

What level of **estate transformation** is needed to enable the future **Multispecialty Community Provider (MCP)** models to be implemented and deliver full potential benefits?

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# Context



**EHCH**  
Enhanced  
Health in  
Care Homes

**PACS**  
Integrated  
primary &  
acute care

**MCP Model:**

- Whole system, whole population approach through integrated health and public sector services
- Preventative care and increase in self-care and rehabilitation
- Longer service contract lengths

**UEC**  
Urgent &  
Emergency  
Care

**ACC**  
Acute care  
collaborations

# Study Objectives

To propose a list of estate transformation requirements formulated from correlations identified in the literature, to be tested against the Vanguards in operation and other industry professional's opinions.



To design and carry out primary research with providers, commissioners and estate professionals involved in the MCP models to gain first-hand insight into operations, issues and successes to date.



To integrate the above learning to identify estates strategy requirements to support MCP delivery.

# Vanguards – Reported results to date



Within a year Better Local Care, Southern Hampshire MCP increased its total population size from 75,00 to 800,000 people across 17 localities (NHS England, 2016).



A 29% reduction in A&E attendances from care homes and a 23% reduction of emergency admissions in Rushcliffe - Principia Partners in Health (Lloyd, T. et al., 2017).



A&E attendances reduction of 16%, as well as 16% reduction in first outpatient appointments - Fylde Coast MCP (Jones, S. 21 March 2017).



A staff survey has shown that 80% of staff have seen a positive change in collaborative working - All Together Better Sunderland (Jones, S. 21 March 2017).

# What Estate changes are happening to support MCP implementation? (Secondary Research)

Local Estates Forums are being formed (e.g. West Wakefield)



Extensive condition and utilisation surveys of all NHS buildings (Better Local Care)



Shared public sector estate strategies are being developed (e.g. Stockport Together)

# Proposed Estate transformation Requirements (Literature Reviews)



# Semi-structured interviews - Interviewees

Position	Company/type	Interviewee's Role in relation to the MCP
Director of Organisational Development and Human Resources	Vanguard 1 (West Midlands)	The Vanguard management lead from the CCG perspective
Chief Finance and Operating Officer	Vanguard 1 (West Midlands)	The vice chair of the MCP Board and Finance and Estates Plead for the CCG
Service Development Facilitator and Sharing & Learning Lead	Vanguard 3, All Together Better Sunderland (North East England)	To promote and share the learnings that have been achieved to date
GP Partner	Vanguard 2, (West Midlands)	GP lead in the Vanguard
Director of Transformation	First Community Health & Care, Community Provider (initial development towards an MCP model)	Strategic Lead and responsible for the development and delivery of the MCP
Estates Manager	First Community Health & Care, Community Provider (South East England) (initial development towards an MCP model)	Responsible for implementing the Estate Strategy to support the new model
Local Area Director	Community Health Partnerships (CHP)	Lead a team of Strategic Healthcare Estate Planners
Senior Strategic Account Manager (London and the South)	NHS England, New Care Models Programme – Five Year Forward View	Strategic account manager for geographical footprints for whole system approach across MCP and PACS

# Interview Areas Questioned

Context of clinical and estate operations against the MCP locality

Governance, accountability, and provider regulation (including contractual impact)

Progress and success of the implementation to date

Implementation issues to date

The impact on or interdependencies with the estate (e.g. pressures, occupancy, usage, room requirements)


Topics and suggestions identified from the literature review set out in the proposed estate transformation requirements



# Interview Results Analysis

The MCP Model	
Variables	Constants
Organisational form	Whole system approach across health and public sector services (one team)
Contract type (virtual, partially integrated, fully integrated)	Enhanced primary and community care
Governance structure (commissioner led, provider led, jointly led)	Re-provision of services from the acute into the community
Contract size (population size)	Overarching outcomes to improve population health and increase self-care
Population demographics	
Geographical/locality characteristics	

The Existing Estate Model	
Variables	Constants
Building sizes	All accountable to existing national policies and guidance
Quality and condition of premises	Leases held individually with providers with demised spaces
Building configurations	Provider service contracts hold estate funding
Geography/locality	Void space in the system is accountable to the CCGs
Stage of strategic planning development	

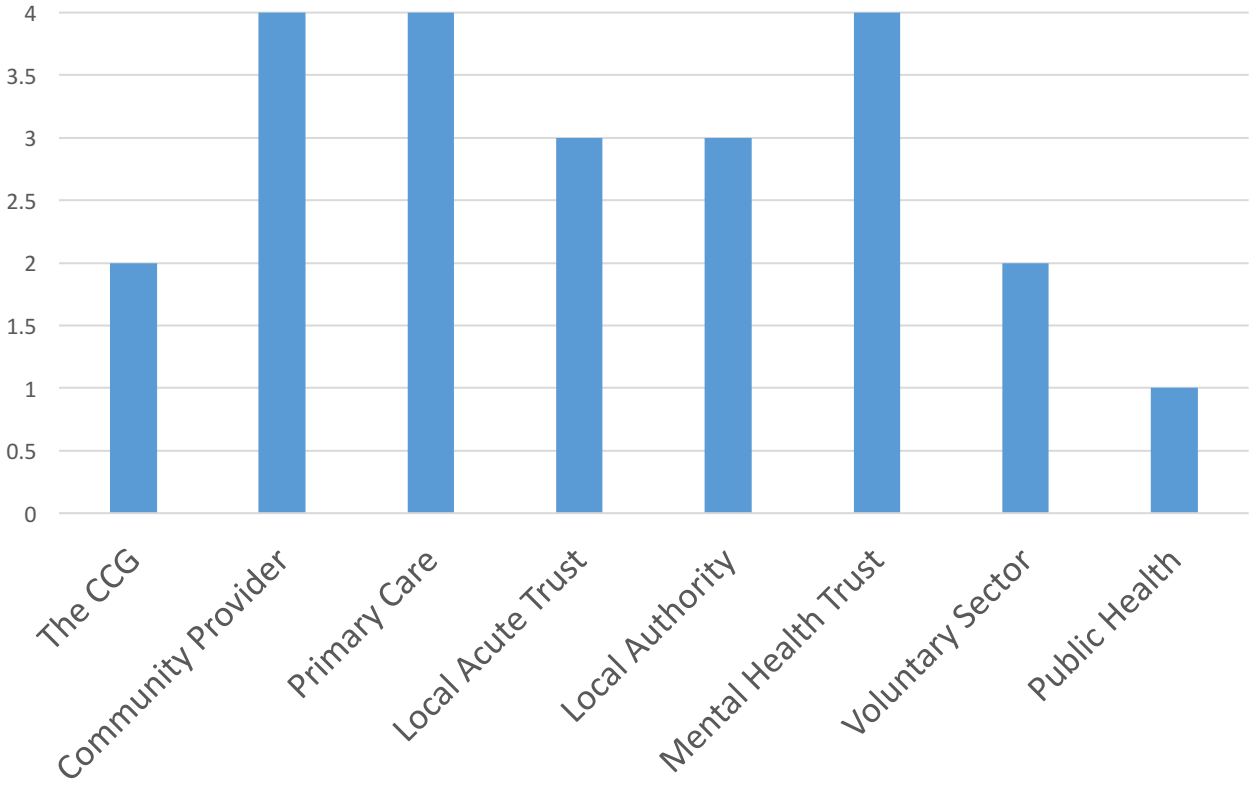


‘Within all of our different provider partners, there are different estate programmes and estate strategies. So the MCP is an alliance, and everyone works to their own estates.’ (Vanguard)

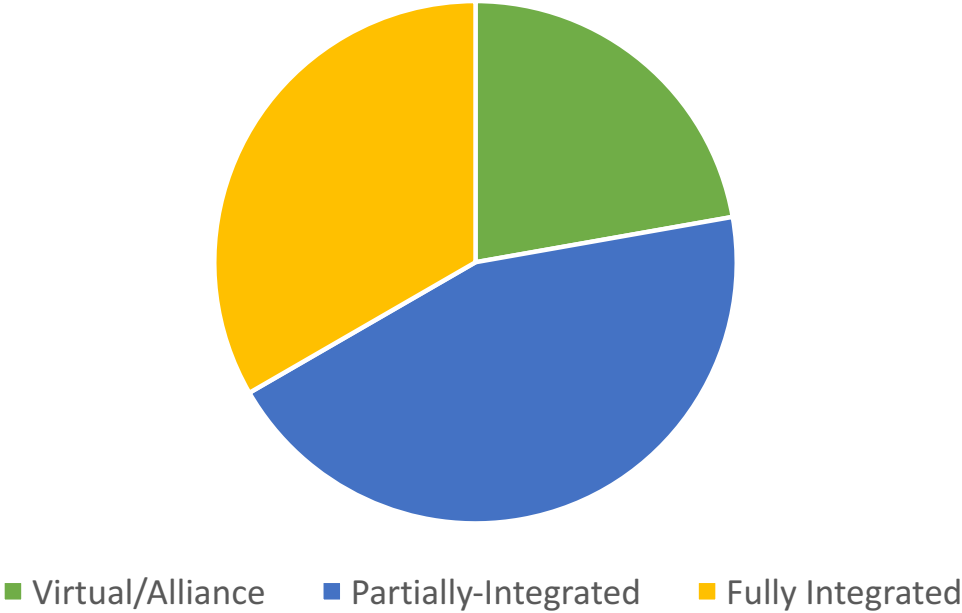
‘Not currently involved within the implementation plans, but the model is only just being developed.’ (Community Provider)

‘Acknowledging the estates strand at the earliest possible opportunity is key.’ (CHP)

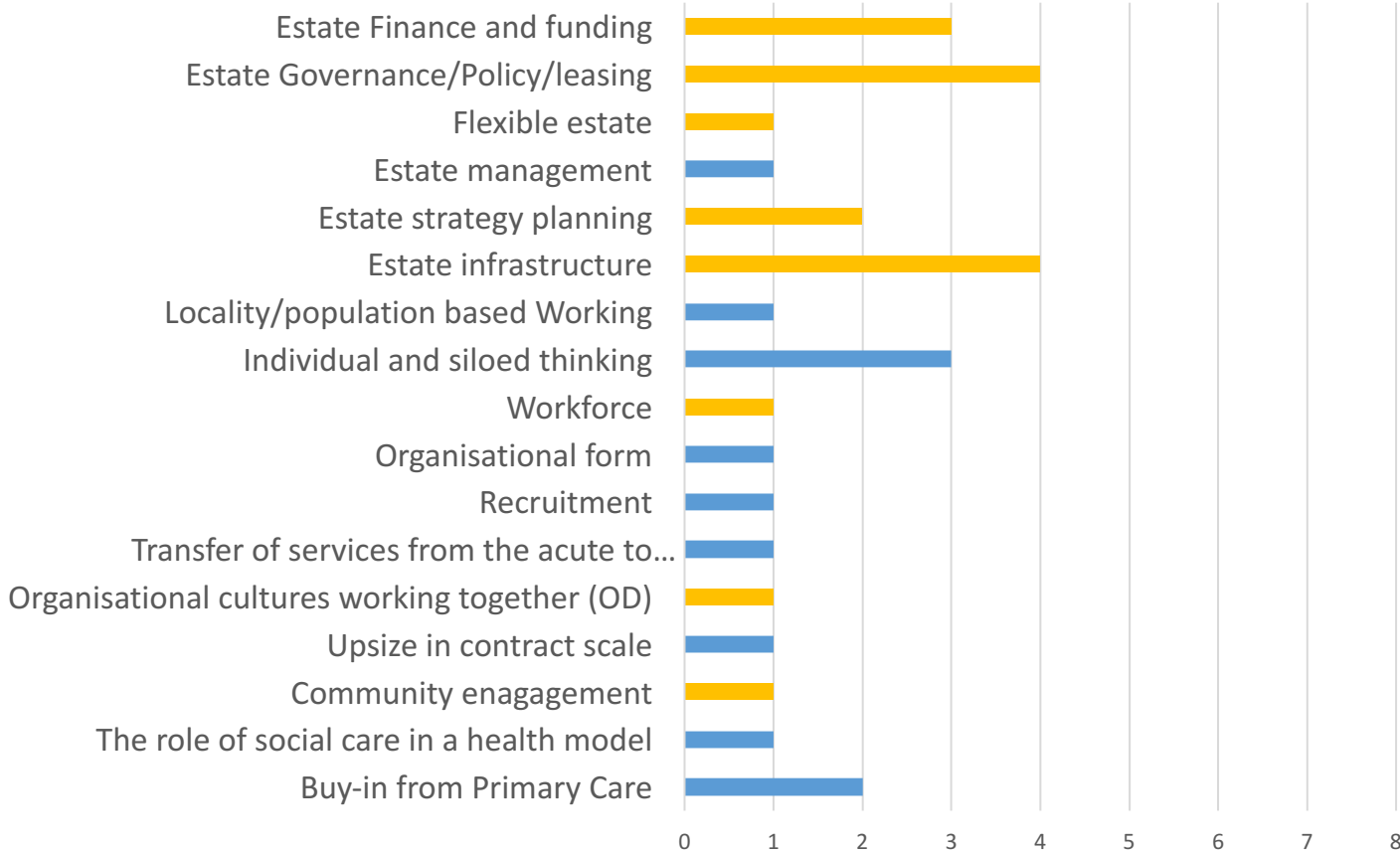
MCP Stakeholders



Weighting of contract types being considered

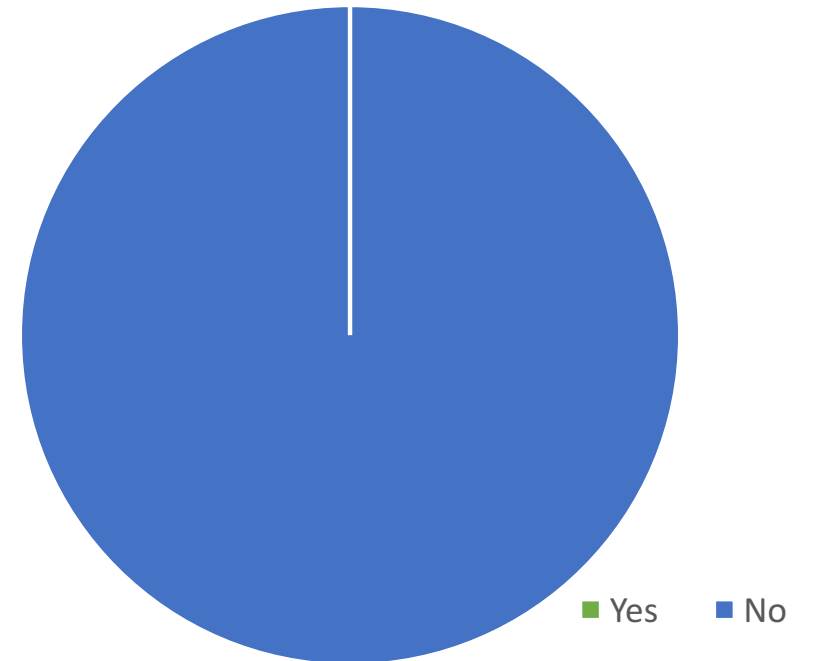


## Challenges



Key: Yellow = also identified as an enabler

Does the existing estate sufficiently support requirements?





'You do need flexible estate.' (NHS England New Care Models Team)

'I think you will see different models of the use of clinic rooms, but overall I would expect to see more flexibility.' (NHS England New Care Models Team)

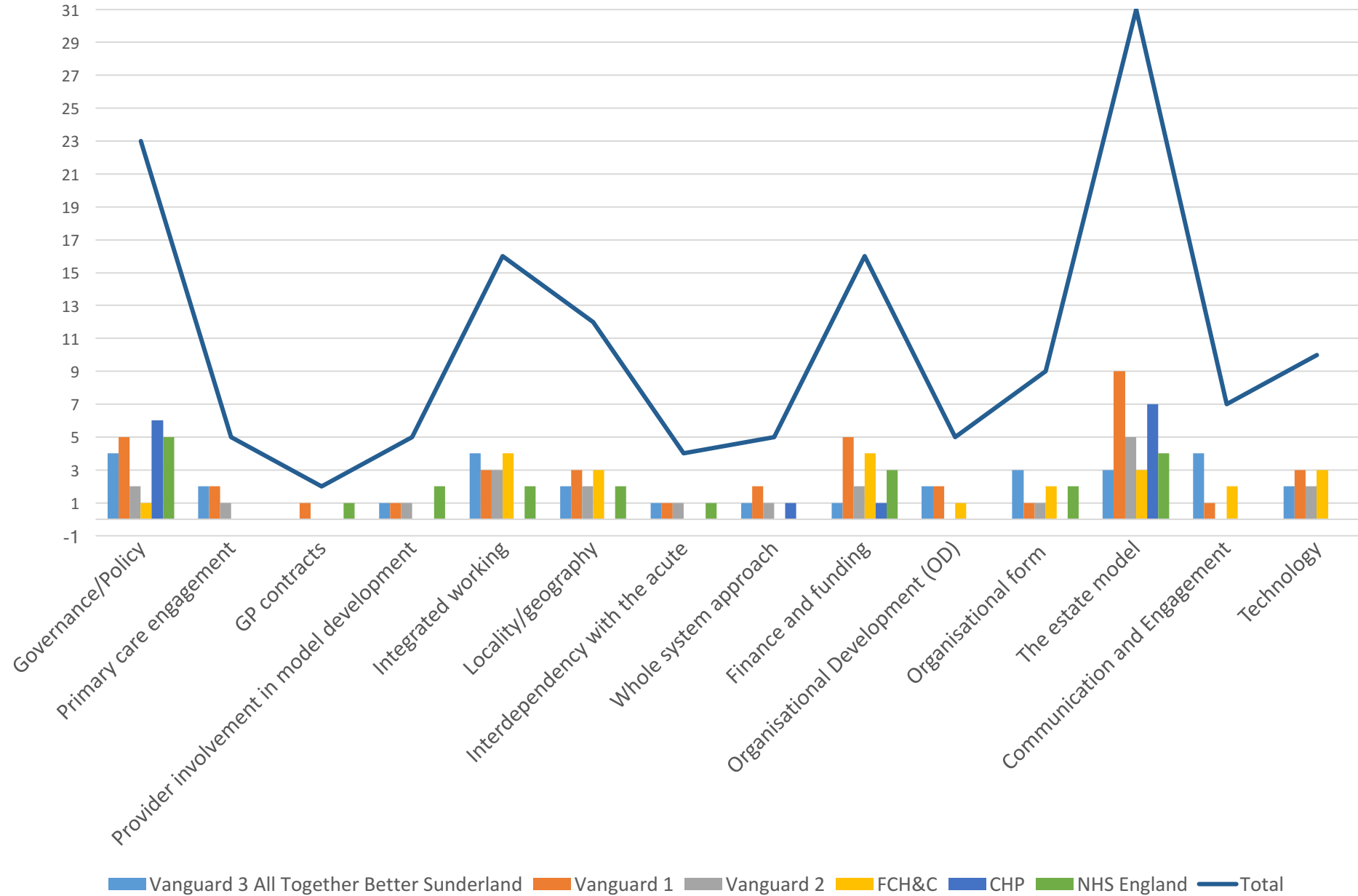
'The model has to have an element of flexibility of occupation and estate use.' (CHP)

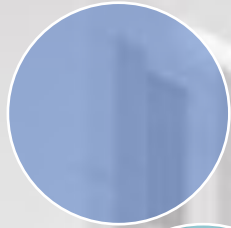
# Respondent's Estate Portfolio Change Requirements



- System change to enable shared usage of space
- Relocating wards in acute settings into the community
- Future new hospital buildings designed without outpatient facilities
- New training space and group rooms
- System change to enable buildings to be fully occupied
- Disposal of buildings not in an appropriate location
- Disposal of building not large enough for shared usage
- Alterations within existing buildings to increase occupancy

# Overall Responses - Recurring Themes





'As it stands at the moment the current rules don't work for what we are trying to do for estates.' (Vanguard)



'If we have draconian, stringent leasing arrangements that prevent shared use, then you can have all the buildings in the world, but it is not going to enable a multi tenanted, multi-occupied approach that the model needs.' (CHP)

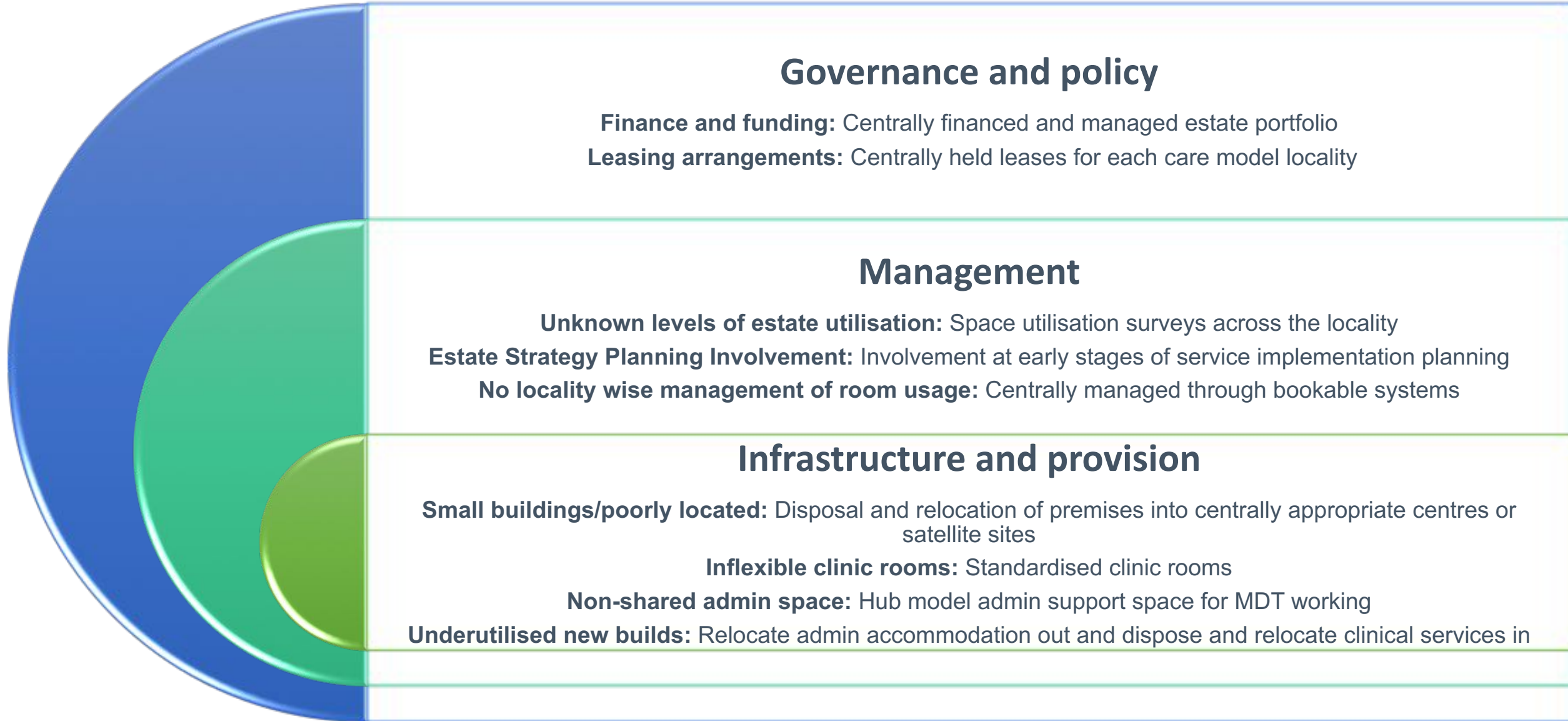


'We need a mechanism where all of the estates is in one place.' (Vanguard)





Estate transformation proposals fell within three main blockers identified:



## Governance and policy

**Finance and funding:** Centrally financed and managed estate portfolio  
**Leasing arrangements:** Centrally held leases for each care model locality

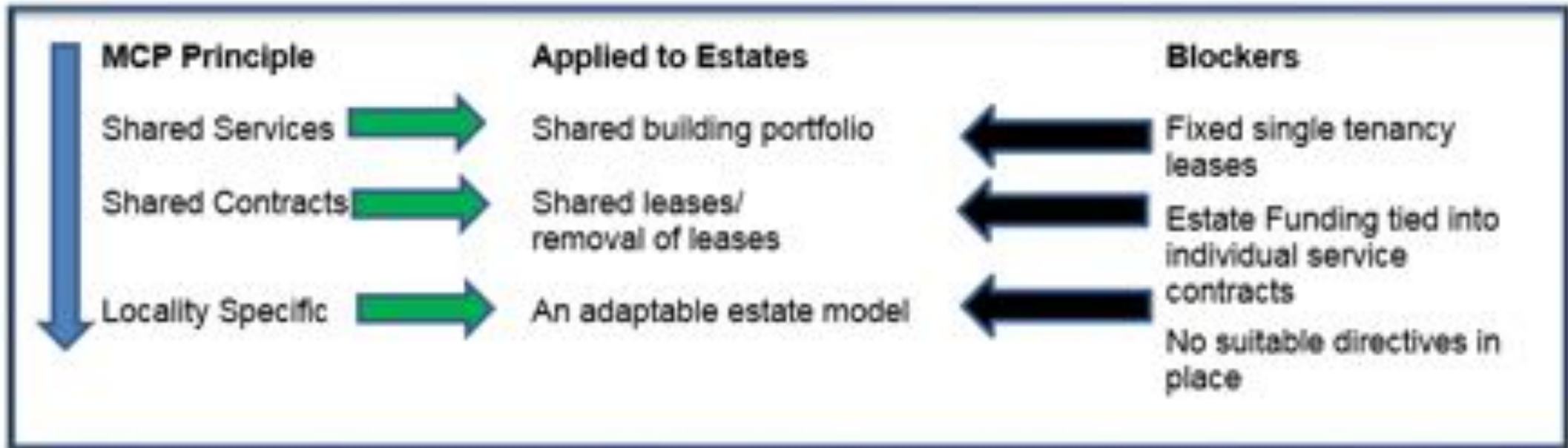
## Management

**Unknown levels of estate utilisation:** Space utilisation surveys across the locality  
**Estate Strategy Planning Involvement:** Involvement at early stages of service implementation planning  
**No locality wise management of room usage:** Centrally managed through bookable systems

## Infrastructure and provision

**Small buildings/poorly located:** Disposal and relocation of premises into centrally appropriate centres or satellite sites  
**Inflexible clinic rooms:** Standardised clinic rooms  
**Non-shared admin space:** Hub model admin support space for MDT working  
**Underutilised new builds:** Relocate admin accommodation out and dispose and relocate clinical services in

# Applying the MCP Principles to Estate Planning and Management



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