DEVELOP AND PROVIDE HEALTH CARE SERVICES

Principles covered:

9   **DEVELOP HEALTH SERVICES THAT HELP PEOPLE STAY WELL**

10   **CREATE INTEGRATED HEALTH AND WELLBEING CENTRES**

tcpa

The King's Fund

THE YOUNG FOUNDATION

Public Health England

NHS

The structure of the Putting Health into Place publications

The learning from the Healthy New Towns programme has been distilled into four publications. This publication, the fourth in the series, covers principles 9-10. The other publications are an executive summary and two documents covering principles 1-3 and 4-8 respectively. The principles will be of interest to different audiences, and at different stages of the planning process.

The four Putting Health into Place publications

Executive Summary

Principle 1
Plan ahead collectively
Principle 2
Assess local health and care needs and assets
Principle 3
Connect, involve and empower people and communities

Principle 4
Create compact neighbourhoods
Principle 5
Maximise active travel
Principle 6
Inspire and enable healthy eating
Principle 7
Foster health in homes and buildings
Principle 8
Enable healthy play and leisure

Principle 9
Develop health services that help people to stay well
Principle 10
Create integrated health and wellbeing centres

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OVERVIEW
DEVELOP AND PROVIDE SERVICES

Health services in new places must help people and communities to stay well, rather than focus solely on the treatment of illness. This means changing traditional approaches to health care.

This publication shares learning from the Healthy New Towns demonstrator sites on how to develop health services that help prevent ill health and provide integrated care when it is needed. It includes broader lessons for local areas to consider when planning new services, drawing on the experience of areas involved in the NHS new care models programme[1] and direction provided in the 10-year NHS Long Term Plan.

These elements make up the final two Healthy New Towns principles:

9   Develop health services that help people to stay well
9.1   Strengthen and integrate 'out-of-hospital' care
9.2   Develop the future workforce
9.3   Link health services to wider community assets
9.4   Support self-management
9.5   Use digital technology to support care

10   Create integrated health and wellbeing centres
10.1 Maximise the benefits of integrated health and wellbeing centres
10.2 Strategic estates planning
10.3 Develop a schedule of accommodation
10.4 Options for project funding

This document outlines how to develop and provide services in a new place by using case studies, checklists and simple explanations which will help professionals working across planning, health and development to come together in partnership to create healthier places.

The document should be read in conjunction with the other Putting Health Into Place publications from the Healthy New Towns programme, including: 'Plan, assess and involve' and 'Design, deliver and manage'.

9

DEVELOP HEALTH SERVICES THAT HELP PEOPLE STAY WELL

What this Principle covers:

9.1 Strengthen and integrate 'out-of-hospital' care

9.2 Develop the future workforce

9.3 Link health services to wider community assets

9.4 Support self-management

9.5 Use digital technology to support care

Strengthen and integrate 'out-of-hospital' care

The impact of new housing developments and an increase in population can be significant for health and care services. Often there is a gap in time between people moving into an area and new or expanded services being established, so new developments are often seen as a burden on existing local health, wellbeing and care services. However, this time lag can be better planned for, and communities can make the most of the opportunities that new housing developments bring.

High-quality primary care is vital to sustain the health of a new community and the NHS Long Term Plan committed to increase investment in primary medical and community health services, aiming to create fully integrated community-based health care. This commitment was formalised in the 2019 GP contract which builds on excellent local and regional initiatives to set a national expectation that practices form Primary Care Networks (PCNs) and, through this, deliver enhanced, consistent services for their local populations. This does not only mean additional GPs or new GP practices; primary care is changing, and new places should reflect new ways to provide services rather than replicating old structures.

Integrated care

Integrated care is best defined from the point of view of an individual person: 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'.[2]

The Nuffield Trust describes integrated care as 'a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better co-ordinated and more continuous care'.

This includes:
— Place-based **Primary Care Networks (PCNs)** of local GP practices and community teams – including nurses, GPs, pharmacists, social workers, occupational therapists, physiotherapists and others, who provide integrated care for people's physical, mental health and social care needs at home, in care homes or in local health hubs.[3] PCNs now cover the entire country, with practices receiving extra staff and funding to work at scale, free up GP capacity and provide a consistent care offer in seven

priority areas; which will be defined in national service specifications.

— The Primary Care Network approach builds on the learning from a number of initiatives, including the 'primary care home' model developed by the National Association of Primary Care (NAPC) (see diagram: Primary care home model – p8) and NHS England's Multi-disciplinary Community Provider and Enhanced Health in Care Homes vanguard programmes. These models are based on health, social care and the voluntary sector coming together to focus on understanding local population health needs to redesign services and improve health outcomes. Internationally, examples such as the 'Nuka' model of care in Alaska show how innovative approaches to general practice can provide local people with care that is patient-centred, proactive and co-ordinated.[4]

— The learning from these models suggests that closer working between GPs, care homes and other community-based professionals is improving care and moderating rising demand for hospital care, with lower growth in emergency admissions to hospitals than the rest of England, and improved patient experience.[5]

— National service specifications for enhanced health in care homes, anticipatory care, structured medication reviews, supporting early cancer diagnosis and personalised care will be implemented by PCNs from 2019/20. Specifications for cardiovascular disease case finding and locally agreed action to tackle inequalities will start from 2021.

— As part of the service specifications, it is anticipated the PCNs will be expected to work alongside other community services to identify groups in the local population at high risk of poor health outcomes, providing support where it is most needed; including making the best use of home-based and wearable monitoring equipment to predict and prevent events that would otherwise lead to a hospital admission.

Existing examples of good practice include Barton, where the city council is working with local GP practices and the voluntary sector to provide exercise classes, and strength-and-balance training for older residents to improve their confidence and strength and reduce their risk of falls (which often result in lengthy hospital stays for older people). And in Bicester, work to redesign care for people with diabetes focused on a population health management approach. This means using data to proactively identify people at risk of developing diabetes and then providing services and self-management support to meet their needs, drawing on community resources (see case study p10).

— **Changing the relationship between primary care and specialist hospital care**: GPs and specialists working together in new and more collaborative ways, replacing rigid referral processes with informal advice and remote consultations.

For example, innovations in the Morecambe Bay area included high-definition video links between GP surgeries and the A&E department in Furness General Hospital, and an 'advice and guidance' system allowing GPs to seek advice from a specialist without making a referral. These and other changes in the area were associated with reduced A&E attendances, fewer emergency admissions to hospital, and improved communication across the system.

— **Timely transfer from hospital to community settings** by flexible teams working across primary care and local hospitals – such as in Dorset where health and social care co-ordinators plan for a patient's discharge from the moment of admission into hospital.

— **Improved community response and recovery support** to prevent unnecessary admissions to hospitals and residential care – flexible teams (GPs, allied health professionals, district nurses, mental health nurses, therapists and reablement teams) working across primary care, community services and local hospitals. For example, in Camden, London, the Rapid Response Service is preventing unplanned avoidable admissions by providing care for people in their homes.

Development partners need to be ambitious about what services new places need. But if new services are planned in isolation from the wider system, or engagement is not sought from the community or health and care staff, opportunities to improve health and wellbeing will be missed.

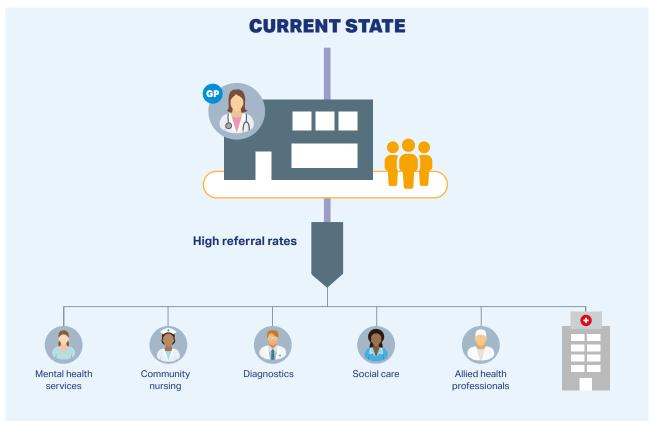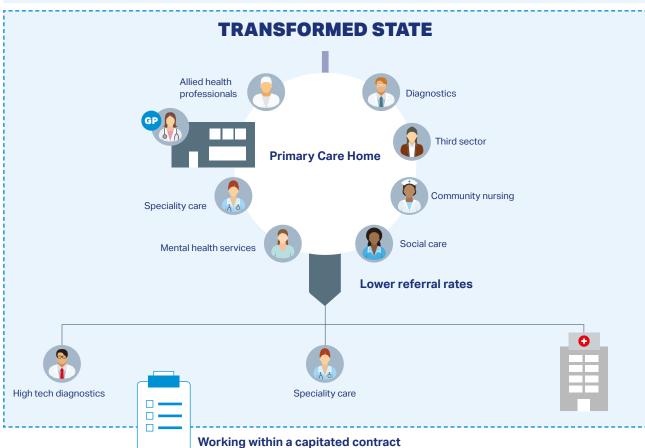## How to strengthen and integrate primary and community care

HOW TO

1 **Going beyond core GP services:** The roll out of Primary Care Networks will ensure a consistent national model of enhanced primary care which enables integration of primary and community care services to support improved health and wellbeing. We expect local areas to use this opportunity to further enhance their primary care offer.

2 **Co-location of services:** Providing multiple services from the same premises creates opportunities to deliver a more co-ordinated experience to people using services, and new facilities need to be designed to enable this (see Principle 10)

3 **Digital infrastructure:** Digital technologies are a key enabler of new approaches to care, for example, building the infrastructure to integrate clinical records and share information across appropriate organisations (see 9.5 p19).

4 **Change management:** Enough time and resources must be devoted to preparing staff and teams for delivering new approaches to care and supporting them through the change.

5 **Education and development:** It is essential to help staff adopt new ways of working – by creating opportunities for mutual learning and skills transfer, for example, between GPs and specialists.

6 **Insights from staff and patients:** These should be used to ensure new approaches are providing the best possible care experience and outcomes in line with the expectations of patients (see Principle 3).

The primary care home model illustrates how primary and community care is transforming to meet the needs of local populations.
Credit: NAPC

CURRENT STATE

High referral rates

Mental health services

Community nursing

Diagnostics

Social care

Allied health professionals

TRANSFORMED STATE

Allied health professionals

Diagnostics

Third sector

Community nursing

Social care

Speciality care

Mental health services

Primary Care Home

Lower referral rates

High tech diagnostics

Speciality care

Working within a capitated contract

CASE STUDY

Lesson from Darlington
Developing 'primary care at scale'

Darlington has strengthened primary and community care by clustering 11 local GP practices into three virtual hubs, each covering a population of between 30,000 and 50,000. In each hub, practices work with other health and social care professionals to develop new services and approaches. The hubs also provide a platform for working together on workforce development and technology, and for sharing premises, back office staff and other resources.

The hubs build on a strong history of partnership working in Darlington and a vision created through dialogue with all partners, including listening to patients about what is important to them.

Tangible changes made so far as a result of the development of primary care hubs include: giving people extended access to GP services outside core hours, seven days a week (delivered by the local GP federation from one centrally located hub), and trialling online consultations in eight of the 11 practices.

Below
Productive General Practice session at Clifton Court Medical Practice, Darlington.

CASE STUDY

Lesson from Bicester
A new model for integrated diabetes care

An integrated diabetes care model was developed across North East Oxfordshire to make best use of resources and improve the quality of care across hospital, community and primary care. This includes an integrated IT system, virtual consultations between GPs and specialists, a strategy for diabetes prevention, and multi-disciplinary meetings to agree how best to manage patients with complex needs.

The diabetes dashboard: Data from GP computer systems is uploaded to a central diabetes digital dashboard. It is refreshed monthly and allows the locality's clinical board and diabetes clinical co-ordinator to track progress and identify scope for improvement.

Economic modelling estimated that for every £1 invested in the digital dashboard, the NHS stands to save £1.77 over 25 years. This saving comes from the reduced need for care as a result of improved diabetes management, with an additional £0.58 saving accruing to the council.

Virtual outpatient clinic appointments: GPs can now book a virtual outpatient appointment with a hospital consultant. Consultants can view the patient's GP notes online and be guided through them by the GP. This allows the consultant and GP to agree changes in the patient's care plan and arrange tests and follow-up appointments together, often avoiding additional hospital appointments.

A strategy for diabetes prevention: Diabetes prevention includes both primary prevention (for example, increasing physical activity across the population) and secondary prevention (helping people with diabetes to manage their condition to prevent adverse outcomes in the future). The strategy in Bicester uses assets in the local community, such as the Health Routes exercise trails (see Principle 5) and connects patients with support from the voluntary and community sector.

Diabetes multi-disciplinary team meetings: Multi-disciplinary team meetings were piloted in North East Oxfordshire in 2017. Their purpose was to identify people with diabetes at risk of developing complications and to plan their treatment together, with input from specialists, GPs, practice nurses and specialist diabetes nurses. Early evaluation of this pilot indicated that primary care professionals and practice managers increased their knowledge and confidence in managing diabetes at practice level through working together.

Enabling factors: Those involved in developing the new care model reported that several factors were critical in the process:

— Co-development between primary and secondary care clinicians
— Technical support from the commissioning support unit
— Financial support from the clinical commissioning group (CCG) and diabetes transformation funds
— Clinical and managerial leadership from the CCG to encourage uptake
— Active engagement of other providers, including leisure services, weight management programmes and local community groups.

Develop the future workforce

Introducing new roles in primary and community care, and extending the roles of existing professional groups, can help improve the service offered to patients and manage demand on the NHS, as well as providing staff with greater development opportunities. National evidence shows there is considerable scope for some tasks typically performed by GPs to be performed instead by other professionals, allowing GPs to make full use of their skills. As such, from April 2019 the new five-year GP contract[6] both increases investment in primary care and provides additional funding to recruit enlarged teams of health professionals to work together within Primary Care Networks.

This includes:
— **Social prescribing link workers.** Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support.
— **Physician associates.** A relatively new role in the UK but growing in number, PAs usually have two years' post-graduate training and can perform a range of clinical tasks.
— **Clinical pharmacists**, who can support GPs by undertaking structured medication reviews, improving medicine optimisation and safety, supporting care homes and running practice clinics.
— **Physiotherapists.** Physiotherapists can act as the first point of contact for many patients in primary care but are not used as widely in England as in some countries.
— **Paramedic practitioners**. Some GP surgeries have experimented with using paramedics to perform home visits and other functions – for example, in Mount View Practice in Fleetwood.

These roles were agreed as they help reduce GP workload, improve practice efficiency and deliver the ambitions of the Long-Term Plan, and because there is both enough practice demand and workforce supply to fill them. The NHS People Plan will also seek to encourage retention and recruitment into agile, multi-disciplinary roles by improving the NHS working environment and encouraging collaborative, inclusive and compassionate leadership.

There are also large numbers of community pharmacists working across England and their clinical skills often go underused in primary care. The role of community-based pharmacy deserves specific consideration as pharmacists provide a wide range of preventative and primary care services including a larger role in helping people to stay well and improve their health and wellbeing. The Healthy Living Pharmacy framework[7] supports pharmacies that wish to provide a wider range of advice, interventions and signposting to other services, supplementing traditional GP services (see case study on Cranbrook).

'We can't expect staff to work in a different way unless they've really explored it and worked through how they feel about it'

Lucy O'Loughlin
Public health consultant, Devon County Council

CASE STUDY

Lesson from Cranbrook
Enhancing pharmacy services

In 2015, Cranbrook Pharmacy began delivering an enhanced service at a time when local GP services had become stretched due to population increase. In 2017, the pharmacy was awarded Healthy Living Pharmacy status, which places the health and wellbeing of the local community at the heart of the team's work and is integral to developing a model of care based on the population's needs.

Developing this enhanced service has included:
— Training staff to advise on healthy living, infant feeding, smoking cessation, and mental health and wellbeing, using Public Health England's Making Every Contact Count (MECC) approach.
— Using pharmacy premises to deliver community health/primary care services and host clinics, such as flu vaccinations.
— Contributing to health promotion campaigns, such as Sugar Smart, and a skin cancer prevention awareness campaign aimed at construction workers.
— Community outreach to mother and baby groups, supporting mothers with breastfeeding.
— Planning a digital portal to connect the pharmacy to healthy living support, as part of a joint approach with other health care professionals in Cranbrook.

These enhanced services have been informed by the health needs assessment for the local population, which identified needs around mental health and wellbeing, smoking and sexual health.

A key challenge has been overcoming the planning restrictions associated with 'use classes' (categories used to group the different uses of land and buildings).

These need to be addressed in advance if enhanced health and wellbeing services are to be delivered with a flexible use of space that is more agile and responsive to community needs. In Cranbrook, the local authority planning team worked with the director of the pharmacy to find solutions to this.

In this case, the local pharmacist overcame obstacles and exploited opportunities by working with the public health team in Devon County Council, the CCG, the lead planner for the town, the Academic Health Science Network, the Local Pharmaceutical Committee and Devon Doctors, who deliver primary care in the town.

There have also been targeted efforts to build close relationships between the pharmacy and other parts of the system. For example, in 2018 the pharmacy and GP surgery administrative teams participated in a 'walking in your shoes' initiative to understand more about their respective services, and how they could work together more closely.

Enhanced pharmacy services form an integral part of a wider, ongoing transformation in Cranbrook. Through this the development partners aim to co-produce a new model of living involving a shift from an illness treatment service to a comprehensive and proactive health and wellbeing system. The pharmacy is a lead partner in developing this new approach.

Below
Louise Johnson is a pharmacy dispenser and Healthy Living champion

Link health services to wider community assets

Places and communities have assets which play an important role in maintaining good health, wellbeing and social connections. There is considerable potential to increase these positive effects by linking local assets more closely with health and care services (see Principle 3 and Principle 4). This has the potential to significantly amplify the impact of primary care, other health services and community groups.

In some new places voluntary sector organisations do not initially have a strong presence in health care provision, but the NHS and public health teams can help the voluntary and community sector to support residents in new neighbourhoods by commissioning services and directing local people towards emerging and existing groups. New places also have physical assets, such as walking routes, which can be capitalised on to support health and wellbeing. For all these reasons, new places offer fertile ground for linking health services to wider community assets and services.

To clearly understand the opportunities that exist, development partners need to begin by mapping the local assets (see Principle 2). This process should involve residents, who will often be most familiar with their neighbourhood's resources. Principle 3 provides links to toolkits that can assist with this process.

Once the mapping stage is complete there are a range of ways to encourage uptake of these services. One such method is social prescribing, whereby people are guided towards appropriate community resources by trained individuals working in GP practices or elsewhere. Social prescribing can make use of community navigators or link workers, who keep abreast of the resources and assets available locally and talk to people to establish their best options (see case study on Whitehill & Bordon).

Social prescribing is designed to support people with social, emotional or practical needs, and schemes often target vulnerable groups, involving various activities that are typically provided by voluntary and community sector organisations such as arts groups, gardening, cookery and sports (see Principle 6 and Principle 8). Often these are commissioned by councils and grant funders, meaning that partnership working between councils, other funders and the NHS is essential to ensure these services can deal with increases in demand due to population growth associated with new developments.

What are community assets?

? SIMPLY EXPLAINED

Health services in new places have the opportunity to take a wide range of community assets into consideration when planning new services, including:

Social assets, based on relationships and connections with friends, family and neighbours.
Community assets, including voluntary sector organisations working to improve health and wellbeing, and less formal groups such as book clubs and associations.
Physical assets, such as parks, libraries and leisure centres.
Personal assets, including the knowledge, skills, talents and aspirations of individuals.

Building on the success of local social prescribing initiatives, the GP contract fully funds social prescribing link workers in Primary Care Networks from 2019/20 onwards. PCNs will be able to recruit, and fully recoup costs for, a set number of social prescribing link workers to deliver personalised care delivery and link PCNs to the care community in which they operate.

HOW TO

How to develop an asset-based approach to care

1. Conduct an asset-mapping exercise with local residents and organisations (see Principle 3).

2. Ensure there is a thriving voluntary, community and social enterprise (VCSE) sector in the local area, supported by adequate multi-year investment, training and support from local government and NHS partners. This needs to include adequate funding for evaluation.

3. Work with local people to find creative ways of connecting residents to the wider range of community resources, such as timebanking.[10]

4. Create incentives for local VCSE, NHS and care organisations to work together to meet the health needs of the population in a co-ordinated and cost-effective fashion.

5. Support PCNs to make use of the additional role reimbursement scheme to recruit social prescribing link workers.

6. Explore new roles, such as 'community navigators' or 'care navigators'; people trained to help direct people to relevant local groups and resources.

7. Use digital platforms that make it easier for health professionals and others to identify and connect with wider local assets.

8. Provide training and information to ensure staff understand the value of an asset-based approach and have the support they need to make it part of their practice.

9. Ensure plans are co-produced, well publicised and that there is sufficient public awareness and buy-in from local voluntary groups.

10. Draw on existing resources, such as the collection of practical tools produced as part of NESTA's Realising the Value programme,[11] the Health Foundation's work on health as an asset[12] and NHS England's summary and reference guides for PCNs.[13]

Local areas may also choose to supplement social prescribing staff provided through the new contract framework with other community assets. One of the most effective methods of linking people to non-medical support is through training and supporting local people as peer supporters or signposters. Several demonstrator sites have recruited local 'health champions', who receive training to help promote health in their neighbourhoods (see Principle 3). People employed in public-facing jobs can also play a particularly important role promoting health through their interactions with local people. In the NHS this is sometimes referred to as MECC – making every contact count – and it can be adapted for people working in many settings.[8] For example, in Bicester MECC training has been provided to people employed in leisure services, the fire service, a community café, community groups and local businesses. Similarly, in Whitehill & Bordon MECC has been rolled out to health, community and voluntary sector workers. An evaluation of MECC found it had considerable potential for changing staff behaviours and promoting health among members of the public.[9]

CASE
STUDY

Lesson from Barking Riverside
Using a digital tool to support social prescribing

HealthUnlocked is a tool that can be embedded in patient record software so that GPs and other health care professionals can prescribe a social or support activity during a consultation, in the same way that a medical prescription would be given. The social prescription is then emailed to the patient. The aim of embedding HealthUnlocked in the primary care IT system is to make it as simple as possible for GPs to use.

The Thames View practice in Barking became a test site for HealthUnlocked in March 2018. GPs were trained on how the tool worked and posters about HealthUnlocked services were displayed in waiting and consultation rooms. To gain sufficient uptake, it was necessary to provide intensive support to GPs and other users, and to deploy 'nudge' techniques, such as regular check-in phone calls with practice staff.

HealthUnlocked is intended to support social prescribing in GP practices without needing to create a dedicated role, such as a community navigator. Formal evaluation of the pilot in several sites is under way across the borough.

An evaluation of the pilot at one site found that most social prescriptions were related to mental health, particularly depression or anxiety. The findings were presented to local people who as a result were inspired to set up their own community groups that people could be referred onto. A fund was created for community groups to bid to for support, specifically for those with depression and/or anxiety, and established that the impact of the group would be evaluated. As a result of this, three new groups providing talking therapies and peer support are being funded and delivered in community spaces in the Thames Ward area.

Below
HealthUnlocked enables GPs in Barking Riverside to prescribe a social activity, for instance encouraging people to go out into local green spaces.

CASE STUDY

Lesson from Whitehill & Bordon
Making social prescribing work in practice

Several initiatives in Whitehill & Bordon have tested ways of linking GP practices with other local resources.

The first used a local service called Surgery Signposters to help people understand, access and navigate community-based services that could improve their health. The scheme is delivered by local charity Community First Wessex at Forest and Badgerswood Surgeries, in Bordon. It offers residents 40-minute appointments with trained volunteers who can direct them to local community organisations and charities that provide help with stopping smoking, losing weight, support with caring or dementia issues.

Lessons from the Surgery Signposters pilot include:

— Create a clear publicity plan to ensure there is awareness and buy-in from all practice and voluntary groups.
— Provide training and information for staff to use the service effectively.
— Obtain patient feedback through surveys to gain insight into the scheme's impact.
— Ensure primary care staff are aware of the correct IT codes to use for social prescriptions.

The pilot also showed that simply directing people to relevant forms of support is not always enough to encourage people to make contact with the groups and resources available in their local community. A higher level of assistance and support is sometimes needed.

Building on this, a pilot initiative is being delivered by housing provider Radian in three GP practices in Whitehill & Bordon. The team at Radian offers practical support, for example by physically accompanying people when they attend a community group or activity for the first time. The pilot uses a piece of software which allows the GPs to make referrals from the practice's IT system directly to the referral handler at Radian who can update information on a patient's progress and share information easily.

A further initiative was a pilot of a social crisis service to support people experiencing mental distress and social issues that affected their health. It was commissioned by East Hampshire District Council and delivered primarily by charity Havant and East Hants Mind. Mind crisis workers were embedded in Pinehill Surgery in Bordon and provided more extensive support for social needs than a GP would typically be able to offer (including longer appointments). The pilot also involved sharing relevant GP data (with consent) with the voluntary sector and the council to support a more joined-up approach. The service achieved high levels of engagement with a client group that has traditionally been poorly engaged and received positive feedback from patients and GPs.

Early economic analysis suggests that for every £1 invested in the Mind social crisis pilot, the NHS stands to save £1.39 over 25 years in reduced treatment costs. The council and Department of Work and Pensions gain additional returns of £0.35 and £0.74 respectively per £1 invested.

Left
Practice manager Sue Hazeldine and Dr Anthony Leung at Badgerswood Surgery discuss their Surgery Signposting service.

Support self-management of health conditions

Supported self-management means increasing the knowledge, skills and confidence a person has in managing their own health and care. It is particularly relevant to people with a long-term health condition. Giving people the same choice and control over their mental and physical health as they have come to expect in every other part of their life is morally the right thing to do and can reduce health inequalities and deliver better outcomes and experiences.[14]

Creating an environment in which local people are empowered to manage their own health conditions requires the active involvement of the NHS, councils and the VCSE sector. A collection of case studies published by the Local Government Association[15] shows that in some areas of England, councils are playing a leading role. This can include ensuring that the principles of self-management are embedded in all council delivered or commissioned services, engaging local community groups and clubs, and creating self-care campaigns. NHS organisations can support this by implementing the NHS Comprehensive Model for Personalised Care,[16] working directly with patients to increase their skills and confidence in managing their conditions. A national specification setting out the requirements of PCNs in delivering personalised care will be included in the PCN network contract from 2019/20 onwards.

Demonstrator sites have taken various approaches to supporting self-management. In several cases they have used new digital technologies that can support a significant shift of power and control into patients' hands, as in the Darlington case study described below. Behavioural health coaching is another approach that Darlington and other demonstrator sites have explored. This involves structured support from a trained coach (often working in GP practices) to help people set their own goals for managing their health and overcome personal barriers to doing so.

Because no single approach to self-management is right for all groups and circumstances, partners across health, councils and developers will need to assess the merits of different approaches, including digital self-management tools, educational interventions, and one-to-one support. This will involve drawing on the available evidence (see box) as well as working with patients and clinicians to understand local needs and issues.

A crucial part of this is ensuring self-management support is accessible to those being targeted. People who find it harder to engage with health issues or have very complex problems are less likely to take up the support available in many cases. They may need a more tailored one-to-one approach, such as health coaching, whereas for others providing information and advice can be enough. A range of options is therefore required so that the intensity and type of support can be matched to the individual.

Supported self-management: what works?

GOOD TO KNOW

✓ Evidence from more than 200 systematic reviews found the most effective ways to support self-management include:

— Self-management education that is integrated into routine health care for people with specific conditions
— Generic self-management education courses co-led by peers or lay people
— Interactive online self-management programmes
— Telephone-based support and telehealth initiatives
— Self-monitoring of medication and symptoms.

✓ Disease/condition-specific programmes or peer support and mentoring services that allow people to learn from others may be more effective than generic educational courses, particularly in reducing people's use of health services and related costs.

✓ Various practical resources and tools on self-management, including case study examples, are available as part of NESTA's Realising the Value resource centre.[17]

HOW TO

How to develop supported self-management approaches

1 Offer people a range of support options, including digital self-management tools, educational interventions, and one-to-one support.

2 Involve patients and the voluntary and community sectors in developing the approaches.

3 Ensure that help with self-management is accessible to all and reaches the groups in greatest need of support.

4 Work with local health professionals to make self-management part of routine practice.

5 Train whole teams in providing self-management support, not just individual staff members.

6 Evaluate success using a validated tool such as the Patient Activation Measure (PAM)[18] to assess levels of knowledge, skills and confidence in self-management.

CASE STUDY

Lesson from Darlington
Using digital technology to support self-management

Health and wellbeing services in Darlington have used digital technologies to collect clinical data remotely, avoiding the need for patients to attend an appointment. This was successfully trialled with patients taking warfarin (often prescribed to people at risk of developing a blood clot) and those at risk of malnutrition and under a dietician's care.

Anyone taking warfarin needs to have their INR levels tested regularly. INR – international normalised ratio – is the standardised measurement of the time it takes for blood to clot. In Darlington a digitally enabled INR pathway places the monitoring of INR levels in the hands of the patient through a digital device that remotely reports back to the primary care provider.

This change has had two primary impacts:
— Empowering patients to take control of their own health outcomes. This has resulted in more people keeping their INR levels within safe limits, and the risk of stroke decreasing.
— Reducing pressure on primary care by avoiding the need for frequent check-ups in general practice.

Implementing the new approach to INR testing and other digitally enabled pathways has exposed several potential barriers to change, including challenges associated with linking up IT systems across the different organisations involved. One of Darlington's core principles has been the use of open platforms based on national interoperability standards to allow data to be moved between different systems used by health and care providers. This supports better integration across organisations and more patient-centred care.

Key successes reported across the digital projects in Darlington include:

— Patients feeling better supported and cared for
— Improved clinical capacity due to improved triaging of patients and ability to plan caseloads
— Patients meeting their goals more quickly
— Improved self-management.

Patients using the digital INR pathway have said they value the freedom, control and knowledge they have gained regarding their condition.

Use digital technology to support care

Technology is fundamental to the integration of health and care services, underpinning the ability to get information to the right person at the right time, and allowing people to engage with their health and wellbeing in new ways. But while there are technical challenges with getting technology in health and care right, there are equally important cultural challenges that need to be addressed.

Health care services in new developments can be highly innovative, because legacy contracts and digital programmes do not exist and so the necessary infrastructure can be built afresh. But it is important not to replicate what is already being done in the wider local area as this may replicate pre-existing challenges and barriers to improvement. New places should consider conducting a digital asset-mapping exercise to understand current initiatives and resources available locally and exploring what is already available nationally to understand any gaps. The NHS Digital Maturity Assessment is one tool available to help organisations to assess where they are in relation to three themes: readiness, capability and infrastructure.[19] This approach:

— Offers a framework to explore digital implementation, planned commitments, information governance, areas of opportunity and items requiring further development.
— Allows for a better understanding of the gap between the existing situation and the ambition.
— Encourages knowledge sharing and collective problem solving.
— Supports more targeted collective investment decisions.

For public-facing digital systems, it is also important to understand the digital skills of the local population and where gaps might lie. The Good Things Foundation and NHS England have developed tools to improve digital skills and participation across the general population.[20]

At the same time, digital projects need to carefully manage the cultural aspects of change; identifying passionate local champions, engaging intended users (for example staff, patients, carers), building organisational relationships and investing in staff skills and training. NHSX, which is responsible for technology, digital and data policy across the Department of Health and Social Care and NHS England/ NHS Improvement, provides key information and tools to support the digital development of health and care services.[21]

Addressing information governance

Information governance (IG) can be a difficult issue and dealing with it sensitively is core to building trust with other organisations. This should be considered at the outset of any project supported by technology, especially when sharing citizens' information. Some important guidance includes:

— The Data Security and Protection Toolkit (formerly the IG toolkit)[22]
— Information Governance Alliance resources[23]
— Local Government Association IG resources[24]
— Information Commissioner's Office health and social care FAQs and guidance.[25]

This guidance lays out how to remain compliant, as well as how the security of data is best ensured.

Digital innovation: where to start

Existing digital health innovations vary hugely by local area, but below are some programmes to start with:

— The global digital exemplars are a selection of NHS trusts that have received funding to develop their digital programmes.[26] These exemplars can provide useful direction and focus for local digital health projects.
— The local health and care record exemplars are places that have received funding to develop place-based technologies, such as shared care records.[27] People involved in these can advise on where digital projects might already be being developed locally.
— Academic health science networks are organisations that cover the country and support NHS organisations to adopt and spread innovations. They frequently have good links with industry and run their own accelerator programmes to incubate health technology. AHSNs have good oversight of local digital assets and can help with transformation.

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10

CREATE INTEGRATED HEALTH AND WELLBEING CENTRES

What this Principle covers:

10.1 Maximise the benefits of integrated health and wellbeing centres

10.2 Strategic estates planning

10.3 Develop a schedule of accommodation

10.4 Options for project funding

10.1

22 Create integrated health and wellbeing centres | Maximise the benefits of integrated health and wellbeing centres

Maximise the benefits of integrated health and wellbeing centres

To support the growth of the new and integrated approaches to health and wellbeing described in Principle 9, new developments need buildings that help to break down the traditional boundaries between different services. One of the important ways this can be done is through co-locating key services into health and wellbeing centres or community hubs, bringing together GP practices, other health care services, and a range of leisure, education, wellbeing and community activities in one place (see Principle 7). Successful health and wellbeing centres do not follow a standard template but should be co-developed with local people to respond to both current and anticipated local needs (see Principle 3).

For example, the planned health and wellbeing hub in Barking Riverside will include:

— Community-curated spaces where local people will be able to contribute to the appearance and function of the building, for example, through taking part in community art groups.
— 'Universal' space – areas that can be used flexibly for a range of purposes.
— Specialist clinical areas, shared between several services.
— Co-located back-office functions such as administrative support; enabling better communication between services and a more person-centred approach.

Across England there are several further examples of health and wellbeing hubs providing similar models of integrated services. The Community Heath Partnerships website is one useful source of case studies, many of which have been completed or are at a later stage of development than those in the demonstrator sites.[28] One example is Orford Jubilee Community Hub in Warrington, which combines health care, leisure, education and other services, including libraries and housing advice.

Realising the benefits of having multiple services sharing a facility can be challenging. Ongoing efforts are needed to deliver true integration in practice, and these efforts need to build from a well-articulated care model and agreed processes (Principle 2 and Principle 9) and should continue once the facility has opened and is providing services to local people (see checklist).

Key development steps
All business cases for health and wellbeing centres should follow the steps listed in NHS England business case process.[29] These steps need to be overseen by a project board of the key stakeholders involved in developing the centre, including NHS commissioners and providers, local authority planners and developers (see Principle 1). This shared governance structure needs to keep all parties committed to ensuring the strategic fit of any development against overarching estates plans.

Sharing a building does not by itself mean that services work together in a co-ordinated way for patients. To maximise the potential benefits for local people, the following are needed:

— Clarity on what the new facility is expected to deliver, outlining the desired objectives, how they will be achieved and evaluated.
— Shared understanding of the strategic opportunity to change how and other services are provided, rather than it just being a building project.
— Ongoing support at a senior strategic level, from both commissioners and the organisations providing services in the new facility.
— Significant investments in change management and service redesign, with a focus on new working processes and multidisciplinary team-working.
— Development of shared reception spaces and back-office functions where possible.
— Engagement with local communities to shape the facility's services and its future development.
— A permanent manager on site, with the seniority and influence to ensure services work together in an integrated way.

Create integrated health and wellbeing centres | Maximise the benefits of integrated health and wellbeing centres **23**

10.1

Lesson from Ebbsfleet Garden City
Developing the vision for the health and wellbeing hub

CASE STUDY

Ebbsfleet Development Corporation aims to build up to 15,000 new homes and create 30,000 new jobs at the Garden City. The Healthy New Towns programme has supported the development of a vision for a Health Education and Innovation Quarter (HEIQ), which will include opportunities for health innovation, research and education, encompassing both a regional diagnostics centre and a health and wellbeing hub providing primary care services for a population of 50,000.

To develop the concept for the hub, external design consultants led a collaborative 'visioning' and co-design process. This helped to produce a set of requirements that reflected the aspirations of the clinical commissioning group, together with those of key stakeholders and user groups, including local GPs, third sector partners and local communities.

The visioning process used the following approach:

— An examination of a series of national and international best practice examples that illustrated the concept of innovative health and wellbeing facilities.
— A collaborative design process conducted through two events, which enabled co-design around not only the services being proposed but also the look and feel of the proposals.
— Production of a 'vision report', which has allowed local partners to visually express their ambition for the hub, and which provides clarity for potential investment partners about how the hub could form a core part of a lively city centre.

The engagement events were the largest public events held in Ebbsfleet Garden City to date. Funding for work like this can be applied for through the One Public Estate programme (see Simply explained box).

The proposals developed for the hub include allocating 70% of floorspace to wellbeing services, compared to 30% for health services. Planned wellbeing activities include community planting and food growing (see Principle 6), cooking lessons, music lessons and performances, arts and craft workshops, fitness and yoga classes and IT training.

One Public Estate (OPE)

SIMPLY EXPLAINED

This national programme gives councils technical support and funding to enable public services to get more from their assets, through enabling collaboration between organisations.

'We wanted to make sure we were responding to what the local aspirations and ambitions were; our number one thing is that we're about community building'

Kevin McGeough
Healthy New Towns programme director, Ebbsfleet Garden City

Strategic estates planning

Planning for health and wellbeing centres needs commissioners to identify local needs and agree the ambition for new approaches, as described in Principles 2 and 9. These then inform decisions about whether new facilities are needed, and what form they should take.

The Strategic Estates Planning Service (SEPS) is hosted by NHS England and NHS Improvement, helping the NHS to transform its estate to meet local clinical need. It can help identify which estates projects to prioritise and assess a range of options for estate development. Given how large and varied the NHS estate is and with the Naylor Review identifying 'surplus land' worth around £2.7bn[30] it may not be necessary to build new facilities if existing premises and locations can be repurposed or redeveloped. Examining the options to use existing NHS land differently needs to involve CCGs, councils, health care providers, the STP/ICS estates lead, and NHS Property Services where appropriate. Any proposals for new integrated health and wellbeing centres will need to be explicitly identified as a priority within STP/ICS local estates strategies to maximise opportunities for public sector capital funding.

As part of the Strategic Estates Planning Service, support is available from local NHS Strategic Estates Advisers who offer impartial advice to estates teams in STPs and ICSs to help develop and implement their estates strategies. The service works across all parts of the health system, encouraging partnerships across the wider public sector. The team is developing guidance for standardised primary and community care facilities (which will allow local adjustment) that can be rolled out at scale. Through use of standardised designs and costings they expect the business case and approvals processes to happen more quickly.

Tools for assessing the impact of new developments on demand for health care
The Healthy Urban Development Unit (HUDU) Model is a tool to assess the health service requirements and cost implications of new residential developments. The model, while designed for London, can be used by agencies across the country by inputting local data.[31]

The Strategic Health Asset Planning and Evaluation (SHAPE) tool is an application provided by Public Heath England to inform the strategic planning of services and physical assets across a whole health economy. SHAPE

can also be used to support a One Public Estate approach through being able to import local authority data.[32]

By undertaking a local estate asset review to understand the use of existing premises, Darlington identified that the needs of the new population could be met without building new health care facilities. It is working towards developing a 'virtual hub', in which care is delivered through integrated working across several existing facilities (see Principle 9). Similarly, in Barton, the approach has been to adapt and extend an existing neighbourhood centre rather than build an entirely new facility (see Lesson from Barton and case study from Halton).

Learning from Healthy New Towns demonstrator sites highlights that the following are needed as part of strategic estates planning:

— Council planning officers, Clinical Commissioning Groups (CCGs), GPs, Primary Care Networks and STP/ICS need to work closely through a formal governance mechanism from an early stage to ensure that there is a common understanding of proposals for developing integrated approaches to care and to maximise potential use of existing or new estate/facilities.
— Staff from CCGs, STP/ICSs and NHS Trusts need to work with council planning officers to discuss potential Section 106 and Community Infrastructure Levy (CIL) contributions from developers (see Options for project funding) to obtain appropriate funding for health centres and facilities.
— All local public sector stakeholders should align their estate needs through the One Public Estate approach (in which the available public estate is used fully and efficiently).
— Commissioners, providers and local government should also consider whether the NHS estate can be used for other health-related purposes that will support the delivery of clinical services – such as opportunities to develop research and education facilities, step-down units allowing people to be discharged from hospital, or assisted living/key worker accommodation – subject to ensuring that appropriate land values or social values are achieved and within relevant capital constraints.

Development of health facilities and estates may need to be phased to coincide with the growth of a community over time. Several demonstrator sites are planning phased

developments, with parts of new health facilities initially being built as external fabric only (a 'shell and core' approach). These parts of the building will be completed and fitted out once the level of demand has grown sufficiently and the exact requirements for the space are known.

Lessons from Barton
Adapting existing facilities

CASE STUDY

The redevelopment of the Barton Neighbourhood Centre has taken two years and was paid for by pooling Section 106 funding and council regeneration money. The health and wellbeing hub at the neighbourhood centre was extended and the clinical space is now three times larger, providing extra capacity for Barton's new and existing residents.

One of the objectives of the Barton Healthy New Towns Programme was to trial new approaches to care. The aim of this strand of activity was to commission new activities to which patients could be referred to help them cope with long-term health conditions, both for their own benefit and to relieve pressure on surgeries and hospitals.

The redevelopment shows how adapting and extending existing public buildings can create facilities that support new approaches to support this. For example, the social prescriber, who works at the health and wellbeing hub, was able to work alongside providers who operated within the centre to offer a range of services to help them cope with health issues.

Social prescribing, in brief, is a process whereby GPs (and sometimes other health professionals), prescribe some social activity or organise a referral to a mental health/social care support agency to improve health rather than, or in addition to, medical measures.

The social prescriber supported 320 people to access a wide range of services including the food bank, and health-promoting activities such as dance, fitness classes, breakfast clubs and Barton Advice Centre (which supports people with benefits, housing or other challenges).

Right
The Barton Neighbourhood Centre runs a wide range of health promoting activities. George Martini runs the regular Zumba class.

CASE STUDY

Lesson from Halton Lea
The ambition for Halton Hospital and Wellbeing Campus

At the centre of Halton's vision for its healthy new town is the Hospital and Wellbeing Campus (HWBC). This multi-use facility is intended to provide health care, leisure, work and education opportunities from one site for the residents of Halton Lea and beyond. As Warrington and Halton Hospitals NHS Foundation Trust owns the land earmarked for this development, the project shows how the NHS estate can be used in different ways to support the local community.

The ambition for this campus is to rebuild and transform an existing hospital site to provide:

— Enhanced health care facilities
— A leisure centre
— A range of housing, including social housing, assisted living and key worker accommodation
— A series of green spaces
— A venue for community activities.

Governance
Positive engagement between the trust and the local authority supported open dialogue about the potentially transformative effect of the campus. There was also engagement with existing partners who were keen

to explore expanding the offer available to the local community, through introducing new ideas such as a cyber café, market halls and Halton garden bridge.

An operational group led by the Trust's director of transformation defined the vision, developed proposals and tested them with clinicians and care professionals through engagement events. Project partners considered this an effective and positive approach to governance.

Stakeholder engagement
An important aspect of developing the vision has been the manner in which stakeholder engagement has taken place. From the outset, clinical strategies have been shared with all stakeholders.

Engagement sessions were used to rapidly and collaboratively establish a shared vision, which enabled architects to be appointed to develop a conceptual design. Community engagement activities also influenced the process, with publicly accessible growing spaces and places of safety being included as a result of feedback from local people.

Layout of proposed campus in Halton
Credit: Copyright Gilling Dod Architects

New nature buffer
Green space

New woodland walk

Community centre
Arts and crafts

Multi-generational housing
Residential

Feature clock tower

Residential

Growing spaces

Multi-generational housing
Residential

Water feature
(including rainwater collection)

Nursing home
and nursery

Residential

Pet gardens

Mental health
reflection gardens

Hospital & wellbeing building
(including mental health)

Intermediate care &
rehabilitation (Health
care building)

Leisure centre
Community

Develop a schedule of accommodation

Integrated health and wellbeing centres must be developed around a schedule of accommodation that supports the new services being proposed, including new care models and approaches to service delivery. NHS Health Building Notes should be used to support this process.[33] These provide guidance on the design and planning of new health care facilities and strategies for co-locating other services. The guidance helps commissioners and planners to consider the proposed approach to care and to calculate the number of consulting and treatment rooms needed for clinical services.

However, demonstrator sites highlighted a key challenge: the approach to care is continually evolving in response to multiple external issues, and often changes faster than the development process. Integrated services and new approaches to care will require flexible use of consulting, interview and group rooms. Demonstrator sites have used the floor areas set by Health Building Note HBN11-01, which provides best practice guidance on the selection and zoning of facilities for delivering primary and community care services, to create a framework that can be reinterpreted to suit services being proposed in their developments[35]. Some demonstrator sites have increased the number of interview and group rooms while reducing traditional consulting room numbers.

This approach can help to demonstrate the long-term viability of the facility, potentially making the pursuit of funding more successful (many projects are still assessed for viability against Health Building Note HBN11-01). This is particularly important given that a health and wellbeing centre will have an expected lifespan of some 60 years, over which period approaches to health and care are likely to change considerably.

Clinical rooms for treatment such as for podiatry and dentistry are by their nature highly specialised environments and are subject to nationally agreed clinical space standards to provide suitable functionality. Project teams should take care to ensure an appropriate number of such specialist rooms is provided, based on the local assessment of current and future need.

Schedule of accommodation

A **Schedule of accommodation** is an itemised list of accommodation facilities and provisions required by the end user of a building project. It may include the number, location and size of rooms, furniture and fixtures, and environmental conditions (temperature and lighting etc) required.[34]

SIMPLY EXPLAINED

In addition, new digital technologies play an important role in enabling integrated health and wellbeing centres to be more effective and efficient. Each integrated health and wellbeing centre development needs to consider:

— How services working in a health centre can use digital technologies to provide a more co-ordinated and person-centred experience (for example by sharing data and insights).
— Whether digital systems such as apps and wearable technologies can help patients manage their own health conditions, as has been done in Hampshire with technology-enabled care in the home.
— Whether management and administrative staff can use digital technologies to gain real-time information on use of space in the building, supporting the employment of universal bookable rooms and flexible working spaces.
— The need for high speed internet connectivity in the centre itself and strong connectivity across the wider area.
— The ability to incorporate technological innovation in the centre as needs change or new innovations come online, changing the scope of what can be delivered on site

Developing a 'concept of operations' (ConOps) can be helpful in showing how a range of services and digital technologies can be integrated in a health and wellbeing centre. Given the long timeframes involved in building a new health centre (often two to five years), digital planning needs to be done iteratively and revisited periodically to ensure the most up-to-date technology is used.

Testing new ideas
Developing a health and wellbeing centre in which services are truly integrated requires making significant changes to working practices. This means it is important that commissioners and practitioners test or 'prototype' ideas before starting to develop a new facility.

SIMPLY EXPLAINED

ConOps

A concept of operations (**ConOps**) is a document describing the likely way a system will operate in easily understood language, allowing those without a technical background to know what it is and how it functions.[36]

A ConOps can be used to help partners to clarify how a health and wellbeing centre might operate in practice, once built, using 'day-in-the-life' scenarios. These allow partners to better understand how the centre will work and what people, technology, processes and physical attributes are needed to allow it to function effectively.

Demonstrator sites use a variety of approaches to test their ideas for health and wellbeing centres.

Barking Riverside, for example, aims to test the feasibility of its planned health and wellbeing hub by introducing the proposals first in an existing local health centre that has under-used space. Many changes are being tested, including introducing universal use bookable rooms, shifting administration staff to more flexible working practices, introducing community-curated spaces, and trialling a digital appointment-booking system. Importantly, the approach to testing these changes includes understanding the impact on patient experience by engaging with local people and seeking their views through a local community health champions group.

Similarly, at Cranbrook, where there is already a general practice, plans are in place to establish a larger interim facility to serve the community until the proposed hub is ready in 2023. The interim facility will enable early testing, evaluation and refinement of new approaches to care, and will further inform the detailed planning of the health hub.

Given the long lead time typically needed to deliver new facilities, opportunities to prototype and evaluate can also be done using digital technologies. Testing of working practices through a virtual model of the planned health centre known as a 'digital twin' allows simulation exercises to be conducted and refinements to be made to the proposals well in advance of any construction. For example, in the Mater Private Hospital in Dublin a digital twin was used to simulate workflows in the radiology department so that the optimal layout of the department could be established without conducting time-consuming and disruptive real-world tests.

Options for project funding

NHS organisations and local authorities can sometimes secure money from developers as part of the planning process to help fund new health facilities and to offset costs involved in improving existing facilities. Developer contributions (Section 106 payments) secured as part of planning permissions have provided significant funding for new health care infrastructure needed to support growth in many areas (see Principle 2 for a wider development process perspective on this).

Funding can also be sought through the community infrastructure levy (CIL) in areas where the planning authority has chosen to implement it. CIL involves changing from an upfront negotiation of developer contributions on a site-by-site basis to one where health organisations (including CCGs) will need to make the case to the local planning authority (LPA) for investment and release of appropriate funds to support investment in health care infrastructure.

Some demonstrator sites reported challenges with securing sufficient Section 106/CIL contributions for health care infrastructure. For CIL contributions, health care facilities are included in the category of 'community works', which receive only 60% contributions, meaning that health care organisations may need to find other sources for the remaining 40% of costs.

Further information on securing funding through section 106 and CIL is available in an NHS guide.[37] To ensure there is suitable consideration of funding requirements for new health and care infrastructure, health care organisations must engage with the planning process at both Local Plan and individual planning application level. Local planners are statutorily required to consider the view of the local CCG, and it is critical that CCGs engage in this process.

Demonstrator sites have used several funding routes to support planned health facilities. For example, Barton used multiple sources to support the development of a health and wellbeing hub, including a combination of Section 106 and Oxford City Council regeneration funding. Halton Hospital and Wellbeing Campus sought initial financing from central NHS estates capital funds.

The Northstowe demonstrator site has obtained significant funding through partnership working. Here the master developer (government agency Homes England) is providing land and funding of £14.5 million to bring forward the planned community hub with community facilities, a health centre and a library in one building.

Other funding opportunities for new health facilities, over and above Section 106 and CIL, will need to be explored locally and must make a clear case for improving outcomes for patients. There are capital funding options available via the NHS, which would need to be developed in compliance with the relevant NHS capital regime guidance. Advice and guidance on how to access NHS capital funding can be provided by the NHS Strategic Estates Planning team.

Capital funding for projects led by health care agencies may also be explored through dialogue with the Department of Health & Social Care.

For proposals to succeed, stakeholders must openly discuss their financial position and ability to fund new facilities before the project initiation stage. This ensures there is clarity on commercial viability for the lead organisation without establishing undue financial risk. Bringing in external professional advisers to support early financial modelling may help to ensure projects do not get aborted after significant work has been undertaken.

SIMPLY EXPLAINED

Section 106 and CIL

A **Section 106 agreement** is a contract between a developer and the council and relates to the planning permission for a particular project. The developer agrees to make a payment to the council or provide an in-kind contribution to mitigate the project's impact. For instance, the developer could provide money to the council to be used to improve a nearby park or provide health care facilities, or, as part of the development the developer could provide a building for use by the community. In areas of low land value there may be little or no funding available through Section 106 agreements.

Community infrastructure levy is operated by some, but not all, councils responsible for planning. In areas where it applies, land owners or developers of large sites will be required to pay the levy which the council will pool with other CIL payments and use to provide infrastructure in the local area. The council will establish a list of types of infrastructure that the CIL money can be used to fund, which could include health care buildings, schools, parks, road improvements etc. Again, in areas of low land value CIL is unlikely to be available.

'Working with an external contractor with specialist expertise in obtaining funding through Section 106 and CIL has paid for itself many times over, bringing in over £4 million of capital funding from developers which goes directly to practices. Having expertise to draw on has also helped build relationships between the CCG and local planning departments'

Kate Laverty
Head of primary care and locality development, NHS Horsham and Mid Sussex CCG

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