Estates Plan it is worth noting that the CCG would like to explore the options with the trust for developing a health and social care campus on the site. Capacity for the delivery of community services is severely compromised across East Surrey, and specifically within the Redhill area, the CCG is keen to ensure that opportunities to optimise the use of the East Surrey site are taken forward, encouraging rationalisation of the estate and integration between community and secondary care.

1 http://www.local.gov.uk/onepublicestate
3 Key Drivers and Challenges

This section of the document explores the context within which health and social care is delivered in East Surrey. It highlights the key national policy drivers and places them within the context of the local population and the need to tailor responses to the specific needs and challenges within our population.

3.1 National Context

The shape of health services is changing. Primary care and community services are at the very heart of the modern NHS. Many activities that traditionally have happened in an acute hospital can now be undertaken more effectively and more conveniently in community settings, community hospitals, GP surgeries or in the patient’s own home.

Since 2006 when the Department of Heath (DH) published “Our health, our care, our say”, the direction of travel for the NHS has been to shift from acute hospital based services to a more local model, providing innovative, flexible and accessible primary and community care. This has since been followed up by various policy documents from the Department of Health that further support this strategy, including NHS 2010-2015: From Good to Great. Preventative, People-Centred, Productive (2009), Equality and Excellence: Liberating the NHS (2010), The NHS belongs to the people - A Call To Action (2013) and Everyone Counts – Planning for Patients 2014/15 to 2018/19 (2013).

This strategic direction is reiterated in NHS England’s Five Year Forward View (October 2014). It confirms the need to concentrate on the investment in public health and the prevention of ill health as a social and economic necessity. It looks to support the development of new models of care that integrate health services, both physical and mental, with both statutory and voluntary social care. And, it emphasises the need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services.

The General Practice Forward View published by NHS England on 21 April 2016 aims to help GP surgeries “get back on their feet” and to improve access for patients. The five-year plan includes an increase in funding to expand the workforce, improve the infrastructure and support a major programme of improvements to strengthen and redesign primary care.

3.2 Sussex and East Surrey Sustainability and Transformation Plan

In December 2015, the NHS Planning Guidance 16/17 - 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England was tasked with producing a five year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years.
In January 2016 44 STP footprints were established nationally to bring together health and care organisations that were locally defined and based on natural communities, existing working relationships, patient flows and took into account the scale needed to deliver the transformational change required to secure sustainable services and organisations and to improve the health outcomes of the populations served.

The Sussex and East Surry STP footprint is a large and diverse region, with 23 major health and social care organisations serving 1.7m people. Three “place-based” areas have been established each defined around local communities, led by GPs with support from a wide range of professionals and empowered to co-design person-centred services. Figure 1 illustrates the three place-based areas and the constituent organisations.

Figure 1. Three Place-based areas

The challenge is to improve the health of our communities, make it quicker and easier to access services, to deliver improvements identified by regulators and find a way to do so within a tighter budget than we have faced in many years. Each place-based area has developed its own plan that sets out the key challenges faced and a programme of work to address these challenges, delivering a sustainable health and care economy, addressing inequality and improving health outcomes.

3.2.1 Central Sussex and East Surrey Alliance – Place-based Plan

The Central Sussex and East Surrey Alliance (CSESA) has produced a place-based plan which sets out the vision and the programme of work that needs to be undertaken in the short and long term to deliver sustainable change.

Figure 2. Vision Statement Central Sussex and East Surrey Alliance (CSESA)

We will invest to develop a system of healthcare that is less reactive and less hospital bed-based. It will deliver a great start in life and continue to promote people’s wellbeing, their ability to stay healthy, to self care and be cared for at home. We will bring together a system which places integration at its centre, providing more care and services closer to patients’ homes and places of need. Led by primary care, we will build on the good work already in progress, promoting collaboration between all organisations working across health and social care.
Four strategic objectives have been identified as critical to realising the CSESA vision for health and care and five delivery streams have been prioritised. These are illustrated in the figure below.

**Figure 3. CSESA Objectives and Priorities**

3.2.2 **Multispecialty Community Provider**

How these priorities are delivered aligns well with the multispecialty community provider (MCP) model. This provides opportunities for a far wider range of services to be delivered out of hospital, bringing together health and social care professionals along with voluntary and community groups to provide more tailored services designed around the needs of individuals.

The emergence of these new models will inform the development of the strategic estate plans across the public sector. As the models mature and more services are provided within a community setting the estate will need to adapt and develop to facilitate these changes. Flexibility will be important to ensure that the estate is an enabler rather than a barrier to change.

3.3 **East Surrey CCG**

East Surrey CCG relates to two local authority areas, Reigate and Banstead and Tandridge, and commissions services for a population in the region of 181,600. Health services in East Surrey face many challenges over the coming years including growth in the overall population numbers and in black and minority ethnic populations, variation in the quality of services, as well as significant financial challenges partly as a result of the inherited imbalance of resource allocation.
Through the STP process the CCG is working closely with its commissioner and provider partners to implement a transformation programme of change to maximise resources and improve the quality of care.

3.3.1 Out of Hospital Strategy

The implementation of the CCG’s strategy for primary care and community services is a key component of this transformational programme. It aims to reduce the reliance on hospital care through improved primary, community and urgent care provision in out of hospital settings. This is supported by further development in the approach to prevention, self-care, and shared decision making.

Figure 5. Out of Hospital Care – designed around the person
A key emerging theme from the work on the out of hospital strategy is the need to develop hubs that have the capacity to co-locate services in one location, improving access to diagnostics and providing primary and community care clinicians (including mental health) with the support that they need to better manage their patients in the community. Social care will be a key component in this integrated model of care to ensure that there is continuity of care when health services are no longer required.

The CCG describes these enhanced facilities as a health and social care campus where the integration of services is facilitated by co-location on one site and patients are able to access the services required with the minimum of travel.

The key areas within East Surrey that are being considered for these enhanced models are:

- Oxted
- Caterham
- Horley
- Redhill/Reigate
- Lingfield

Providing services locally and increasing primary care access to diagnostic tests will enable patients to be better managed in primary care thus reducing unnecessary referrals, preventing over-reliance on hospitals, and giving primary care providers a more holistic view of patients’ health, thereby supporting and enabling prevention.

To replicate these services in all primary care facilities would not be possible, due to space and cost constraints, so a hub is developed that houses the diagnostic and enhanced services, providing rapid access and support to the surrounding primary care providers.

*Figure 6. A Hub and Spoke Model*
3.4 GP Networks

Our commissioning strategy will have a significant impact on primary care:

- GP practices will increasingly need to work collaboratively to provide proactive, accessible and coordinated care;
- Multi-disciplinary services will be delivered through a range of practice based hubs and spokes, based on the service need of an area;
- Four GP networks will support the delivery of urgent care services across East Surrey.

In response to this 17 of the East Surrey GP practices have joined together to form a GP federation, Alliance for Better Care (ABC). The aim is that in working as a federation, primary care will:

- Act as a single entity, but care will be locally tailored
- Be at the centre of out of hospital care
- Seamlessly integrate with community services, mental health and social care
- Speak with one voice
- Be on an equal footing with other providers

To ensure that the local focus is maintained the GP practices are arranged into four networks based on geographic localities. The GP networks are illustrated in figure 7.

*Figure 7. East Surrey Primary Care Networks*
Primary care networks are intended to support five key objectives:

- Providing a building block for delivering more services in primary and community care, around which partner agencies can coalesce and to enable the development of integrated, network-based teams, for example to manage people with long-term conditions and complex needs more effectively.
- Working together as practices to improve resilience and sustainability – not just through increased size, but also through the development of a wider range of staff roles, career pathways and training and development opportunities.
- Better access to a wider range of services for patients.
- Improving the consistency of service provision through the networks and Federation, and reducing variability.
- Improving efficiency and value for money, both within primary care and for the wider health economy.

### 3.5 The Population of East Surrey

The current population of East Surrey is in the region of 181,600 and is due to increase at a rate of over 1% per year.

The key characteristics of East Surrey are:

- An increasingly aging population, currently 17% are over 65
- A generally healthier population, compared with the England average
- Lower than average deprivation, but a number of children still live in poverty
- Higher than average life expectancy for men (81 years) and women (84 years) with a difference in the life expectancy of men across Reigate and Banstead (7.4 years lower in the most deprived areas)
- A reduction in all causes of mortality rates and early death rates from cancer, heart disease and stroke, which are all better than the England average.

### 3.5.1 Population Growth in East Surrey

The Office for National Statistics (ONS) estimate what future populations are likely to be using the trends in births, deaths and movement in and out of the area from the previous five years. The latest population projections are based on the 2012 mid-year estimate and are provided here through to 2025. There is greater uncertainty about the population projections the further in the future the estimates go, so the estimates towards the end of the next decade should be interpreted with caution.
The table below shows that the East Surrey CCG population is expected to grow by 11% in the next 10 years, which is higher than the Surrey average (8%). The age cohort of 65 and over is projected to grow by 21%. Within this age cohort, those 85 and over are projected to grow 40%. However, the absolute number of those aged 85 and over continues to be a small proportion of the overall population of the CCG.

**Figure 8. Population Growth in East Surrey 2015 – 2025**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>34,300</td>
<td>35,500</td>
<td>36,700</td>
<td>37,700</td>
<td>38,100</td>
<td>38,600</td>
<td>4,300</td>
<td>13%</td>
</tr>
<tr>
<td>15-29</td>
<td>28,700</td>
<td>28,500</td>
<td>28,200</td>
<td>28,100</td>
<td>28,400</td>
<td>28,700</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>30-44</td>
<td>37,800</td>
<td>37,900</td>
<td>38,800</td>
<td>39,700</td>
<td>40,600</td>
<td>40,600</td>
<td>2,800</td>
<td>7%</td>
</tr>
<tr>
<td>45-64</td>
<td>48,000</td>
<td>49,300</td>
<td>50,400</td>
<td>51,300</td>
<td>51,900</td>
<td>52,800</td>
<td>4,800</td>
<td>10%</td>
</tr>
<tr>
<td>65 and over</td>
<td>32,800</td>
<td>34,100</td>
<td>35,400</td>
<td>36,800</td>
<td>38,500</td>
<td>40,400</td>
<td>7,600</td>
<td>23%</td>
</tr>
<tr>
<td>85 and over</td>
<td>5,200</td>
<td>5,600</td>
<td>5,900</td>
<td>6,200</td>
<td>6,700</td>
<td>7,300</td>
<td>2,100</td>
<td>40%</td>
</tr>
<tr>
<td>All ages</td>
<td>181,600</td>
<td>185,300</td>
<td>189,500</td>
<td>193,600</td>
<td>197,500</td>
<td>201,100</td>
<td>19,500</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: ONS 2012 Sub national projection

Population growth is uneven and concentrated in different parts of the CCG area. This presents challenges for service and estates planning. Between 2015 and 2025, population growth is concentrated in South Park and Woodhatch wards and Oxted South where population is expected to grow by over 11%. There will be a population increase to a lesser extent in Horley, Redhill and Caterham.

There is also a wide variation in population density (population per hectare) between the wards in Tandridge. Westway, to the north-west of Caterham, has a population density of 43.0 people per hectare while Dormansland has a population density of only 1.2 people per hectare. Further increases in population density in growth areas will place additional pressure on services, particularly in the Caterham wards.

The population estimates do not take into account some of the potential new housing developments described in the section below.

### 3.5.2 Deprivation in East Surrey

Health is affected by a wide range of factors beyond the level of the individual including environmental, social and economic factors. Not only do they act on health directly but they can constrain the choices individuals make which affect their health. For example, the health of people who live beside busy roads will be affected not only by the air pollution but also because they may be less willing to walk along the road and are
therefore less physically active. By working with partners to improve the wider determinants of health, the CCG can reduce the demands on the health service by keeping the local population healthier.

The Marmot Report, ‘Fair Society, Healthy Lives: Strategic Review of Health Inequalities post 2010’, laid out in great detail the variety of health impacts deprivation has across the life course of individuals. People living in deprived communities have more risky health behaviours and experience more long term conditions at earlier ages, with consequent impact on the individuals and the health service. The CCG will want to ensure that local service provision takes into account areas of deprivation where need for health services is likely to be greater.

Deprivation is measured using the Index of Multiple Deprivation, which incorporates deprivation across seven domains, including income, employment, health and disability, education training and skills, barriers to housing and services, crime, and living environment.

According to the 2015 English Indices of Deprivation the four most deprived LSOAs within East Surrey CCG are in the wards of:

- Merstham
- Horley West
- Redhill West
- Horley Central

In comparison to the 2010 indices, East Surrey is considered to be prospering, with lower deprivation than the national average and low numbers of children living in poverty. However, the number of Lower Super Output Areas (LSOAs) falling with the 20 per cent most deprived areas in England has increased from 33 to 47 suggesting that the concentration of relative deprivation has spread.

**Figure 9. East Surrey - Overall Deprivation by LSOA**
Many of the risk factors for poor physical and mental health are associated with deprivation including poor housing, unemployment, poverty, poor education, and high crime. In East Surrey life expectancy for both men and women is higher than the England average. However, life expectancy is 7.4 years lower for men and 5.8 years lower for women in the most deprived areas of East Surrey than in the least deprived areas.

Crucially it is recognised that the scale of the challenges facing health and care services are such that the CCG cannot expect to fulfil its responsibilities by working alone, or by looking at health needs in isolation from the wider social determinants that impact on well-being such as housing, education, employment and lifestyle choices.

3.5.3 Access to Primary Care

The Department for Transport estimate the travel time by several modes of travel (car, public transport, cycling and walking) to key local services, including health services, shops, offices and other services. This dataset provides a wealth of information showing how easily local people can access essential services. The map produced below shows a variation in access to primary care health services using public transport. The map shows that some LSOAs may have as low as 32.2% users who are at risk who can access a GP (practice or surgery) within a reasonable time by public transport or walking.

*Figure 10. Percentage of at risk users with access to GPs by public transport/walking*
3.6 Commissioned Services

Fundamental to our commissioning strategy is the shift from people being seen and treated in hospital to being seen and treated in the community and in primary care. The delivery of more healthcare services out of hospital will broaden the range of activities taking place in primary care settings.

Our plans are based around our geographical GP networks. The network approach provides the basis for continually reviewing the needs of local populations to identify for example the most deprived areas, prevalence of illness and to identify through risk stratification people with high levels of health needs and therefore most vulnerable.

3.6.1 Acute Services in East Surrey

Surrey and Sussex Healthcare NHS Trust (SASH) provides emergency and non-emergency services to the residents of East Surrey, north-east West Sussex, and South Croydon, including the major towns of Crawley, Horsham, Reigate, Redhill, Oxted and Caterham. In our area, the trust provides acute and complex services at East Surrey Hospital in Redhill. In addition, it provides a range of outpatient, diagnostic and less complex planned services at Caterham Dene Hospital and Oxted Health Centre, in Surrey.

There are pressures to reconfigure acute services in East Surrey. In our hospitals, patients are waiting too long for planned care services and are not being seen quickly enough when they attend A&E. Mandatory performance indicators such as referral to treatment waiting times and the four hour emergency department standard are not being consistently met.

Pressure on acute health services will continue to increase as the population ages. The number of people with conditions such as diabetes, coronary heart disease and chronic obstructive pulmonary disease is expected to increase over the next five to ten years. With more people living longer with long-term conditions or disabilities the acuity of patients requiring acute care will increase.

The priorities in the STP are to improve care closer to home thus reducing pressure on the acute system to allow them to focus on specialist acute care. This is imperative if we are to have a sustainable acute healthcare system in East Surrey.

3.6.2 Community Services

The community services in East Surrey, as with all healthcare services, are seeing an increase in the acuity of their patients as more people are living longer but getting sicker in their old age. Whilst much of the care is delivered in the patient’s own home
there are also many clinic based services offering treatment. A major challenge for the community provider is to identify suitable accommodation for the clinic based services to be delivered.

Whilst the CCG can work with the community provider to develop new models of care that meet the CCG and STP objectives, without suitable estate from which to deliver these services implementation will be jeopardised. The current situation is more opportunistic than planned and therefore services are not consistently delivered across East Surrey. The Redhill area provides significant challenges with very little accommodation available.

This lack of capacity is already having a detrimental impact on the provision of the MSK service which requires co-location of both treatment rooms and a gym. A gym is also a critical resource for neuro, cardiac and pulmonary rehabilitation services. Large areas such as this are difficult to find in existing premises and more likely to require extension to an existing building or be purpose built in a new development, both of which require investment in the community estate.

With community services a key component in out of hospital care the provision of suitable accommodation in the right location is critical for the realisation of a sustainable health and care system.

3.6.3 Urgent care services

Nationally services can be highly fragmented and generate confusion among patients. The East Surrey vision for urgent care is for a system that is as straightforward as possible, with patients aware of and able to access appropriate high quality clinical care and support at the right time and in the right place. In East Surrey a number of GP localities will support the delivery of urgent care services across East Surrey.

3.6.4 Mental Health Services

Surrey and Borders Partnership NHS Foundation Trust (SaBP), provides health and social care services for people of all ages with mental health problems, drug and alcohol problems, and learning disabilities in Surrey and North East Hampshire.

As with our community services, SaBP have difficulty in finding sufficient accommodation from which to deliver their services. They have recently requested the opportunity to refurbish and occupy unoccupied space within the Conifers building at Caterham Dene.

3.6.5 Primary Care

The quality of most primary care is good, yet there are wide unwarranted variations in performance, quality and accessibility of primary care across East Surrey.
Some patients find it hard to get a convenient appointment with their GP and the services available are inconsistent. There are also wide variations in quality and outcomes measures between different practices. The key driver is to improve the outcomes:

- Reduced inappropriate hospital admissions resulting in better patient outcomes and experience for those exposed to preventable admissions;
- Less duplication of tests and diagnostics from improved systems and processes resulting in better clinical outcomes and patient experience;
- More robust prescribing processes, delivering better patient safety and experience;
- Improved quality of referral and more targeted referral process means increased patient safety and better clinical outcomes. Equally this could result in a smoother experience for patients with quicker access to the right care and support.

There are a number of primary care levers, which if aligned and used differently can have a significant impact on improving primary care proactive provision and therefore reduce the reliance on hospital care:

- Local Commissioned Services (including public health)
- Practice Development and Delivery Schemes
- Quality Outcome Framework (QoF)
- Local and Direct Enhanced Services
- PMS KPIs (these are linked to QoF targets)

The CCG has greater influence on some of these than others; however with co-commissioning there may be greater opportunity to influence the design of national levers.

The recruitment of GPs remains a challenge both nationally and locally. Primary care needs to change in order to deliver a sustainable model of healthcare that addresses the changing needs of their population now and into the future. ES CCCG fully recognises these challenges and have committed to delivering a transformational Primary Care Strategy.

The CCG’s emerging Primary Care Strategy aims to support the achievement of a larger primary care and integrated workforce providing increased access in order to meet people’s physical, mental and social care needs leading to:

- Prevention of avoidable ill health and premature mortality by addressing the
local health needs identified within the East Surrey CCG Prevention Plan and Health Profile using ward level data and the prevalence gap among GP practices;

- Improved access to integrated services for more difficult to engage people in order to close the health gap; and

- An integrated out of hospital case management model of care that supports increased primary care capacity, a wider range of clinical services, harnessing of technology and improved patient care, satisfaction and outcomes.

3.6.6 **Pharmacies**

There are over 30 pharmacies in East Surrey which, in addition to GP practices, provide public health services such as sexual health, health checks, drug and alcohol and smoking cessation. Pharmacies also provide advice on healthy lifestyles, support public health campaigns and support self-care.

Pharmacies have a key role in future healthcare e.g. prevention and management of long term conditions.

The three most common themes that emerged from the public survey carried out as part of the Pharmaceutical Needs Assessment (2015) were that the public would like to see:

- Increased opening hours (and staffing levels) of pharmacies
- A reduction in waiting times for prescription
- For pharmacies to concentrate on the core offer of dispensing and sales rather than additional services

CCGs are able to commission services such as minor ailments services, palliative care schemes and other medicine optimisation services under the NHS Standard Contract to meet the needs of the local population.

3.7 **Housing developments**

East Surrey has a growing population, which together with a decline in household sizes, means that in planning new housing developments the number and types of houses offered needs careful consideration. The siting of these developments need to make the best use of land within urban areas whilst protecting the environment and people’s quality of life. Health services will need to respond to the changing demographics that are a consequence of large housing developments.

Key characteristics of the housing market in East Surrey:
- High house prices which result in pricing people out of the market, particularly the younger age group 16 – 34
- A wealthy ageing population that dominate the housing market
- Over 30% of the district is 4/5 bedroom detached homes on large plots, which is much higher than the average 19% across England
- Limited tenure, type and stock to offer housing choice and enable mixed communities
- Concentration of elderly accommodation, particularly in Caterham
- Unauthorised and temporary traveller pitches within Tandridge District Council

3.7.1 **Reigate and Banstead Borough Council (RBBC)**

The RBBC Core Strategy was adopted in 2014 and forms the first part of their Local Plan. This set out the overall scale and location of growth that will take place in the borough between 2012 and 2027.

Of importance for the CCG are the following key growth areas:

- **Redhill town centre** – earmarked for regeneration, the urban development of 1,610 homes and a possible further 1,000-1,400 homes as a sustainable urban extension to the east of the town;
- **Reigate** – south and southwest possible sustainable urban extension developments for 500-700 homes;
- **Horley town centre** – priority regeneration area, urban developments of 98 homes;
- **Horley north east and north west sectors** – plans for up to 2,400 homes, of which 600 will be delivered in spring 2017; and
- **Merstham** – priority regeneration area with potential urban extension to the south east.

The development of a Development Management Plan\(^2\) sets out how the Core Strategy will be developed. As part of the first stage in the preparation of this plan the public were asked for their views. This consultation period ran from 1 August 2016 to 10 October 2016. The next consultation is due to be undertaken in summer 2017.

Tandridge district is predominantly rural, with high quality landscapes and rich heritage making it a desirable place to live. Tandridge has the highest percentage of designated Green Belt of all local authority areas in the country, with 94% of the land in the district designated as Metropolitan Green Belt. It is also a district with a growing population, shrinking household sizes and an ageing demographic, all of which impact on the supply and availability of homes. This in turn is driving house and land prices to extreme levels.

The South East Plan allocated the requirement for an additional 2,500 homes in Tandridge between 2006 and 2026, and average of 125 homes per year. However, in the preparation of the Local Plan, a Strategic Housing Assessment was undertaken in November 2015, which identified the need for an additional 9,440 homes between 2013 and 2033. This equates to an additional 470 homes being required per year.
TDC have published the document “Our Local Plan – Sites Consultation”\(^3\) and are consulting with the public between 4 November and 30 December 2016. Of 300 sites originally put forward 126 are now being considered for development.

A small proportion of the housing requirements can be accommodated within existing settlements but fall short of realising the figures identified within the Strategic Housing Assessment. Of significance to the CCG is the option for the development of two new/extended settlements at Blindley Heath and South Godstone, both capable of delivering in the region of 2,000 homes. Both of these developments are in the South Tandridge primary care network and would place pressure on practices already operating at, and beyond, capacity.

4 **New Models of Care**

Throughout the country new models of care are being piloted which bring together providers, offering a range of integrated services with the aim of improving the health and well-being of the population served but also delivering a sustainable model of health and social care into the future. In East Surrey we believe the future of local primary care services rests in the development of strong GP networks and are exploring options for the creation of integrated service models, such as a multi-specialty community provider, offering a range of services out of hospital.

These models offer a focal point for a far wider range of care needed by registered patients, which will bring benefits to the whole health and care system as well as securing the principles of registered lists.

As these new models of care develop ESCCG will need to work closely with the NHS property companies and the local authorities to ensure that the estate becomes an enabler to these new ways of working rather than a barrier.

4.1 **Primary Care**

Whilst the design of the model of care has yet to be finalised the CCG have undertaken significant work with primary care, focusing on three key areas:

- The development of the primary care networks.
- The model of care for complex case management.
- The model of care for improved access to primary care.

Taking the work to date, it is possible to form a hypothesis about the direction of travel and from this assess what the requirements for the estate in the future are likely to be.

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\(^3\) [http://www.tandridge.gov.uk/Planning/planningpolicy/emergingpolicy/localplan.htm](http://www.tandridge.gov.uk/Planning/planningpolicy/emergingpolicy/localplan.htm)
To date the focus has been on developing a new model of care for the management of people with complex needs with the aim of improving health outcomes and quality of life. The new model will mainly be delivered on a network basis, moving to a more locally deployed, person centred and integrated model of care, but where economy of scale is important this may be shared across more than one network.

Whilst this has been the focus to date the CCG are also working with their public health colleagues to establish models that aim to prevent ill health and promote wellbeing. This will be developed on a network basis to ensure that it is locally focused to meet the needs of the population. The outputs from the first workshop on the Caterham Dene development (Figure 22) represent some initial thoughts on how services and activities could be configured to achieve an integrated approach across the spectrum of health and care, from prevention through to end of life care.

4.1.1 **Complex Case Management**

The key components of the local model are the development of care coordination delivered through the networks and a lead practitioner approach with multi-disciplinary care planning and monitoring through a network Multi-Disciplinary Team (MDT). The proposed new model combines these functions into a single team per network, and builds on the successful model of care coordination provided at Oxted Health Centre and across some other practices through the existing ESCCG Unplanned Admissions Locally Commissioned Service (LCS).

Intensive integrated care will be augmented as and when required by adding the right specialists to enhance the local team for those at higher risk. This may be through clinician to clinician dialogue or direct patient contact depending upon need.

The development of a proactive and knowledgeable administrative capability that can support all professionals and provide a single point of contact for patients with complex needs is key to successful implementation. This will reduce the non-clinical burden on clinicians’ time thus increasing the clinical capacity for patient contact.

The model of care for complex case management is outlined in the figure below alongside the model for improving access to primary care services.
In establishing a local integrated approach we aim to make every contact count to improve the determinants of health, not only through our core health and social care services but in combination with social prescribing, working closely with voluntary and community sector organisations.

An impediment to the delivery of this model is the demand for urgent on the day appointments which constrains the ability to ring-fence primary care clinicians’ time for the management of patients with complex needs. The approach to the management of urgent care is therefore a critical component in the overall model of care.

4.1.2 Urgent Care

The main aim is to make urgent care part of the integrated locality model so people only go to hospital when they need for those things that can’t be managed locally and come home as soon as they are well enough to be looked after by the local team.

However, the current model is not sustainable and a new model is being developed based on the hypothesis that by working together in a structured way across practices, urgent on the day demand can be managed more effectively. Triage and urgent appointments could be managed and provided through the networks (or combinations of networks) for all on the day demand. The model also assumes that a significant proportion of demand can be moved through alternatives, such as self-care, pharmacy, e-consult and telephone advice. The figure below indicates that approximately 26% of GP consultations could be avoided if alternative options were available.
4.1.3 Long Term Conditions

The model of care for long term conditions has not yet been developed but is likely to proceed on the basis outlined in the Five Year Forward View, which envisages greater management of patients in primary care with better clinician to clinician access to secondary care advice and support.

5 The Current Healthcare Estate

In response to these needs, NHS organisations in Surrey have been working with the borough and district councils to understand the NHS, local authority and community asset base and explore opportunities for joint working. Identifying future needs early allows for better planning and allocation of resources.

The estate is one of the key enablers which supports the CCG with the delivery of community healthcare. Examples of other enablers would be associated with IT and workforce. However, unlike these the estate is a physical structure that cannot always be readily adapted and the timescales for both the procurement and exit of facilities can be lengthy. The CCG estate is provided through three principal routes, NHS Property Services owned facilities, GP practice owned buildings or third party landlords. In all instances the CCG as system leader influences and shapes the basis through which these properties support healthcare delivery.

It is critical that the estates planning across East Surrey, and its boundaries, is done in collaboration to ensure sound investment and disinvestment decisions are made to support the delivery of a sustainable health and social care economy not only in East Surrey but across the south east of England.
We are actively pursuing involvement with the county council who are active in the One Public Estate programme that looks to make best use of public estate and leverage opportunities to deliver best value options.

5.1 **The Primary Care Estate**

The following provides an overview of the primary care estate that serves the population of East Surrey. We acknowledge that currently the information supplied varies in levels of detail and accuracy and this will be rectified and updated as more information becomes available.

The following figure provides a map of the locations of the 18 practices that service the CCG population. The clusters of practices tend to serve the larger conurbations whilst the more dispersed practices are in rural areas.

*Figure 14. Map of Primary Care Practices in East Surrey*

The information about each practice is presented in the context of its GP network, that have been established to drive forward the primary care strategy and which is illustrated in Figure 7. The following provides a brief narrative of each site and confirms whether the practice have expressed an interest to apply for funding for practice improvements.
Redhill and Merstham

5.1.1 Greystone House Surgery

99 Station Road
Redhill, Surrey
RH1 1EB

List Size 2015: 12,800

GIA of premises: 658m²

Tenure: Freehold, owned by partners

Greystone House was built in c1997 as a purpose built facility for the provision of primary care services under the GMS contract. The practice has eleven GPs of which six are partners. They are a training practice and have up to two trainees at any given time. They also have a complement of seven nursing staff.

Services provided within the practice include: wellbeing prescriber, smoking cessation, gynaecology, ultrasound, neurology, advanced minor procedure and vasectomies. These services are also available to the wider network of practices.

In addition the practice provides space for the community provider to carry out a range of services and provides a base for community nurses.

Midwife clinics, counselling, bowel screening and retinopathy clinics are provided on a sessional basis.

The council’s adopted Core Strategy identified that approximately 1,600 new homes would be provided within the Redhill urban area between 2012 and 2027, of which approximately 750 homes would be located in the town centre as part of regeneration projects.

Whilst the practice premises are well maintained and in good condition the desire to move towards a primary and community care hub is restricted by the available space.

The practice bid via the ETTF process has been successful and will be included in phase 2. The proposal is to extend the practice by a further 209m² to enable the community hub to be established and to provide additional capacity for primary care to extend the range of services and to cope with the additional capacity requirements driven by the increasing list size.
5.1.2 **The Hawthorns Surgery**

1 Oxford Road  
Redhill, Surrey  
RH1 1DT

List Size 2015: 8,517

GIA of premises: 529m²

Tenure: Leased from a third party

The Hawthorns Surgery was originally built in 1983, with an additional extension in 2004. The practice has five GPs. The practice is an accredited GP training practice. In addition the practice has three practice nurses, two phlebotomists and a senior nurse practitioner.

In addition the practice provides space for other providers to carry out a range of services. Clinics include stop smoking, counselling, ultrasound, midwife and child health.

The council’s adopted Core Strategy identified that approximately 1,600 new homes would be provided within the Redhill urban area between 2012 and 2027, of which approximately 750 homes would be located in the town centre as part of regeneration projects.

The practice submitted an expression of interest to the CCG, to be included within the ETTF bids, to carry out alterations to the record storage area which will create an additional office for the practice manager, thereby releasing the current office for an additional consulting room. The additional consultation area would help cope with the increasing list size and capacity for F2 training.

The scheme has not been prioritised for investment at this stage but will be considered for a minor improvement grant in 2017/18.

5.1.3 **Holmhurst Medical Centre**

12 Thornton Side  
Watercolour  
Redhill, Surrey  
RH1 2NP

List Size 2016: 9,856
GIA of premises: 721m²

Tenure: Leased from a third party

Holmhurst Medical Centre was built in 2008 alongside a new housing development. The practice has six GPs, three nurses and two healthcare assistants. The community nursing service is located on the first floor.

Holmhurst Medical Centre also houses Dorking Healthcare who provide outpatient clinics for colorectal surgery, dermatology, gastroenterology, gynaecology, orthopaedics, paediatrics, urology, general surgery and rheumatology.

The top floor of the premises is currently unoccupied.

5.1.4 The Moat House Surgery

Worsted Green
Merstham
RH1 3PN

List Size 2015: 10,806

GIA of premises: 680m² not including two recent extensions.

Tenure: Freehold owned by partners

The Moat House Surgery currently has five partners, working from purpose built premises. Additionally the practice has two associate GPs, two specialist nurse practitioners, three practice nurses, a HCA and a phlebotomist.

The surgery offers a wide range of health care services including minor surgery, family planning, hormone replacement therapy check, well woman checks, child health, maternity care, diabetic clinic, asthma clinic, cardiovascular clinic, counselling and weight loss clinic.

There is currently a large building development in the area, which will provide new homes, shops and a library.

5.1.5 Woodlands Surgery

5 Woodlands Road
Redhill
Surrey RH1 6EY

List Size 2015: 11,191

GIA of premises: unknown

Tenure: Freehold owned by partners

The practice has six GPs, two nurses and two healthcare assistants. In addition the community nursing service is based at the surgery.

The surgery offer a wide range of clinics including antenatal and post natal, family planning, obesity clinic, asthma, hypertension, diabetes, COPD, heart disease and stop smoking.

Reigate and Horley

5.1.6 Birchwood Medical Practice

Kings Road
Horley
RH6 7DG

List Size 2016: 16,158

GIA of premises: 725m²

Tenure: Leased from Nexus Health Investment Ltd

The practice transferred into the current building in May 2005.

The practice has four partners and an additional seven salaried GPs. The practice is a training practice and currently has five trainee GPs. There are four nurses and two HCAs also supporting the practice. The surgery offers a wide range of services to their patients including: women’s health, child health, diabetes, minor surgery, vasectomy, INR, asthma, phlebotomy.

The premises are currently shared with community nurses who lease their space from NHS Property Services who hold a lease on 15% of the property.

Horley is rapidly expanding with plans to build over 2,400 new homes by 2027 of which 600 will be released to the market in spring 2017. In addition there are two new nursing home developments and three sheltered housing units planned.
The practice has submitted a proposal to lease more space within the building to accommodate an increasing list size and to extend the services offered. Minor works will be required to bring the accommodation up to clinical standards. The funding of these works will either be through a minor improvements grant or through section 106 money that the council has indicated may be available in this financial year 2016/17.

5.1.7 **Wayside Surgery**

Kings Road  
Horley  
RH6 7DG

List Size 2015: 3,871

GIA of premises: 536.10m²  
Surgery occupy 60% of building, remaining 40% is vacant.

Tenure: Leased from Nexus Health Investment Ltd

The Wayside surgery is located in a purpose built building, completed in 2004/5.

The surgery has four GPs working within the practice with only one permanent GP and the remainder provided on a locum basis, a practice nurse and a healthcare assistant.

A wide range of services are offered including chronic disease management – asthma, COPD, coronary heart disease, diabetes, epilepsy and special needs checks.

Half of the first floor of the building is currently unoccupied. The intention was for a dental surgery to move into the area, two of the rooms were lead lined but unfortunately this did not come to fruition. The practice currently occupies two rooms on the first floor and Virgin Healthcare one room.

First Community Health and Care are working with NHSPS to explore the opportunity of relocating from the Horley Health Centre to the accommodation on the first floor to enable expansion and to free up space at Birchwood (see above). The funding of these works has yet to be decided but may be through NHSPS customer capital.

5.1.8 **Smallfield Surgery**

Wheelers Lane  
Smallfield  
Horley RH6 9PT
Smallfield Surgery serves the whole of Smallfield, the surrounding villages and the eastern part of Horley. There are six GPs, two trainee GPs, a practice nurse, two health care assistants, and a number of other administrative and reception staff.

The surgery offers a full general practice service and run specialist clinics for children and pregnant women, diabetes, asthma and heart disease sufferers and for patients needing minor surgery.

Smallfield Surgery is an accredited GP training practice and usually has at least one postgraduate trainee.

5.1.9 **South Park Medical Centre**

42a Prices Lane
Reigate
Surrey RH2 8AX

List Size 2015: 4,600

GIA of premises: 268m²

Tenure: Leasehold

The South Park Medical Practice was built approximately 20 years ago for the provision of primary care services. The practice is part of the Malling Health UK network. The building has not been well maintained and is no longer fit for purpose without significant investment.

The practice has two GPs, two nurses and a HCA. The surgery offers a wide range of clinics including asthma, COPD, diabetes, contraception, smoke cessation, and midwifery.

The PMS contract runs out in March 2017 and following unsuccessful attempts to find an alternative solution, the proposal for dispersal of the list will be considered by NHS England in November.
As additional housing is planned in this area and to the south, the future impact on practices in Reigate, Horley and Redhill will need to be understood and planned for.

### 5.1.10 The Wall House Surgery

Yorke Road  
Reigate  
Surrey RH2 9HG

List Size 2016: 16,500

GIA of premises: 790m$^2$ when current works completed

Tenure: Freehold owned by partners

The Wall House Surgery is an old building to the north of Reigate town centre. The practice has five GP partners, five associate GPs, an advanced Nurse Practitioner and four practice nurses.

The surgery offer a wide range of clinics including: asthma, child immunisation/development, COPD, coronary heart disease, cryotherapy, diabetes, dietary advice, dressings/ear syringing, family planning, hypertension, INR, phlebotomy, well-man and well-woman clinics.

The practice is currently undergoing substantial extension, which will see the GIA increase from 458m$^2$ to approximately 790m$^2$.

### North Tandridge

#### 5.1.11 Warlingham Green Medical Centre

1 Church Road  
Warlingham  
Surrey CR6 9NW

Current List Size: 6,620

GIA of premises: 445m$^2$

Tenure: Freehold owned by partners

Warlingham Green Medical Practice hosts a dental practice and has a counsellor who works from the building. The entrance has been extended to provide an extended
reception and waiting area. Warlingham Green and its branch site Chaldon Road Surgery work in conjunction with the North Tandridge network.

The practices have twelve GPs, of which five are partners and seven are associates. In addition there are three nurses and two healthcare assistants at the Warlingham Green site with one nurse and two healthcare assistants at Chaldon Road.

The practice offer a wide range of clinics and services including, coil and implant contraceptive clinics, minor surgery, ambulatory blood pressure and ECGs, asthma clinics, diabetic clinics and maternity care.

There are currently extension works taking place at the Warlingham Green site which will provide additional consulting rooms on the ground floor and two additional rooms on the first floor.

In addition a second bid was submitted via the ETTF programme to extend the building onto the area above the current manager’s room and dental surgery. This scheme has not been prioritised in this round.

5.1.12 Chaldon Road Surgery

Chaldon Road
Caterham
CR3 5PG

Current List Size: 4,600

GIA of premises: 329m²

Tenure: Freehold owned by partners

Chaldon Road Surgery is the branch site of Warlingham Green Medical Practice.

The premises are old and in need of refurbishment and updating. Access to the building is not DDA compliant and limits the patients who can use the service, even if it is the most conveniently located. The proposed changes to the entrance to the building in conjunction with the installation of a lift will make the building fully DDA compliant for access.

The clinical area is currently very over-utilised with frequent space problems for clinical
staff. A bid was submitted via the ETTF programme for works to increase capacity and address the DDA issues. This bid has not been prioritised for ETTF funding but the DDA compliance issues with regard to the main entrance have been prioritised for funding via a minor improvement grant.

5.1.13 **Townhill Medical Practice**

Guards Avenue  
Caterham  
Surrey CR3 5XL

List Size 2016: 13,025

GIA of premises: 948m$^2$

Tenure: Freehold owned by partners

The Townhill Medical Practice was built in 2004 for the provision of primary care services. The building also houses an ambulance station and a pharmacy. The practice has two partners, seven salaried GPs, two registrars, one diabetes nurse specialist, three practice nurses, one phlebotomist, one urgent care practitioner and one healthcare assistant. The surgery is a local centre for cardiac referrals.

The surgery offers a wide range of clinics including child health, women’s health, diabetes, warfarin, minor surgery, cryotherapy and asthma/COPD.

5.1.14 **Elizabeth House Medical Practice**

515 Limpsfield Road  
Warlingham  
Surrey CR6 9LF

List Size 2015: 5,623

GIA of premises: 550m$^2$

Tenure: Freehold owned by two partners

The Elizabeth House Medical Practice was fully refurbished in 2008 for the provision of primary care services. The practice has two partners and two associate GPs, a nurse practitioner and two practice nurses.

The practice offers a wide range of clinics including antenatal, child health, diabetes, respiratory, heart disease and cryotherapy. The building also houses an osteopath,
podiatrist and a counsellor.

The second floor of the building is empty requiring a second fix. This comprises of three large rooms measuring 77m² with lift access. An expression of interest for development money has not been submitted.

5.1.15 **Caterham Valley Medical Practice**

Eothen House  
Eothen Close  
Caterham CR3 6JU  

List Size 2016: 9,394  

GIA of premises: 445m²  

Tenure: Freehold owned by partners  

Caterham Valley Medical Practice is located in a former art school built in 1998.

The practice has four full time principal GPs serving approximately 9,000 patients. Caterham Valley is a training practice so there are often fully qualified doctors attached to the practice in preparation for entering general practice in their own right. The practice also takes part in the teaching of undergraduate medical students.

The practice offers antenatal, post natal, adult/child immunisation, well woman, family planning, well baby, well person, asthma, diabetes, COPD, heart disease, blood pressure, minor operations, phlebotomy, as well as minor treatments by the practice nurse.

The practice sublet accommodation to a pharmacy, podiatrist, dentist and chiropractor.

The practice has been prioritised for a minor improvements grant in 2016/17 to bring an existing vacant room into clinical use.

5.1.16 **Whyteleafe Surgery**

19 Station Road  
Whyteleafe  
Surrey CR3 0EP  

List Size 2016: 5,987
GIA of premises: 198m²

Tenure: Freehold owned by partner

Whyteleafe Surgery was built in 1989 as a purpose built two storey facility for the provision of primary care services.

The practice has five GPs, one nurse and three healthcare assistants. They are a teaching practice for final year medical students and regularly accommodate them. They are accredited to take FY2 doctors but there is insufficient room to accommodate them.

The surgery is currently operating at capacity and under space target for GMS. They have submitted an expression of interest for an extension to their first floor in the current roof void, and a second floor. This was prioritised for submission by the CCG but was not successful in the latest round. This would have created space for administration services and therefore freed up space for four additional consultation rooms which would have allowed the practice to become a training practice for registrars and FY2s. The bid also included a lift to the first floor for disabled access.

South Tandridge

5.1.17 Pondtail Surgery

The Green
Godstone
RH9 8DY

List Size 2016: 7,290

GIA of premises: 310m²

Tenure: Freehold owned by partners

The Pondtail Surgery occupies two buildings in the centre of Godstone. The buildings were converted and upgraded 16 years ago.

There are four GPs, a nurse practitioner, and two practice nurses. The surgery provides a phlebotomy service four days per week.

The surgery offer child health clinics, well woman clinics, well man clinics, stop smoking, antenatal, minor surgery, asthma, diabetes, COPD, heart disease and hypertension clinics.
5.1.18 **Oxted Health Centre**

10 Gresham Road  
Oxted  
Surrey RH8 0BQ

List Size 2015: 16,757

GIA of premises: 621m$^2$

Tenure: Leased from Primeoak Investments

The health centre is part of a large building which also houses Oxted library. An adjacent building houses Tandridge District Council, the base for adult social care and community nursing services, and East Surrey CCG. The practice occupies the upper floor for its clinical practice with administration services based on the lower floor. The remainder of the lower floor is occupied by First Community Health and Care, Virgin Healthcare services and Surrey and Sussex Healthcare Trust.

The surgery has 10 GPs and supporting nursing staff.

A wide range of services are offered to patients including: women’s health, child health, smoking cessation, minor injuries, diabetes, commuter clinic and ultrasound. In addition the Surrey and Sussex Healthcare Trust provides outpatient clinics.

5.1.19 **Lingfield Surgery**

East Grinstead Road  
Lingfield  
Surrey RH7 6ER

List Size 2015: 10,528

GIA of premises: 337m$^2$

Tenure: Freehold owned by partners

The surgery is situated in the village of Lingfield in the south east corner of Surrey and close to the West Sussex and Kent borders, where a practice has existed on the same site for over 30 years. The premises are purpose built but now struggling to meet the demands of the list size. The building is over 300m$^2$ under space target.

The surgery has six GPs and three nurses. A wide range of services are offered to patients including: ante-natal clinic, asthma clinic, cardiac clinics, cervical smears,
childhood immunisations, child health surveillance, COPD, diabetes clinic, food bank vouchers, IUCD, minor surgery and cryotherapy, phlebotomy clinics, smoking cessation, travel, family planning, HRT, injection clinic, hypertension, counselling and a wellbeing advisor.

The list size at the practice is growing rapidly; it is the only surgery within the village and serves a large rural catchment area.

The property has a large car park to the front; the rear and side aspects abut residential properties.

The practice applied to close its list due to problems with recruitment and the increasingly difficult working conditions. Given the lack of primary care coverage in this area it is not an option to cease provision and NHS England declined the application.

The CCG submitted an application via the ETTF for the funding to construct a new purpose built facility that is fit for purpose and will provide the capacity to meet future demand. This bid has been successful and initial discussions with the practice will begin in November.

5.2 The Networks – Strengths, Weaknesses, Opportunities and Threats

The four primary care networks form the basis for the forward view with regard to the future service configuration and the estate to support delivery. There is no doubt that, with an ageing population and the development of new homes, the demand for primary care will continue to increase. This, in combination with the strategic direction to reduce the reliance on acute providers and to provide more care out of hospital, will increase the need for fit for purpose clinical accommodation in the community.

As the primary care network model becomes established it is important that each network is capable of delivering the new models of care. This section looks at the current space provided within each practice and compares this with current space guidance and explores the strengths, weaknesses, opportunities and threats to each network with regard to the ability of the estate to meet future need.

The space analysis has been undertaken using the NHSE Project Appraisal Unit (PAU) PID Space Calculator for GMS (2016). This provides an estimation of space based on guidance within HBN 11-01. Some key assumptions have been made in populating the model; they are presented in the tables below.
Figure 15. Assumptions used for NHSE Space Calculator

<table>
<thead>
<tr>
<th></th>
<th>List Size</th>
<th>October 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Contacts/patient/year</td>
<td>5.3</td>
<td>(RCGP figure)</td>
</tr>
<tr>
<td>Building open weeks/year</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Opening hours</td>
<td>08:00 – 18:30</td>
<td></td>
</tr>
<tr>
<td>Appointment Duration</td>
<td>18 minutes*</td>
<td></td>
</tr>
<tr>
<td>Room Utilisation</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

* appointment time is a blended time of 80% patients requiring 15mins and 20% (complex patients) requiring 30 mins.

The results of the space analysis are presented in the tables below. Whilst this gives an approximation of space requirements, based on 2016 list sizes, it does not reflect the increase in list sizes that will be generated by proposed housing developments and importantly does not take into account the enhanced services that GPs are now providing within their premises over and above basic GMS (the basis for the space calculator).

From the analysis it can be seen that there is wide variation in the space available for GMS across the networks. It should however be noted that the calculations are based on a 50 hour working week (five days x 10 hours per day). Additional capacity would be made available if extended hours were offered. For example, with a working week of 70 hours the space requirements would reduce by approximately 27%.

5.2.1 Redhill and Merstham Network

Figure 17. Redhill - Space based on NHSE PAU Space Calculator.

<table>
<thead>
<tr>
<th></th>
<th>List Size</th>
<th>Current GIA m²</th>
<th>Space required</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greystone House</td>
<td>13251</td>
<td>658</td>
<td>744</td>
<td>-86</td>
</tr>
<tr>
<td>Hawthorns</td>
<td>8568</td>
<td>525</td>
<td>496</td>
<td>29</td>
</tr>
<tr>
<td>Holmhurst</td>
<td>9794</td>
<td>721</td>
<td>496</td>
<td>225</td>
</tr>
<tr>
<td>Moat House</td>
<td>11005</td>
<td>680</td>
<td>579</td>
<td>101</td>
</tr>
<tr>
<td>Woodlands Road</td>
<td>11117</td>
<td>579</td>
<td>579</td>
<td>0</td>
</tr>
</tbody>
</table>

|                      | 53735     | 3163           | 2894           | 269       |

Permission to gain access to the Woodlands Road premises was not forthcoming and therefore an assumption has been made that their current space is acceptable to carry out their clinical activity.

As a network Redhill is currently well provided for with the exception of Greystone House. The practice has been successful in their submission to receive funding via ETTF.
for the expansion of the practice. The extension will provide an additional seven clinical rooms (209m²) and the design will provide an out of hours entrance thus designing in flexibility to extend opening hours in the future. The practice already offers a wide range of enhanced services and also works closely with the community provider to offer an integrated service for patients.

**Strengths:**

- Good quality primary care accommodation.
- Well established service model at Greystone Surgery in line with new models of care.
- Well served by public transport.

**Weaknesses:**

- Holmhurst and Hawthorns both owned by third party and landlord permission would be required for any adaptations.

**Opportunities:**

- Top floor of Holmhurst Medical Centre is currently unused. Could be brought into use with funding and permission of landlord.
- Greystone House and Hawthorns Medical practice are adjacent buildings and provide an opportunity for joint working to better use clinical capacity.
- East Surrey Hospital offers opportunity to create additional accommodation – possibly urgent care or health and social care campus.
- Potentially significant funding (CIL and S106) to accrue from housing developments.
- Increased capacity through extended hours working.

**Threats:**

- Potential large housing developments within the area increasing demand.
- Dispersal of list at South Park increasing demand.
- Lack of funding to invest in primary care.
- Close proximity of East Surrey Hospital – patients using acute care as an alternative to primary care.

**5.2.2 Reigate and Horley Network**

*Figure 18. Reigate and Horley - Space based on NHSE PAU Space Calculator.*
There is a significant shortfall of space within the Reigate and Horley network and with significant housing developments this provides a significant challenge to the CCG. In addition it is likely that the South Park practice list will be dispersed in 2017 resulting in additional pressures on the remaining practices.

A proposal to extend the clinical capacity at the Birchwood practice is being considered but requires relocation of community services into an adjacent building to free up space in the health centre. This would provide the practice with an additional five clinical rooms equating to 95m$^2$ of additional consulting space, but still leaves the practice under the calculated space requirement.

The Wall House practice is currently undergoing building works to extend the GMS clinical space and meet statutory compliance for access. The figure of 790m$^2$ presented in the table is post completion of these works.

**Strengths:**
- Good quality clinical accommodation.

**Weaknesses:**
- Large geographical area with little “central coverage” with the loss of South Park Clinic.

**Opportunities:**
- Spare accommodation on the first floor of Horley Resource Centre (Wayside) could be brought into use with investment.
- Birchwood and Wayside practices are in adjacent buildings and offer opportunity for integration and better use of the estate.
- Due to proximity the Birchwood, Wayside and Beechcroft buildings could provide sufficient space for the establishment of a health and social care hub.
- East Surrey Hospital offers opportunity to create additional accommodation – possibly urgent care or health and social care campus.
- Potentially significant funding (CIL and S106) to accrue from housing developments.
- Increased capacity through extended hours working.

**Threats:**
- Potential large housing developments within the area increasing demand.
- Dispersal of list at South Park increasing demand.
- Lack of funding to invest in primary care.
- Close proximity of East Surrey Hospital – patients using acute care as an alternative to primary care.

### 5.2.3 North Tandridge Network

**Figure 19. North Tandridge - Space based on NHSE PAU Space Calculator.**

<table>
<thead>
<tr>
<th>North Tandridge</th>
<th>List Size Oct 2016</th>
<th>Current GIA m²</th>
<th>Space required</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caterham Valley</td>
<td>9364</td>
<td>445</td>
<td>496</td>
<td>-51</td>
</tr>
<tr>
<td>Elizabeth House</td>
<td>5811</td>
<td>550</td>
<td>331</td>
<td>219</td>
</tr>
<tr>
<td>Townhill</td>
<td>12990</td>
<td>948</td>
<td>744</td>
<td>204</td>
</tr>
<tr>
<td>Warlingham Green (inc Chaldon Road)</td>
<td>11163</td>
<td>774</td>
<td>579</td>
<td>195</td>
</tr>
<tr>
<td>Whyteleafe</td>
<td>6072</td>
<td>198</td>
<td>331</td>
<td>-133</td>
</tr>
</tbody>
</table>

The Whyteleafe premises are the outlier in the North Tandridge network. Unfortunately they were unsuccessful in securing funding for additional space in 2016/17 but could be prioritised for investment in 2017/18 should any additional funding opportunities be available. The Chaldon Road practice, a branch surgery of the Warlingham Green practice, is also undersized but is compensated by the additional space provided at Warlingham Green through previous extensions.

The Caterham Dene Hospital is located within this network and provides an opportunity for the development of a health and social care campus on the site which could also accommodate additional space for primary care.

**Strengths:**
- Overall sufficient primary care clinical accommodation.
- Caterham Dene Hospital site – a large site with a good range of services to support primary care.
Weaknesses:

- Transport links with the other networks.

Opportunities:

- The redevelopment of the Caterham Dene site to provide a health and social care campus.
- Caterham Masterplan – ensure that health is included within the plan.
- Elizabeth House premises has c77m² unused space which, with investment, could be brought into use.
- Increased capacity through extended hour working.

Threats:

- New housing developments increase demand.
- Failure to invest in the future of Caterham Dene hospital – no longer fit for purpose.
- Lack of funding to invest in primary care.

5.2.4 South Tandridge Network

Figure 16. South Tandridge - Space based on NHSE PAU Space Calculator.

<table>
<thead>
<tr>
<th>South Tandridge</th>
<th>List Size Oct 2016</th>
<th>Current GIA m²</th>
<th>Space required</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lingfield</td>
<td>10637</td>
<td>337</td>
<td>661</td>
<td>-324</td>
</tr>
<tr>
<td>Oxted</td>
<td>16592</td>
<td>600</td>
<td>909</td>
<td>-309</td>
</tr>
<tr>
<td>Pond Tail</td>
<td>7388</td>
<td>310</td>
<td>413</td>
<td>-103</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34617</strong></td>
<td><strong>1247</strong></td>
<td><strong>1983</strong></td>
<td><strong>-736</strong></td>
</tr>
</tbody>
</table>

The South Tandridge network is the most seriously disadvantaged with regard to clinical accommodation. All practices have a significant deficit which amounts to some 736m², the equivalent of an additional surgery.

Both Oxted and Lingfield have been identified as potential locations for the development of a health and social care campus. The successful application for funding, through the ETTF process, for the development of new premises in the Lingfield locality provides the practice and CCG with an opportunity to develop a purpose designed facility that meets their aspirations for out of hospital care. Oxted is more challenging with the facilities already operating at full capacity. Additional capacity could be made available by extending the hours of operation.
Strengths:
- Well established service provision in Oxted in line with new models of care.

Weaknesses:
- Three practices geographically remote – limits opportunities to share resources.
- A large rural area with poor transport links.

Opportunities:
- A successful ETTF submission provides an opportunity to redevelop the Lingfield practice.
- Potential to create a purpose built health and social care hub as part of the Lingfield development.
- Potentially significant funding (CIL and S106) to accrue from housing developments.
- Increased capacity through extended hours working.

Threats:
- Potential large housing developments within the area increasing demand.
- Pressure on primary care in East Grinstead.
- Lack of funding to invest in primary care.

In summary, whilst there are weaknesses in the current primary care estate there is also a range of opportunities available to address some of the issues. Where practices are in adjacent properties joint working and planning could make better use of the facilities and provide additional clinical consulting time without any significant investment in the fabric of the buildings.

There are also pockets of unused space which, with minimal investment, could be brought back into use.

A significant threat to all networks is the increase in demand brought about by new housing developments. It is critical that the CCG ensure that health is considered at the planning stage and that the local authorities are mindful of the investment required.

5.3 NHS Property Services Estate

NHS Property Services (NHSPS) are the CCG’s “property partner”. NHSPS was created by the Health & Social Care Act 2012, 100% owned by the Secretary of State for Health. On formation in April 2013, NHS Property Services inherited approximately 3,700 holdings
from 161 predecessor organisations (primary care trusts and strategic health authorities), with a value of around £3 billion.

CCGs are not able to enter into property agreements directly, NHSPS always take the head-lease with a sub-lease then being entered into with the provider. As commissioner the CCG is liable to the terms of the lease until such time as the occupancy term expires – this includes all service charges, utilities and rent.

In April 2016 NHSPS introduced a Market Rent Policy which recovers all occupancy costs at a commercial rate. The provision of these costs allows the CCG to make more informed decisions regarding the usage of buildings and where efficiencies and revenue savings can be made.

In total the East Surrey related NHSPS estate extends to ten holdings which cover some 10,000 m² with a total running cost of £2.39 million per year (2016/17).

The top five buildings by cost equate to nearly 79% of the overall annual cost.

**Figure 20. Top five properties by cost (source NHSPS)**

<table>
<thead>
<tr>
<th>Property</th>
<th>Tenure</th>
<th>Annual Cost 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caterham Dene Hospital (inc. Conifers)</td>
<td>Freehold</td>
<td>£1,226,384</td>
</tr>
<tr>
<td>St John’s Court</td>
<td>Leasehold</td>
<td>£244,696</td>
</tr>
<tr>
<td>Beechcroft</td>
<td>Freehold</td>
<td>£186,297</td>
</tr>
<tr>
<td>Oxted Health Centre</td>
<td>Leasehold</td>
<td>£118,132</td>
</tr>
<tr>
<td>Horley Resource Centre (Wayside)</td>
<td>Leasehold</td>
<td>£102,584</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£1,878,093</strong></td>
</tr>
</tbody>
</table>

5.3.1 **Caterham Dene Hospital**

The Caterham Dene Hospital is a medium sized community hospital located on Church Road in Caterham on the Hill. It provides inpatient accommodation for patients requiring rehabilitation, other services are provided on an outpatient basis including a busy minor injuries unit catering for patients over the age of 18.

There are a range of community services based at the hospital including health visitors, school nurses, district nursing teams and therapists. The hospital also provides the base for the Rapid Assessment Clinic.

The Caterham Dene hospital site totals approximately five acres of which half houses the current hospital and the remainder is a field to the south of the hospital, which is currently laid to grass and unused. The ownership of the site passed to NHS Property Services when NHS Surrey Primary Care Trust ceased operation.
The hospital itself is made up of two distinct buildings, the “hospital” which is a mixture of three, two and one storey elements, and Conifers which is a large single storey building to the south of the site. In total the space occupied by the clinical and administrative services amounts to some 2,725m². Of this space 81% is provided in single storey buildings and does not represent efficient utilisation of the site.

Conifers amounts to some 657m² of single storey space, of which 76% is unused. This is classified as void space and the CCG is charged by NHSPS (the landlord) for the rent and associated service charges. The building is in a state of disrepair externally and requires investment from the landlord to bring the void space back into clinical use.

Surrey and Borders Partnership NHS Trust are pursuing an interest in occupying this space; the CCG is supportive of this request as it will reduce void costs payable to NHSPS.

An initial workshop has been held to explore options for the future of the site. The figure below gives an illustration of the types of services that could be provided on the site. This builds on the health and social care campus creating a community resource that also focuses on prevention and wellbeing.
An options paper is due to be presented to the ESCCG Governing Body in December 2016. At this stage the decision will be made whether to invest in developing a Strategic Outline Case to identify a preferred way forward.

6 Key Themes Emerging from the Review

6.1 Model of Care

The immediate priority for the CCG is to establish a sustainable model of care that reduces the reliance on secondary care services. Presently the CCG is running a substantial deficit and the model of care is very acute-centric. The ambition is to provide appropriate scale up and scale down solutions working across the health economy.

The CCG is presently reviewing its integrated model of care to ensure that services are provided in the right localities. It is likely that the “health and social care campuses” will be centred around:

- Oxted
- Caterham
- Horley
- Redhill/Reigate
- Lingfield (a sub-site, but necessary due to the travel times and distances involved to other sites)

The emerging model of care has challenges associated with the interaction across the borders of West Kent and more particularly with Crawley Hospital in Sussex. Within the CCG area a key priority is to contribute to the sustainability of the East Surrey Hospital site in Redhill.

The development of the STP and place-based plan is enabling the CCG to contribute to plans that extend wider than its own boundary whilst ensuring that the health and care systems, and the infrastructure that supports them, is fit for purpose and sustainable within East Surrey.

The emerging service model is closely aligned with an MCP and the opportunities to fully implement this and establish deliverable benefits will be influenced by the use of both the NHSPS community estate and the GP primary care estate. The Strategic Estates Plan should be driven by the model of care and therefore it is critical that this is established as soon as possible.

### 6.2 Community Services Accommodation

The review has highlighted a severe deficit in suitable accommodation available for the provision of clinic based community services. Currently services are operating in dispersed locations which compromise the opportunities for integration. Of the accommodation occupied some of it is below modern space standards and non-compliant with current control of infection guidance. FCHC operate from the following premises.

*Figure 23. Location of FCHC services in East Surrey*

<table>
<thead>
<tr>
<th>Property</th>
<th>Space m²</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caterham Dene</td>
<td>960</td>
<td>Rapid Access Centre (RAC), Minor Injuries Unit (MIU), rehab ward, occupational therapy, occupational health, physiotherapy, audiology, podiatry, specialist nurses, office base for community matrons, district nurses, evening and night service, 0-19 teams, out of hours service and admin and clerical</td>
</tr>
<tr>
<td>Conifers</td>
<td>102</td>
<td>Physiotherapy and SALT (includes gym space)</td>
</tr>
<tr>
<td>Moat House Surgery</td>
<td>-</td>
<td>District nursing, Merstham 0-19 teams</td>
</tr>
<tr>
<td>Holmhurst Medical Centre</td>
<td>-</td>
<td>District nursing team</td>
</tr>
<tr>
<td>Oxted Therapies Unit</td>
<td>232</td>
<td>Physiotherapy, podiatry, paediatric</td>
</tr>
</tbody>
</table>
As NHSPS rationalise the estate that they lease from third party landlords the accommodation for community services is dwindling. This is evidenced in the requirement to vacate St John’s Court in Redhill and Beechcroft in Horley, both housing administrative bases for community teams. Whilst this was actioned some time ago both buildings are still partially occupied by other providers and the CCG are subject to void charges for the space vacated by FCHC.

Of main concern is the lack of clinical space for the delivery of the MSK service. This lack of capacity is already having a detrimental impact on provision of the service which requires colocation of both treatment rooms and a gym.

With community services a key component in out of hospital care, the provision of suitable accommodation in the right location is critical for the realisation of a sustainable health and care system which delivers care locally.

6.3 **Caterham Dene Hospital**

The site is suitable for the development of a health and social care campus to support the out of hospital strategy. High-level options have been explored for potential developments on the site. The next stage is for the CCG to decide whether it wishes to proceed to developing a Strategic Outline Case to establish the way forward.

6.4 **Primary Care Estate**

The primary care estate is variable with regard to capacity and condition. Some
practices are housed in converted properties whilst others benefit from purpose built facilities. However, many of them, regardless of age or suitability, are already operating at capacity and have no space to absorb any future growth in list size or to extend the range of services provided in line with the expectations of modern primary care practice.

The level of requests for funding through the ETTF process has resulted in the allocation of the total five year budget in the first round of submissions. This source of funding is therefore unavailable to any schemes identified over the next four years.

The CCG has been supportive of practices bidding for funds to improve their accommodation through the minor improvements grant process but the funding is limited and only high priority schemes have been put forward for consideration in 2016/17. In preparation for 2017/18 the CCG needs to put into place a prioritisation process, in anticipation of future funding becoming available.

### 6.5 Future Housing Growth

The CCG has been advised through the local authorities that there will be progressive housing growth of approximately 1,000 units per year between 2015 and 2030. This needs to be verified for the consequences that this will have on health and care services and the CCG will need to ensure that the local authorities are cognisant of the funding required to deliver additional capacity.

### 6.6 Void Costs and Property Opportunities

There are a number of significant property opportunities to explore that could release financial savings to the CCG. Other opportunities to be explored are clinically focussed but should enable optimal use of the estate across the health and social care sector whilst also providing the opportunity for system wide savings.

A Local Estates Forum (LEF) should be established as a priority to ensure strategic estate planning is aligned to the STP and place-based plans.

### 6.6.1 Void Costs

The CCG are liable for void costs in all properties either owned or leased by NHSPS where there is unoccupied space. In 2016/17 the CCG are currently liable to pay in excess of £500,000 void costs. The table below sets out the buildings attracting these costs.
Figure 24. 2016/17 Void Costs

<table>
<thead>
<tr>
<th>Property</th>
<th>Tenure</th>
<th>Rent</th>
<th>FM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beechcroft</td>
<td>Freehold</td>
<td>£9,217</td>
<td>£26,853</td>
<td>£36,070</td>
</tr>
<tr>
<td>Caterham Dene - Conifers</td>
<td>Freehold</td>
<td>£74,385</td>
<td>£122,078</td>
<td>£196,463</td>
</tr>
<tr>
<td>Oxted Health Centre</td>
<td>Leasehold</td>
<td>£20,124</td>
<td>£10,309</td>
<td>£30,433</td>
</tr>
<tr>
<td>St John's Court</td>
<td>Leasehold</td>
<td>£107,150</td>
<td>£64,163</td>
<td>£171,313</td>
</tr>
<tr>
<td>Horley Resource Centre</td>
<td>Leasehold</td>
<td>£48,529</td>
<td>£19,707</td>
<td>£68,236</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td></td>
<td>£259,405</td>
<td>£243,110</td>
<td>£502,515</td>
</tr>
</tbody>
</table>

**Beechcroft**

This building is owned by NHSPS and previously housed administrative facilities for FCHC and Virgin Healthcare. FCHC has previously vacated the building as it was deemed not fit for purpose. The sole occupier is now Virgin Healthcare.

Further investigation is required to ascertain the condition of the building and whether it is economically viable to bring it back into full use. Given the current lack of primary care capacity, which is due to worsen with a growing population, consideration should be given to fully utilising the space. Alternatively if this is not possible then vacation of the building should be expedited and the site offered for disposal.

**Caterham Dene – Conifers**

A large proportion of the space in the Conifers buildings has been vacant for some considerable time. The CCG have agreed that SaBP can occupy this space whilst the future of the Caterham Dene site is considered. SaBP aim to carry out the required works ready for occupation in February 2017. Negotiations are underway with NHSPS to agree the terms of the lease.

**Oxted Health Centre**

Information with regard to the lease agreement with NHSPS is lacking in detail and further investigation has been instigated with NHSPS. However, it is likely that the void costs relate to two large unoccupied rooms, one previously used as an x-ray room and the other currently unoccupied but suitable for office accommodation.

**St Johns Court**

This is administrative space that is no longer required by the CCG and negotiations are in place to “hand back” to the landlord in January 2017. First Community Health and Care vacated the majority of the space leaving only a small area occupied by Virgin Healthcare. Retaining this building is a significant cost pressure to the CCG and negotiations should be expedited to find alternative
accommodation for Virgin Healthcare and to relinquish the lease.

**Horley Resource Centre (Wayside)**

The majority of the first floor of the Horley Resource Centre is currently vacant with the exception of two rooms utilised by the Wayside Medical Practice and one by Virgin Healthcare. The Wayside Medical Practice occupies the ground floor.

The CCG have advised NHSPS that they support the move of FCHC services, currently co-located with the Birchwood Medical Practice, into the void space on the first floor. Negotiations are underway to carry out the works necessary for occupation and to agree the operational policy for the building.

This move will realise the benefit of reducing void costs to the CCG and providing the Birchwood Medical Practice with much needed clinical accommodation, however it will still leave Birchwood with less space than is indicated by its current list size. With 600 new houses being delivered in north west Horley in spring 2017 and the likely dispersal of the South Park practice list in April 2017, primary care clinical capacity in Horley is likely to be severely constrained for the foreseeable future.

**6.6.2 East Surrey Hospital**

The East Surrey Hospital site has seen substantial investment in recent years and the CCG would be keen to maximise the use of this site. With the continuing pressure on primary care and the introduction of new care models the CCG wish to explore the opportunities that the hospital site could provide in supporting the urgent care model along with other opportunities for integration.

In summary, there are some significant opportunities for the CCG to work with NHSPS to reduce the void costs by either arranging for full occupation of vacant space or surrendering leases/disposing of properties where there are no future requirements identified.

**6.7 The Future Estate**

The models of health, care and wellbeing will develop over years and as these models mature so will the need for more, less or different types of accommodation to support these activities.

Whilst much of the estate is inherited, in general it consists of generic consulting type accommodation that can be flexibly used by different clinicians, and by others, for one to one consultations. It is unlikely that this need will change in the future and it is therefore more about the capacity to provide the services rather than the type of accommodation being a constraint.
It has already been demonstrated that the availability of clinical accommodation within the networks is variable, and within practices is mainly used to support primary care. As MDTs are established the ability for the team to work and meet will require that suitable accommodation is available in at least one location within each network.

For any new developments, it is key to ensure that the development plan will accommodate these emerging needs and that the buildings themselves are flexible and adaptable to facilitate change. This may be achieved through the use of standardised, multi-functional spaces that can be used by different clinical and community users.

6.7.1 Health and Social Care Hubs

The CCG is planning to develop health and social care hubs that bring services together to facilitate integration and deliver a holistic service offering. The exact service configuration has yet to be agreed, but in general the provision of generic accommodation, as noted in figure 25, would accommodate the majority of services. The quantum of this accommodation supplied would be specific to the estimated demand for the locality served.

In addition to the generic accommodation there are instances where specialist accommodation is required, for example gymnasiums for physiotherapy and rehabilitation services and diagnostic rooms such as x-ray. To retro-fit specialist accommodation into existing premises is usually difficult and costly so the main options would be for extension to existing premises or inclusion in new developments. The location for such services will need to be agreed at the outset and taken into consideration in the strategic estates planning.

*Figure 25. Generic accommodation requirements*

<table>
<thead>
<tr>
<th>Function</th>
<th>Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Generic consulting rooms</td>
</tr>
<tr>
<td></td>
<td>Treatment rooms</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Generic consulting rooms</td>
</tr>
<tr>
<td></td>
<td>Treatment room</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Generic interview rooms</td>
</tr>
<tr>
<td></td>
<td>Group rooms</td>
</tr>
<tr>
<td>Specialist Nurses</td>
<td>Generic consulting rooms</td>
</tr>
<tr>
<td></td>
<td>Treatment rooms</td>
</tr>
<tr>
<td></td>
<td>Group rooms</td>
</tr>
<tr>
<td>Visiting Clinicians</td>
<td>Generic consulting rooms</td>
</tr>
<tr>
<td></td>
<td>Treatment rooms</td>
</tr>
<tr>
<td></td>
<td>Group rooms</td>
</tr>
<tr>
<td>Case Management and MDT</td>
<td>Work stations and offices</td>
</tr>
<tr>
<td></td>
<td>Meeting rooms</td>
</tr>
<tr>
<td>Booking in and waiting</td>
<td>Reception and Waiting areas</td>
</tr>
<tr>
<td>Administration</td>
<td>Work stations and offices</td>
</tr>
</tbody>
</table>
7  **Procurement and Funding Options**

The procurement and funding options depend very much on the scale of the project and whether the expenditure is categorised as capital or revenue. In general if the investment is over £5,000 this would be deemed capital expenditure.

The following sets out the procurement routes available and the potential sources of funding to progress local schemes.

7.1  **Capital Funding Sources**

7.1.1  **Estates and Technology Transformation Fund (ETTF)**

In January 2015, funding for the first tranche of a £1 billion four year investment programme in primary care infrastructure was announced. The second tranche is now available for 2016-2019 and bids were submitted in June 2016.

Since the submissions another round of prioritisation has been undertaken with only three schemes being put forward for further consideration:

- Lingfield Practice redevelopment (successful in phase 3)
- Greystone House Practice (successful in phase 2); and
- Whyteleafe Practice (unsuccessful).

7.1.2  **Minor Improvements Grants (MIG)**

NHSE administered the minor improvements fund which allows GP practices to undertake improvements to their premises. The mechanism allowed for NHSE to fund up to 66% of the costs with the remainder being met by the practice.

The prioritisation of schemes for MIG funding has now been delegated to CCGs and a budget based on capitation allocated. ESCCG has a budget of £38,000 for 2016/17. This equates to £57,000 of building works with 34% of the cost being covered by the practice. These figures are inclusive of irrecoverable VAT.

Three of the schemes not going forward in the ETTF process are being considered for a minor improvement grant:

- Birchwood Medical Practice;
- Chaldon Road Surgery; and
- Caterham Valley Medical Practice.
7.1.3 **Section 106 Monies (S106)**

Section 106 funding is sought as part of the planning application process to mitigate the impact of development and is paid once development is completed or occupied. This money is specific to the development, and how the money will be used is identified from the outset. In some instances the developer will be required to carry out the works.

Reigate and Banstead District Council has identified £42,000 of S106 money to be made available to the CCG in 2016/17. We would seek to utilise some of this funding prior to allocating minor improvement grants.

7.1.4 **Community Infrastructure Levy (CIL)**

CIL is a charge which is levied on developments as a percentage of the capital investment. The receipts from this fund are not tied to the development and can be used elsewhere within the council area to improve infrastructure. An agreed percentage, at the council’s discretion, will be used within the locality from which the charge is levied.

Both district councils have introduced CIL in 2016 and as such have not yet received any significant payments. However, Reigate and Banstead Borough Council believe that they are likely to accumulate in the region of £4 million to £5 million in the next five years. Whilst unlikely to fund a significant development, it is a source of funding to increase capacity of existing premises to accommodate growth in the population due to local housing developments.

7.1.5 **DH/Treasury Funding**

Although limited, discretionary capital funding is still available for the development of new schemes. A business case would need to be prepared clearly setting out the costs and the benefits that the investment would realise.

For example, there is the potential for the Caterham Dene scheme to generate significant capital receipts that could be invested to construct new facilities however this would be subject to the development of a business case and approval by the DH Capital Team. It is not a given that capital generated by a scheme can be reinvested.

7.1.6 **Third Party Development (3PD)**

This option has been traditionally used to fund the development of new GP practices. A third party funds the development of the facility and NHSPS would enter into a lease agreement with the developer. NHSPS would then recover their costs from the tenants (if primary care, this is reimbursable by NHS England).
7.1.7 **Debt and Equity Funding**

These are the main forms of funding used by NHS LIFT. Debt financing occurs when a company raises money for working capital or capital expenditure by selling bonds, bills or notes to individuals and/or institutional investors. In return for lending the money, the individuals or institutions become creditors and receive a promise the principal and interest on the debt will be repaid.

Equity funding represents an ownership stake in the company. It gives the shareholder a claim on future earnings, but it does not need to be paid back. Community Health Partnerships take a 40% equity share in any NHS LIFT scheme on behalf of DH.

The client does not need access to capital money to progress the scheme but must ensure that the scheme remains affordable.

7.1.8 **Lottery Funding**

Whilst unlikely to provide significant funding for an entire scheme, in circumstances where the scheme would have a significant positive impact on the community, lottery funding can be accessed e.g. National Lottery Reaching Communities Fund. This could be utilised to fund some of the community resource type developments and activities. [http://www.lotterygoodcauses.org.uk/funding-finder](http://www.lotterygoodcauses.org.uk/funding-finder)

7.1.9 **Social Investment**

The development and sustainability of a community campus hinges on developing a robust funding model, which secures investment capital and has a viable on-going revenue model. For many this is unchartered territory, and the support and funding supplied by organisations such as [bigpotential.org.uk](http://www.bigpotential.org.uk) assist in evaluating the options available.

7.2 **Procurement Routes**

The procurement route chosen depends very much upon the scale of the works required. For example, a minor improvement to a GP surgery can be procured using local contractors and providing three quotes to test value for money. A larger procurement would have to take a more formal route and either utilise an existing framework such as Procure 22 or advertise in the Official Journal of the European Union (OJEU). The latter would involve a full competitive process.

7.2.1 **Design and Build**

This would involve procurement by the NHS of the required work/premises using construction industry “Design and Build” contracting (D&B). This would need to be taken forward through OJEU process. Under D&B a single contractor would be
appointed to both design and build the required facilities.

Alternatively, under traditional competitive tendering the NHS could select and appoint its own design team (if required) and then procure a contractor to undertake the works/construct the required facilities in accordance with the client’s design solution.

Under both of these arrangements the NHS would be responsible for financing the development and for the on-going building maintenance.

7.2.2 **Procure 22 (P22)**

ProCure22 (P22) is a Construction Procurement Framework administrated by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England. P22 represents the third iteration of the DH Framework providing design and construction services for use by the NHS and social care organisations for a range of works and services.

Following a robust procurement exercise six Preferred Supply Chain Partners (PSCPs) have been appointed to the new framework in September of this year.

This is a design and build procurement and the client will need to have access to capital money to fund the scheme. The benefit of P22 over a traditional design and build is that the PSCPs have already been selected through the Official Journal of the European Union (OJEU) process and therefore only a mini-competition between the PSCPs is required in order to select a preferred partner.

7.2.3 **Public, Private Partnership (PPP)**

In primary care the preferred public private partnership (PPP) is NHS LIFT. It was procured to lever in financing to make a significant improvement in the quality of primary care premises. NHS LIFT creates a market for investment in primary care and community-based facilities and services, by involving the private sector in financing the new developments.

It is a joint venture company made up of public and private sector partners. Community Health Partnerships, one of the NHS property companies, has responsibility for safeguarding the NHS 40% share in this joint venture.

Organisations are only able to access this form of procurement if they are in an NHS LIFT area i.e. were partners to the original procurement and establishment of the LIFT company. East Surrey is not in that position and therefore as it stands would be unable to adopt this procurement route.

However, there has been recognition that it should be an option to all, and a business
case is currently with DH to extend NHS LIFT nationally. The decision on the business case is expected in November of this year, and if approved, it is likely that an OJEU notice would be placed early next year. Selection of the preferred partners would take in the region of one year meaning that a PPP option could be available to ESCCG for any large redevelopment such as the Caterham Dene site.

NHS LIFT funds the construction of the building and once the new building is commissioned the space is then leased to NHS bodies, GPs, local authorities, voluntary sector organisations and commercial organisations who have chosen to participate in the scheme. The costs of maintenance and lifecycle replacement are included within the lease costs.

If there is public capital available then a capital injection of up to 20% of the capital costs can be made to improve the affordability of the scheme i.e. reducing the lease costs for the tenants. This would be subject to approval from DH.

8 Conclusion

The key aspects of the estates plan are to ensure sustainability of primary care given the increased demographic growth & housing developments, support for development of the four primary care networks that will support the out of hospital model of care, provision of fit for purpose estate and delivery of the Five Year Forward View and the GP Forward View.

A major challenge facing the CCG is the vulnerability of some of the practices with the potential for list closures and hence the practices inability to invest in the development of premises to meet future demand.

The availability of suitable property for conversion or land for new builds is scarce and provides a significant challenge for the CCG. The CCG is currently liaising with the county council who are participants in the One Public Estate programme. The CCG is also working with other providers to look at all opportunities where the integration of services could provide opportunities for joint investment in the development of facilities.

The current financial position of the CCG places constraints on the investment that can be made and the future feasibility of primary and community care estate are contingent on the ability to access external funding sources such as the ETTF, Section 106, CIL etc.

Without investment in the estate and infrastructure required to support patient care some areas of the local health economy will see either a reduction or potentially a loss of primary care services at a time when expansion and transformation of out of hospital services are needed to prevent the over reliance on acute hospital care.
The applications for funding via the ETTF aim to not only support the practices in facilities that are fit for purpose but that match the strategic ambition of the CCG in transforming the healthcare in East Surrey.

The development of the CCG’s Strategic Estates Plan is emergent. Further work needs to be undertaken to ensure that the most accurate and up to date information is available in order that informed decisions can be made about the future of the estate, not only in the CCG area but across the border with Sussex and with partner organisations as part of the STP and place-based plans.

The establishment of a Local Estates Forum should be pursued to ensure there is adequate estate in East Surrey to deliver current and future service needs.

### 8.1 Next Steps

The final iteration of the Strategic Estates Plan is contingent on some key decisions being made regarding the future model of care across East Surrey. Specifically confirmation on where the health and social care hubs are to be located, and the services to be provided, will inform investment decisions.

By March 2017 the CCG should work towards:

- Establishing a Local Estates Forum;
- Confirming the locations of the health and social care hubs;
- Confirming services to be provided from these hubs;
- Making the decision on whether to proceed to Strategic Outline Case for the Caterham Dene site re-development;
- Pursuing the S106 money available in 2016/17;
- Identifying future requirements for primary care premises development and submit applications to Reigate and Banstead Borough Council and Tandridge District Council for Community Infrastructure Levy funding;
- Putting in place a process for the prioritisation and allocation of the 2017/18 minor improvements grant funding; and
- To work with Surrey County Council to submit a bid to One Public Estate for funding to support further feasibility work on the Caterham Dene redevelopment and the wider public estate.